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S. HRG. 111–610

# THE PREVENTABLE EPIDEMIC: YOUTH SUICIDES AND THE URGENT NEED FOR MENTAL HEALTH CARE RESOURCES IN INDIAN COUNTRY

## HEARING

BEFORE THE

## COMMITTEE ON INDIAN AFFAIRS
## UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

March 25, 2010

Printed for the use of the Committee on Indian Affairs

U.S. GOVERNMENT PRINTING OFFICE

58–331 PDF WASHINGTON : 2010

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
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# THE PREVENTABLE EPIDEMIC: YOUTH SUICIDES AND THE URGENT NEED FOR MENTAL HEALTH CARE RESOURCES IN INDIAN COUNTRY

**THURSDAY, MARCH 25, 2010**

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

The Committee met, pursuant to notice, at 9:37 a.m. in room 628, Dirksen Senate Office Building, Hon. Byron L. Dorgan, Chairman of the Committee, presiding.

## OPENING STATEMENT OF HON. AL FRANKEN, U.S. SENATOR FROM MINNESOTA

Senator FRANKEN. [Presiding.] I call the hearing to order.

The Chairman, Senator Dorgan, will be here shortly. This is a hearing on a topic of great importance to our American Indian communities in Minnesota and across the Country. On behalf of the Minnesota tribes, I want to thank the Chairman for his leadership in getting the Indian Health Improvement Act included in the health reform law.

American Indian teens commit suicide at rate nearly three times the national average, and the rate is much higher in the Upper Midwest and the Great Plains, five to seven times higher than the national average.

Each suicide is an unspeakable tragedy from which families and communities will never recover. We must learn from these tragedies. We must find models and fund programs that work to prevent suicide in Native communities.

As you may know, this month is the fifth anniversary of the Red Lake massacre, and so I want to share with you an example of how the learning continues in the Red Lake community even in the face of ongoing challenges.

Last spring, Red Lake High School tragically lost another student to suicide. Based on the changes at the school following the 2005 tragedy, the school immediately brought in what is called a CBTS team, Cognitive Behavioral Trauma in School, following the suicide. The CBTS team of mental health providers from Montana has a history with tribal communities and worked with the school to assess the community's needs following the suicide.

During the assessment, mental health workers discovered that there was a suicide pact, that six other students had plans to take

their own lives. Fortunately, the team was able to intervene and get students appropriate treatment. And now these six students are back in school. Clearly, this model worked by intervening early and minimizing more damage, and clearly we have a problem as long as any suicide is occurring among our youth.

I look forward to hearing from today's witnesses. I thank you all for being here today and sharing your wisdom. I look forward to hearing from you about other models that are working in tribal communities and how we can get them the resources we need to turn this tide.

The Chairman will be here any minute now. Unfortunately, we are going to have to go for a vote fairly early. And so I read all your written testimonies last night, and thank you for those. I think what we are going to do today is, if you can keep your testimony brief right now, we have your written testimony. I think that the Chairman will be here any second, but we will start the testimony now. And at a certain point, all the Members of the Committee who either come, will have to leave to go to the Floor to vote on the business before us.

Again, I just want to thank you all. I want to thank you for your wisdom and your stories. And why don't we just begin with Mr. Grinnell?

**STATEMENT OF RANDY E. GRINNELL, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY ROSE WEAHKEE, DIRECTOR, DIVISION OF BEHAVIORAL HEALTH**

Mr. GRINNELL. Thank you, Senator.

Good morning. I am Randy Grinnell. I am the Deputy Director for Indian Health Service. I am accompanied today by Dr. Rose Weahkee. She is the Director for the Division of Behavioral Health.

Today, I appreciate the opportunity to testify on youth and the need for mental health care resources in Indian Country. Mental health care services are crucial for the well being of American Indian and Alaska Native communities.

As you know, the IHS plays a unique role in the Department of Health and Human Services because it is a healthcare system established to meet the Federal trust responsibility to provide healthcare for American Indians and Alaska Natives.

Good morning, Mr. Chairman.

The IHS, in partnership with Indian tribes, provides high quality comprehensive care in public health services through a system of IHS, tribal and urban-operated facilities and programs based on treaties, judicial determinations and acts of Congress to an estimated 1.9 million federally-recognized American Indians and Alaska Natives.

Our duty is to uphold the Federal Government's obligation to promote health among American Indian and Alaska Native people, communities and cultures to honor and protect the inherent sovereignty of tribes.

This week, the President signed the Patient Protection and Affordable Care Act, the health insurance reform bill passed by Congress. This new law permanently authorizes the Indian Health Care Improvement Act. In addition to the many improvements

made in the Indian health system, this law authorizes a comprehensive youth prevention effort as part of the behavioral health services.

I would like to acknowledge Chairman Dorgan's leadership on this issue and the Committee's effort to improve access to healthcare for American Indians and Alaska Natives.

Suicide is a complicated public health challenge, with many contributing risk factors. American Indians and Alaska Natives face a greater number of these risk factors. Indian Country has communities where suicide can take on a contagious form often referred to as suicide clusters. The suicide act becomes a form of expression of the despair and hopelessness experienced by some Indian youth. Suicide and suicidal behavior and their consequences send shock waves through many tribal and urban communities.

The current system of services for treating mental health problems is a complex and often fragmented system of tribal, Federal, State, local and community-based services. American Indian youth are more likely than non-Indian children to receive treatment through the juvenile justice system and inpatient facilities.

IHS and SAMHSA are working closely together to formulate long-term strategic approaches to address the issue of suicide and mental health care in Indian Country. IHS and SAMHSA are actively involved on the Federal Partners for Suicide Prevention Work Group. In partnership with tribes, IHS is currently developing two five-year strategic plans, one to address suicide and one to address behavioral health. These two plans will foster collaboration among tribes, tribal organizations, urban and other key community resources, and provide the tools and framework for the next five years.

The IHS Mental Health Program provides primary community-oriented outpatient mental health and related services, case management, prevention programming and outreach services. Many IHS tribal and urban mental health programs do not have staff to operate 24/7. Some providers are so overwhelmed by the demand for services, particularly during suicide outbreaks, that even well-seasoned providers become at risk for burnout.

Strategies to remedy these problems include special pay incentives, loan repayment and scholarships, active recruitment, development of the Indians Into Psychology Program, and emergency deployment of commissioned officers.

IHS first received $13.7 million in 2008 and now receives recurring funding of $16.3 million to develop pilot projects for model practices for meth and suicide reduction in Indian Country. The Methamphetamine and Suicide Prevention Initiative, or MSPI, marks a significant milestone in suicide prevention efforts in Indian Country that embraces the President's direction for tribal engagement and partnership.

IHS worked closely with tribes and tribal leaders over some time to craft this model. MSPI now supports 127 community programs targeted at prevention and intervention pilot programs, the first of its kind in Indian Country, and represents a shift from Federal to tribally based program delivery. Local communities determine needs and establish programs to meet those needs.

Tele-behavioral health services are being used or in planning stages at over 50 tribal and IHS sites. In Alaska, where often there is no other options, tele-health based behavioral health services have worked. A Southwest tribe currently provides youth and child tele-behavioral health services and now shows an appointment rate of over 95 percent being kept.

Services are also being delivered in schools and youth treatment centers. In some locations, only within the past five years, has the telecommunications infrastructure been reliable enough for clinical care.

We are targeting $19 million of the health funding to provide hardware for basic infrastructure development and also to acquire state of the art videoconferencing equipment for the tribal, urban and Federal sides to improve access for videoconferencing.

The 2011 budget request for mental health is $77 million, an increase of over $4.2 million above the 2010 enacted level. The 2011 budget request for alcohol and substance abuse is $205 million, an increase of over $11 million from the 2010 level, and includes an increase of $4 million to hire additional qualified behavioral health counselors and addiction specialists.

In summary, we look forward to the opportunity to address this urgent need for mental health care services in Indian Country.

Mr. Chairman, that concludes my statement. Thank you for the opportunity to testify and we will be happy to answer any questions.

[The prepared statement of Mr. Grinnell follows:]

PREPARED STATEMENT OF RANDY E. GRINNELL, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY ROSE WEAHKEE, DIRECTOR, DIVISION OF BEHAVIORAL HEALTH

Mr. Chairman and Members of the Committee:

Good morning, I am Randy Grinnell, Deputy Director of the Indian Health Service (IHS). I am accompanied by Rose Weahkee, Ph.D., Director, Division of Behavioral Health. Today, I appreciate the opportunity to testify on youth and mental health care resources in Indian Country. Access to mental health care services is an important component of fostering well-being in American Indian and Alaska Native communities.

As you know, the Indian Health Service plays a unique role in the Department of Health and Human Services because it is a health care system that was established to meet the federal trust responsibility to provide health care to American Indians and Alaska Natives. The IHS provides high-quality, comprehensive primary care and public health services through a system of IHS, Tribal, and Urban operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The IHS has the responsibility for the delivery of health services to an estimated 1.9 million federally-recognized American Indians and Alaska Natives. 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 duty 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 and 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 appropriations for "the relief of distress and conservation of health" of American Indians and 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 provides the authority for the provision of programs, services, functions and activities to address the health needs of American Indians and Alaska Natives. The IHCIA also includes authorities for the recruitment and retention of health professionals serving Indian communities, health services for people, and the construction, replacement, and repair of healthcare facilities.

This week, the President signed the Patient Protection and Affordable Care Act, the health insurance reform bill passed by Congress. This new law permanently authorizes the IHCIA. In addition to the many improvements made to the Indian health system, the law authorizes a comprehensive youth suicide prevention effort as part of the behavioral health services. I want to acknowledge Chairman Dorgan's leadership on this issue, and the Committee's effort to improve access to health care for American Indians and Alaska Natives.

**Background**

Suicide is a complicated public health challenge with many contributing risk factors. In the case of American Indians and Alaska Natives, they face, on average, a greater number of these risk factors individually or the risk factors are more severe in nature for them. Every year, several communities in Indian Country experience crisis episodes during which suicides take on a particularly ominous and seemingly contagious form, often referred to as suicide clusters. In these communities, the suicidal act becomes a regular and transmittable form of expression of the despair and hopelessness experienced by some Indian youth. While most vividly and painfully expressed in these communities, suicide and suicidal behavior and their consequences send shockwaves through many communities in Indian Country, including urban communities. Access to adequate care is critical for those seeking help for their loved ones in crisis, or those left behind as emotional survivors of such acts.

IHS "Trends in Indian Health, 2002–2003" reports:

- The American Indian and Alaska Native suicide rate (17.9) for the three year period (2002–2004) in the IHS service areas is 1.7 times that of the U.S. all races rate (10.8) for 2003.
- Suicide is the second leading cause of death (behind unintentional injuries) for Indian youth ages 15–24 residing in IHS service areas and is 3.5 times higher than the national average.
- Suicide is the 6th leading cause of death overall for males residing in IHS service areas and ranks ahead of homicide.
- American Indian and Alaska Native young people ages 15–34 make up 64 percent of all suicides in Indian Country.

On a national level, many American Indian and Alaska Native communities are also affected by very high levels of poverty, unemployment, accidental death, domestic violence, alcoholism, and child neglect.[1] Significant health disparities among American Indians and Alaska Natives exist across the spectrum of substance abuse problems. The most current IHS health data statistics indicate:

- Alcohol-related age-adjusted mortality rate (43.7) for years 2002–2004 for AI/AN in the IHS service areas as compared to the U.S. all races rate (7.0) for the year 2003.[2]
- Drug-related age-adjusted mortality rate (15.0) for years 2002–2004 for AI/AN in the IHS service areas as compared to the U.S. all races rate (9.9) for the year 2003.[3]
- *NOTE:* Rates are per 100,000 population and are adjusted to compensate for misreporting of American Indian and Alaska Native race on the state death certificates.

According to a 2001 mental health supplement report of the U.S. Surgeon General, "Mental Health: Culture, Race, and Ethnicity", there are limited mental health

[1] Manson, S.M. (2004). *Cultural Diversity Series: Meeting the Mental Health Needs of American Indians and Alaska Natives.* National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning.

[2] U.S. Department of Health and Human Services. Indian Health Service. Trends in Indian Health, 2002–2003 Edition. Washington: Government Printing Office, Released October 2009. ISSN 1095–2896. p. 91.

[3] U.S. Department of Health and Human Services. Indian Health Service. Trends in Indian Health, 2002–2003 Edition. Washington: Government Printing Office, Released October 2009. ISSN 1095–2896. p. 196.

services in Tribal and urban Indian communities.[4] While the need for mental health care is great, services are lacking, and access to these services can be difficult and costly.[5] The current system of services for treating mental health problems of American Indians and Alaska Natives is a complex and often fragmented system of tribal, federal, state, local, and community-based services. The availability and adequacy of mental health programs for American Indians and Alaska Natives varies considerably across communities.[6] American Indian youth are more likely than non-Indian children to receive treatment through the juvenile justice system and in-patient facilities.[7]

**Addressing Mental Health Care Resources in Indian Country**

IHS and Substance Abuse and Mental Health Services Administration (SAMHSA) work closely together to formulate long term strategic approaches to address the issue of suicide and mental health care in Indian Country more effectively. For example, IHS and SAMHSA are actively involved on the Federal Partners for Suicide Prevention Workgroup. In 2001, the Office of the Surgeon General coordinated the efforts of numerous agencies, including IHS, SAMHSA, Centers for Disease Control and Prevention (CDC), National Institute for Mental Health (NIMH), Health Resources and Services Administration (HRSA), and other public and private partners to develop the first, comprehensive, integrated, public health approach to reducing deaths by suicide and suicide attempts in the United States in the National Strategy for Suicide Prevention. This resulted in the formation of the ongoing Federal Partners for Suicide Prevention Workgroup.

Currently, in partnership with tribes, IHS is developing strategic plans to address suicide and behavioral health for the Indian health system. These strategic plans will foster collaborations among Tribes, Tribal organizations, Urban Indian organizations, and other key community resources. These collaborations will provide us with the tools we need to adapt the shared wisdom of these perspectives, consolidate our experience, target our efforts towards meeting the changing needs of our population, and develop the framework that will serve to pave the way over the coming years to address suicide and behavioral health in Indian Country.

The IHS is responsible for providing mental health services to the American Indian and Alaska Native population it serves. The IHS Mental Health/Social Service (MH/SS) program is a community-oriented clinical and preventive mental health service program that provides primarily outpatient mental health and related services, crisis triage, case management, prevention programming, and outreach services. The most common MH/SS program model is an acute, crisis-oriented outpatient service staffed by one or more mental health professionals. Many of the IHS, Tribal, and Urban (I/T/U) mental health programs that provide services do not have enough staff to operate 24 hours/7 days a week. Therefore, when an emergency or crisis occurs, the clinic and service units will often contract out such services to non-IHS hospitals and crisis centers.

There are many reasons for a lack of access to care. Indian Country is predominantly rural and remote, and this brings with it the struggles of providing support in settings where appropriate local care may be limited. Rural practice is often isolating for its practitioners. The broad range of clinical conditions faced with limited local resources challenge even seasoned providers. Some providers are so overwhelmed by the continuous demand for services, particularly during suicide outbreaks, that even well-seasoned and balanced providers become at-risk for burn-out.

For example, there are situations where the appropriate treatment is known, such as counseling therapy for a youth survivor of sexual abuse, but there are simply no appropriately trained therapists in the community. One of our IHS Area Behavioral Health Consultants told me recently that there was only one psychiatrist in her half of a large Western state attempting to serve both the Indian and non-Indian population. Despite years of effort, the IHS Area Office had been unsuccessful in recruiting a fulltime psychiatrist to serve the tribes in that region.

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[4] U.S. Department of Health and Human Services. (2001). *Mental Health: Cultural, race, and ethnicity supplement to mental health: Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

[5] Manson, S.M. (2004). *Cultural Diversity Series: Meeting the Mental Health Needs of American Indians and Alaska Natives.* National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning.

[6] Ibid.

[7] Ibid.

Over the years, we have attempted to apply a number of remedies to these problems including adopting special pay incentives in order to make reimbursement packages more competitive, making loan repayment and scholarship programming available for a wide range of behavioral health specialties including social work, psychology, and psychiatry, along with active recruitment, development of the Indians into Psychology program, and emergency deployment of the United States Public Health Service Commissioned Corps.

**Methamphetamine and Suicide Prevention Initiative**

The IHS received an appropriation in the amount of $13.782 million in FY 2008, an increase of $2.609 million in FY 2009, and $16.391 million in FY 2010 for a national initiative to support the development of pilot projects for model practices for methamphetamine and suicide reduction programs in Indian Country.

The Methamphetamine and Suicide Prevention Initiative (MSPI) implemented by IHS and its tribal partners nationally, marks a significant milestone in suicide prevention efforts in Indian Country as well as tribal/federal partnerships for health that embraces the Administration's commitment to tribal engagement and partnership.

MSPI now supports 129 community developed prevention and intervention pilot programs across the country. Each program represents partnerships between tribal communities and programs and the IHS, to develop, implement, and disseminate promising prevention and treatment service programs nationally.

To create the overall MSPI approach, IHS engaged in close collaboration with Tribes and Tribal Leaders over the course of almost a year. During this time, we crafted a model, and the IHS accepted all of the Tribal Leaders' recommendations for approaches and funding allocations with only minor adjustments for disbursement methodologies. It was and remains a creation of close collaboration and partnership with Tribes.

It is a new program focusing on suicide and substance abuse in Indian Country. The program is completely community driven from conception through execution for each program in each community. Indian communities decide what they need and establish programs to meet those needs.

**Indian Tele-health Based Behavioral Health Services**

IHS recognizes the need to support access to services and to create a broader range of services tied into a larger network of support and care. As evidenced by the Alaska experience, where there are often no workable options other than tele-health based behavioral health services, we know such services work and are acceptable to many if not all of our clinic populations. As another example, a Southwest tribe has been providing child and youth-specific tele-behavioral health services for the past two years and has achieved a show rate of >95 percent for scheduled appointments. This is an outstanding rate when other clinics with face to face provider availability only achieve a 65–70 percent show rate.

As a system of care, tele-health based behavioral health services are either actively being used or in planning stages for over 50 Indian health system sites (both tribal and federal). They include a range of programming, from a broad variety of mental health services, to specific and intermittently available services such as child psychiatry consultations. Services are being delivered in a range of settings including clinics, schools, and youth treatment centers. Only within the past five years has the telecommunications infrastructure, in some locations, become available and reliable enough to be used routinely for clinical care. The lack of infrastructure is a significant issue for many tribal communities.

MSPI dollars in the amount of $863,000 are also being used to establish a National Tele-Behavioral Health Center of Excellence. An intra-agency agreement was signed in early August 2009 with our Albuquerque Area Office, which has agreed to take the lead on establishing a national center to promote and develop tele-health based behavioral health services. They are working in partnership with a number of regional entities including the University of New Mexico and the University of Colorado. The University of New Mexico Center for Rural and Community Psychiatry is a leader in the use of tele-health technologies in rural settings. The University of Colorado Health Sciences Center and the VA Eastern Colorado Healthcare System are leaders in tele-health outreach to veterans including Indian veterans in the northern Plains, the State of New Mexico, and the Tribes and Pueblos of the region. Services are provided to a number of settings including school clinics, youth residential treatment centers, health centers, and others. They hope to leverage their ability to use federal service providers and provide technical and program support nationally to programs attempting to implement such services.

We have been tracking visits to behavioral health clinics using tele-health technology, and have preliminary indications that IHS programs are increasingly adopting and using these technologies. Tele-behavioral health services require adequate and reliable bandwidth if they are to be sustainably implemented. Increasing bandwidth utilization strains the telecommunications infrastructure. IHS was fortunate enough to be the recipient of ARRA funding to improve our telecommunications infrastructure which will increase the reliability and availability of appropriate bandwidth across the Indian healthcare system. Approximately $19 million of our Health Information Technology ARRA funding will be spent to provide new routers, switches, and basic telecommunications infrastructure to ensure current needs are met, as well as improve our ability to prioritize traffic over the network. ARRA funding is also supporting a mass procurement of state-of-the-art clinical videoconferencing equipment that will be distributed to Tribal, Urban, and Federal care sites depending on need later this fall. We are working to improve access to videoconferencing and bandwidth capacity to strengthen our telecommunications infrastructure. As one of our providers who is active in telemedicine told us recently, "My patients are very patient and are willing to tolerate surprisingly bad connections. But when my image freezes up with regularity I may as well be using the telephone." We are investing in the infrastructure expansion, support, and maintenance needed to keep pace with potential service demands and to plan for the long term success of this and any new Indian tele-mental health effort.

We see many benefits to the use of telemedicine for the treatment of youth suicide. This technology promises to connect widely separated and often isolated programs of varying sizes together in a web of support. Whereas small clinics would need to develop separate contracts for services such as child and adult psychiatric support, pooling those needs in a larger pool provides potential access to a much larger array of services, and does so more cost-effectively and more conveniently for patients. Such a system could potentially move some clinics that are available every other Friday afternoon for 4 hours to systems where clinic time for assessments is available whenever the patient presents. This could translate into 24/7 access to emergency behavioral health service in any setting with adequate telecommunications service and rudimentary clinic staffing.

Such a system has other desirable consequences such as opportunities for mutual provider support. For example, currently when psychiatric providers take vacation, are on sick leave, or are training in places where they are the sole providers, there are often either no direct services at that clinic for that time period, or a temporary doctor with limited understanding of the clinic is hired to provide services. Sufficient services could be provided via tele-health connections to reduce or eliminate discontinuities in patient care and do so at significantly less expense. Providers with particular specialty interests can share those skills and knowledge across a broad area even if they themselves are located in an isolated location. Burn out due to professional isolation is also decreased as videoconferencing readily supports clinical supervision and case management conferences. Universities providing distance-based learning opportunities have demonstrated for years that educational activities can also be facilitated by this technology. Families can participate in care even when at a distance from their youth, promoting improved contact and better resolution of home environmental concerns which is often the key issue in a youth transitioning successfully from a residential program to home. Recruitment becomes less problematic because providers can readily live and practice out of larger urban or suburban areas and are thus more likely to continue in service over time with sites. The resulting pool of providers accessible for hiring could also increase because relocation to an isolated location may not be necessary. Such services would require behavioral health providers including psychiatrists, psychologists, clinical social workers, and therapists in addition to the tele-mental health technology.

Activities, including the National Tele-Behavioral Health Center of Excellence funded by the MSPI, will also help us understand how to effectively deliver such services, and in particular, will provide more focused experience in providing services to Indian youth. We believe tele-behavioral programs can become an integral part of the IHS behavioral health services, strengthen our clinical expertise in using tele-health services, and expand access to needed behavioral healthcare. We are working to augment the ability of the IHS Tele-Behavioral Health Center of Excellence to promote and support such services across the Indian health system.

**IHS FY 2011 Budget Request for Mental Health Services**

The FY 2011 budget request for Mental Health is $77,076,000; an increase of $4,290,000 over the FY 2010 enacted level. This increase represents: increases of $748,000 for Federal and Tribal pay increases; increases of $748,000 for non-medical inflation of 1.5 percent; population growth increases of $1.092 million, and increases

of $1,702,000 for staffing/operation costs for new/expanded facilities. We strive to support American Indian and Alaska Native communities eliminating behavioral health diseases and conditions by: (1) maximizing positive behavioral health and resiliency in individuals, families, and communities; (2) improving the overall health care of American Indians and Alaska Natives; (3) reducing the prevalence and incidence of behavioral health diseases; (4) supporting the efforts of American Indian and Alaska Native Communities toward achieving excellence in holistic behavioral health treatment, rehabilitation, and prevention for individuals and their families; (5) supporting Tribal and Urban Indian behavioral health treatment and prevention efforts; (6) promoting the capacity for self-determination and self-governance, and; (7) supporting American Indian and Alaska Native communities and service providers by actively participating in professional, regulatory, educational, and community organizations at the National, State, Urban, and Tribal levels.

**IHS FY 2011 Budget Request for Alcohol and Substance Abuse Services**

The Alcohol and Substance Abuse Program (ASAP) exists as part of an integrated behavioral health team that works collaboratively to reduce the incidence of alcoholism and other drug dependencies in American Indian and Alaska Native communities. The FY 2011 budget request for Alcohol and Substance Abuse is $205,770,000; an increase of $11,361,000 over the FY 2010 enacted level. This increase represents: increases of $1,840,000 for Federal and Tribal pay increases; increases of $2,605,000 to fund the costs of providing health care and related services; population growth increases of $2,916,000, and; increases of $4,000,000 for a grant program to expand access to and thereby improve the quality of treatment for substance abuse treatment services by hiring additional qualified and trained behavioral health counselors and other addiction specialists to enhance substance abuse care in Federal, Tribal, and Urban facilities. The purpose of the IHS Alcohol and Substance Abuse Program is to raise the behavioral health status of American Indians and Alaska Natives to the highest possible level through the provision of preventive and treatment services at both the community and clinic levels. These programs provide alcohol and substance abuse treatment and prevention services within rural and urban communities, with a focus on holistic and culturally-based approaches. The Alcohol and Substance Abuse Program exists as part of an integrated behavioral health team that works collaboratively to reduce the incidence of alcoholism and other drug dependencies in American Indian and Alaska Native communities.

**SAMHSA's Role in Addressing Youth Suicides**

American Indian and Alaskan Native tribes also look to SAMHSA for help is addressing youth suicides. Through its Garrett Lee Smith State and Tribal Grants, 20 American Indian and Alaskan Native tribes or tribal organizations have received grants ranging from $400,000 to $500,000 a year to prevent suicide. This represents 31 percent of all grants given out in the last four years under this program. In addition SAMHSA:

- Funds the Native Aspirations project which is a national project designed to address youth violence, bullying, and suicide prevention through evidence-based interventions and community efforts. Through the Native Aspirations project, a total of 25 American Indian and Alaska Native communities determined to be the most "at risk" develop or enhance a community-based prevention plan.
- Supports the Suicide Prevention Resource Center (SPRC) which is a national resource and technical assistance center that advances the field by working with states, territories, tribes, and grantees and by developing and disseminating suicide prevention resources.
- Funds the National Suicide Prevention Lifeline, a network of 141 crisis centers across the United States that receives calls from the national, toll-free suicide prevention hotline number, 800–273–TALK.

  The National Suicide Prevention Lifeline's American Indian initiative has worked to promote access to suicide prevention hotline services in Indian Country by supporting communication and collaboration between tribes and local crisis centers as well as providing outreach materials customized for each tribe.

In summary, we look forward to opportunities to address the mental health care needs in Indian Country. We are committed to using available technologies including our growing national telecommunications infrastructure to help increase access to sorely needed behavioral health services. For the Indian Health Service, our business is helping our communities and families achieve the highest level of wellness possible.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to testify. I will be happy to answer any questions that you may have.

## STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA

The CHAIRMAN. [Presiding] Mr. Grinnell, thank you very much. We appreciate your work and your testimony. I apologize for being delayed just a bit because of traffic. My colleague opened the hearing. I appreciate that very much.

I wanted to mention as we begin now hearing from other witnesses that we are going to have to do things a little differently this morning. I will explain it. We were in session, I think until close to three a.m. this morning with votes, and are coming back at 9:45. You just heard the buzzer. The first votes will likely start at 10 o'clock and last—10-minute votes until 2 o'clock this afternoon. So we will be voting for four hours. Because they are 10-minute votes, we won't be able to leave the Floor.

We probably will not have to leave here until 10:10 because the first vote will be the only vote that is a 20-minute vote. So what I would like to do is, we will go ahead and hear as many witnesses as we can before we have to leave. I want to make certain that all of the testimony is a part of the permanent record.

Then I am going to ask that we adjourn the hearing, and we are going to have the remainder of what is now a hearing, become a listening session. The Staff Director, Allison Binney, and the Deputy Staff Director on the minority side, Rhonda Harjo, will assume our places and receive the remaining testimony, and it will still be a part of the permanent record.

This is a very important subject, very important. And we have Coloradas Mangas, a sophomore in high school on the Apache Reservation in New Mexico; Dr. Clayton, Medical Director, American Foundation for Suicide Prevention in New York City. Doctor, thank you for being with us and thanks for your work.

And Ms. Laurie Flynn, Executive Director, TeenScreen National Center for Mental Health Checkups at Columbia. We thank you very much for being here.

Mr. Hunter Genia, Behavioral Health Administrator, Saginaw Chippewa Indian Tribe, Mt. Pleasant, Michigan; and Ms. Novalene Goklish, Senior Research Coordinator, Celebrating Life Youth Suicide Prevention Program, White Mountain Apache Tribe.

I know that Senator Franken and I have both had experience with these issues on our reservations. I have a note in front of me about a young man who took his life this week on the Standing Rock Reservation, and I will call his parents sometime later today.

I spoke this weekend with the Tribal Chairman at the Spirit Lake Nation, where Avis Little Wind took her life and who I have spoken about often. The late Avis Little Wind was 14 years old, and her brother took his life just within recent weeks.

We have clusters of suicides, teen suicides especially, that are very troubling. We are trying to everything we can to recognize it, put a spotlight on it, and understand how to address it in order to save the lives of some, particularly young people who think things are helpless and hopeless, and choose this way of responding.

It is not the right way to respond, and the work, Mr. Grinnell, that your organization does is very important. We just, as you know, had a crew be dispatched to Standing Rock a while back.

So let me thank all of you. I just wanted to say that as a way of explanation, I am pleased you are here. There was some talk of having to cancel the hearing. I said, we have people that have traveled here. We want to begin this hearing and do the best we can, after which we will convert this to a listening session, but we want to continue it and have a formal hearing record because many of you have taken great pains to be here.

With that, I want to hear the next witness, Coloradas Mangas. I have read your statement and it is a poignant statement. I so appreciate your being here and talking to us about what this is like through the eyes of a high school student. You have seen a lot and experienced a lot at this very young age.

Coloradas Mangas, you may proceed.

**STATEMENT OF COLORADAS MANGAS, SOPHOMORE, RUIDOSO HIGH SCHOOL, MESCALERO APACHE RESERVATION, NM**

Mr. MANGAS. Good morning, Mr. Chairman and Mr. Franken and other distinguished guests. It is a great honor and privilege to testify on a public health and social justice issue that has disproportionately affected Indian communities throughout my country.

My testimony is dedicated in honor to those whose voices will never be heard and who continue to suffer in a culture of silence and shame.

[Greeting in native language.]

Mr. MANGAS. How are you? My name is Coloradas Mangas. My mother is CriCri Mangas and my father is Carl Mangas. I have two sisters who are Danielle and Kiana Mangas. I am Chiricahua Apache from the Mescalero Apache Indian Reservation in New Mexico. I am 15 years of age and currently a sophomore at Ruidoso High School in Ruidoso, New Mexico.

I am here due to my past and I am a survivor of teen suicide. It is my sincere hope that my words will inspire change and help address these serious situations. Allow me to begin by telling you about my past.

The first time I had to deal with teen suicide was when my sister Danielle's friend killed himself. I was in the seventh grade and it was hard for me to see my sister in that stage. The second time was when my sister Kiana's friend killed himself about two years ago. Next was in September of 2009 at the beginning of the school year. That is when it really had taken a hard toll. My friend killed himself. He was a good helper and a person to all. He was a fire and rescue worker and had seen it all, things I could never imagine. No one saw it coming.

My friend is Larry Anjotti who is the 19 year old posted on the left hand side to you and on this side to these people.

Two weeks later, my sister Kiana's other friend killed herself. That was a hard one, not only for her, but for a lot of youth on the reservation as she was a friend to all. Her name is Brandy Little. She is the 17 year old on the bottom of the poster board on this side and on this side.

My grandmother passed into the next life right after she killed herself. After that, another two weeks went by and my other friend killed herself. Another two weeks later, my other friend killed herself. That night, I didn't know what to do and I had no one to run to or to talk to.

These two people, one of them is Kayla Sheff, who is the 17 year old on the top of the board. My mother I couldn't get a picture of her, so I am sorry that I couldn't be able to put her on there.

The only thing I could do was go to church. It was the one thing, and I attend youth group regularly at our Reformed Church. As I was at church, I got a message I never thought I would get, a text message from my friend saying she loved me and that I will always have a place in her heart. I didn't know what to do. The only thing I could do was call the police, who didn't respond. I went and I walked in the woods from 9 o'clock p.m. to midnight. I looked everywhere, every tree, and I found her. It was a good thing I found her when I did. Otherwise, she would have been gone forever.

I knew that this issue was bigger than I could handle by myself. I made an appointment with the psychologist at the mental health clinic. It was nice having someone who listened and understood what I was going through. I am more of an exception than the rule because most youth would not go to the mental health clinic. The stigma and shame keeps people away.

When I look at the resources that our neighbors have in the town of Ruidoso, I can't help but notice how limited our IHS hospital is when it comes to basic care and, more importantly, mental health services. We have a mental health clinic with only one full-time psychologist, one psychologist to serve a community of 4,500 children, youth and adults. It is my understanding that she is currently on administrative leave indefinitely. With her gone, we have a huge gap in the continuity of care.

What troubles me is that law enforcement and the court have a larger role to play during an attempt or completed suicide compared to our mental health clinic. Most attempters don't seek help and some are court-ordered to attend therapy. This role of the courts and law enforcement criminalizes their behavior and makes their recovery seem less important.

I applaud our community, though. The tribal administration finally understands that our community-based services are not connecting in a vital way to meet the challenges of children and youth with serious mental health needs and their families. With this said, our tribe has recently applied for the SAMHSA Systems of Care Grant. It is my hope that we can fundamentally change the way our services are delivered.

Due to the most recent rash of suicides, a new program started in the community called Honor Your Life Program. It is a SAMHSA Garrett Lee Smith-funded program that is designed to implement and evaluate a comprehensive early intervention and suicide prevention model.

A new program that is supposed to change attitudes and beliefs about suicide can be culturally taboo, because in our culture, we do not talk about death. When it comes to suicide, talking about death and dying is the only way to break the culture of silence that is taking the lives of so many of my friends and other youth.

I believe in change. I believe that we can meet the needs on our reservation. First, we need to increase program awareness and cooperation, targeting both youth and adults to get involved in these programs. Second is by helping the mental health clinic become fully staffed, getting faster hiring approval for these clinicians, and ensuring faster Medicaid approval for persons referred to residential treatment centers.

Having more providers is vitally important. We have four providers at our school I attend and it seems unjust that we only have one provider for our community on the reservation. We need more than one psychologist so more people can be seen more regularly. Having one provider means that most people are operating in a crisis mode between long visits. We could also help by getting providers to work with the law enforcement during suicide attempts or completions to immediately provide family-based aftercare.

Other things that I believe would prevent suicide is by giving the youth more things to do so it would get them away from drugs, alcohol and idle trouble. We need more leadership activities to inspire our youth to change their life courses. Sometimes I think our community forgets that a tribe's legacy rests in its children and not in how well the tribe's enterprises operate.

We desperately need a shelter for our youth if they need a place to stay at certain times when the home life becomes very toxic. We have heard from other youth that if they just had a place to go for the night, they would not have made an attempt on their life.

I am very thankful to have the opportunity to share these ideas that other youth in Mescalero also have. I am also from a new generation of young men and women who believe in breaking the silence and seeking help. I come from people whose pride runs deep, but I also understand that sometimes pride can keep us from asking for help.

So lastly, I would like to thank not only my friends, but also the people that believe in me and mostly mainly all of you for your time in listening to me. And I would also like to thank everybody for helping me take another step towards my plans of becoming a future leader of not only my people on the reservation, but people across the Country.

And in my native language, Ixehe'. Thank you.

[The prepared statement of Mr. Mangas follows:]

PREPARED STATEMENT OF COLORADAS MANGAS, SOPHOMORE, RUIDOSO HIGH SCHOOL, MESCALERO APACHE RESERVATION, NM

Good Morning Honorable Members of the Committee on Indian Affairs and other distinguished guests. It is a great honor and privilege to testify on a public health and social justice issue that has disproportionately affected Indian communities throughout the country. My testimony is dedicated in honor of those whose voices will never be heard and who continue to suffer in a culture of silence and shame.

[Introduction in Apache Language] English Translation: My name is Coloradas Mangas. My mother is Cri-Cri Mangas and my Father is Carl Mangas. I have two sisters: Danielle and Kiana Mangas. I am Chiricahua Apache from the Mescalero Apache Indian Reservation in New Mexico. I am 15 years of age and currently a sophomore at Ruidoso High School in Ruidoso, New Mexico.

I'm here due to my past and I'm a survivor of teen suicide. It is my sincere hope that my words will inspire change and help address this serious situation. Allow me to begin by telling you about my past.

The first time I had to deal with teen suicide was when my sister Danielle's friend killed himself, when I was in the seventh grade. It was hard for me to see my sister

in that stage. The second time was when my sister Kiana's friend killed himself two years ago. Next was in September of 2009 at the beginning of the school year. That's when it really started to take a hard toll. My friend killed himself. He was a good person and a helper to all. He was a Fire Rescue worker and he had seen it all. Things I could never imagine. No one saw it coming.

Two weeks later, my sister Kiana's other friend killed herself. That was a hard one. Not only for her, but for a lot of youth on the reservation as she was a friend to all. Right after she killed herself. my grandmother passed into the next life. After that, another two weeks went by and my other friend killed herself. Two weeks later, my other friend killed herself. That night I didn't know what to do. I had no one to turn to or talk to.

The only thing I could do was go to church. It was a Wednesday night and I attend youth group regularly at our Reformed church. As I was at church, I got a message I thought I never would get. A text message from my friend saying she loved me and that I'll always have a place in her heart. I didn't know what to do. The only other thing I could do was call the police—who didn't respond. I went and walked in the woods from 9 p.m. to midnight. I looked everywhere, every tree, and I found her. It was a good thing I found her when I did, otherwise she would be gone forever.

I knew that this issue was bigger than I could handle by myself. I made an appointment with the psychologist at the mental health clinic. It was nice having someone who listened and understood what I was going through. I am more of an exception than the rule because most youth won't go to the mental health clinic. The stigma and shame keeps people away.

When I look at the resources that our neighbors have in the town of Ruidoso, I can't help but notice how limited our I.H.S. hospital is when it comes to basic care and more importantly, mental health services. We have a mental health clinic, with only one full time psychologist. One psychologist to serve a community of 4,500 children, youth and adults. It is my understanding that she is currently on administrative leave—indefinitely. With her gone, we have a huge gap in the continuity of care.

What troubles me is that law enforcement and the court have a larger role to play during an attempt or completed suicide compared to our mental health clinic. Most attempters don't seek help and some are court ordered to attend therapy. This role of the courts and law enforcement criminalizes their behavior and makes their recovery seem less important.

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Due to the most recent rash of suicides, a new program started in the community called the Honor Your Life Program. It is a SAMHSA funded program that is designed to implement and evaluate a comprehensive early intervention and suicide prevention model.

A new program that is supposed to change attitudes and beliefs about suicide can be culturally taboo, because in our culture, we don't talk about death. When it comes to suicide, talking about death and dying is the only way to break the culture of silence that is taking the lives of so many of my friends and other youth.

I believe in change. I believe that we can meet the needs on our reservation. First, we need to increase program awareness and cooperation—targeting both youth and adults to get involved in these programs. Second, by helping the mental health clinic become fully staffed, getting faster hiring approval for these clinicians, and ensuring faster Medicaid approval for persons referred to residential treatment centers.

Having more providers is vitally important. We have four providers at the school I attend and it seems unjust that we only have one provider for our community on the reservation. We need more than one psychologist so more people could be seen more regularly. Having one provider means that most people are operating in a crisis mode between long visits. We could also help by getting providers to work together with law enforcement during suicide attempts or completion to immediately provide family based aftercare.

Other things that I believe would help prevent suicide, is by giving the youth more things to do so it would get them away from drugs, alcohol, and idle trouble. We need more leadership activities to inspire our youth to change their life course. Sometimes I think our community forgets that a tribe's legacy rests in its children and not in how well tribal enterprises operate.

We desperately need a shelter for the youth if they need a place to stay at certain times when the home life becomes very toxic. We have heard from other youth that

if they just had a place to go for the night, that they would not have made an attempt on their life.

I am very thankful to have the opportunity to share these ideas that other youth in Mescalero also have. I am also from a new generation of young men and women who believe in breaking the silence and seeking help. I come from a people whose pride runs deep, but I also understand that sometimes, pride can keep us from asking for help. Lastly, I would like to thank my friends and the people that believe in me and mostly for your time. In my Native language, Ixehe' [Thank you].

The CHAIRMAN. Coloradas Mangas, you are wise beyond your years. Thank you for your testimony and for being here. We appreciate that very much.

And Dr. Paula Clayton is with the American Foundation for Suicide Prevention. We appreciate that work.

Dr. Clayton, I should tell you that many of us have had experience with this issue of suicide. I walked in and found a friend of mine who had taken his life one morning, and it is a moment you never, ever, ever forget. I mean, it is as if it happened 10 seconds ago.

So I thank you for the work and for the work of the Foundation and appreciate your being here. We will take your testimony and then see if we can get Ms. Flynn's testimony. A vote has started, so we will have about 10 minutes before Senator Franken and I will have to leave and then we will have the Staff Directors continue the rest of the listening session.

Dr. Clayton?

**STATEMENT OF PAULA J. CLAYTON, M.D., MEDICAL DIRECTOR, AMERICAN FOUNDATION FOR SUICIDE PREVENTION**

Dr. CLAYTON. Good morning, Senator Dorgan and Senator Franken.

My name is Paula Clayton. I am a physician and I do serve currently as the Medical Director of the American Foundation for Suicide Prevention.

Suicide is the 11th leading cause of death in the United States, and the third leading cause of death in teens and young adults from the ages of 15 to 24. In one study of a well-monitored tribe, which are here today, the suicide rate in young adults, rather than being nine per 100,000 was 128.5 per 100,000. It was 13 times the rate of the rest of the youth of the United States.

In this single tribe, there were 25 deaths of teens and young adults in a year. And the thing is that they did very excellent monitoring. And so that is one thing we need. We need suicide attempt and suicide completion monitoring on all these tribes and pueblos.

Suicide is the result of unrecognized and untreated mental disorders. In more than 120 studies of a series of completed suicides across the world, at least 90 percent of the people who died by suicide were suffering from a mental illness at the time of their death. The most common is major depression, followed by alcohol abuse and drug abuse, but all psychiatric disorders have an outcome of suicide.

So the major risk factors for suicide are the presence of an untreated mental disorder, a history of a past suicide attempt, and a family history of suicide or suicide attempts. That has to be taken into account.

The most important interventions, then, are recognizing these disorders and treating them. Every culture has a bias against doing that. These must be identified in each of these cultures and overcome.

One such effort to present youth suicide to the general population is two films AFSP has developed. It is in this little package called, More Than Sad. The first is about depression and is for the teens in the high school. And the second is a companion film to help teachers recognize the mental illnesses that teens suffer from that may lead to suicide. Both deal with recognition and treatment.

The first one for the teens depicts four teenagers with different types of depression who are referred to treatment by four different people. One is a parent. Another is peers and the guidance counselor. The third is the kid himself. And the fourth is the primary care physician.

The package is currently being used in more than 1,000 schools across the United States, and I am sure it is in North Dakota, and has recently been adopted by the State of Alabama to show in every high school in that State.

A similar film could and should be made for and about Native American teens. Although the film would need clinicians and a filmmaker who are culturally sensitive, the messages are the same: depression is a medical illness; it is not your fault; it is okay to seek help; and treatments can make you well.

A second approach being used in the general population is screening for early detection and referral, and this is best exemplified by TeenScreen, which you will hear about. For young adults, AFSP has an anonymous online screening program that is evidence-based and approved by the Suicide Prevention Resource Center. It involves having a counselor available to respond quickly to an email questionnaire that the troubled young person submits to engage them sort of in a dialogue in order to finally convince the person to come in for an evaluation. It is proven to engage people who are not known to the health system because it is anonymous and online.

The third, but extremely important aspect of suicide prevention is to train nurses, other health personnel and primary care physicians to recognize disturbed kids and begin treatment early. I would think that this should entail getting the entire tribe or pueblo involved. There are many public health models of para-professionals being the first source of recognition.

Those people who do not respond to the initial treatment then need to be referred to mental health services or substance abuse specialists. The referral process, which is apparently not always the same, needs to be clear and simple. Substance abuse treatment should start with self-help groups. There are proven short-term psychotherapy interventions for suicide attempters and for people with depression in the general population. Money needs to be invested in these treatment programs that are developed for Native American youth.

Finally, AFSP believes that suicide postvention behavior is an important part of prevention. So we have multiple ways to interact with survivors. AFSP has already done two suicide support group training programs in South Dakota, which included Native Amer-

ican participants. AFSP is writing a postvention instruction for middle and high school personnel to guide them in their plans in the aftermath of a suicide. Our Web site contains many other resources that for someone who has lost someone to suicide that could be used or modified.

Suicide in Native American youth is rising and is in crisis. Depression can be fatal. Excessive drinking and drug use can be fatal. The fatality is mainly suicide. Culturally sensitive, but sustained efforts, with multiple approaches offer the best hope.

Obviously, if there is a shortage of treatment resources, which there seems to be, then dollars need to be allocated to develop innovative treatments for Native Americans. We must reduce this fatal outcome.

Thank you.

[The prepared statement of Dr. Clayton follows:]

PREPARED STATEMENT OF PAULA J. CLAYTON, M.D., MEDICAL DIRECTOR, AMERICAN FOUNDATION FOR SUICIDE PREVENTION

Good morning Chairman Dorgan, and Ranking member Barrasso, and members of the Committee. Thank you for inviting the American Foundation for Suicide Prevention (AFSP) to provide testimony on Youth Suicides and the Urgent Need for Mental Health Resources in Indian Country. My name is Paula Clayton. I am a physician. I currently serve as AFSP's medical director. My responsibilities include overseeing and working closely with the AFSP's scientific council to develop and implement directions, policies and programs in suicide prevention, education and research. I also supervise staff assigned to the research and education departments within AFSP.

Prior to joining AFSP I served as professor of psychiatry at the University of New Mexico School of Medicine in Albuquerque. I also currently serve as professor of psychiatry, Emeritus, for the University of Minnesota, where I was a professor and head of the psychiatry department for nearly twenty years. My research on bipolar disorder, major depression and bereavement allow me to understand some of the antecedents of suicide and to appreciate medical research and public/professional education programs aimed at preventing it.

AFSP is the leading national not-for-profit organization exclusively dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide. You can see us at *www.asfp.org*.

To fully achieve our mission, AFSP engages in the following Five Core Strategies, (1) Funds scientific research, (2) Offers educational programs for professionals, (3) Educates the public about mood disorders and suicide prevention, (4) Promotes policies and legislation that impact suicide and prevention, (5) Provides programs and resources for survivors of suicide loss and people at risk, and involves them in the work of the Foundation.

I have provided the committee staff with a Power Point presentation I recently delivered here in Washington, DC on March 8, 2010, entitled, "Suicide Prevention—Saving Lives One Community at a Time."* I also included a copy of AFSP's 2010 Facts and Figures on Suicide. Both documents will provide Committee members and their staff an overview on the issues associated with suicide in America today, along with some examples of programs and services to prevent this major public health problem.

Suicide is the 11th leading cause of death in the United States and the third leading cause of death in teens and young adults from ages 15–24. The suicide rate in this younger group is about 9/100,000. In one study of a well monitored tribe the rate was 128.5/100,000 or more than 13 times that of all other US young people. In this single tribe there were 25 deaths in one year. Monitoring of suicide attempts and suicide is an essential first step.

Suicide is the result of unrecognized and untreated mental disorders. In more than 120 studies of a series of completed suicides, at least 90 percent of the individuals involved were suffering from a mental illness at the time of their deaths. The

*The information referred to has been retained in Committee files and can be found at *www.afsp.org/index.cfm?page__id=598DA610-DC4C-A681-45A4701729BA0C93*.

most common is major depression, followed by alcohol abuse and drug abuse, but almost all of the psychiatric disorders have high suicide rates.

So, the major risk factors for suicide are the presence of an untreated psychiatric disorder, the history of a past suicide attempt and a family history of suicide or suicide attempts. The most important interventions are recognizing and treating these disorders. Every culture has strong biases against doing that. These must be identified and overcome.

One such effort to present youth suicide to the general population is two films AFSP developed. The first is about depression and is for teens and the second is a companion film to help teachers recognize the mental illnesses in teens that may lead to suicide. Both deal with recognition and referral. The first depicts four teens with different types of depression who are referred for treatment by four different people (parent, peers and a guidance counselor, the kid himself and a primary care physician). The package is currently being used in more than 1,000 schools across the country and has recently been adopted by the State of Alabama to show in every high school in the state. A similar film could and should be made for and about Native American teens. Although such films need clinicians and a filmmaker who are culturally sensitive, the messages should be the same: depression is a medical illness, it is not your fault, it is OK to seek help and treatments can make you well.

A second approach being used in the general population is screening for early detection and referral. An approach best exemplified by Teen Screen. For young adults AFSP has an anonymous online screening program that is evidenced based and approved for use by the Suicide Prevention Resource Center. It involves having a counselor available to respond quickly to an e-mail questionnaire that the troubled young person submits to engage them in a dialogue in order to finally convince the person to come for an evaluation. It is proven to engage young people who are not known to the health system.

A third, but extremely important aspect to suicide prevention is to train nurses, other health personnel and primary care physicians to recognize disturbed kids and begin treatment. I would think this should entail getting the entire tribe or pueblo involved in the endeavor. There are many public health models of paraprofessionals being the first source of recognition. Those young people who do not respond to initial treatments need to be referred to mental health and substance abuse specialists. The referral process needs to be clear and simple. The substance abuse treatment should also start with self help groups on the reservations. There are proven short term psychotherapy interventions for suicide attempters and for people with depression in the general population. Money needs to be invested to develop such therapies for Native Americans.

Finally, AFSP believes that suicide postvention behavior is important in suicide prevention, so we have multiple ways to improve this aspect of care. AFSP has already done two suicide support group training programs in South Dakota that included Native American participants. AFSP is writing postvention instructions for middle and high school personel to guide them in their plans in the aftermath of a suicide. AFSP's website contains many other resources that those who have lost someone to suicide can review and use or modify.

Chairman Dorgan, Ranking member Barrasso, suicide in Native American youth is rising and is an absolute crisis. Depression can be fatal. Excessive drinking or drug use can be fatal. The fatality is mainly by suicide. Culturally sensitive but sustained efforts with multiple approaches offer our best hope to get students into treatments. Obviously, if there is a shortage of treatment resources, than dollars need to be allocated to develop innovative new treatments for Native American youths. We must reduce this fatal outcome. The American Foundation for Suicide Prevention is ready and willing to offer our expertise and advice to this Committee and to all members of Congress as you make the important decisions on how to reduce suicide in the Indian nations.

I will be happy to answer any questions you and your colleagues might have. Thank you.

**Attachment**

American Foundation *for* Suicide Prevention

SPAN USA

# 2010 Facts & Figures on Suicide

***Suicide is a preventable public health problem and a leading cause of death in the United States. More investment in suicide prevention, education and research will prevent the untimely deaths of thousands of Americans each year.***

## Suicide - Basic Facts:

- An American dies by suicide every 16 minutes, and more than 33,000 die by suicide every year.*
- 2,300 Americans attempt to take their life each day.*
- 90% of the individuals who die by suicide had a diagnosable psychiatric disorder at the time of their death.*
- Depression, bipolar disorder and substance use disorders are among the leading causes of suicide.
- For every female suicide, there are four male suicides, but three times as many females as males attempt suicide.*
- Suicide is the third leading cause of death among those 15-24 years old.*
- 14.3 of every 100,000 people age 65 and older died by suicide in 2004, higher than the rate of about 11 per 100,000 in the general population.**
- Male Veterans have double the suicide rate of civilians.**
- More Americans die each year by suicide than by homicide.
- Suicide is the eighth leading cause of death for American Indians/Alaska Natives of all ages.***

*NATIONAL CENTER FOR HEALTH STATISTICS FOR THE YEAR 2006
**NATIONAL INSITUTE OF MENTAL HEALTH
***SUICIDE PREVENTION RESOURCE CENTER

## Suicide - The Cost:

- Suicides in one year cost the U.S. $13 billion in lost earnings.*
- 1.3 million years of life are lost to suicide annually.**
- Suicide attempts requiring hospitalization cost the U.S. $3.8 billion each year.***

*KNOX, K.L. ET AL. AMERICAN JOURNAL OF PUBLIC HEALTH. 2005;95:1859-1863
**NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL, WISQARS (WWW.CDC.GOV/NCIPC/WISQARS)
***SUICIDE PREVENTION RESOURCE CENTER

### Suicide Death Rates 2006

SOURCE: NATIONAL CENTER FOR HEALTH STATISTICS

*For more information call (202) 449-3600*
*or visit our websites at www.AFSP.org or www.SPANUSA.org*

The CHAIRMAN. Dr. Clayton, thank you very much.

There are four minutes remaining in the vote, so Senator Franken and I will have to depart shortly.

Laurie Flynn, I would like to have our staff connect with you after this hearing with respect to the TeenScreen Program. It appears to me TeenScreen is something that perhaps could be very helpful for us to collaborate with you and try to move it in a much more significant way nationally. I had a chance to review a bit of what you have written, and it seems to me very, very inspiring.

So two things: number one, we apologize for the inconvenience of this short hearing; number two, all of the statements will be part of the permanent hearing record; number three, the hearing record will remain open for two weeks, and we will submit written questions and would like to complete the hearing record with questions from the Senators.

In the meantime, I want to adjourn the hearing and then begin a listening session with our Staff Director and the Deputy Staff Director on the minority side for the remaining testimony.

We thank you very much for being here.

The hearing is adjourned and the listening session will begin. And I would hope Ms. Binney and Ms. Harjo will come up and take their chairs.

[Whereupon, at 10:12 a.m., the Committee proceeded to other business.]

# LISTENING SESSION ON THE PREVENTABLE EPIDEMIC: YOUTH SUICIDES AND THE URGENT NEED FOR MENTAL HEALTH CARE RESOURCES IN INDIAN COUNTRY

**THURSDAY, MARCH 25, 2010**

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

The listening session began at 10:12 a.m. in room 628, Dirksen Senate Building, Allison Binney, Majority Staff Director/Chief Counsel and Rhonda Harjo, Deputy Chief Counsel of the Committee, presiding.

## STATEMENT OF ALLISON C. BINNEY, MAJORITY STAFF DIRECTOR/CHIEF COUNSEL, SENATE COMMITTEE ON INDIAN AFFAIRS; ACCOMPANIED BY RHONDA HARJO, DEPUTY CHIEF COUNSEL

Ms. BINNEY. Good morning. I am Allison Binney. I am the Staff Director for Chairman Dorgan on the Senate Committee on Indian Affairs. And with me is Rhonda Harjo, the Deputy Chief Counsel for the Vice Chairman.

So as Chairman Dorgan said, we are going to go ahead and continue on with the listening session, so this listening session will continue to be broadcast via the website, and it is still available for people to watch it. We are still going to continue with the transcript that will then be available to all the Committee Members.

With that, let's go ahead and begin with Ms. Laurie Flynn from the TeenScreen Project.

Thank you, Ms. Flynn.

## STATEMENT OF LAURIE FLYNN, EXECUTIVE DIRECTOR, TEENSCREEN NATIONAL CENTER FOR MENTAL HEALTH CHECKUPS, COLUMBIA UNIVERSITY

Ms. FLYNN. Thank you and good morning. Again, I want to join my colleagues in thanking the Senator, the Chairman for organizing this hearing and session, and I want to thank you very much for gathering the wonderful group that you have to share information about how we address this very, very significant public health problem.

I am very honored to be here this morning. My name is Laurie Flynn. I am the Executive Director of the TeenScreen National Center for Mental Health Checkups at Columbia University. I have

been at Columbia University working with this program since 2001.

The TeenScreen National Center's mission is to prevent adolescent suicide and reduce the disability associated with mental illness by mainstreaming mental health checkups as a routine procedure for adolescents in healthcare, in schools and other youth-serving settings.

We are able to provide our tools, our training, our technical assistance and support to communities throughout the Country at no cost because we have been very generously funded by a family philanthropy.

As a parent whose oldest daughter made a very serious suicide attempt at age 17, I want to thank the young man to my right, Carlos Mangas, for his lovely testimony, very moving. And I really think that having the photographs of these young people here with us really helps to keep our minds directed to the ultimate goal, and it is to step up to this problem for our youth in Native American and Alaska Native communities.

We have heard from Dr. Clayton and we have heard from our colleagues at the Indian Health Service the significant statistics that surround the tragedy of adolescent depression and youth suicide. And what I want to share with you very briefly is one part of an effort at solution.

We know that suicide in adolescents nearly always is an outgrowth of depression and other serious mental illnesses. And we know that 20 percent of adolescents suffer from a mental disorder at some point during their youth. We know that about 10 percent or 11 percent of those youngsters have a disorder significant enough to seriously impair their functioning. These are the youth at great risk.

And yet only about one-fifth of youngsters with mental illnesses are identified and receive services, and we have reason to believe that in Indian Country that number may even be smaller.

Yet we know there is a window of opportunity of perhaps two to four years between the onset of the first symptoms of mental disorder and the development of the full-blown disorder which can then create severe outcomes, including death.

Screening for mental illnesses can be accomplished. We have been doing this now for a number of years using a variety of evidence-based screens that can be safely and effectively administered in a wide range of settings.

Screening for mental illness with an evidence-based tool in primary care settings, physicians' offices and clinics, has been proven much more effective than informal interviews, which tend to miss over 50 percent of youth at risk. We know that by identifying youngsters with signs of mental illness early, we can begin to provide the range of supports to the family, to the community, and to the youngster that can make a lifesaving difference.

These are not just my opinions. Screening is based in over 20 years of solid science led at Columbia University. Mental health screenings or mental health checkups, as we call them, have been safe and effective. The Institute of Medicine in its national report last week recommended regular screening for adolescents for mental disorders.

The U.S. Preventive Services Task Force has recommended annual depression screening and primary care for all of our teens. Our program is recognized by SAMHSA in its national registry of evidence-based practices. We know that mental health checkups can be administered safely in a variety of ways. In schools, and we have had a lot of experience in Indian Country with the Gila River Schools, with Turtle Mountain Schools, and with the Riverside Indian School.

For many years, we have seen in a variety of Indian Country settings, as well as working with Alaska Native sites, that these mental health checkups can be administered in ways that are culturally sensitive and surround the youngster with the immediate help and support if they need it.

In schools, we provide a service that trains the guidance counselor, the school nurse or a visiting health professional to work with the youngster, to provide the checkup which is self-administered. It is a brief screen.

Let me just give you an example of what it looks like. This is the one we use most frequently in doctors' offices. It is this simple. It is an evidence-based checkup. It can be given on a clipboard while the youngster is in the waiting room waiting for his appointment with his primary care physician or with the health practitioner.

It can be scored within a minute and it can indicate whether or not the youngster has problems that require further counseling, further probing or referral if necessary if there is a real crisis at hand. We always work to engage the family and the community because we know that health and healing will require the engagement of all the youngsters' close connections.

We do know, too, that for youngsters who have the most severe depression and are at greatest risk for suicide, it is essential that programs like tele-medicine and the program that has been active in the situation in New Mexico can make the difference.

We believe that early detection, identifying the youngsters who need the help, and being able to sort out quickly which ones are at the greatest risk will help us use our limited resources most effectively. And in combination with community supports, efforts to increase the availability of appropriate mental health resources, and tele-medicine, we can make a real difference for youngsters in Indian Country.

We are delighted to offer our program to officials at the Indian Health Service, to various tribal councils, and to Members of this Committee so that we can work with you as partners to reduce this ongoing tragedy, to implement mental health checkups, to identify those youth who are in trouble who need support, and to help them get lifesaving assistance.

Thank you.

[The prepared statement of Ms. Flynn follows:]

PREPARED STATEMENT OF LAURIE FLYNN, EXECUTIVE DIRECTOR, TEENSCREEN NATIONAL CENTER FOR MENTAL HEALTH CHECKUPS, COLUMBIA UNIVERSITY

Good morning Chairman Dorgan, Ranking Member Barrasso, and members of the Committee. I am honored to appear before you today to present testimony about the tragic and ongoing problem of youth suicide in Indian Country. My name is Laurie Flynn and I am executive director of the TeenScreen National Center for Mental Health Checkups at Columbia University. I have served in this capacity since Janu-

ary 2001, and I am pleased to share information about our program and our role in addressing adolescent suicide.

The mission of the TeenScreen National Center is to prevent adolescent suicide and reduce disability associated with mental illness by mainstreaming mental health checkups as a routine procedure for adolescents in health care, schools, and other youth-serving settings. From our beginning, we have provided tools, training and technical assistance at no cost, and we now support mental health screening in more than 900 sites in 43 states, including tribal settings.

We are fortunate to be funded by a generous family foundation. Our benefactors share our dedication to reducing the devastating impact of undetected depression and other serious mental health problems on adolescents and their families. As a parent whose oldest daughter made a very serious suicide attempt at age 17, I can understand the ongoing pain of families in Indian Country as they struggle to find help and hope for their children.

**Depression and Suicide among Native American and Alaska Native Youth**

Today's hearing is important because youth suicide remains a significant public health challenge in the United States. Suicide is the third leading cause of death for all youth 11 to 21 years of age, and it accounts for approximately 12 percent of all deaths in this age group. As alarming as these statistics are, we know that the problem is much worse among American Indian and Alaska Native youth. The suicide rate for American Indian and Alaska Native youth is almost twice that of young people generally, and suicide is the second leading cause of death among 15- to 34-year-olds in these populations.

Unfortunately, suicide rates do not capture the full extent of the problem. According to data cited by the Centers for Disease Control and Prevention (CDC), there are approximately 100 to 200 suicide attempts for each completed suicide among young people 15 to 24 years of age. Among American Indian and Alaska Native youth attending Bureau of Indian Affairs schools, a 2001 Youth Risk Behavior Survey found that 16 percent had attempted suicide in the preceding 12 months.

Despite these alarming numbers and widespread recognition of the epidemic of youth suicide among American Indian and Alaska Native youth, we are still not doing enough to identify and assist young people suffering from depression and mental illness. National Institute of Health (NIH) research shows that more than 90 percent of all individuals who commit suicide are suffering from diagnosable mental illness in the year preceding their death. Yet, according to the Substance Abuse and Mental Health Services Administration (SAMHSA) more than half of all persons who die by suicide have never received treatment from a mental health provider. Once again, the picture is even worse in tribal communities, with even fewer individuals receiving treatment.

This epidemic of preventable suicide among young people has been exacerbated by shortfalls in funding for the Indian Health Service (IHS), provider shortages, and the difficulty of providing services in rural, isolated locations. Each year, funding shortfalls within IHS limit referrals for medically necessary contracted health services. The vacancy rate for physicians in the IHS is approximately 20 percent, and 27 percent of the IHS workforce—nearly one-third—will be eligible for retirement in 2011. And the rural nature of Indian Country provides additional hurdles for both patient access and provider recruitment.

Despite these challenges, there are effective and efficient ways to improve the early identification and treatment of mental illness and reduce needless deaths by suicide. Mental health screening can identify youth most at risk and provide intervention early, when it is most effective.

**Defining Mental Health Screening**

Mental health screening, also referred to as a mental health checkup, refers to the administration of a standardized, evidence-based mental health questionnaire, such as the Pediatric Symptom Checklist (PSC) or the Patient Health Questionnaire 9 Adolescent (PHQ–9A). These mental health screens include between 9 and 35 questions and take 5 to 10 minutes to complete. The questionnaire is then scored to determine whether additional follow-up is necessary. It is important to note that a positive mental health screen is not a diagnosis of mental illness. Rather, a positive score on a mental health screen is an indication that further evaluation by a health or mental health provider is necessary. Whether provided in a school, community, or medical setting, the TeenScreen mental health checkup involves providing assistance with referral for mental health evaluation or treatment to interested youth and their families, who may accept or decline to receive services. In school and community settings, where a formal referral network like those in many

medical settings may not exist, active steps to engage parents and assist them in linking to services are encouraged.

While some have raised concerns about whether mental health screening might increase thoughts of suicide, research published by Gould et al. in the *Journal of the American Medical Association* demonstrated that there is no increased risk posed by mental health screening. Inquiring about mental health status, suicidal ideation and previous suicide attempts does not increase distress or suicidal thoughts in youth. The research also found beneficial effects for depressed youth and previous suicide attempters post-screening. Anecdotal evidence suggests that many young people are relieved to have the opportunity to discuss their mental and emotional concerns in a confidential setting.

**Why Screen for Depression—Science and Research Support**

The importance of early detection, through screening of mental illness, has been well documented through medical research and by governmental entities. In 1999, the Surgeon General released both *The Surgeon General's Call to Action to Prevent Suicide and Mental Health: A Report of the Surgeon General.* These publications highlighted mental health screening as an effective tool for suicide prevention and suggested that primary care providers and schools could provide effective settings for the detection of mental illness. In 2003, the President's *New Freedom Commission on Mental Health* recommended an increase in early identification efforts by primary care providers. More recently, the Institute of Medicine (IOM) and National Research Council (NRC), in their report *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities,* recommended that the federal government make preventing mental, emotional and behavioral disorders, and promoting mental health in young people a national priority. Medical panels and professional groups have also recommended mental health screening for adolescents, including the United States Preventive Services Task Force (USPSTF), the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American Medical Association (AMA).

A mental health checkup using an evidence-based, standardized tool should be incorporated into the annual well-child visit for all adolescent youth as part of routine preventive care. We now know that in youth up to age 21 there is a window of opportunity of two to four years, between the first symptoms and the onset of the full-blown diagnosable disorder, when treatment is most effective at reducing the severity of specific disorders.

However, we also know that primary care providers often rely on informal, unproven mental health screening methods and that mental health issues are sometimes not addressed at all. Further compounding the problem, many young people do not receive regular preventive care visits. This is especially true for American Indian and Alaska Native youth in rural settings, where the closest pediatrician may be several hours away. In fact, according to the AAP, the average number of well-child visits within the American Indian and Alaska Native populations has dropped more than 35 percent over the last decade. As a consequence, it is important to incorporate mental health screening into a wider array of youth serving programs, such as those offered in school and community-based settings.

**TeenScreen Schools and Communities—Our Work with Tribal Communities**

The TeenScreen Schools and Communities program has been affirmed as an evidence-based method of addressing youth suicide. The TeenScreen Schools and Communities program is included in the Best Practices Registry for Suicide Prevention put out by the Suicide Prevention Resource Center (SPRC). The program is also included in the SAMHSA National Registry of Evidence Based Programs and Practices (NREPP). TeenScreen has assisted a number of school and community based sites in providing mental health screening and referral to youth in Indian Country. Together, these programs have offered mental health screening to thousands of young people. I would like to highlight a few of these programs.

A number of Garrett Lee Smith grantees have chosen to incorporate TeenScreen into their suicide prevention efforts. Signed into law on October 21, 2004, the Garrett Lee Smith Memorial Act (GLSMA) was the first federal suicide prevention program targeted toward youth and it created grants for states and tribal organizations to create and implement statewide/tribal suicide prevention plans. In all, at least 13 grantees in 12 states have incorporated TeenScreen into their suicide prevention programs, including both campus and state/tribal grantees.

*Gila River Behavioral Health Authority*

One such grantee is the Gila River Behavioral Health Authority Youth Suicide Prevention Project in Sacaton, Arizona. This program serves the Gila River Indian

community, which includes a population of 14,000 located on 372,000 acres south of Phoenix. The Gila River grant-funded services include TeenScreen.

The Gila River Regional Behavioral Health Authority began providing mental health screening to youth in schools within the region during the 2007–2008 school year. In the first year of screening, they were able to provide just 80 screenings, due to a low rate of parent consent. They also noted that a lack of good communication channels has made implementing large scale programs, such as TeenScreen, more challenging.

With continued effort and by building trust in the community, the Gila River Regional Behavioral Health Authority was able to increase their screening rate considerably during the 2008–2009 school year, with a total of 455 youth screened. This was an increase of more than 400 percent, and the program has trained 11 teachers, counselors and staff at four sites to implement the TeenScreen program and promote its sustainability.

Among students screened in the program, 87 youth (approximately 19 percent) screened positive due to risk of suicide or need for early intervention services. All youth identified were referred for some type of support services: 74 youth were referred for mental health services and 13 were referred for non-mental health services, such as social support services.

The Gila River program is continuing its screening program in the 2009–2010 school year, and the grant funding is currently authorized through September 2011.

*Turtle Mountain Schools of Belcourt, North Dakota*

In 2002, Paul Dauphinais, Ph.D., a practicing school psychologist employed by the Turtle Mountain Community School District, learned of the TeenScreen Program and decided to work to bring mental health screening to Turtle Mountain Schools. The schools are located in Belcourt, North Dakota and on the Turtle Mountain Chippewa Indian Reservation.

At the onset, Dr. Dauphinais knew that community support would be critical to the success of the screening program. By educating community members and giving presentations on the subject to key stakeholders, he was able to garner support from the Tribal Chairman, parents, school administration, and area treatment providers who would provide clinical interviews and referral resources for youth identified through the screening process.

By 2004, Dr. Dauphinais developed a screening plan that would enable him to offer screening in Turtle Mountain's middle and high schools. He developed and strengthened relationships with local entities and staff that would participate in administering and supporting the screening program. Eventually, his screening team was comprised of school personnel, Indian Health Service (IHS) clinicians, community treatment providers and one case manager, whose position was funded by a Safe and Healthy Students Grant. (This position was first funded during the program development phase of the project, and has continued to be funded in each subsequent year.) Coordination with IHS staff and clinicians provided a unique opportunity for collaboration, which benefited the families that both the schools and IHS exist to serve. The well-orchestrated screening program also ensured that no single system was overwhelmed with referrals at any given time, and that each youth and family, starting with the most critical cases, received appropriate referral services and case management.

During the 2004–2005 school year, fewer than one hundred students participated in the program. Despite seeing lower numbers than the screening team anticipated, this first year allowed the team and supporting organizations to familiarize themselves with the screening process and work to best utilize the community's limited resources for the youth who required follow-up interviews and referral services. Over two hundred youth (225 total) were invited to participate in the program during the 2005–2006 school year. One hundred twenty-five youth received parent consent and were screened. Of those youth, 33 scored positive on the screening instrument, requiring a clinical interview with program staff.

Unfortunately, personnel difficulties and a lack of funding resulted in a stalled program, i.e. they were no longer able to provide screening, in 2008.

*Riverside Indian School of Anadarko, Oklahoma*

Riverside Indian School (RIS) is a federally operated off-reservation boarding school located in Anadarko, Oklahoma. RIS is the largest Bureau of Indian Affairs boarding school in the United States, with an enrollment of 600 students in grades four through 12 and students from more than 100 different tribes across the United States. The student population is 100 percent American Indian.

Gordon Whitewolf is a school therapist and counselor at RIS. Mr. Whitewolf provides counseling and therapeutic services for students experiencing variety of behav-

ioral and mental health problems. He is an Oklahoma Licensed Behavioral Practitioner, and an Internationally Certified Alcohol/Drug Counselor.

By 2002, Mr. Whitewolf was well into his tenure at RIS and witnessed first-hand the alarming rates of mental illness, substance abuse and suicide risk among his students. He felt that through his work at RIS, he and his colleagues could proactively identify youth who might be at the highest risk for suicide or other mental health concerns. Mr. Whitewolf found that many students came to RIS with a variety of mental health problems that were not previously identified. Some youth were struggling with depression and suicidality; others were dealing with anxiety-related disorders, associated with separation from their family and friends, and learning to adjust to a new environment.

Mr. Whitewolf set out to identify a program or intervention that would enable the RIS counseling and medical staff to identify students in need of immediate intervention, as well as those students who would benefit from additional support throughout the school year. A colleague presented him with preliminary information about a new mental health checkup program being offered by Columbia University. After collecting information on the program and presenting it to the Director of Student Services, he was granted permission to bring the TeenScreen Program to RIS during the 2002 school year.

"Native American's have survived centuries of historical trauma and infirmity," Whitewolf says. "Today, Native American youth face similar discord constructed by society such as violence, racism, substance abuse, and mental health problems. These problems impact youth in different ways, and may bring about a feeling of hopelessness or worthlessness. That is why Riverside Indian School implemented the Columbia University TeenScreen Program. The Program helps staff identify those students showing evidence of suicidal ideation, previous suicide attempts, possible mood disorder, as well as substance use."

In the program's first year, Mr. Whitewolf and the counseling team offered screening to the entire student body. The screening team consisted of two school therapists who administered the screening questionnaire and provided clinical interviews, and a nurse practitioner who provided case management services. In addition, close consultation and cooperation with Parent Liaison staff and Medical Center staff ensured that every element of the student's care and well-being was considered.

The results of the screening in the first year were telling: staff found that 17 percent of youth screened reported suicidal ideation or a previous suicide attempt; 20 percent reported problems with substance abuse; and 19 percent reported symptoms of depression. Mr. Whitewolf and RIS counseling staff assisted youth at highest risk immediately, and provided follow-up assessments (and treatment when necessary) for all students who screened positive. With such a large segment of the student population suffering from mental health and substance abuse problems, screening allowed the counseling team to provide triage evaluations to all students, and identify youth at highest risk, ensuring that cohort of students receives the critical care they need.

Since his initial success in 2002, Mr. Whitewolf and colleagues routinely offer mental health screening to all new students at the beginning of each school year. "The TeenScreen Program provides an opportunity for therapeutic intervention for students in need of services, and the ability to assist each student both at school and when they return to their respective tribal community upon completion of the school year," Mr. Whitewolf has explained. In addition, he has stated that screening has allowed counseling staff to communicate more effectively with the medical unit on campus, creating a unique system that fosters better over-all care for RIS students.

**Lessons Learned**

These case studies highlight both the successes and the challenges of reaching at-risk youth in Indian Country through mental health screening. Thousands of young people have received a screening, and hundreds have been connected to needed support services. More importantly, for many youth, the screenings serve as an opportunity to start a conversation about mental and emotional health.

However, much as in medical settings, we cannot reach all young people through these screening programs. Funding shortfalls often lead to the end of a screening program; when a grant runs out, the program stops. We also know that some of the most at-risk young people cannot be reached in a school setting. Mental illness is the leading cause of disability-related school dropout, and youth suffering from mental illness are much more likely to leave school before graduation. In fact, a 2010 report from the University of California, Los Angeles (UCLA) Graduate School of Education and Information Studies found that fewer than 50 percent of American

Indian and Alaska Native youth in the Pacific and Northwest of the United States graduate from high school.

**Recommendation—Integrate Screening into Multiple Youth Serving Settings**

In order to provide comprehensive services and reach as many at-risk youth as possible, it is imperative that we provide opportunities for prevention and early intervention in all youth-serving settings where appropriate supports can be arranged. This may include, but is not necessarily limited to, medical, school and community settings.

In American Indian and Native American communities, cultural programs can play an important role in promoting and providing access to mental health screening. TeenScreen site coordinators in Indian Country have repeatedly stressed the importance of engaging tribal leaders to communicate about the importance of mental health screening and to build trust within the community. Many suicide prevention programs incorporate initiatives to celebrate and preserve Native culture into their efforts, and these settings should play a role in helping to identify at-risk youth through screening.

The health care reform bill signed into law by President Obama on Tuesday will go some way to helping to expand mental health screening in the medical setting. The language includes provisions to provide United States Preventive Services Task Force recommended services without cost-sharing in benefit plans, which includes annual depression screening for adolescent youth ages 12 to 18. However, we know that mandating coverage of a service does not always translate into the service being provided in clinical practice. Therefore, we must continue to work to raise the visibility of the need for mental health screening as we expand access in multiple youth-serving settings.

**Recommendation—Expand Telemedicine With Focus on Mental Health of Youth**

Identifying youth in need of mental health services through screening is of little utility if we are unable to connect them to necessary services. As we referenced earlier, the IHS suffers from a provider shortage for all types of providers, and child and adolescent psychiatrists are in short supply, not just in the IHS, but the system more generally. Furthermore, the rural and often isolated locations in which many American Indian and Alaska Native youth reside contribute to the difficulty of connecting them to appropriate mental health providers.

An important solution to addressing these challenges has been the expansion of the use of telemedicine services, including telepsychiatry. For example, the University of New Mexico's Center on Rural Mental Health has been providing telepsychiatry services, also referred to as tele-behavioral health services, to the Mescalero tribe and others in New Mexico. Through a contract with the IHS and the State of New Mexico, the Center is able to offer patient diagnosis, treatment, and supervision services. The Center is also able to help address the workforce shortage by providing additional training and supervision to mental health providers, such as social workers.

The success of such programs has spurred an increased investment in tele-behavioral health services. The Methamphetamine and Suicide Prevention Initiative (MSPI) included funding to establish a National Tele-Behavioral Health Center of Excellence, and at least 50 IHS and federal sites are using or in the process of creating tele-behavioral health services. The American Recovery and Reinvestment Act of 2009 (ARRA) also provided funding to expand the infrastructure necessary to support telemedicine.

The health care reform legislation signed into law earlier this week also includes provisions that will help expand access to services for American Indian and Alaska Native youth. New grant moneys for telepsychiatry projects are included in the legislation, as well as provisions targeted toward addressing IHS workforce recruitment; improving rural health services; reducing health disparities; and expanding access to preventive services.

These are all steps in the right direction, but we remain far from being able to serve all youth who are in need of mental health services adequately. We must continue to address the shortage of services through common-sense, proven approaches such as telemedicine.

**TeenScreen National Center as a Resource**

Thank you for the opportunity to testify. The TeenScreen National Center stands ready to serve as a resource, and I look forward to working with the members of this Committee as you develop policies to improve the lives of American Indian and Alaska Native youth.

Ms. BINNEY. Thank you, Ms. Flynn.

Next, we will hear from Hunter Genia, who is the Behavioral Health Administrator at the Saginaw Chippewa Tribe in Michigan.

**STATEMENT OF HUNTER GENIA, ADMINISTRATOR, BEHAVIOR HEALTH SERVICES, SAGINAW CHIPPEWA TRIBE**

Mr. GENIA. Good morning. [Greeting in native language.]

My name is Hunter Genia. I am the Behavioral Health Administrator for the Saginaw Chippewa Indian Tribe. I would like to thank the other panelists that have spoken. Probably unlike many of them, except for the young man that spoke, I don't work on a Federal level. I actually work in our tribal community on the ground level and kind of see what is going on for our nation.

I also work with a collaboration of tribes in Michigan that are recipients of a SAMHSA grant called Access to Recovery. I believe that was originally started under the Bush Administration and has continued hopefully under the Obama Administration. I want to talk about that briefly as well.

I also recognize that where I come from, the Odawa and Ojibway Nation in Michigan that I descend from Pontiac, who back in the 1700s was a leader among the Great Lakes tribes that tried to thwart the expansion of Western Civilization because his fear was that we would adopt too many of the non-native ways and we would lose ourselves and become lost.

And I think what we are seeing here in Indian Country is a deep psychological wound that has not healed for many, many generations and hundreds of years. We have seen this through the Indian boarding schools that often goes untalked about here in America in our history books. And we have not recovered as an Indian people in this Country as a result.

A lot of people believe that the Indian boarding schools was only from the 1870s to the 1930s. But in Michigan, we had one Indian boarding school that remained open until the early 1980s. And my own brother and my own sister attended these schools. And if you want to talk about trauma, it has only been disclosed in recent years that sexual abuse, physical abuse, emotional abuse has occurred in these Indian boarding schools, often led by a lot of the church institutions and missionaries.

But as the Administrator, I have been asked to try to address some of the lack of resources that we have in our community regarding mental health services. So for the last four years, I have been the Saginaw Chippewa Behavioral Health Administrator, and prior to that for six years, our Clinical Mental Health Director. Prior to that, for 10 years I worked in the American Indian urban population where there is virtually zero dollars for Indian healthcare for the majority of the American Indian population that live in non-reservation communities.

The Saginaw Chippewa Behavioral Health Program and the Saginaw Chippewa Indian Tribe is providing nearly 70 percent of our funding just to operate our own programs. So the amount of dollars coming from Indian Health Service or other grant funders is much less than that. So I just want to point that out.

So right now, our tribe is putting over $1.5 million into just our behavioral health services. We offer an outpatient mental health,

substance abuse, residential program, but we are very unique as a tribe. And I also want to point out that the majority of gaming tribes are not profitable. The majority of gaming tribes are in the red and can't do what we are doing and providing. So in Michigan, our tribe is very unique.

One of the things I want to point out about the Access to Recovery grant is that it also recognizes our cultural and spiritual beliefs and our teachings and our ceremonies, and that they are actually utilized in our efforts in recovery. So whether we are working with adolescent children or adults or elders, the majority of our people are asking that traditional and cultural practices be a part of their treatment process.

And that is one of the beautiful things about the Access to Recovery grant, which is under SAMHSA, is that it actually acknowledges and respects who we are as an indigenous people here in this Country.

And I just want to point out and remind people that it wasn't until 1978 that the American Indian Freedom of Religion Act was even passed in this Country, which took a special act by Congress. So until then, many of our people have had to live in generations of hiding and privatize, really, who we are as an indigenous people. And I just want to point that out because I think a lot of these programs are great, but it is not really talking about where a lot of these wounds are originating from.

And so oftentimes what we have are band-aid approaches to addressing American Indian health needs, especially the mental health needs.

During the 2008 and 2009 fiscal years, at any given time we have had an average number of up to 60 tribal members, community members waiting to access our behavioral health services. During this time, they could wait up to an average of three months before they could even see a counselor of a clinician. And I just point that out because if we had more funding, we could add more staff to our programs and our resources and be able to address some of those needs.

The Saginaw Chippewa Indian Tribe also made a decision to build our own residential treatment facility. Before we even laid the first brick down to build this facility, we had phone calls from all of the other Michigan tribes asking if our residential facility will be open to their tribes. And unfortunately, they are not. And some of that has to do with some of the Indian Health Service policies regarding funding and some of the access to care.

But one of the reasons why we built the residential treatment center on our own reservation is because other than our tribal residential program, our community members had to travel at least six to eight hours or out of State to even access culturally sensitive treatment facilities and programs. Otherwise, it would go to non-native programs that oftentimes were not sensitized to our values, our traditions and our culture. And therefore, a lot of the non-native approaches to treating our people were often utilized and a lot of our people were discriminated against or biased in those treatment settings that they were non-native.

So I think since we opened up our own residential program, over 250 of our own tribal members have gone through our residential

program. And if that residential program was not there, probably the majority of them would have never even gone into treatment at all.

So one of the things I want to point out is, our tribe is footing the bill for most of our Indian health care, not the United States or the Federal Government or Indian Health Service, for that matter. We are very fortunate that all the tribes of Michigan are part of the Access to Recovery grant under SAMHSA, but it still is not adequate funding to provide the level of services and care that we need in our tribal communities.

I am 40 years old. I got my master's in social work from Grand Valley State University. I don't drink. I don't do drugs. I don't smoke. But I am very much in a non-conceited way unique in that regard.

I was talking to a young man here earlier before the meeting started that is from Pine Ridge. I think the difference is that somebody along the way said that I could be somebody and had an opportunity. And I think we can call it mental health illnesses and things of that nature, but the fact is that the majority of American Indian youth in this Country don't see the opportunity. They are not given a chance to see what dreams that they can aspire to.

If you look across the Nation here, how many of our people do you see that are in politics? How many do you see that are in sports? How many do you see that are in entertainment? Virtually none. Until we are able to place our own people in places of leadership that our young people can turn on the radio or look on TV and see, all they see is what is there on our reservation communities. And they don't understand coming to Washington, D.C. is a possibility for them, you know, to be a Governor, to be a Senator, to be a Congressman. It is very far and few in between.

And I think what we are trying to do and address in our community, I will give you two examples. Last October, we had GONA, Gathering of Native Americans. It is a four-day training actually facilitated by our own people, which initially started under SAMHSA. And it brought all of our community together in a good way, in a good place to talk about things that we needed to do to heal as a community.

Because that is one thing that we all have as universal truths in Indian Country is that there is a lot of walking wounded people in our community that have not healed from post-traumatic historical trauma. And until we address some of those things and give it a name and acknowledge those, I am not sure that all the programs in the world are going to help. We need to focus on healing and wellness in our tribal communities and look at those kinds of things that are generated from multi-generational traumas.

The other thing that happened in our community is that with the assistance of White Bison, is that we have the Journey for Forgiveness hosted in our community. And that, for the first time in the Mt. Pleasant community, addressed the impact that Indian boarding schools had on our people. And as you know, Indian boarding schools was very good at taking away our language, our culture and our traditions, and basically their goal was to Americanize us.

So I think a lot of what is happening in Indian Country is that we have big who am I cultural identity issues that are going on

among a lot of our young people. Where do we belong? How do we fit in? Are we invited to the table? Are we important? I think a lot of our young people don't feel that.

And so a lot of the things that we are trying to do in our community is to let them know that they are important and to help programs set up like that.

But I will say that the majority, 60 percent to 70 percent of our behavior health funding is because our tribe made it a priority, the Saginaw Chippewa Indian Tribe. If we were to rely on Indian Health Service's funding or the Federal Government, I mean, we would not have a majority of our programs available to our own community.

And so we need more funding. We need more resources. We need more American Indian Native American leaders to step up and be a part of our tribal communities and lead these efforts and be seen and be visible in this Country in our communities.

So that is basically my main message that I wanted to bring here. And I thank you for the opportunity, and I hope that in the future years that more funding and resources will be available to our tribal communities. But I also know that we as native people have to take the leadership role in making that happen.

[Phrase in native language.]

[The prepared statement of Mr. Genia follows:]

PREPARED STATEMENT OF HUNTER GENIA, ADMINISTRATOR, BEHAVIOR HEALTH SERVICES, SAGINAW CHIPPEWA TRIBE

Ahnii, Giwesinini Ndihzinkaaz, Wabezhenshi dodem, Mt. Pleasant, MI ndojibaa. My name is Hunter Genia and I am the administrator for the Saginaw Chippewa Indian Tribe Behavioral Health Services in Mt. Pleasant, MI., approximately one hour north of Lansing, our state capitol. The Saginaw Chippewa Indian Tribe behavioral health services provides mental health services to all eligible Native Americans of any federally recognized tribe residing in a five county district in the central lower peninsula of Michigan. The Saginaw Chippewa Tribe has over 3,400 tribal members with roughly 50 percent of our population being under the age of eighteen.

I have been the administrator here for 4 years and prior to that, the mental health director of our program for six years. Upon my employment here we were an outpatient mental health, substance abuse, and prevention program providing clinical mental health services to over four hundred fifty open clients, with no residential services. In 2005, we opened up our own residential treatment center, funded solely by the Saginaw Chippewa Indian tribe.

During my tenure as the Administrator and Clinical Director, the Saginaw Chippewa Indian Tribe has carried the burden financially for providing the Behavioral Health care for our tribe. The Saginaw Chippewa Indian Tribe is providing 66 percent of our operational budget in this current fiscal year which equates to roughly 1.9 million dollars. The Saginaw Chippewa Indian Tribe Behavioral Health Program during the last four years has provided over 8 million dollars to support Behavioral Health Services; this figure does not include any Indian Health Service funding.

During the 2008 and 2009 fiscal years at any given time we had an average number of sixty tribal members waiting to receive services. The average waiting time to receive services once on the waiting list could be up to three months before they could receive any type of counseling services. The Saginaw Chippewa Indian Tribe made a decision to build a residential treatment center here on our reservation. The primary reason for this was so that our tribal community members could access this care without having to travel several hours, or out of state to receive Native American residential services. Distance to residential treatment provided a barrier for a lot of our tribal members to access services when needed. The closest Native American residential program was located over eight hours away, which made it virtually impossible for family members to participate in the treatment process. Since we have opened up our residential services we have provided care to over 250 Saginaw Chippewa Tribal Members. The residential treatment center operational costs are solely funded by the tribe. The majority of Native Americans receiving residential

cares with us have had a combination of mental health and substance abuse disorders, known as co-occurring. Many of our tribal members have preferred to remain on our waiting list with our tribal services instead of seeking behavioral health services with other agencies and programs.

During my employment with the Saginaw Chippewa Indian Tribe, barriers to providing appropriate behavioral health care in our tribal community have been; inadequate staffing levels, lack of available psychiatrist for adults and children, adult and child psychologist to see clients in need of specialized treatment and assessments, cultural competency, Native American staff, and funding. Other issues include inadequate prevention, education, and screening for early identification of youth or adults at risk for suicide. In order for these barriers to be addressed effectively adequate funding is needed.

Many of our tribal community children are faced with enormous challenges that can be barriers to success in their lives. Higher prevalence of physical, emotional, sexual abuse and neglect are experienced by children and adolescents in our tribal communities. Our community's children are more likely to experience a higher prevalence of substance abuse, domestic violence, mental illness, neglect and or have witnessed such before they reach the age of eighteen than any other racial ethnic group. Due to these higher rates of behavioral health issues roughly 40 percent of our clients we see are children and adolescence.

The substance abuse and mental health issues we face and see in our community can be traced back to multigenerational trauma experienced by their parents, elders, and grandparents before them. A lot of the trauma can be traced directly to federal policies and practices like the Indian Boarding Schools. I am not surprised by this comparison which has gone severely unaddressed in tribal communities due to a lack of resources, funding, and staffing. Our tribal community has begun to address the mental health devastation that past federal government practices and policies have contributed to our people. Mental health issues we are addressing such as historical trauma, relocation, grief and loss, foster placement, physical, sexual, emotional, spiritual abuse, reactive attachment disorder, and trauma in tribal communities is enormous. This is what we see everyday coming into our clinic. This also means that specialized treatment and care is called for along with the acknowledgment and respect for cultural, traditional, and spiritual practices that were outlawed thirty years ago prior to 1978's American Indian Freedom of Religion Act. Also prior to this, the 1975 Indian Child Welfare Act was passed which protected our tribal children from being erroneously removed from their homes and community. These acts took special legislation and acts of Congress to protect our tribal community and our most precious resource, our youth.

As an American Indian raised in an large urban American Indian population in Grand Rapids, MI and also on my reservation in Mt. Pleasant, Michigan, I can tell you that in both respects, it comes down to financial and people resources. Unmet needs are still very rampant today for the American Indian population who need access to substance abuse and mental health care that are appropriate for their level of needs. Often times in my experiences, the city, county, and state levels do not want to work cooperatively with the tribal governments and communities to ensure that we are able to access this care equitably.

I thank you for allowing me to be here this morning.

**Attachment**

## Suicide Prevention Risk, Protective Factors, and Recommendations Provided by Hunter Genia

Some of the Risk Factors include:

- Mental Illness
- Substance Abuse
- Loss
- Failure/Academic problems
- Incarceration
- Previous suicide attempts

Some Protective Factors include:

- Cultural/Religious beliefs
- Coping/Problem Solving Skills
- Ongoing health and mental health care
- Resiliency, self esteem, direction, mission, determination, perseverance,
- Optimism, empathy
- Intellectual competence, reasons for living

My recommendations to all of you that are decision makers and in positions of leadership in our country today is to do the following:

- Increase funding for American Indian youth prevention mental health and substance abuse programming and make sure the funding goes directly to the tribes.
- Review and revamp US public school education curricula to increase appropriate awareness of Native Americans today and our contributions to this society. Utilization of Native American authored resources should be the standard not a recommendation.
- Increase substance abuse and mental health treatment dollars. Currently, we have no tribal culturally appropriate specific mental health impatient treatment facilities for our youth and adults. Many of our tribal community members have to attend non-tribal health facilities that do not acknowledge or understand tribal spirituality and practices, therefore many of our people will wait until they are very sick to ask for help.
- Grants and federal dollars need to recognize traditional, cultural, and spiritual practices and people of the tribes as equals to mainstream western mental and substance abuse methodologies. States and the agencies in charge of overseeing dollars to tribes can be roadblocks to better care in tribal communities.

- Continued support for the Access to Recovery (ATR) SAMSHA funding which acknowledges tribal traditions, spiritually, and customs as viable methodologies in substance and mental health treatment.
- United States issue an apology to the Native American tribes. Canada, Australia, and New Zealand are examples of other countries that have done the same. This step would promote healing and relations between the tribes and United States.
- Increase overall healthcare funding for Indian Health Care via Indian Health Services.
- Increase the number of Gathering of Native Americans (GONA) community based healing trainings in Native American communities.
- Consult with U.S. Interior Department's assistant secretary Larry Echo Hawk on his national symposium on protection of children.
- Consult with One Sky Center, they developed a resource for Suicide Prevention for American Indian and Alaska Native Communities.
- Consult with Native Wellness Institute out of Oregon for community based healing and wellness initiatives.
- Invite Native community based trainers and spiritual leaders, not just tribal council leaders to find out what works. There are some great native community based trainers that have done great work like Billy Rogers and Theda New Breast.
- Native non-profit organizations like United National Indian Tribal Youth (UNITY) out of Oklahoma need to have increased funding to assist native youth.

Ms. BINNEY. Thank you, Mr. Genia.

Next, we will hear from Novalene Goklish, who is the Senior Research Coordinator for Celebrating Life Youth Suicide Prevention Program, White Mountain Apache Tribe/Johns Hopkins Center for American Indian Health, Celebrating Life/Johns Hopkins Project.

Thank you.

**STATEMENT OF NOVALENE GOKLISH, SENIOR PROGRAM COORDINATOR, WHITE MOUNTAIN APACHE YOUTH SUICIDE PREVENTION PROGRAM**

Ms. GOKLISH. Thank you. Good morning. My name is Novalene Goklish. I direct the suicide prevention efforts of my tribe, the White Mountain Apache.

Youth suicide, as you have heard, is the single biggest human loss a family or community can experience. It is destroying American Indian and Alaska Native communities. When you think of other behavioral health problems that affect youth, drug abuse, obesity, diabetes, some believe our Indian communities tend to see what is to come for other U.S. populations unless interventions are developed to stop these tragedies.

In the United States, suicide is the third leading cause of death for youth ages 15 to 24. Within the White Mountain Apache Tribe, our rates of death for this age group are 13 times the U.S. average and six times the all-Indian rate. In the United States, up to

500,000 persons a year require emergency department care as a result of a suicide attempt.

On our reservation alone, with a population of 15,500 members, our Indian Health Service hospital treats more than 200 youth a year for suicide attempts. The White Mountain Apache Tribe is devastated, but not broken by our problems of suicide. We see it as an obstacle we must overcome in order to share lessons learned with the world.

We choose research as our tool, with the help of our long-time partners, Johns Hopkins Center for American Indian Health. We have tackled past health disparities by producing public health interventions that now save more than 3 million lives a year worldwide. Today, we are turning our research focus on a range of interventions to prevent youth suicide. We are designing this research so that it can be reproduced across Indian Country and in rural and indigenous communities across our Nation and our world.

I want to share with you the important elements of our work. The White Mountain Apache Tribe, with technical support from Johns Hopkins, has developed the first tribally mandated suicide surveillance and follow-up system in the United States. In 2001, our tribe mandated that all health and human service providers and tribal members report suicidal behaviors to the Centralized Suicide Prevention Task Force.

These behaviors include suicidal ideations, attempts, deaths, binge drinking, drug use and cutting, which are also forms of self-injury in our community. Johns Hopkins assists in managing date, tracking quarterly patterns in suicidal behaviors and reports the information back to all tribal departments.

Along with Johns Hopkins, we have trained and employed a team of case managers who follow-up on every incident reported through the suicide surveillance system. The case managers assist youths at risk for suicidal death and triage youth and their families to available care. Prior to this, very few youths who attempted suicide, less than 25 percent, ever received treatment due to numerous treatment barriers. This the first community-based follow-up and triage system of its kind in this Country.

We are grateful for grants from SAMHSA, Garrett Lee Smith Youth Suicide Prevention Program and the Native American Research Centers for Health, managed by NIH and IHS. With this support, we are now developing evidence-based prevention interventions, including the following.

First, we have adapted an emergency department intervention of youth who have attempted suicide and their family members. Apache case managers meet with the youth and their families to help them develop a safety plan to keep the youth alive. We are now developing a research trial to prove the effectiveness of this intervention.

Second, we have adapted a life skills curriculum to be used in home outreach by Apache case managers with at-risk youth and their families. The curriculum teaches conflict resolution, coping and problem solving skills. We are planning a randomized control trial of this intervention in the near future to prove its effectiveness.

Third, we have trained and certified two Apache case managers to conduct gatekeeper trainings in our community, and that is myself along with my colleague Francene Larzalere-Hinton, who is sitting behind me.

Fourth, we have developed an Elders Advisory Council. Our elders are focusing on promoting traditional protective factors. They are speaking in elementary and middle schools and taking groups of at-risk and healthy kids on field trips to sacred sites on our reservation. They are teaching the youth the core strengths of our Apache heritage and are creating media campaigns to promote protective factors on our reservation.

Native communities have tremendous resiliency. We have survived untold adversity by blending our traditional wisdom with new technologies. Culturally appropriate research is a great example. We must harness the power of traditional understanding and rigorous scientific research to stop youth suicide.

Tribal and university partnerships that are built on trust and long-term commitment, such as the White Mountain Apache Tribe and Johns Hopkins, are the most powerful means for achieving renewed health.

Federal funds are well spent in the arena of suicide prevention to reduce the high toll of medical costs and human suffering to ensure our most precious asset, which is our youth, so that they can live to their full potential. In our belief system, every human life serves a purpose to maintain the health and well being of Mother Earth.

We must find the means to re-learn as a human race that life is sacred, that life is precious, that life is meant to be lived out serving our greater common purpose.

Thank you.

[The prepared statement of Ms. Goklish follows:]

PREPARED STATEMENT OF NOVALENE GOKLISH, SENIOR PROGRAM COORDINATOR, WHITE MOUNTAIN APACHE YOUTH SUICIDE PREVENTION PROGRAM*

Mr. Chairman and Members of the Committee, good morning. I am Novalene Goklish. I direct the suicide prevention efforts of my Tribe, the White Mountain Apache.

Youth suicide is the single biggest human loss a family or community can experience, and it is destroying American Indian and Alaska Native communities. When you think of other behavioral health problems that affect youth—drug abuse, obesity, diabetes—some believe our Indian communities tend to see what is to come for other U.S. populations, unless interventions are developed to stop these tragedies.

In the United States, suicide is the third leading cause of death for youth ages 15–24. Within the White Mountain Apache Tribe, our rates of death for this age group are 13 times the U.S. average, and 6 times the All Indian rate. In the U.S., up to 500,000 persons a year require Emergency Department care as a result of suicide attempt. In our reservation alone, with a population of 15,500 tribal members, our local Indian Health Service hospital treats more than 200 youth a year for suicide attempts.

The White Mountain Apaches are devastated but not broken by our problems of suicide. Rather, we see it as an obstacle we must overcome in order to share lessons with the world. We choose research as our tool. With the help of our long-time partners, Johns Hopkins Center for American Indian Health, we have tackled past health disparities by producing public health interventions that now save 3 to 5 million lives a year worldwide. Today, we are turning our research focus to a range of interventions to prevent youth suicide. We are designing this research so that it

*DISCLAIMER: None of the opinions expressed within are those of Johns Hopkins University.

can be reproduced across Indian country and in rural and indigenous communities across our nation and our world.

I want to share with you the important elements of our work:

The White Mountain Apache Tribe, with technical support from Johns Hopkins, has developed the first tribally mandated suicide surveillance and follow-up system in the United States. In 2001, our Tribe mandated that all health and human service providers and tribal members report suicidal behavior to a centralized suicide prevention task force. These behaviors include: suicidal ideation, attempts, deaths, as well as binge drinking, drug use and cutting, which are also forms of self-injury in our community. Johns Hopkins assists in managing data and tracking quarterly patterns in suicidal behaviors and reports the information back to all tribal departments.

In addition, with Johns Hopkins' help, we have trained and employed a team of Apache case managers who follow-up on every incident reported through the suicide surveillance system. The case managers assess youth's risk for suicidal death and triage youth and their families to available care. Prior to this, very few youth who attempted suicide (<25%) ever received treatment due to numerous treatment barriers. This effort is the first community-based follow-up and triage system of its kind in the country.

Our tribe has been fortunate to receive federal funding for our suicide prevention research. We are grateful for grants from SAMHSA's Garrett Lee Smith youth suicide prevention program and the Native American Research Centers for Health, managed by NIH and IHS. With this support, we are now developing evidence-based prevention interventions. What has been accomplished to date is state-of-the-art, and includes the following:

- First, we have adapted an Emergency Department intervention for youth who attempt suicide and their immediate family members. Apache case managers meet directly with the youth and their families to help them develop a safety plan to keep youth alive; we also help them connect to available services and follow-up to ensure they go. More than anything, we teach them that their suicide attempt was very serious and taking one's life is not the Apache way. We are now doing a research trial with 30 White Mountain Apache youth who've attempted suicide to prove the effectiveness of this intervention.
- Second, we have adapted a life skills curriculum to be used in home outreach by Apache case managers with at-risk children and their families. This curriculum, originally called the American Indian Life Skills Curriculum, was previously designed for schools. We have found that many of our youth who are at risk do not regularly attend school. Nor are their families involved with their schools. The curriculum, which we have named, "Re-Embracing Life," teaches conflict resolution, coping and problem-solving skills. It serves as extra support as the Apache case managers work to get youth and families to available mental health treatment on the reservation. We are planning a randomized controlled trial of this intervention in the near future, so we can prove its effectiveness.
- Third, we have trained and certified two Apache case managers to conduct ASIST gatekeeper training in our community. We as Apaches have renamed this intervention ASIST "caretaker" training. The training educates adults who work with at-risk youth to recognize signs of suicide and connect youth to care. The Apaches are planning to culturally adapt the ASIST training to be more relevant to Native peoples.
- Fourth, we have developed an Elders advisory council. Our elders are focusing on promoting traditional protective factors. They are speaking in elementary and middle schools, and taking groups of at-risk and healthy kids on field trips to sacred sites. They are teaching youth about the core strengths of their Apache heritage. Elders and youth are also creating media campaigns to promote protective factors on our reservation.

Some unique highlights of our work include:

- The Apache community-based suicide surveillance system is the first of its kind in the country. We hope it becomes a resource to other tribal nations across North America, and will strengthen culturally specific responses to suicide prevention and treatment.
- The training and employment of Apache case managers to increase the safety net and community connections for suicidal youth is completely unique. It has great potential for solving current barriers to mental health care on reservations and in other indigenous communities worldwide.

- Johns Hopkins and the Apaches have had a 30-year relationship developing evidence-based public health interventions that have been disseminated across the globe. The suicide prevention work is being designed accordingly, to have relevance in populations worldwide.
- The interventions we are designing are low cost and tap and strengthen our local human resources. Much of the prevention and post-intervention is focused on connecting youth to caring adult family members and to community treatment resources. The latest data from the CDC demonstrates that bridging connections to families is the most powerful prevention strategy.

Native American communities have tremendous resiliency. We have survived untold adversity by blending our traditional wisdom with new technologies. Culturally appropriate research is a great example. We must harness the power of traditional understanding and rigorous scientific research to stop youth suicide. Tribal-university partnerships that are built on trust and long-term commitment—such as the White Mountain Apache Tribe and Johns Hopkins—are the most powerful means for achieving renewed health. Federal funds are well spent in the arena of suicide prevention to reduce the high toll of medical costs and human suffering and to ensure our most precious asset—our youth—live to full maturity and potential. In our belief system, every human life serves a purpose to maintain the health and well-being of Mother Earth. We must find the means to re-learn as a human race that life is sacred; that life is precious; that life is meant to be lived out serving our greater common purpose.

Ms. BINNEY. Thank you.

So we are in a listening session right now, and as I said earlier, it is continuing to be webcast, so a lot of people in Indian Country watch our hearings via webcast, so we wanted to continue to do that. And there is a transcript that is still being taken that will be given to each of the Members of this Committee afterwards.

We thought that it would be helpful to go ahead and engage in a dialogue about this issue since you are all here, and maybe ask some questions. I know some of you have to leave, though, I think particularly Mr. Grinnell, you might have another function to go to. So feel free to leave when you need to, but we thought it would be nice to ask some questions and engage in a dialogue.

As part of the Indian Health Care Improvement Act that just was signed into law, there was a smaller bill that was basically aimed at youth suicide prevention in Indian Country that Chairman Dorgan sponsored and several Members of this Committee on both sides of the aisle sponsored as well.

And our hope is that that will make some progress in the prevention of youth suicides in Indian Country, but we know it won't solve the problem. And that is why we are holding the hearing today is to basically learn what are some other ideas that are working out there already that we can try to inject into the system nationally.

And with that, I would like to go ahead and ask some questions, Rhonda and I, and start with Coloradas Mangas.

Mr. Mangas, you mentioned in your testimony that there is a stigma with suicide among some Indian youth your age. And I grew up in a Native American community and am part Native American, and I agree with that, but I don't fully know where it comes from.

And since you are in the midst of it now, I was wondering if you had some thoughts about why there is a stigma with it?

Mr. MANGAS. This is kind of hard for me.

Ms. BINNEY. We can start with someone else, too.

Mr. MANGAS. Most youth won't go to our mental health clinic because there is stigma of shame that keeps people away. It is because they are afraid of getting talked about.

Myself, I know that by going to the mental health clinic, that I would be talked about by other Native American youth and by many other Native American people that I live with on the reservation. But I took that chance of going to the mental health clinic to get myself help.

I believe that most people really won't go because the problems that they have are big and then by adding on more problems of other people talking about them, it makes it even harder for them. So it is like most people want to seek help, but they won't do it because of the shame that is there of getting talked about or by having other people put you down because you did go these mental health clinics, or because you did show your face at one of these faces that most people won't even dare be seen walking out of a building like that.

And most of our youth that did do this, I believe that if they did go and get help, that yes, they would have got talked about, but the help that they would have received would have really helped them in a way that they wouldn't have made these attempts on their life or completed these attempts.

And it is hard for a lot of youth to get talked about. I mean, it is like just every little thing you do, you get criticized for what you did or you get placed a name on you that you don't really appreciate or something. And like for me, many of these children that I go to school with, they all like to talk about each other, and I knew that from the minute being seen walking out of this building, I was going to get talked about. But I was willing to take that risk just to get myself help.

And it was hard for me to get talked about because many of these people are like, oh, we have seen you walking out of this building, and I am, like, well, it is because I needed help. I really think that I needed help at the time. That is why I seeked it.

I wasn't afraid of getting talked about by these people or by other children, and I just put all that aside from the minute I walked into the building, thinking, well, this is going to help me and this is going to help my future because it's not something that I should be doing is making an attempt with my life. That is why I seeked help.

And the shame that is there for many of these children, they can't overcome it because it is too big on some people. I mean, if our people weren't afraid of going or being seen walking out of this building, I am pretty sure that many of the kids that did complete suicide would still be here with us today.

And I think it is just a shame that comes from being seen walking out of this building is what is kind of helping these kids stay away from this building because of not wanting to be seen or not wanting to be talked about.

And that is what I think is kind of leading to some of these suicides is that these children are seeking help, but they do not want to be criticized for seeking that help or being seen walking out of this building and get talked about.

Ms. BINNEY. Yes. Thank you.

So in light of those comments, Ms. Flynn, do you run into any problems using the TeenScreen questionnaire? Because if there is a stigma in Indian Country amongst the youth to kind of have a little bit, have shame if you go into a building and seek help. It seems to me that there might be a similar stigma or thoughts of shame if you are filling out a form and a questionnaire specifically about suicide and whether you are high risk. So have you run into that?

Ms. FLYNN. One of the keys, I think, is to try to bring mental health checkups into as many settings as is possible. So we have found that making mental health checkups available in schools, maybe as part of a health class or a science class, as part of a larger discussion about health and what we are learning about our emotions and the mind/body interaction. It can be built into that sort of a discussion in schools.

We also find that by inserting it into the routine sports physical as part of the basic checkup with your primary care physician in the clinic, just continuing to have it as a component of total health. It enables us to bring it forward and talk about it in the way that we, there are a lot of things we didn't use to talk about, a lot of disorders and diseases where the stigma has slowly eroded because we bring them forward. We explain and we talk about them openly.

It is also, I think, very important to pick up on what we have heard about these significant cultural components, and even the spiritual and historical components that are particular to Alaska Native and American Indian communities. And here again, where we see mental health checkups endorsed and supported by youth development organizations, by tribal elders, by leaders in the health community, it becomes something that is seen as part of healing the nation and supporting the youth.

We have also, frankly, heard in individual interactions from youngsters that although it may be difficult and awkward at the beginning for these kinds of issues and conversations to begin, but once they start, just as we heard from Coloradas, youngsters are relieved to have a safe and confidential place to go to deal with the concerns they have, to ask for the help that they need. Sometimes all they need is an opportunity for that open conversation to begin.

Ms. BINNEY. Thank you.

You mentioned the need to, as Mr. Genia was talking about, incorporate cultural and traditional aspects of Native American life. Does the questionnaire do that?

Ms. FLYNN. The questionnaires themselves, and we didn't invent these questionnaires. They are science-based screening tools and there are a variety of them. They are standard. What makes them appropriate is how they are explained; how they are administered; the education and support that surrounds the setting and the individual who is part of that. But they themselves are, just as with any physical health check-up, they are just basic questions that enable us to determine whether someone is at great risk for suicide; is beginning to show symptoms of depression or not.

The really important thing is to make them comfortable and culturally sensitive to the community in which they are being implemented.

Ms. BINNEY. Dr. Clayton, were you going to add something?

Dr. CLAYTON. I just wanted to add that, that the good thing about our film that I am recommending that you make with Native American youths in it. This was a film that the State of New York paid us to make. They asked us to make a suicide prevention film and we gathered a group of experts, and they were child psychiatrists and psychologists. And they said, we don't want to talk about suicide. You have to teach kids to talk about depression, and they didn't want kids to talk about themselves. They wanted them to show what it looks like to be depressed.

So we wrote 17 scripts. It took us two years. And then we hired a company and these are acted. So there are two girls and two boys, and one of them is a very good student. One of them is kind of, she is slowed by her depression. One of the kids, a boy, drinks too much and is irritable and pushing away his friends. And the fourth one is bullied on the computer. And so they all have different depressions and they get into treatment differently. It is 26 minutes, and we did test it, focus group test it on kids. And then we show it now in high schools, and I said it may be in 2,000 high schools around the Country.

And it does help the stigma. That is the whole idea of the film. It helps the stigma so that in school, there is a teacher guide, and the teacher is taught how to show the film in school. And it starts the conversation, we got feedback. I got feedback this week from a teacher who showed it in her school and she said afterwards two kids came up to her and talked about their own problems and she could then refer them. We talk about what to do next, which in this film is to refer to the guidance counselor, but each school has its own sense of where to go next.

But it really is a de-stigmatization film. We actually are going in May to win the American Psychiatric Association award for the best de-stigmatization film for this year.

So I really think there are scripts that have to be written so you have to know the culture and know what these kids present as. But once that is done, it is an amazing way to de-stigmatize depression in the school and drinking. We actually, because there was so much drinking, there is a party and there is all this other stuff, and beer bottles. And we had to get permission from the State school psychologist. They also looked at it, the head of the New York State School, to make sure that it wasn't excessive, the drinking and that. But they said, oh, no, that is the way it is. It is okay to do that.

So I mean I think a film is a really powerful way to begin to go. Then because we made this one film for kids, the State of New Jersey had passed a law that all teachers needed a two-hour training program in suicide prevention before they can be recertified. So we then went on and made a second film for teachers, and it shows clips of the kids, but it also has teachers talking about what they have seen in kids in school.

So again, you could do it with Native American teachers in Native American schools. So I really think it is a powerful tool that you should investigate.

Ms. HARJO. Thank you.

I have a couple of questions that I wanted to direct to Mr. Grinnell before you have to leave. And then, of course, there are

a few that could apply to the entire panel. So if anybody wants to respond after Mr. Grinnell, please feel free to do so.

First of all, as you know, healthcare services are important to treatment and screening for mental health issues and other risk factors that face Indian youth. But as we have heard from testimony today and in prior hearings, health providers are not the only element that is important in reducing suicide attempts and ideation.

Could you elaborate a little bit more on the partnerships that you referenced in your written testimony, not only with other Federal health agencies, but also with other components of the tribal community like law enforcement, the courts and schools?

Mr. GRINNELL. Yes. The first partnership I would like to talk about is actually under Dr. Roubideaux, our Director, her first priority has been consultation with tribal leaders. Under her tenure, she has actually established the National Tribal Advisory Committee for Behavioral Health. It is composed of tribal leaders across every area of IHS and there has been ongoing consultation with them about the strategic plans, as well as the funding that we receive for MSPI, for the Methamphetamine and Suicide Prevention Initiative, as well as other funding within behavioral health.

And so first and foremost, the Indian Health Service is reaching out and having consultation with tribal leaders, and that is the direction that the Director wants to go.

Secondly, the ongoing partnerships and collaboration that is taking place now, especially with SAMHSA and with other agency heads. Dr. Roubideaux has met with Pamela Hyde, the new Administrator for SAMHSA, as well as staff. Dr. Weahkee and her staff have been meeting with her colleagues at SAMHSA as well.

And she currently sits on a number of Federal committees, and I will let her elaborate on some of the other partnerships and activities that are underway.

But Dr. Roubideaux is fully committed to engaging with tribal leadership. She fully believes also that the success that we will have with these programs in behavioral health will be at the local level. They will be tribally managed. They will be tribally administered. They will establish the priorities. They will be culturally sensitive as well.

So I would like Dr. Weahkee to also talk about some of the other collaborations and partnerships that are underway as well.

Ms. WEAHKEE. Thank you. So a couple of the other partnerships I represent IHS on are the Federal Partners for Suicide Prevention Workgroup. And there are a number of Federal agencies that sit on that workgroup, including SAMHSA, CDC, the V.A., Department of Defense, a whole range of Federal agencies.

And we meet on a monthly basis to, one, share what we are doing in terms of addressing suicide prevention in the populations that we serve, but also to figure out ways where we can collaborate.

One of the things that we did collaborate on was that CDC, IHS and SAMHSA sponsored a meeting on suicide among American Indian and Alaska Natives and Hispanic Latino adolescents last September, where we invited national suicide prevention organizations such as the Suicide Prevention Resource Center and other Federal

agencies and tribal leaders to provide input and recommendations on how we should address suicide.

In addition to that, as Mr. Grinnell mentioned, we are working very closely with SAMHSA in terms of coordinating our suicide prevention efforts. Also recent discussions occurred with the Veterans Administration in terms of outreach to Native veterans and their families of suicide prevention. So we are working very closely with their Suicide Prevention Office.

And also in addition to that, working with BIA and BIE, the Bureau of Indian Education and Bureau of Indian Affairs, on how we coordinate our suicide prevention efforts in Indian Country.

So these are all in the planning stages in terms of implementing specific strategies. And again, working with our National Tribal Advisory on Behavioral Health to ensure that we are including the tribal voice in what we are implementing.

A few of the other national organizations that we work with are the National Suicide Prevention Lifeline, of the hotline, in terms of outreach and making sure that Indian Country is aware of that resource. We also have a relationship with Health Canada, the First Nations and Innuit Health Branch. And again, we share information on best practices and the strategies that both of our countries are engaging in to address suicide in Indian Country.

Ms. HARJO. Thank you.

Mr. Grinnell, we received testimony today from Ms. Flynn regarding some of the multiple activities they are conducting at Riverside Indian School, for example. Have you all been able to examine those types of activities and whether this is something that you could import into your strategies that you are working with with the BIA and BIE?

Mr. GRINNELL. I would like Dr. Weahkee to address that, if I could.

Ms. WEAHKEE. In terms of a national perspective, we haven't looked specifically at the TeenScreen, but definitely in terms of screening. She mentioned the Institute of Medicine report and the National Preventive Task Force and that they do promote screening among adolescents.

As an agency, one of our performance measures is screening for depression and we are expanding that into addressing screening for adolescents. So in terms of implementing that within our system, promoting integration of behavioral health in the primary care system, including screening for such issues as depression, is an important element that we are promoting nationally and that we are training on nationally all of our providers in our system.

Ms. BINNEY. Just to follow-up on that, one of the things is, Senator Dorgan has been personally impacted by suicide. And so one of the things that happens in Indian Country is many times when there is a suicide in Indian Country, we hear about it. He gets a note about it and he tries to call the family because it is a personal issue to him.

But one of the things that seems to be lacking is sort of a database on the amount of suicides that are going on in Indian Country. It seems that if we had better data, we could sort of better figure out where the crises are and where more funding or emergency funding needs to be sent out to.

And Ms. Goklish over at White Mountain Apache Tribe, they have implemented a mandatory surveillance and follow-up system. And I wonder if that is something, what your thoughts are if that could be implemented nationally in Indian Country. As Congress considered that, we would probably be going through the Indian Health Service to implement that.

Ms. WEAHKEE. We do have a suicide surveillance tool. It is called a suicide reporting form that we use in our system. It is part of our resource and patient management system. So it does collect information in terms of the gender, whether the person has attempted, whether there has been a death by suicide, if there is ideation, a plan, a means.

And so that is the tool that we do utilize, so we do collect that information currently. However, this is for the programs who actually are using the resource and patient management system. As you may know, many of our tribal programs choose to use another clinical information system and so their data may not necessarily be captured on our system. We do have some of that data.

One of the projects that we are currently working on is developing what we call a behavioral health data mart so that we can capture that information in one place. And someone, for example, myself could look at the data not only nationally, but all the way down to the service unit level and perhaps see the top 10 communities where there are suicide completions.

And hopefully, in terms of implementing that system, that we can, like you are saying, intervene much earlier by identifying when there are a high number of suicide attempts or suicide completions in a community.

Ms. BINNEY. Is the reporting mandatory or voluntary?

Ms. WEAHKEE. It is part of our performance measures, one of our GPRA performance measures, so that is something that is promoted. We do train all of our providers in terms of utilizing that system. The different programs can also generate their own reports, so it is useful in that way. But we still do have a long way to go in terms of improving our system to make sure that all of our providers are properly trained, know the tool is there, and actually enter that data into the RPMS system.

And the other piece of that is just working in terms of the partnership with CDC on suicide surveillance. They will be coming out with a published report on suicide surveillance definitions, so we will be looking at that in terms of improving our system.

Ms. HARJO. I think that data is really important, but that only applies to people who actually present or stop in to IHS or the tribal health facilities. What about the children that, I guess for lack of a better term, fall through the cracks, who don't show up to IHS? Or as Mr. Mangas referenced, will not go into the behavioral health center or have dropped out of school?

We don't have those youth-serving settings applying to those children. How do we reach out to those kids so that we can provide them with appropriate interventions and prevention services? And this is for the entire panel.

Dr. CLAYTON. I think the study that has mandatory surveillance, that Novalene talked about, is the answer. I mean, it is an amazing outreach where they train para-professionals, people in the commu-

nity to collect the data once the police or the health center or the E.R. has notified them. And they have a form they fill out. And they get pretty complete data on both attempters and completions, but it depends on the community and these para-professionals who fill in all this information.

She can tell you more about it, but it is very impressive.

Ms. BINNEY. Does it also depend on where there are mental health providers on the reservation? I mean, do you need them? Because I know in many Indian reservations, there is a significant vacancy in the mental health providers out there. So do you need to have those there in order to do the mandatory surveillance?

Ms. GOKLISH. No, our surveillance system, because spikes that we had on the reservations was implemented by the Tribal Council. And we do know that we have a shortage of mental health providers. And so the Tribal Council decided that we as a community needed to take our own action by doing something, and therefore they implemented the mandatory reporting and they also established the Prevention Task Force. And they started working with Johns Hopkins to establish some type of protocol so that we had the reporting system plus also a follow-up system so that, like what Rhonda said earlier, where they fall through the cracks.

We have a lot of that, where they don't go to the Indian Health Service. Of if they do, like for some of the examples that we have, a young lady went to the hospital because she wanted them to check her neck. She said her neck was hurting. She wasn't feeling well. And she explained to them that she was having thoughts of suicide. So in their system, it is put in there as her having ideations.

Once we receive the form and then our case managers, para-professionals follow-up with the young lady, she told us that it was an actual attempt. She hung herself. Her mom took her in to have her checked, but they never explained to the medical provider, the doctor, that her mom found her hanging and cut her down.

And so our data that we get, it is from a large range of different departments on the reservation. We work very closely with all the schools on the reservation. We also get self-referrals because we do a lot of in-services, so therefore a lot of community members are aware of the surveillance system that we do work on.

And it is not restricted to age. Our age group that is at high risk is 15 to 24, but the people that we receive a yellow form on is whomever. And so the youngest child that we have followed up with was only three years old and they were in the preschool program. And once we received this form the staff was shocked because of the age. And our oldest that we have ever followed up with is in their 70s.

And so, it is not restricted to age. Suicide is not restricted to anybody. It goes after whoever regardless of what your wallet looks like. And so we feel as a community that if we don't take action ourselves that it is not going to stop. And by us being able to follow-up with the youth, myself and Francene, we are also the ones that follow-up. We are out there doing these follow-up visits along with the other staff that we work with.

And it is hard to do this on a regular basis. Monday through Friday, we are constantly following up with individuals who have sui-

cidal behaviors. But more than 80 percent of them will never receive treatment. So we know that, if we at least talk to them, at least somebody is talking to them. If they are not going to get help from our Behavioral Health Program or the hospital, at least someone is talking to them.

We have also started an outreach program with the churches. We have quite a bit of churches on our reservation. One day I decided to go ahead and call all of the churches to see if they would be willing to meet with some of the community members who attend their churches because that is a request we were getting.

And so once I started talking to them and explaining why I was asking these questions and if they would be willing to talk to some of their members from their congregation, and they agreed that they would be willing to do that. But if the person needed further help, that we could also provide them with some referral forms so that they could get more assistance.

Our whole purpose of the reporting system is so that we can connect them to services to try to get them some type of help. And if they are really at high risk, then we try to keep following them until we get them something. But we hold on to a lot of our forms and we follow them. We have a long tracking system, so we follow them and try to find them and we have a 90-day window. Once we receive the form, we have the form for 90 days until we find them.

We receive over 500 referrals, the yellow forms that we call them because it is on yellow paper, the referral form. We have over 500 a year that come through our office and we follow-up with more than 80 percent of that. And we are able to enter that and track that. And so we know exactly what is going on, why it happened, if they were using drugs or alcohol, if they got into an argument or a fight.

So we ask a variety of questions to better understand what is going on, to better understand why our youth are doing what they are doing, why are they taking their lives. So that is why we said coping skills. They need some type of skills to help them get through this. And so it allows us to look into that further and to try and develop the program that we are also working on.

Thank you.

Ms. HARJO. I want to follow-up with you on your program out there, but I want to grab Randy Grinnell before he leaves. I guess this will be sort of my last two questions.

We often hear and have heard today about the intergenerational trauma that faces Indian people and youth in particular. What kind of research is out there or has been conducted on that issue?

Mr. GRINNELL. I will let Dr. Weahkee address the research questions.

Ms. WEAHKEE. Yes, there has been quite a bit of research. Marie Yellow Horse Braveheart, Bonnie Duran, all of those individuals, Joseph Gone, have focused on historical trauma and its impact in terms of the mental health issues that we are seeing today in Indian Country and how important it is to not only address the current traumas that many native communities are experiencing such as domestic violence and sexual assault and all of these issues that we hear about, but also to address the issues around historical trauma.

And as Hunter mentioned, until we acknowledge that this is also playing a role and a factor in Indian communities, we really won't begin that healing process. So I think by acknowledging historical trauma, the boarding school experience and what impact that has had on Indian Country, then we can move forward and begin to heal.

And you see that as part of components of the programs in Indian Country such as GONA, the Gathering of Native Americans, where they acknowledge historical trauma. But thankfully, now we have a lot more native researchers who are focusing on that issue.

Ms. HARJO. Do you think fetal alcohol disorders play a role in some of the mental issues of the youth today?

Ms. WEAHKEE. Yes. Fetal alcohol spectrum disorders definitely play a role. As you know, alcohol abuse and substance abuse are huge issues in Indian Country, and so that is something that as an agency we also focus on to ensure that we are educating communities about that issue, training our physicians and healthcare personnel in terms of screening and identifying early when that is an issue, and also having that as one of our performance measures, making sure that we are screening woman of childbearing age so that we can intervene earlier. So, yes.

Ms. BINNEY. It seems that, and Mr. Mangas has probably seen this in his community, several times in 2009, including on the Mescalera Apache Reservation, one or two suicides sets of a string, and you end up with a cluster. And I know that both Indian Health Service and SAMHSA try to be helpful in responding to those situations.

But it seemed like there was a lack of resources. And every department is being pulled in hundreds of directions, and we are in our economy and our Country is in a deficit right now. But when it comes to lives, particularly of youth, Indian youth, do you feel that there are enough resources available to address the problem, not just funding-wise, but mental health providers, resources, materials, research?

Mr. GRINNELL. As far as resources, and I am definitely not the expert on suicide, but it takes an effort of more than just the community. When you talk about a local community, then you talk about the larger community that it takes in order to really have an impact and prevent this major health issue.

The health aspect is just one component of it. Rhonda mentioned about justice and the importance of it. One of the things that has been pointed out, especially in some of the communities, is public safety is a major issue. That is something that has a tremendous impact on it.

I know that in some of the work that we have been involved in, such as at Rosebud and so forth, the youth said it is an issue about hope. And that comes into, as I mentioned in my written testimony about poverty in some of the places. In the reservations, there is high, high poverty, unemployment, these other factors that really come into play. We have heard about the issues about kids in schools concerned about their safety and bullying and all those things.

And so it is going to take more resources than just within the health arena. It is going to take all the partners working with the

tribes. And the key to this, and I really believe the success of this is really going to be at the local level. It is going to be the tribal leadership and their ability to establish their infrastructure and to maximize the resources that are available. And I think it is up to us and it is incumbent on us to help them to identify those resources and try to find ways to get those resources to those communities.

I know that one of the things that Secretary Sebelius has been since she has been in her position is really reaching out to tribal leaders to have consultation with them, to have true consultation about what is going on within HHS, about the programs that they have, and trying to improve the access of those resources for tribes.

And I think it is going to take a collaborative effort among everybody to really make sure that the resources are out there, they are effective, and they are there when they are needed.

Ms. HARJO. Well, one of the resources that was mentioned today in written testimony was having more youth shelters, particularly when the home life becomes toxic. According to the testimony, for some youth if they had a place to go for the night, they would not have made an attempt on their life. And that is very disturbing to hear, I think.

But for the entire panel, what kind of recommendations do you have for engaging the parents and the families so that these youth can feel secure at home?

Mr. GENIA. I just want to share a little bit. Some of the things that Novalene and Coloradas have pointed out is tribes being able to take ownership in their own direction for wellness and wellbriety on our reservations. And again, I want to point out that over 80 percent of the American Indian population live off-reservation and oftentimes a lot of our efforts are directed towards on-reservation.

And so when we are talking about funding and resources, we need to remember our people that are in the cities and urban areas that don't have any Native American health centers and oftentimes struggle with going to local community mental health agencies. There is a big trust and fear factor there.

I think one of the things that I see that has happened here, the success of White Mountain Apache is that they took ownership in developing their own program. In our residential treatment program, nobody directed us to do that except for our own Tribal Council. Now that we have opened it and increased access to it, over 250 of our own tribal members have gone through our own residential treatment program in just a little over four years.

If they were to go to Wisconsin, Minnesota or out west to where the Native American treatment centers are, I would guess probably over 200 of them wouldn't have gone at all. And so we need to put the dollars directly into the tribal communities and let us take our own direction and ownership with that.

And like what Mr. Grinnell had said is support us. Don't be a roadblock for us and make it harder with a lot of the red tape that prevents those dollars from coming directly to the tribal behavioral health centers.

Now that we have had a lot more of our own people go through residential treatment, we have more of our own people saying, you

know what? It is okay to get help. They are in recovery. They are sober. When I go to tribal membership meetings, I can sit down and talk to our people that said, a year ago I mean they didn't want to even show their faces. Their heads were covered, their hats low in shame. And now, they are bright. I mean, they are going to tribal college. They have jobs. They are working for our tribe.

And I am hoping that for our residential treatment program that a lot of them that have gone through recovery and are staying sober will actually come back and work for our own treatment center so that they can help those that are coming up behind them.

So when we are talking about reducing stigma and making it okay is that we need to feel good about it is okay to get treatment; that it is actually a cultural warrior value of courage and bravery, not one of weakness and shame.

And that is kind of what is happening in our community. We have had a lot of initiative towards wellness, well-briety, of all the things, of putting a name to it. Nobody liked to talk about how much sexual abuse has gone on in Indian Country because it was shameful to talk about it. It was the secrets and nobody wanted to talk about it and where it happened.

Now, we have a lot more people that are coming out and talking about it. And now that that they begin to talk about it, it makes it okay that it is, you know what? I don't have to feel ashamed of that anymore. So I think the same thing applies to alcohol and drug treatment, any kind of mental health, you know, issues or disorders.

And we have a lot of our spiritual leaders, our traditional people that are involved in our treatment care. Behind our Behavioral Health Center, we have a 55-foot longhouse and we have a sweat lodge and we have a teaching lodge. And we have 80 percent of our people or more that are asking for those approaches to be a part of their treatment. They are asking for it.

So we are just able to provide it, but they are the ones that when they come into treatment and are part of that intake and assessment process, they are saying, I want to learn more about language. I want to learn about my clan. I want to learn, I want to meet with a traditional healer.

And the funding source is, whether it be SAMHSA, IHS or other organizations, they need to recognize and acknowledge that that is who we are as tribal people, instead of saying, you know what? We are not going to pay for that type of service because we don't value and recognize that those are valid methodologies to helping our people, when we are that it is, and our people are getting better slowly.

We have a lot more work to do, but they are getting better and more people are saying, you know what? I feel good about being native and being sober and well. So I think those are some of the things that we need to take a look at is reducing the roadblocks to recognizing that there are more than just Western methodologies to treatment and care.

Ms. BINNEY. And it sounds like it goes—your statements just now go to Coloradas' statement of a stigma, and your tribe was basically able to break the stigma. But it sounds like that was only possible for, and I am wondering which one is the most important.

It sounds like the Saginaw Chippewa Tribe made this a priority, mental health. And it sounds like as part of making it a priority, the Tribal Council decided to invest a significant amount of its own money into the effort.

The Saginaw Chippewa Tribe is fortunate in that it is one of those few tribes that do have a successful Indian operation. If you didn't have that, I wonder if you would be able to be as successful with it.

So given the resources and given the Tribal Council making it a priority, and maybe Novalene can discuss it too. I mean, to really go after breaking the stigma in the community, I mean, it sounds like it needs to be raised to the level of a top priority with the entire tribal community, particularly the leadership.

Mr. GENIA. I would say absolutely. I mean, in the saying of, you can't give away what you don't have. I mean, so if we as a native people are not well, how are we going to give away wellness? How are we going to give away positive mental health if we are not well ourselves?

And we can have all the experts come in and tell us how to do it, but really it is up to us as a tribal community to take ownership in saying, you know what? Can we share with you what we think will work for our people? And can you help us that way and not the other way around?

And I think we are seeing a change and we are seeing a shift, but it is just in recent years where they are actually listening to the local tribal communities in helping us to not make getting funding such a red tape and bureaucratic process.

So definitely if—and I want to restate the Saginaw Chippewa Tribe is the exception when it comes to gaming and making money, the resources a priority to our tribal community. Most of the tribal communities in Michigan are not in that position. And when we go to tribal behavioral health quarterly meetings in Michigan, you are right. There are a lot of vacancies. There are a lot of position. I mean, we get recruited to go work for their tribes because they cannot fill those positions and we don't have enough of our own tribal people going into the counseling, social work, mental health, behavioral health fields.

So we have to come up with examples like what Nova in her community is doing, is by empowering our own people, our elders, our parents, peer to peer type of programs to invest in that way.

Ms. BINNEY. And it sounds like partnerships with research institutions, educational institutions are helpful. It seems like that is a hard partnership, maybe, to establish, coming from a Native American community myself, because there are a lot of distrust issues that are multi-generational because of multi-generational trauma.

And so I was wondering, Ms. Goklish, how did the White Mountain Apache Tribe develop the partnership with Johns Hopkins?

And I know, Ms. Flynn, that TeenScreen works with several tribes and I wonder how those partnerships came about.

Ms. GOKLISH. Our relationship with Johns Hopkins started in the early 1980s when we were having problems with diarrhea on the reservation and a lot of fatalities due to that, with infant fatal-

ity death. The tribe reached out and asked for assistance, and Johns Hopkins was the university that responded.

And Dr. Mathuram Santosham was the physician that came out, who is sitting behind me, and he came out then. And he was to work on the reservation with the tribal community for one year on the oral rehydration solution that was being developed at that time, which we now know as Pedialyte. And so that was the first time that they ever did that in any community and it was being done on our reservation.

It started in October of 1979, and Dr. Santosham came out and he was scheduled to be there for one year. He lived on the reservation for six years, working as a physician, and Johns Hopkins was able to establish a relationship with the tribe and also the Indian Health Service to start this research study program so that they could develop the oral rehydration solution.

And from there, they remained on the reservation and we have had a 30-year relationship with them since. They have never left. We have always had an office there. I have been working with Johns Hopkins for 13 years, and worked on several different programs. And a lot of our community members, some of them feel that certain programs we shouldn't be doing, but a lot of the programs that are developed under Johns Hopkins are not programs that are decided by Johns Hopkins. It is the tribal community that decides on what we are going to work on as a community, and then that is then taken before our local health board members and our Tribal Council.

And we usually have meetings with them on a regular basis to decide on what different areas we also need to look at. Like recently, binge drinking is now an issue on our reservation. We are having a lot of problems with binge drinking. This past year in 2009, we have had 10 suicides on our reservation. I already named the population size that we have, so that is really high.

And then in October, the school suspended over 50 kids from the local high school for binge drinking at school. So the kids are actually going to school and they are drunk. They are already intoxicated by 10 o'clock in the morning. And so the schools are reaching out. And so now, they are reaching out for help to the tribe and the tribe is gearing them towards us and saying, we want you guys to focus on this.

And so that is why the relationship is really strong. They reach out and they tell the staff that they have at the Center for American Indian Health with Johns Hopkins exactly what they want Johns Hopkins to focus on and that is how we have been able to work with them.

And when Dr. Santosham was there, he was able to build a strong relationship with the tribal leaders and it was a relationship that has continued to this day. He has worked with a lot of the delegates that were in office then who are in office now. And so, we are able to move forward and establish different programs and protocols that we have to follow that the tribe wants us to abide by.

And so, yes, we are the ones, we work directly under Johns Hopkins, but we are tribal members and we work directly in our community. And we also are the ones who maintain the data and tracking system of all the projects that are there, and all the data

belongs to the tribe. And whenever Johns Hopkins wants to utilize the data for whatever reason, they still have to go back to the tribe and ask their permission to use whatever they need, even though they are the ones that found the funding to work on certain programs and design different data templates for us to collect different data that we are working on.

And so it has been a long relationship. But it is because they took the commitment to stay and remain in our community. That is why the relationship is still strong.

Ms. BINNEY. Thank you.

Ms. Flynn, how did the tribal partnerships develop with Columbia University?

Ms. FLYNN. In our case, in each of the areas where we have worked, one of the members of the tribal leadership reached out to us. And I think why we were able to continue and move forward was because we made very clear that we wanted to learn from them and with them as we moved forward with implementation; that we didn't have a particular point of view about how the screening needed to be implemented; that we wanted to learn what was appropriate within that cultural context in that specific community; and that we were there to provide support and help. But again, it was, as you have heard, it was their leadership. It was their program. It is their youth. And I think that that fit very well with the general context in Indian Country, and so our program has been well received.

The other thing, I think, was that we felt and continue to feel very strongly that respect for the family and for the parents and engaging them as part of recovery is a very important component. So we really emphasize in all of our settings the significant importance of reaching and educating and engaging and helping families. Because parents want to do what is the very best thing for their children. Even parents who are impaired care deeply about their children. And whatever strength they can bring needs to be tapped because the health professionals and the programs have a tendency to fade away, but family remains, just as the tribal culture and community remains.

So we have always emphasized the importance of the family. And I think that, too, fit within the values framework of the tribal communities that we have been working with.

Ms. BINNEY. Dr. Clayton, does the American Foundation for Suicide Prevention have any partnerships with tribal communities?

Dr. CLAYTON. The only partnerships we have had are in our postvention works. And we have this training program to teach people to run support groups after there has been a suicide. And so we do it all over the Country. It is a day and a half program. And in South Dakota, we have done it twice in two different communities, and Native American people have come.

Now, I did not ask our survivor leader what the follow-up on that was because we do collect follow-up data. Have you actually held support groups in your home or in your church? You can do it wherever you please. So I don't know if, we have those data, but I don't know it.

And we have also reached out to V.A. hospitals, too. And had meetings in V.A. for survivor training. Again, it is all this postvention training that we have been involved in.

Ms. BINNEY. And it does seem that a movie, like you said, with Native American actors would probably resonate with Indian communities.

I don't know what you think about that, Mr. Mangas, being able to go into a classroom and kind of see your own peers, other Native Americans in the movie about suicide, and sort of how to respond to that.

Mr. MANGAS. I think it would really help a lot of the youth that are on the reservation because, like, many of us don't really have nobody to look up into these movies or stuff. All we mainly see is white actors or Mexicans or any other people except Native Americans.

And what if Native American actors being in like a suicidal movie or something like that, like showing what Native Americans really actually do go through, it would help a lot of the Native American youth, knowing that they are not the only ones out there that are going through this, and there are other reservations across the United States that do go through these suicidal attempts or suicidal completions like this.

And having other Native American youth from my reservation, like, seeing these movies or stuff, it would kind of help them not only knowing that they were not the only ones out there suffering with this kind of stuff, but knowing that there is help out there besides what we do have on the reservation. And they could go to our Council and kind of ask them to refer these people to come to our reservation and to help us not only with the suicide and drinking and stuff like that, but like with depression and with problems at home that would lead to these suicides, and that would lead these children to like using drugs or alcohol or getting into trouble.

It kind of, to me, it would kind of help the youth understand that there is help and that they don't always have to make an attempt on their life to get this help. They could as easily just go out there and ask a teacher or another person if they could see if they could try and help this youth to get this help to the reservation so that everybody could have it and not just people from different reservations like here in the East or out on the West Coast.

Because there are many reservations that are right in the middle of the United States that really don't seek this help because of, like, the shame and stuff that comes with it. Seeking this help is too great on some of the people. There is such a great honor of not even needing this help or anything, that they are too afraid or too shameful to seek it at the last minute.

And by having Native American actors in movies or stuff like this, then it would kind of help the youth to understand, well, we can seek this help because other Native Americans out there are seeking this help, and they are not ashamed of it, so we shouldn't be ashamed of it.

Ms. HARJO. You had referred to the film as helping the students, the Indian youth. But what would you say to the service providers, to the teachers, to the doctors and other people out there in the

community? What do they need to be doing to help these young people who will not seek out help?

Mr. MANGAS. They need, like, some of the people need to kind of put these cultural values into some of the youths' heads because many of the youth where I come from don't really respect their culture. They don't want nothing to do with it. And by having these, like our elders or like our Tribal Council leaders or just mainly their parents, having them put these cultural values into their head, and having them understand, well, this isn't what our Native American people used to do when they were having problems way back when, or they wouldn't use to use these ways of having people see that they need help.

They would have, it would kind of help the youth to understand, well this isn't what we should be doing because it is not what our people would want for us. And it is not what our people went through way back when to get us to where we are today.

And by having the elders put these cultural values in some of these people's heads or the youths' heads, it would kind of really help some of the youth to understand, well, my people did this for me, and I should be trying to help my people instead of trying to bring all this depression and all this to my people. I should be out there making an effort to help other youth better going through this and helping them to get through this so that they won't make these attempts on their life or make these completions with their life.

It would kind of really help a lot of youth because on our reservation, the thing about death is that whenever you do something to your body and you die, that is the way you are going to go into the next world. If you hang yourself, there is going to be a rope around your neck when you go into the next world. If you shoot yourself and you shoot your head off or something like that, that is how you are going into the next world.

And some of these youth don't understand, well, that is what our people used to believe way back when and that is why they wouldn't make these attempts or completion of suicide. That is why they would be out there fighting for their lives or fighting against other people.

And it would kind of really help a lot of youth to understand, well, maybe this is true. Maybe we will go into the next world looking like that. And some of these youth are so high on their horse that they want to look so perfect and everything, and then they do make this attempt on their life they are not understanding, well, what if this is really what is going to happen to me in the next life? What if I do come out looking like that?

And I believe that some of these kids don't really understand what their cultural values are and what is being taught to them. And so I think that if the elders and the Tribal Council would get out there and teach these children, well, this is what is going to happen in the next world. This is what you are going to look like if you do this to yourself in the next world.

I think it would help a lot of youth to understand, well, maybe I shouldn't do that because I want to look the same way for the rest of my life, even in the next world. And I think that would kind of help a lot of the youth to understand, well, we shouldn't make

these attempts on our life or we shouldn't make these completions on our life about suicide.

Ms. BINNEY. That is such an interesting point, in light of Mr. Genia talking about a lot of the people who have now gone through the residential program are asking about their culture and wanting to get more in touch with their culture.

Mr. GENIA. I want to kind of comment on that, too, because we built our own behavioral health facility, which has our prevention program, outpatient, residential. We have a domestic violence emergency shelter. Prior to that, where our program was, we had people that requested to come into the side of the building or behind the building to their appointments because receiving services for mental health and substance abuse was like, they didn't want anybody to know.

And slowly that has started to change, where we have had people in leadership within our tribe actually go through our residential program. And I am just, I am really so proud of them for doing that and taking the courage and that step to get help for themselves. Now other people can see that and say, you know what? It is all right. It is a good thing to do that to try to help myself.

But one of the things I wanted to mention, and I will mention this again, is that over half or half of our Native American population are under the age of 18. So probably your experiences and like mine going through secondary education is that oftentimes we were the only Native American student in our college or graduate courses.

And one of the things that I had done when I went through Grand Valley State University is that they were sending all these students these opportunities to go and study about other cultures from other countries. And I was thinking why are they putting so much money into sending people to Europe, to wherever, anywhere but tribes.

And so about six years ago, I had approached the master's in social work program about having their students come up to stay with us on the reservation for two weeks, and it is going on its sixth year. And I can tell you, in that short two weeks, they have learned more than they will ever learn in public school education through college education about who we are as a people, as a culture, our values, our history, why we deliver treatment services, mental health services the way that we do.

Now it is a very popular program, but we can't do that for all the universities and their social worker counseling programs. Unfortunately, we have no minimum standards here in America about what outcomes they need to learn about Native Americans in this Country.

So there is this population of populations graduating not knowing who we are, and there is a lot of ignorance. So I really think we need to somehow address some of the education standards so that people really still refer to us as those people, that we are still part of the invisible population here in America.

And until we do really look at some of those core things, I mean, I think we are always going to be kind of the minority and feel that way. Anyway.

Ms. HARJO. Earlier, in previous hearings as well as this one today, we have received testimony that many of the cultural practices need to be incorporated into treatment for behavioral health. But we also received testimony today that there perhaps should be some of the behavioral health methodology incorporated into some of the cultural settings, like screening, for example.

Ms. Goklish and Mr. Genia, what do you think about that as tribal health providers, the recommendation that screening ought to be incorporated in some of the cultural settings?

Mr. GENIA. I would definitely agree. Actually, in our behavioral health program, we have a cultural healer that is a part of our behavioral health staff. And so when we have ceremonies, actually, we have substance abuse treatment groups that actually meet in our longhouses and some of the groups actually go into sweats and our other cultural practices. So that is already happening in our setting.

And I would also say that because we don't have enough Native Americans in the field of counseling and social work, that a lot of the non-native staff actually stay on to work with us because there is something different than they have ever experienced in a non-native organization with their spiritual practices and cultural practices. So it is really kind of a unique thing that is happening.

But to get to your question is I definitely believe that we need our traditional healers, our spiritual leaders, our faith. She mentioned working with the churches and stuff. I mean, everybody has to come on board and this has to be a multi-disciplined, multi-faceted approach to addressing health issues in our tribal communities, including suicide prevention. It has to be okay to talk about. It has to be okay to receive help. And the more of our people that are in different disciplines within a tribal community, even if they are just non-working tribal members and staff, I think that is great. And we need to do that. And we are doing that somewhat already in our tribal community.

Ms. GOKLISH. For us, we really don't have a lot of our culture and tradition tied into, like, the behavioral health services that are provided. They do offer assistance if somebody would like a medicine man to do a prayer for them or if they would like to speak with a medicine man. If they can't provide the financial means that, the behavioral health services would be able to assist with that.

We feel that on our reservation, that a lot of our, not just our youth, but a lot of our tribal members feel a sense of loss. They don't have a sense of belonging because they really don't know the traditional setting. They don't know our culture, the language. We are losing our language, like a lot of other tribes are.

And so for us, being able to incorporate a lot of the cultural aspects into a lot of the questionnaires that are being asked, or like I don't know what type of surveys they have or what type of intake assessments they do, but in there, maybe ask information on how or what type of questions they can ask that would be culturally appropriate.

And then also to work directly with them to see what other things they would do, maybe they can incorporate sweats or other things that would make them feel more like they can be com-

fortable being native and then going and getting help for the mental problems that they might be having. We don't have a lot of that on our reservation. That is where we started working with our Elders Council. And the unique thing about our Elders Council is the majority of our Elders Council are very traditional, and the other half have a strong Christian faith. But that doesn't cause conflict with anything that we are doing with the youth because it is not about our elders. It is about our youth.

And so when our elders come together, when we first started this, we thought that we would have a problem with that because of their belief system and because they are older and you have to, we are very respectful of our elders. But working with this, our Elders Council that we have established, we have been able to do a lot with them. We have been able to work with the youth and the elders have been able to talk to them about what it means to be White Mountain Apache and that in order for them to be complete, what they need to understand.

And so we haven't reached out to a lot of kids, but the ones that we have been able to touch, we know that we have been able to make a difference just with our elders working with them, taking some of the kids to the sacred sites. When we took some of them to a couple of the sacred sites, some of the kids, they didn't even know that we were still on the reservation. They thought we had actually left.

So that is sad because they don't even know how big the land is. They don't know where it ends. They thought that we were going somewhere, on this big field trip off the reservation. We never left the reservation. The whole time, we were taking them on these field trips so they could better understand who they are and where they come from.

And so I think that the more we include things like that into the behavioral health, the mental health, that it is going to help them better understand who they are, accept who they are, and then it will make them even stronger so that they can become healthy again.

Ms. HARJO. Part of the testimony today indicated that the Federal dollars spent on Indian youth suicide prevention or Indian suicide prevention in general reduces a lot of the medical cost that is associated with the treatment and aftermath.

Mr. Grinnell or any of the panel, Ms. Goklish, is there any estimates about how much we are actually saving?

Mr. GRINNELL. No, I don't think we could come up with that information right now. I am not sure that we are able to capture that because that is a prevention aspect. I can ask some of our staff to look into it and we can get back with you.

Ms. HARJO. That would be really helpful.

Ms. Goklish, you elaborated on several aspects of the mandatory surveillance system. Of course, that being mandatory, could you describe, what are some of the teeth to that system out there? How do you require people to actually report?

Ms. GOKLISH. Well, the teeth in it is the resolution itself. And so the tribe did pass the resolution mandating all tribal departments, health providers and tribal members to report suicidal behavior. So the teeth in itself is the resolution that was passed.

And I think the backbone behind it is the staff that are working directly on it, which is us. And you know, us providing in-services on a regular basis to all departments on the reservation, reminding them that this is mandated by the tribe, and that when the tribe, considering that they are a sovereign nation, that they make their laws and that that is one of the laws that they have passed.

And so we work closely with the Police Department and other departments on the reservation, along with the Indian Health Service. We have a really strong relationship with the Indian Health Service and our Tribal Council on implementing this with all departments.

If we feel resistance from any department, we don't go back to the Tribal Council and let them know. We don't do that. We work directly with that department to make sure that they understand that this is something that the tribe wants and the community has accepted this, as part of our responsibility as natives, what we need to do to take better care of ourselves and also to step up and say that, yes, either I am suicidal or I do have a family member who is suicidal and that they do need help. I would rather have that person mad at me than that person gone.

And so we do have family members that will fill out a form on another family member, a friend will fill it out on another friend, or another individual will fill it out on themselves, saying that, yes, I do need help. I do recognize that I am suicidal.

And when we first started doing this, we had a hard time because speaking about suicide, it is a taboo. We were told, you don't speak about it because it is going to happen. You don't need to advertise it.

And so when we first started doing this, it took us a long time to get where we are at. So we have been working and doing this for nine years. It started in 2001, but actually the tribe's been really struggling with suicide for 19 years. And so it has been a long time that we have been trying to get help. And when we first had the spike on our reservation, I was in high school then. And so a lot of my cousins, my friends died from suicide. There are a lot of names out there.

And so, with the 19 years, there comes a lot of numbers of the people that have passed by suicide. And so with us, it is the tribes that put in those policies and we are enforcing it, but with permission from the tribe. We are tribal members, but we do work for an outside agency or department, which is Johns Hopkins.

But we are tribal members and I think that is what gives us strength and that we speak in our language and that we can explain to the community the importance of us doing this. And that, yes, it is taboo for a lot of our elders, but since we have established our Elders Council, they have told us that even though it is taboo, it needs to be spoken of because if we don't speak about it, it is going to continue and it is going to continue to take lives on our reservation.

And so with that, we were able to produce a DVD that we use, which we call New Hope. Our production crew is native and our actors are native. And so the DVD that we produced is geared towards youth who have made an actual attempt to make them realize that the impact that it has on their family and the community.

One attempt that we have has a big impact because the first responders who are going out there are also community members and so it affects them. And so they deal with that, and we explain that to the youth.

And the core purpose of that particular DVD is for them to understand that they do need help and that their attempt was serious and that it wasn't a joke. And that they could have ended their life and they wouldn't be here today. And so that was a DVD that we also produced.

Ms. BINNEY. That sounds similar to your guys' movies as well, Dr. Clayton.

Ms. FLYNN. Could I just add one comment. I searched through my papers in response to your question. I do have some information about how screening of youth can save healthcare dollars. And I have just a quick from the field story to share. It did not occur with American Indian population, but it did occur recently. And it is why we are working as well in emergency departments because so often that is a primary care spot for many youth.

With the advent of electronic medical records at Cincinnati Children's Hospital, a young girl came in, age 16, and her name was typed in for the first time as the electronic record came online. They saw over 35 previous entries. She had been seen in the emergency room for ear ache, headache, stomach ache, back ache, a whole panoply of symptoms. She had had all kinds of tests, MRIs. She had had all kinds of blood tests. She had been admitted overnight twice for all kinds of procedures.

Finally, on this 37th or 40th admission, she was screened for depression, which indeed she was found to have very significant and severe symptoms of depression, showing up as physical health symptoms. Perhaps because of stigma, she didn't want to discuss these other issues.

When she was asked about it, she readily acknowledged this was a problem. And indeed, now they have been able to address what was really driving all of these repeated visits for symptoms that were in fact symptoms of untreated depression.

I think it is not a rare example. We hear from emergency departments across the Country that this is a component that brings youngsters into the emergency room.

Ms. HARJO. So from that experience, one, is it perhaps a recommendation or something that needs to be evaluated as to the training for other providers, the rest of the community as the White Mountain has done in identifying these types of issues and symptoms?

Ms. FLYNN. I think absolutely. As we see integration of mental health, physical health, we look at the whole health of the youngster. And we realize that it is in adolescence that a lot of these significant mental health issues first arise. This is when we can first find the symptoms, but we do need colleagues across healthcare to learn about this, to be part of identifying and then connecting youngsters who need help to the treatment and supports they need. I think that is where we have to work together.

Mr. GENIA. Can I just add? A lot of the research and stuff, too, shows that when at the impact or onset that someone has been

traumatized, a lot of their developmental emotions, maturity levels kind of are thwarted at that age.

And if you take a look at what has happened a lot in Indian Country is that a lot of, whether women, parents that are at that age now have been victimized or traumatized in some way in their own tribal communities or wherever they grew up at, in their adolescence or teen years or younger.

And I guess the point I am trying to make really is that a lot of our efforts as far as putting money more into the prevention, the youth, adolescent ages is kind of where we need to be directing a lot of our monies. I mean, we do have treatment programs and stuff, and that is good to see. But we know that the majority of our youth, again, are under the age of 18. And if we can develop them, help them, nurture them and help them grow that hopefully this cycle will continue to stop.

So, and you had asked about the behavior, the money put into prevention versus medical care. And one of the statistics, Jessica, who is on the National Indian Health Board kind of pointed this out, too, was that for about every dollar that is spent in prevention, we save about three dollars in medical care costs or more.

So it makes a lot of sense if direct a lot of those efforts in Federal funding towards those efforts. We could be saving a lot more in healthcare costs down the road.

Dr. CLAYTON. I would just like to comment one more thing about the film, and then something else. I think the film is also useful, they have used in schools for the parents, too, at PTAs, to show them that kids can get depressed. And this isn't just a growing pain or bad behavior or a bad patch they are going through. It really could be depression.

So I think if you make a good film, that it can be used in multiple places. And the way we make sure it is used well is to have a very, very complete facilitator guide for the teacher, hopefully with a mental health worker, but when it is presented. So I think it has a lot of depth to it.

But I would like to say a couple of other things. Senator Franken opened by talking about a tribe in Minnesota who had another set of copycat suicides. And so they called in a team from Montana, he said, to help them evaluate the situation. And they did discover that there was some kind of pact in that particular community.

So I think another thing that should be done is that you ought to have some crisis intervention teams because contagion is a problem for adolescent suicide. There is a contagion thing that we have been involved with now on the campus at Cornell. And there is a contagion in Palo Alto, California in the high school.

So it is really a problem for youth because they are depressed, drinking and impulsive, and then this happens. So you need some well-trained intervention teams, I think, to go to other reservations when something like that starts to occur. You have to do it immediately.

And then I still think there are now very good short-term therapies for depression. There are psychotherapies. I mean, there are many drugs that are good. There are drugs for the treatment of alcoholism that have been used, I am told, in New Mexico successfully in Native American populations.

But there are good short-term psychotherapies. And there is one for suicide attempters that was developed by Tim Beck in Philadelphia, in the heart of the city. And 40 percent of the people in the study were men, which is very unusual, and 40 percent of them were black. So it was really in the neighborhood of downtown Philadelphia.

And they have used that same therapy now for the elderly. They have to adjust it. And I think you need to invest money in developing a kind of psychotherapy, a CBT therapy for Native American youths who are depressed or who make suicide attempts. I think a suicide attempt specific psychotherapy, while you are there, while the person is there, with focus groups. It is a complicated process to develop a psychotherapy, but it is proven to be effective. So I think it would be a mistake not to invest in those kinds of things.

And then finally, the V.A. in order to solve its problem with suicide attempts, it took a long time to work out, but they got the Crisis Hotline, which is all over the United States, to press 1 if you are a veteran, and then it goes to your community of veterans hospitals and that.

And I think you have talked about the Crisis Hotline some, but I think you should have a way to partner with this national Crisis Hotline so that Native American communities could also use it specifically.

I don't know. Those are just my thoughts on it.

Ms. BINNEY. So basically it would be like a, press 2 if you are a Native American?

Dr. CLAYTON. I think you have to press 1 if you are a veteran and then I think 2 if you are just—it was developed as a crisis hotline for the whole Country, not by age or anything. And so then when the veterans presented with this enormous increase in suicides, the first thing they did, it took about a year to partner with them. And so it would be press 3 if you are something, or 2, I don't know how they do it, but I think you need kind of a national crisis hotline.

Ms. BINNEY. I think you are right in that suicide, particularly among youth, can be contagious. And the studies and the stories and the anecdotes have shown that. And I think our hope and our Senators' hope is that having strong leaders in the community like Coloradas and Hunter and Novalene to sort of break away the stigma, that that becomes contagious to where people feel like they can talk about these issues openly and comfortably.

Also there are good young leaders who obviously are very proud of their culture and where they come from and of being Native American, and that becomes contagious as well.

We thank everybody for being here. We are going to wrap up, but I wanted to remind you all that with the hearing, the record will stay open for two weeks, as Chairman Dorgan mentioned. And that him and other Members of the Committee, because they couldn't be here and couldn't be here for the full time, will submit written questions to you for the record, and we will give you some time to respond to those questions as well.

I just want to thank everybody for being here on behalf of Chairman Dorgan, Vice Chairman Barrasso and all the Members of our Committee. We appreciate your coming for the hearing. We are

sorry it got cut short, and we really appreciate your staying around for the listening session and engaging in dialogue with us.

I don't think this Committee is going to stop holding hearings on this issue. They have been holding a number of hearings on this issue over the last seven years, and I think it is going to continue until we can really decrease the number of youth suicides that are occurring in Indian Country.

So again, thank you for being here.

[Whereupon, at 12:05 p.m., the listening session was adjourned.]

# A P P E N D I X

PREPARED STATEMENT OF DR. WARREN ZAPOL, COMMISSIONER, U.S. ARCTIC RESEARCH COMMISSION

Good morning, Chairman Dorgan, Vice Chairman Barrasso and Members of the Committee on Indian Affairs. I am pleased to submit testimony on Youth Suicide in Indian Country as part of the Committee's March 25, 2010, hearing. My testimony focuses specifically on youth suicide in the Arctic and on the goals of the U.S. Arctic Research Commission, which I represent as a commissioner.

I am the Director of The Anesthesia Acute Care Laboratories at Massachusetts General Hospital (MGH) and the Reginald Jenney Professor of Anesthesia at Harvard Medical School in Boston. I received my undergraduate education at Massachusetts Institute of Technology, attended the University of Rochester School of Medicine, and after graduation, served in the Public Health Service (1967–1970) at National Institutes of Health as a staff associate of the National Heart Institute. I currently serve as a commissioner for the U.S. Arctic Research Commission, representing academics and research while focusing on human health. It is in my capacity as the "human health" commissioner that I submit my comments.

The Federal Government, Congress and the Supreme Court have all determined that the Federal Government has a fiduciary responsibility to provide for the health, safety and wellbeing of Alaska Natives and American Indians. With youth suicide rates, especially in Alaska Native males, drastically exceeding the national average—the Arctic Human Development Report states that Alaska Native males are 80 percent more likely to commit suicide than the general American population—the Federal Government is not fulfilling this trust responsibility. Millions of dollars have been provided to stem these deaths, but youth suicide rates among Alaska Natives are increasing and continue to drastically outpace the American population, generally. We owe it to our Alaska Native populations to ensure that the federal funding provided for their health and wellbeing is used to promote maximized benefits—reductions in youth suicides.

Currently, the Federal Government does not know which programs work or which programs work most effectively to reduce youth suicides in Indian Country. It is critical that the Federal Government study these programs to determine how best to fulfill its fiduciary responsibility—without this, the Federal Government will continue to fund prevention and intervention programs, without regard to the programs' effectiveness in reducing youth suicides. This is not fair to our Alaska Native populations.

In recent years, there has been significant improvement in the general health of the Arctic resident populations, but significant behavioral and mental health disparities persist, especially between indigenous and non-indigenous populations of the Arctic. These disparities include unintentional injuries, suicide, homicide, infant mortality, and in part, account for a shorter life expectancy and increased mortality related to suicide and accidents in Arctic residents, as compared to residents in more temperate climates.

Although Alaskans face the same behavioral and mental health issues faced by communities in other states, the severity of many of the problems is often greater and there are special challenges posed by the remoteness of many Alaskan communities. Some of the health problems of greatest concern include, but are not limited to, elevated suicide prevalence, child abuse/neglect, sexual assault, alcohol use, high prevalence of Fetal Alcohol Spectrum Disorders, and unintentional injuries. Additionally, the rates of smoking and obesity are higher in the Alaskan Natives, compared to non-Natives, and there has been a rapidly rising incidence of diabetes.

As described in the Arctic Human Health Assessment Program's 2002 report, the younger age structure, and predominantly remote locations of the majority of the Alaskan Native populations makes the State's communities particularly vulnerable to these disparities; however, it also provides an opportunity for establishing culturally specific, community-based intervention programs that emphasize resiliency and preventive measures for behavioral and mental health promotion. Many agen-

cies and organizations have recognized the need to invest in further research and improve current services. There is also increased attention to the issue of culturally appropriate training of community-based health care providers. It is believed that coordination of these efforts will provide a maximal benefit to the affected communities.

The indigenous populations and other residents of the high northern latitudes disproportionately face a variety of mental and behavioral health and health-related social issues. Although many of these issues parallel those faced by residents of other rural areas, and are similar to those faced by other Native American populations in the lower 48 states, the problems in Alaska are compounded by the challenging physical environment (including extreme cold and photoperiod changes) and limited availability of and access to health services, and aggravated by the rapid social changes of the past few decades.

The Arctic Research and Policy Act, passed in 1984 (P.L. 98–373) and amended in 1990 (P.L. 101–609) was enacted to establish national policy, goals, and priorities for Arctic research. The Act established the Arctic Research Commission and an Interagency Arctic Research Policy Committee (IARPC). The Commission publishes a report on goals and objectives every two years to help guide the activity of the IARPC and its member federal agencies. In its 2009 report, the Commission outlined several research program recommendations. In addition to studies of the Arctic Region, Bering Sea Region, and research on resource evaluation and civil infrastructure, the Commission has called for a review of Arctic health research.

The Commission's recommendation for a research program on Arctic health calls for a focus on mental health in the Arctic since behavioral problems such as alcoholism, drug use, suicide and accidents are among the most frequent causes of ill health and death in Arctic populations (USARC, 2009). The Commission recommended that IARPC begin planning an interagency program to coordinate and emphasize research on mental health concerns in the Arctic, with the National Institutes of Health as the focal point for the effort. In response, a meeting on Arctic Mental Health was held under joint sponsorship of the NIH Fogarty Center and USARC in Anchorage on June 2 and 3, 2009. After a thorough review of the problems with extensive representation from Alaskan Native groups, federal organizations (NIMH, NIAAA, NIDA, Fogarty Center, CDC, etc.), State of Alaska agencies (Dept. of Health, CMO of AK, etc.), state legislators, and voluntary agencies (Mental Health Trust), it became clear that the problem was both difficult and chronic and little progress is being made toward reducing the suicide rate.

It was also believed that it would take extensive research to identify successful interventions, rigorously test them, scale them up, sustain them, and evaluate their effectiveness. The complete discussions of that meeting were published in December 2010 as a supplement to the International Journal of Circumpolar Health and are available on our website (*www.arctic.gov*).

It should be noted that, although a great number of northern residents are at risk and experience disportionate mental and behavioral health complications, there are also Arctic inhabitants who are resilient to these risk factors. These differences can be seen not only between individuals, but between communities or villages, suggesting an important socio-cultural component to resilience. It is unclear what makes some individuals or villages more resilient to the same factors that put so many others at risk. With few exceptions, there is no current, compelling framework to guide development of a primary prevention approach for mental illness or addictive disorders in the Arctic. That is, it is not known which societal strategies are the most effective at fundamentally lowering incidence and prevalence of these disorders. Strategies might include modifications in housing, socioeconomic status, education, environmental hazards, behavior and violence.

In Alaska, multiple federal, state and local agencies are involved in promoting, preventing and treating mental and behavioral health disorders. In some cases, these agencies collaborate with international partners in the pan-Arctic such as the Canadian Ministry of Health. Each of these agencies comprises a critical piece of the infrastructure that supports and maintains the health of Alaskans. For example, within the Federal Government there are at least five agencies active in providing assistance, including the Indian Health Service, Centers for Disease Control, National Institutes of Health, National Science Foundation, and the Health Resources and Services Administration. In addition there are well over 20 non-federal agencies providing behavioral health services in Alaska. A coordinated effort among the various agencies and organizations is needed to provide the most effective prevention and intervention services.

Researchers in the behavioral and social sciences are exploring resilience factors that allow better coping, recovery, and resiliency to social and physical trauma. Research in neuroscience is identifying mediators and mechanisms of altered brain

functioning and behavior. Community-based researchers are employing educational programs to teach cultural values and traditions, within the context of the modern society that may be successful in reducing youth suicides. Additionally, medical research is finding new approaches to diagnose and pharmacologically treat depression.

Focused research is desperately needed to identify more effective and comprehensive strategies for promoting resilience and recovery in individuals who live in the northern communities as well as to facilitate effective coordination among federal, state and local agencies. Despite many trials of intervention or "pilot programs" there is little effectiveness testing of interventions and no interventions have been scaled up to a statewide level. The mental health research agenda for northern residents is much broader than can be accommodated by a single agency. Despite the enormity of the problem, a minuscule amount of funds are devoted to mental health research in Alaska.

The U.S. Arctic Research Commission recommends that $1.2 million be made available for the Institute of Medicine (IOM) of the National Academies of Science to review what research is needed to improve the health of Alaskan Natives. This study will examine the science base, gaps in knowledge, and strategies for the prevention and treatment of mental and behavioral health problems faced by populations in Arctic regions, with a focus on Alaska. Specifically, the IOM research would:

1. Summarize the scope and nature of mental and behavioral health among residents of Arctic regions, with special emphasis on Alaska.

2. Assess the infrastructure for research into the mental and behavioral health issues in Alaska to determine if current mechanisms and resources are appropriate to facilitate progress in the field. This should include an analysis of which federal agencies are funding research programs and the mechanisms used to review research proposals.

3. Describe factors that contribute to promoting resilience and recovery among Arctic residents. Learn if any of these have been robustly tested for effectiveness. Learn if any of these have been scaled-up for large scale implementation. Have any scaled-up programs been tested?

4. Provide recommendations for strategies of implementation and testing of programs designed to increase resilience in the affected populations and reduce health disparities.

5. Describe and assess the infrastructure for prevention and treatment of mental and behavioral health in Alaska; including federal- , state- and community-based programs. This should include examination of collaborative efforts and discussion of ways to improve coordination between the multiple public and private agencies involved in promoting improved mental and behavioral health. The testing of pilot programs for effectiveness will be emphasized, and the scaling potential of pilot therapeutic efforts will be examined.

6. Identify steps that could be taken in the short- , medium- , and long-term to improve the mental and behavioral health of Arctic residents, including research needed to understand the impact of abrupt, Arctic climate change and rapid social changes on mental and behavioral health, improvements in community infrastructure directly related to improved health, changes in prevention and treatment programs, and mechanisms to improve selection and training of personnel for mental and behavioral health care services. Special emphasis will be made on the use of telepsychiatry to augment these efforts.

The U.S. Arctic Research Commission understands the widespread needs for funding of behavioral mental health services in Alaska for Alaskan Natives. In this vein, it is vital that the Federal Government carry out an IOM-based report of our knowledge and knowledge gaps to learn which strategies for sustainable interventions and prevention might most effectively and efficaciously be developed to optimize the use of these federal dollars and achieve the most beneficial effects. Only through rigorous examination and testing can evidence-based, sustainable interventions reduce the complex set of factors that influence mental and behavioral health in the Arctic, especially in Alaska Native youth. Thank you so very much for the opportunity to present this testimony before the Senate panel.

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PREPARED STATEMENT OF JULIA M. WATKINS, EXECUTIVE DIRECTOR, COUNCIL ON SOCIAL WORK EDUCATION (CSWE)

Dear Chairman Dorgan and Ranking Member Barrasso: On behalf of the 3,000 individual members and 650 graduate and undergraduate programs of professional social work education comprising the Council on Social Work Education (CSWE), I respectfully submit the enclosed report, *Status of Native Americans in Social Work Higher Education*,* to the official Committee record for the hearing that took place on March 25, 2010 on Youth Suicides and the Urgent Need for Mental Health Care Resources in Indian Country.

CSWE is a nonprofit national association representing graduate and undergraduate programs of professional social work education. Founded in 1952, this partnership of educational and professional institutions, social welfare agencies, and private citizens is recognized by the Council for Higher Education Accreditation (CHEA) as the sole accrediting agency for social work education in the United States. Social work education focuses students on leadership and direct practice roles helping individuals, families, groups, and communities by creating new opportunities that empower people to be productive, contributing members of their communities.

In 2007, CSWE formed a Native American Task Force to examine the current state of Native Americans in social work education. The report, finalized in late 2009, takes a close look at the disparities that exist with respect to Native Americans in higher education, focusing primarily on social work education. It examines the extent to which social work programs have been successful in recruiting and retaining social work students and faculty, as well as the extent to which all social work students are taught core competencies needed to serve the mental health needs of Indian Country. A primary finding of the report is that social work graduates (regardless of whether they are American Indian/Alaska Native or not) need to have baseline knowledge of Native American culture in order to effectively practice. The report also discusses social work programs across the country that have been successful in recruiting American Indian/Alaska Native students and faculty and suggests that these programs could serve as models for other social work programs.

As you will see by reading the report, and as was discussed during the March 25 hearing, capacity building can be a challenge for professions responsible for providing mental health services, especially to Indian Country. CSWE is committed to addressing the severe shortfalls plaguing the social work profession by implementing the recommendations made in the report to recruit and retain Native American students and faculty into social work programs, and to integrate Native American content into social work curriculum.

I hope you will take a moment to read the attached report. If CSWE or the Native American Task Force can ever be of assistance to the Committee, please do not hesitate to contact CSWE's government relations staff, Ms. Wendy Naus.

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PREPARED STATEMENT OF KEVIN MCCARTNEY, SENIOR VICE PRESIDENT OF GOVERNMENT RELATIONS, BOYS & GIRLS CLUBS OF AMERICAWHAT DO WE KNOW ABOUT ADOLESCENT SUICIDE IN AMERICA?

- One adolescent attempts suicide every minute.

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*The information referred to has been retained in Committee files and be found at *www.cswe.org/File.aspx?id=25694*

- Boys are 4 times more likely to successfully commit suicide than girls; however, girls will attempt suicide 4 times more frequently than boys.
- For every completed suicide, there are 100 kids who attempt it.
- There are 500,000 to 1,000,000 attempted suicides each year.
- There will be 100 suicides a week, 14 a day this year.

Suicide is common to all people, not just a particular ethnicity or socioeconomic group. There are many different reasons for suicide such as loss of a boyfriend/girlfriend, feelings of hopelessness or powerlessness, poor self-esteem, pressure to succeed, stress, family or school problems, abusive situations, depression, loneliness, and sometimes no visible cause at all. As front-line youth development professionals, Clubs are often first-responders to kids in crisis and in regions where suicide attempt and completion rates have skyrocketed, Clubs have established programs and protocol to address the issue. Two examples follow.

## Alaska

When the Boys & Girls Clubs of Southcentral Alaska launched an outreach program for Native youth, they began in remote village of Tyonek. This tiny community of approximately 150 Athabascan Indians had been plagued by alcoholism and a terrible teenage suicide problem, averaging more than one such death every year. The problem was so bad that tribal elders constructed a Suicide Wall to list the names of the young victims.

Since the Boys & Girls Club opened in 1993, not one child has taken his or her own life, and the Suicide Wall has been removed. Today, every youth in the village is a member of the Club, and names are now being added to the Youth of the Month Wall, which recognizes positive contributions by the young people in the village.

Alaska has the highest suicide rate in the nation and Alaskan youth are nearly four times more likely than youth nationwide to commit suicide. In response to this phenomenon, Boys & Girls Clubs launched a statewide suicide prevention initiative, Project LEAD, in 2002. Project LEAD (Leadership, Education, Acceptance, and Determination) is targeted toward at-risk youth in Clubhouse communities throughout urban and rural Alaska. Project LEAD builds protective factors in youth through academic and leadership programming, along with alcohol and substance abuse prevention programming. In the project's first year, sixteen youth suicide interventions took place. To date, 60 suicide interventions have occurred; three interventions were suicide pacts involving a total of nine young people.

The five-year $930,000 project, championed by key legislators, funded an Instructor in each community 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. As a result of the initiative, over 150 front-line Club professionals in 30 communities are trained in suicide intervention skills, and provide watchful support to over 15,000 children and teens statewide. These trained eyes and ears have identified 312 youth who exhibited one or more warning signs and are now building "profiles" on these youth. Profiles are a paper trail of each youth's progress in academic and job performance, peer and family relations, and counseling referrals.

## North Dakota

Boys & Girls Club of the Three Affiliated Tribes forged a critical partnership with the State of North Dakota and the Garrett Lee Smith Memorial Fund in January 2008 to address the devastating trends of suicide among Native American youth. Clubs approached the initiative as a way to change the culture of hopelessness among teens. Clubs worked with health professionals to insert the *Sources of Strength* curriculum in Clubhouses and school-based afterschool programs to reach children as young as age five. *Sources of Strength* is a suicide prevention and health promotion program designed to prepare diverse students to be capable "Peer Leaders" for focused suicide prevention activities with ongoing adult mentoring. The program raises awareness and uses protective factors (sources of strength) that help all students be resilient. The program focuses on positive strengths and resources that help students to overcome problems in their lives.

The Clubs' suicide prevention efforts are supported with a $40,000 grant, as well as in-kind services with Three Affiliated Tribes, Tribal Mental Health, Indian

Health Service, five school districts on the Fort Berthold Indian Reservation, the Gerald Fox Justice Center and the University of North Dakota. To date, 1,364 students are enrolled in at least one of our suicide prevention programs or activities. The program is evaluated by the State of North Dakota on a quarterly basis.

## Other Efforts

Boys & Girls Clubs in New Mexico, Arizona, Oklahoma and Colorado are also meaningfully engaged in teen suicide prevention.

### New Mexico

- Navajo, NM and AZ—Club professionals participate in community-based suicide prevention task forces; the Native HOPE curriculum is utilized in four schools that partner with Boys & Girls Club.
- Mescalero Apache, NM—The community has a grant through the school that uses the Native HOPE curriculum in a community center. There are Club members that attend this program.

The Native HOPE curriculum by Dr. Clayton Small focuses on strengthening adult-youth relationships and community action planning. Key elements include: (1) Culturally competent activities incorporating spirituality, humor, and important values such as belonging, mastery, interdependence and generosity; (2) Teaching team building, adult/youth trust, communication and team effectiveness; and (3) Providing advocates with information, skills and abilities needed to develop and maintain an active community team committed to creating an action plan to implement prevention and wellness activities to increase youth resiliency.

### Oklahoma

- Tahlequah, OK—The school district has a three-year grant for drug and alcohol prevention, and suicide prevention. The grant supports three therapeutic counselors at the high school, and Clubs have access to this resource.
- Chelsea, OK—County-wide counseling services are available in one Club facility.

**Southern Ute, CO**—The Club partnered with the county in its training of 60 gatekeepers in the ASSIST program; Clubs intend to seek support to train kids in the ASSIST program, too.

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PREPARED STATEMENT OF MARY J. WEILER, BOARD CHAIR, AMERICAN FOUNDATION FOR SUICIDE PREVENTION, NORTH DAKOTA CHAPTER

Thank you for the opportunity to provide written testimony for this committee hearing. My name is Mary Weiler—I am a survivor of suicide loss. On October 6, 2005, I lost my young daughter, Jennifer, to suicide.

This shining star graduated with honors, was an accomplished musician, an avid environmentalist, a loving and attentive daughter/sister, an advocate for the poor and disadvantaged—yet struggled with chronic depression and anxiety for over a decade.

Over time, I've come to learn that more than 90 percent of people who die by suicide have an illness such as depression, bipolar disorder, schizophrenia, or substance abuse at the time of their death—sometimes diagnosed, sometimes not. And after reading the letter that my daughter left for us, I have also come to understand that death by suicide is not intentional—it is a result of many complicated factors. I found out that due to the stigma that surrounds mental illness, she lived in fear and isolation and felt she was a burden. At the core, suicide is an escape from psychic pain or distress by a person who cannot—at the specific moment in time—find another way to cope. What I learned is that her experience with depression was totally remote from a normal experience, the horror induced by depression took on the quality of real physical pain that ultimately became unbearable for her.

I have also learned that suicide is influenced by biology, personal and social psychology, roles and relationships, and issues about the very meaning of each of our lives. Many factors come together in a multitude of different combinations to make a death by suicide. The more factors or types of mental distress or illnesses that one experiences, the stronger the state of vulnerability. I have learned that just as

people can die of heart disease or cancer, they can die as a consequence of mental illness. It has been established with reasonable certainty that such severe depression is chemically induced amid the neurotransmitters of the brain, probably as a result of systemic stress, which for unknown reasons causes a depletion of certain chemicals in the brain.

I've also learned that I'm hardly alone: research shows that more than 60 percent of us will lose someone we know to suicide during the course of our lifetime; more than 20 percent of us will lose a family member. Nevertheless, the historical stigma surrounding suicide persists, leaving many survivors of suicide loss feeling misunderstood and abandoned, yearning for comfort and understanding.

Survivors of suicide are also often victims of stigma—people feel awkward and don't know what to do or say to surviving family members. It is stigma that continues to keep suicide from the public's eye. People are afraid of the word, and worse, too often unwilling to be open to talk about the topic. If we can't get through the stigma, we struggle to be able to educate. It is only when we get beyond the stigma that education will be possible and suicide prevention a reality. The stigma issue is so important and critical to suicide prevention that over the last several years the American Foundation for Suicide Prevention (AFSP) has dedicated over 12 Million dollars to research alone and continues to be committed to funding research projects in the future.

North Dakota loses someone to suicide every four (4) days. Suicides rates of American Indian youth are the highest in the nation and escalating in recent years. There is still a great deal of work to be done to bring mental services to the local community to end the stigma and reduce the number of suicides on our reservations.

## What Mental Health Care Resources Are Needed

### *1. Better Data and Definitions—See Attached Public Policy Brief*

Fund demonstration projects in *tele-mental health* to find how these systems can be of greatest benefit in Indian County and fund infrastructure to connect service provides, families, and patients for communication and treatment planning with support networks while in treatment.

Promote and fund the interface of data and a *national registry* through IHS for suicidal behaviors and treatment, to provide data informing continuity of care across systems for inpatient, outpatient, dual diagnosis and other supportive services.

*Collecting statewide data* and establishing a mandatory reporting system to gather data; plan programming, and get youth needed services before they complete suicide.

*Establishing Uniform definitions*—collecting all the types and causes in injuries in emergency rooms is needed to develop uniform definitions (undetermined). Some drowning and single motor vehicle deaths are "misclassified" as natural or accidental when suicide would be more correct. Misclassifying of such deaths contributes to *under reporting* of official numbers.

### *2. National and State Research*

Encouraging research to develop *new treatment initiatives* aimed at reducing suicide by:

- Examining the relationship of domestic violence and child violence on suicide rates.
- Implementing Suicide Screenings Tools for our adolescents and college students such as the Interactive Screening Program through AFSP.
- Improving fire arms storage practices.
- Funding for research to determine evidence-based treatments for American Indian (AI) and Alaskan Native (AN) populations. Seek grant from AFSP.

### *3. Mental Health Services*

Increase funding to Indian Health Service (IHS) to increased the number of credentialed mental health professionals providing services in Indian country.

Increase funding of Indians into Psychology and Indians into Medicine to increase the number of American Indian (AI) and Alaskan Native (AN) providers in Indian Country.

Increase funding of loan repayment programs to recruit and retain qualified mental health service providers in Indian County.

Fund aftercare treatment programs and circle-of-care services for transition and follow-up treatment for Indian youth. Explore Post-vention program offered by AFSP.

### *4. Education and Training*

### Providing Training Opportunities

Require cultural competence training for service providers in Indian Country. Providers must relate to the cultural values of the people they serve.

Fund clinical placement, internship, and post-doctoral residency programs for AI/AN students for experiences working with clients in Indian Country.

Provide training for selected community members to begin Survivor of Suicide Loss Support Groups on the reservations.

### *5. Focusing on Protective and Prevention Factors*

Provide *Skill Building* tools for our young people—problem solving, conflict resolution, non-violent ways of handling disputes and new coping mechanisms.

Foster and celebrate *connectedness and strengths with family and friends.* Enlist the family members and friends in the plan for a young person who is struggling with coping. Explore Sources of Strength—Peer Resiliency Model.

*Restricting access to lethal means of self-harm* (i.e. firearms is still the leading method of suicide death).

*Develop "hope kit" for our young people to increase their social supports*—who to call; knowing the triggers of their depression then having a support person or action to deal with the trigger.

Provide appropriate *funding* for mental health care programs such as "Mental Health First Aid" that help to build community capacity and reduce stigma related to mental health issues and crises.

### *6. Advocacy and Collaboration*

Although suicide is clearly a clinical issue, it is also a *public health issue.* This necessitates a shift in focus from prevention and treatment at the *individual* level to prevention and treatment at the *community* level. Therefore, suicide prevention should no longer be solely the concern of mental health professionals but also that of the entire community.

The AFSP–ND Chapter has been fortunate to be able to collaborate with:

The ND Coalition for Suicide Prevention
The Gay Lesbian Bisexual Transgender community
The ND Department of Health and ND Department of Human Services
The Veterans Administration for Suicide Prevention
Survivors of Suicide Loss Support Groups
Mental Health America–ND
Law Enforcement and First Link
Prairie St. John's—Psychiatric Hospital
R.S.V.P Older Adults Volunteer Program
Public and Private School Districts
Universities and Colleges
Community Churches

In closing, what I have found is that individuals who are suffering from depression are not helped by lectures or by hearing all the reasons they have to live. What they need is to be reassured that they have someone to whom they can turn—be it family, friends, school counselor, physician, or teacher—to discuss their feelings or problems. It must be a person who is very willing to listen and who is able to reassure the individual that depression and suicidal tendencies are very treatable. *Seventy-five percent* of all suicides give some warning of their intentions to a friend

or family member. All suicide threats and attempts must be taken seriously. Treatment is of utmost importance, and may involve medications, talk therapy or a combination of the two.

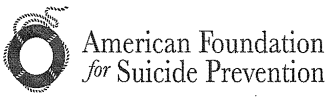
The American Foundation for Suicide Prevention is the only national not-for-profit organization exclusively dedicated to understanding and preventing suicide. AFSP promotes research, awareness and education and reaches out to people with mood disorders and those affected by suicide. In May 2007, the AFSP North Dakota Chapter was formed to engage in the following five core strategies:

- Funds scientific research
- Offers educational programs for professionals
- Educates the public about mood disorders and suicide prevention
- Promotes policies and legislation that impact suicide and prevention
- Provides programs and resources for survivors of suicide loss and people at risk, and involves them in the work of the Foundation

The work of suicide prevention must continue to occur at the community level where human relationships breathe life into public policy. The mindset should always be to improve mental health and get the best value (saving lives) for our spending—NOT just saving money!

If we provide mental health resources to the right people at the right time we can actually save money but most importantly we are SAVING LIVES.

## Attachment



**Public Policy Issue Brief – 2010**

**National Violent Death Reporting System (NVDRS) – Federal Initiative**

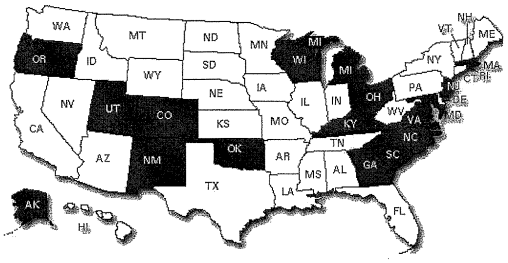
**BACKGROUND**

Each year in the United States, more than 50,000 people die from acts of violence, including more than 33,000 deaths by suicide. Many of these deaths are preventable. However, to design effective suicide prevention strategies, an essential first step is to ensure the availability of complete, accurate and timely information, particularly with regard to the populations at risk and the circumstances and predisposing factors that contribute to deaths from violence. By linking these data, the NVDRS can reveal new insights into the prevention of suicides, insights that can be used by state public health officials to better target their prevention activities.

Today, there exists no other data surveillance system that offers this benefit for such a modest investment. No other data collection or centralization effort carries the inherent value associated with NVDRS and, in fact, no other effort has the ability to directly inform and impact state and federal suicide prevention activities.

In 2002, the Centers for Disease Control and Prevention (CDC) began implementing the National Violent Death Reporting System (NVDRS). The National Violent Death Reporting System (NVDRS) collects data from medical examiners, coroners, police, crime labs, and death certificates to understand the circumstances surrounding violent deaths including suicide. The system currently operates in only 17 states: Alaska, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Michigan, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia and Wisconsin. Implementing the system nationwide is essential to developing, informing and evaluating suicide prevention programs.

**States Currently Part of NVDRS**




**ACTION REQUIRED**

**AFSP/SPAN USA requests $6 million for the NVDRS in FY 2011, an increase of $2,456,000, or 69.3% above the FY 2010 Omnibus. This increase in funding will allow for an additional 8-10 states to participate in the NVDRS. Expansion of the NVDRS will provide a more complete set of information that will be used to design more effective suicide prevention strategies.**

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RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO RANDY E. GRINNELL

*Question 1.* Can you describe how IHS becomes aware of and responds to these tragedies?

Answer. Most of the time, IHS becomes aware of these suicides from IHS Service Unit staff, Tribal health providers, or Tribal leadership. Our experience in responding to these types of events has taught us that our effectiveness hinges on a coordinated community response involving Tribal government; the local Health Departments; Emergency Medical Services; law enforcement; schools; faith-based institutions and spiritual leaders; and pertinent State and Federal offices. Proactive coordination of services and a designated point of contact are particularly important to reduce confusion in the community and increase the effectiveness of each partner's activities, as well as the effectiveness of the overall response. The more we can get people and agencies to work together collaboratively, the more likely the crisis can be managed quickly. A clearly defined intervention plan, consisting of adherence to

a unified message and crisis response is important for those needing immediate assistance and support.

Primary support comes through the IHS Area Office. The IHS Headquarters supports the Area Office in their efforts to assist the Tribal community. The Area Office works closely with the Tribal community to help coordinate IHS resources in the response. "In the case of self-government Tribes additional funding and resources maybe provided to assist in responding to a crisis in their communities."

While most responses are handled by the communities themselves, there are times when a crisis can be of such great magnitude that local response capacity may be inadequate or temporarily overwhelmed. In some of these situations, we may also be able to help coordinate emergency community stabilization assistance utilizing the U.S. Public Health Service Commissioned Corps Emergency Response Mental Health Teams. The IHS Emergency Response Model design responds both to the individual(s) in crisis and the community affected. This model is designed to assist all American Indian or Alaska Native communities in mitigating the immediate crisis, and stabilizing the community so that long-term solutions (planning, prevention, and implementation plans) can be developed by the community.

*Question 1a.* Do each of these communities have a mental health provider?

Answer. These communities often have a mental health provider. However, when there are vacancies or limited behavioral health providers, this can have a negative impact on access to behavioral health care. For example, a Tribal community may have difficulty recruiting certain disciplines such as psychiatrists and psychologists while, in other communities, there may be only one or two behavioral health providers. So, when there is a vacancy or a staff person takes time off, the community may not have access to behavioral health services. The availability and adequacy of mental health programs for American Indians and Alaska Natives varies considerably across communities.

*Question 1b.* How do you think Tribes, the Indian Health Service, and Congress could best work together to improve youth suicide prevention efforts and increase the availability of mental health resources?

Answer. The key strategy that IHS employs to address Indian youth suicide is to work in partnership with Tribes to bring services and resources together to focus on mental health needs and reduce the rate of suicide within American Indian and Alaska Native (AI/AN) communities. Tribes must be involved at every step of developing and implementing suicide prevention strategies within their communities. The IHS is currently working with Tribal leadership to coordinate programs, services, and resources to address this problem. This focus on Tribal collaboration marks only the beginning of a much larger, long-term process.

There also needs to be continued collaboration between Federal partners (such as IHS with SAMHSA, NIMH, DOJ, BIA etc.). This is not only beneficial but it is necessary. Continued coordination of resources across numerous agencies will allow the development and implementation of a comprehensive, integrated, public health approach to reducing deaths by suicide and suicide attempts. IHS plays a key role along with Tribal leaders in this collaboration.

The IHS National Suicide Prevention Initiative has five targeted approaches for suicide prevention and intervention that we continue to implement including assisting IHS, Tribal, and urban Indian programs and communities in addressing suicide utilizing community level cultural approaches, identifying and sharing information on best and promising practices, improving access to behavioral health services, strengthening and enhancing IHS' epidemiological capabilities, and promoting collaboration between Tribal and urban Indian communities with Federal, State, national, and local community agencies.

*Question 2.* Does the IHS track the number of mental health care providers in Indian Country?

Answer. IHS can generate reports that look for certain job categories, but there are limitations to the amount and type of data that can be generated. This information will only provide a "snapshot in time" because there is a great deal of turnover among mental health providers in tribal communities. In addition, behavioral health disciplines may not be clearly defined in data collection tools (e.g., "psychiatrists" fall under the general "medical officer" series); so, it may be difficult to ascertain which of those medical officers are psychiatrists. With over 50 percent of the Mental Health program and over 85 percent of the Alcohol and Substance Abuse program under tribal management, the IHS does not have access to tribal and urban Indian health mental health care provider data.

*Question 2a.* If so, how many mental health care providers work in Indian Country?

Answer. The numbers of mental health providers in the IHS civil service system are as follows:

Social Sciences (0101) = 93
Social Sciences Aid/Technician (0102) = 54
Clinical Psychologist (0180) = 60
Social Worker (0185) = 92
Social Services Assistant/Aid (0186) = 41
Social Services (0187) = 14
Medical Officer-Psych (0602) = 24
Psych Nurse (0610) = 5
Practical Nurse-Psych (0620) = 4

These numbers only represents IHS' federal service and does not take into account Tribal and Urban Indian mental health care provider data.

*Question 2b.* What is the vacancy and turn-over rate?

Answer. Although this information may be collected for IHS the vacancy and turn-over rate for mental health providers is currently unavailable. In order for IHS to be generated both a vacancy and turn-over rate, it (the number of vacancies and number of turn-over) would have to be monitored over a period time. The data for Tribal and Urban Indian programs are unavailable.

*Question 2c.* How many tribes have mental health providers?

Answer. This is a difficult question to answer given the increasing contracting/compacting of mental health programs by tribes and tribal programs, and their having no obligation under P.L. 93–638 to report such information to the federal government for programs they themselves operate. Subsequently, it is difficult to give an answer that accurately reflects all tribes and programs, so while we can report federal staff as in the question below, we are unable to do so for tribal programs. It is our experience and understanding, however, that the vast majority of tribally contracted/compacted programs do have their own providers. For some, most often smaller or more isolated programs, there are tribal consortia that pool resources and providers for their programs and communities. For higher level services as in intensive outpatient, residential, and hospital care, many tribes and tribal programs share resources or utilize contract health services to access providers.

*Question 2d.* And what is the breakdown of between psychiatrists, psychologists, social workers, and other mental health care providers?

Answer. We do not have a breakdown of behavioral health providers for Tribal and Urban Indian health programs. However, for the IHS federal civil service providers, the breakdown is as follows:

Social Sciences (0101) = 93
Social Sciences Aid/Technician (0102) = 54
Clinical Psychologist (0180) = 60
Social Worker (0185) = 92
Social Services Assistant/Aid (0186) = 41
Social Services (0187) = 14
Medical Officer-Psych (0602) = 24
Psych Nurse (0610) = 5
Practical Nurse-Psych (0620) = 4

*Question 3.* Do you think the current funding for mental health and suicide prevention is adequate?

Answer. The President's FY 2011 budget request for an increase of $4 million will help support AI/AN communities in eliminating behavioral health diseases and conditions which include early identification of factors contributing to suicide. The President's total FY 2011 budget request for Mental Health of $77,076,000 is approximately 13.8% over the Omnibus FY 2009 budget of $67,748,000, and approximately 5.9% over the FY 2010 enacted budget of $72,786,000. This is in addition to the $11.3 million increase for the Alcohol and Substance Abuse program which includes funding for the Methamphetamine and Suicide Prevention Initiative (MSPI) program. These increases reflect the President's commitment to addressing the ongoing need for mental health and alcohol and substance abuse programs servicing Indian Country.

*Question 3a.* What kinds of resources and funding do you think is necessary?

Answer. Funding provided for the Methamphetamine and Suicide Prevention Initiative, is now, for the first time, offering community developed and delivered direct services and support in 127 programs across Indian Country. These programs were developed and are now being delivered by the communities themselves, and are acting as pilot projects and community laboratories for innovations that will hopefully be able to be utilized across systems and communities.

Current program funding has been used to develop a suicide surveillance reporting tool which documents incidents of suicide in a standardized and systematic fashion. This tool captures data related to specific incidents of suicide which are essential to accurate data analysis. Through programs like the surveillance reporting tool, IHS can better target resources both now and in the future. In addition, funding for the Methamphetamine and Suicide Prevention Initiative, is now, for the first time, offering community developed and delivered direct services and support in 127 programs across Indian Country. This program is being implemented by communities acting as pilot projects and community laboratories for innovations that will hopefully be utilized across systems and communities. These types of programs and initiative maximize current resources and target current funding to where it is most needed.

*Question 3b.* Of the funding going to tribes for mental health services, how much is devoted to suicide prevention or related activities?

Answer. IHS does not have data on how much of the total funding going to tribes for mental health services is specifically dedicated to suicide prevention. What we do know is that in FY 2010, $16.3 million of the IHS alcohol and substance abuse budget is dedicated to the Methamphetamine and Suicide Prevention Initiative.

*Question 4.* What do you think is the biggest barrier to data collection in the Indian health system?

Answer. We have made substantial efforts over the last several years to improve our behavioral health data collection in the Resource and Patient Management System (RPMS) and will continue these efforts. The biggest barrier to data collection is that not all tribes utilize this electronic method of data collection although it is increasingly being used across our Indian health system. The data from tribes that do not utilize RPMS may or may not be integrated into the larger RPMS data set, dependent upon the tribal program. In addition, tribes can elect to not transmit their data to the IHS national data warehouse. Inconsistent data collection does not provide a complete picture of the health issues in Indian Country.

*Question 4a.* Do you think improvements in tracking and collecting youth suicide statistics would be helpful in preventing youth suicide?

Answer. Yes. In order to address the suicide epidemic in Indian Country, data collection and analysis are pertinent components to developing a comprehensive public health response to the problem. The greater the levels and quality of information available from the point of care through to national programs, the better Indian health programs and health systems can track and trend needs, then target limited resources and services to where they are needed most. The better the data, meaning the better the nature and quality of health information, the better the systems of care can then respond to health needs.

*Question 4b.* In the past, has IHS looked at implementing a mandated reporting system like the one being used on the White Mountain Apache Reservation?

Answer. IHS has already developed and implemented a suicide surveillance reporting tool to document incidents of suicide in a standardized and systematic fashion which is available to all providers in the RPMS health information system. The suicide surveillance tool allows clinicians to document incidents of suicide, including ideations with intent and plan, attempts, and completions. It captures data related to a specific incident of suicide, such as date and location of act, method, contributing factors and other useful epidemiological information. With the expansion of suicide data collection to the primary and emergency care settings, IHS will have more comprehensive and reliable information about these occurrences. The data will be used to better understand the prevalence of suicide in the populations served by IHS, Tribal, and Urban Indian healthcare facilities and to inform intervention and prevention activities.

Most patients with serious suicidal ideation or attempts present first to providers in primary or emergency care. The availability of the RPMS suicide surveillance tool for all providers in IHS, Tribal, and Urban Indian healthcare settings will promote standardized and systematic documentation of suicide events. Suicide data can be analyzed locally through RPMS reports and is exported nationally, so that we can develop a better understanding of this important public health problem.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. AL FRANKEN TO RANDY E. GRINNELL

*Question 1.* Mr. Grinnell, we have a serious shortage of mental health providers in Minnesota, especially on the reservations. In your testimony, you describe the challenges that these providers face in Indian country and some of the remedies that IHS has tried. Your description of telehealth services seems like a point of light and I'd like to see them expanded. Have other remedies have been effective?

Answer. There have been other promising approaches to address access to and quality of mental health care. IHS is promoting the integration of behavioral health services into the general healthcare delivery system through the spread of primary care-based behavioral health services following models already successfully implemented by the Veterans Healthcare Administration and branches of the Department of Defense. A good example of such activities coordinated across the healthcare system is the nation-wide promotion of the Alcohol Screening Brief Intervention model, which has been demonstrated to reduce trauma recidivism by up to 50% in some settings. Such models recognize the complex interrelationship of medical and behavioral health concerns and offer opportunities for early intervention rather than waiting for the development of fully manifested mental health disorders. The IHS is also working to improve the psychosocial care delivered to patients with chronic illnesses such as diabetes and improve their long-term outcomes through recognition of and attention to intertwined behavioral health concerns.

*Question 1a.* What can we do to attract mental health providers to Indian Country and keep them there?

Answer. Over the years, we have attempted to apply a number of remedies to attract mental health providers such as adopting special pay incentives in order to make reimbursement packages more competitive, making loan repayment and scholarship programming available for a wide range of behavioral health specialties including social work, psychology, and psychiatry, along with active recruitment, development of the Indians into Psychology program, and emergency deployment of the United States Public Health Service Commissioned Corps mental health teams. Increasing access and availability to these programs is necessary to attract additional mental health providers. For example, this year the IHS scholarship program received approximately 1,200 applicants while only a little over 100 will be selected. Increasing staff self-care, clinical supervision, and support will also serve to reduce staff burnout and isolation.

Intern programs allow Indian Country to utilize mental health providers still in training that can see patients under the supervision of a licensed health professional. The initiation of pre-doctoral intern programs will help increase the number of patients accessing care and serve as a recruitment tool for psychologists and psychiatrists. Standing Rock has implemented a pre-doctoral psychology intern program and has been able to triple their patient load as a result. In addition, multiple interns have agreed to stay on and continue to practice mental health on the reservation when they are licensed. The IHS Albuquerque Area Office has funded an American Indian psychology intern program since 1993. The Albuquerque Area Office is part of the Southwest Consortium Pre-doctoral Psychology Internship program, which includes IHS, the Albuquerque Veterans Healthcare Administration Medical Center, the University of New Mexico Hospital, and Forensic Health Services. The interns work in numerous sites across the Albuquerque Area. They have trained numerous American Indian psychologists, many of whom now work in Indian Country.

The potential for expanding these types of programs is a way to improve health care and recruit mental health providers. Without psychology internships in rural and underserved areas, there is a failure to complete the "pipeline" of training needed to recruit and retain mental health providers in Indian Country. IHS will continue to make every effort to support and expand psychology internship programs. The President's FY 2011 budget request for over $41 million for Indian Health Professions contributes to this effort.

*Question 2.* What are the challenges that arise when people have to attend non-tribal facilities?

Answer. Although providers in these facilities may be well-trained in medicine and healthcare and are eager to practice and serve American Indian and Alaska Native patients, they lack knowledge and understanding about this population. This can hinder their communication with their patients. We know from the Institute of Medicine that effective provider-patient communication can build respect and trust, resulting in better patient outcomes. We also know that patient-centered care is essential for quality care and, ultimately, more equitable care for all. It is important that providers understand the cross-cultural aspects of mental illness in American

Indian and Alaska Native patients so that they can effectively evaluate and manage these disorders. Providers who understand the differences between Western and traditional Indian perspectives in the role of culture in mental health and how these perspectives may influence the types of mental disorders seen in American Indian and Alaska Native patients can be more effective in treating their patients.

*Question 3.* Can you please discuss what IHS mental health programs do to help *families*, not just individuals with regard to mental health and substance abuse?

Answer. We strive to support American Indian and Alaska Native individuals, families, and communities by: (1) maximizing positive behavioral health and resiliency in individuals, families, and communities; (2) improving the overall health care of American Indians and Alaska Natives; (3) reducing the prevalence and incidence of behavioral health diseases; (4) supporting the efforts of American Indian and Alaska Native communities toward achieving excellence in holistic behavioral health treatment, rehabilitation, and prevention for individuals and their families; (5) supporting Tribal and Urban Indian behavioral health treatment and prevention efforts; (6) promoting the capacity for self-determination and self-governance, and; (7) supporting American Indian and Alaska Native communities and service providers by actively participating in professional, regulatory, educational, and community organizations at the National, State, Urban, and Tribal levels.

Specifically for families, IHS supports the development of locally-driven initiatives that aim to lessen the impact of risk factors while enhancing those factors that are known to protect against suicide, mental health conditions, and alcohol and substance abuse issues. Families provide the essential support and nurturing for individuals, thus supporting families is critical to supporting individuals, and vice versa. The vast majority of mental health programs offer services for both individuals and families. In fact, in most tribal communities and programs it is difficult to separate families and individuals in overall provision of direct services. Indeed, particularly for youth, standard treatment includes regular family involvement. Additionally, traditional knowledge, along with the role of elders, spiritual leaders, and extended family/clans needs to be respected and validated for the important role they play in healing and wellness. In this regard, family, again, is central and integral. Increasing protective factors, as in utilizing traditions and family, are equally or more effective than decreasing risk factors in terms of reducing suicidal risk, mental illness, and alcohol and substance abuse. Family, culture, and tradition are cornerstones to providing effective behavioral health services. IHS works to use practice based interventions that can integrate these to increase their effectiveness in Indian Country. We have found that programs that integrate them are more effective within the communities and with our youth, families, and communities.

Nurturing of children and promoting their safety are the most basic aspects of American Indian and Alaska Native cultures. Protection of children against harm is embedded in cultural and spiritual beliefs, child-rearing methods, extended family roles, and systems of clans, bands, or societies. Traditional family values bring strength to community-driven efforts to prevent suicide, mental health conditions, and alcohol and substance abuse among youth, families, and communities. Every community member including families, businesses, community leaders, and others have a role to play in keeping children and youth safe. Community members can promote protective factors by ensuring their programs include spiritual beliefs, traditional values and healing methods, spiritual and cultural continuity, and ensuring that their young people have a valued role in preserving their heritage.

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RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO PAULA J. CLAYTON, M.D.

*Question 1.* The American Foundation for Suicide Prevention (AFSP) organization has 32 community-based chapters focused on grassroots suicide prevention, including an active chapter in the state of North Dakota. How many of the AFSP state chapters of work with tribal communities? Do you think there are ways for AFSP to get more involved and assist in youth suicide prevention activities in Indian Country?

Answer. AFSP currently has 40 chapters, many of which are on the East Coast, fewer on the West Coast and fewest in-between. As you indicated, our firmest connection with tribal communities is in North Dakota, but an additional two or three chapters have some connections with Native American groups. I believe, however, that if more suicide prevention materials specifically addressing these populations were available, other AFSP chapters would reach out to tribal communities.

We currently have three programs that might be applicable to these communities. One is the award-winning *More Than Sad* film series that I brought with me to the

hearings, which include a film on teen depression designed to be shown to high school-aged youth, and another on youth suicide prevention for teachers and other school personnel. More information about these products is available on the website, *http://morethansad.org.* With the necessary financial resources, these films and the accompanying educational materials could be adapted to specifically address youth depression, drug use, and suicide in Native American communities. We would recommend using Native American teens as the actors and actresses in the teen film, establishing an advisory committee to guide the effort that includes both adults and youth from tribal communities and focus group testing all products while in draft form to assure that they will be readily accepted by the intended audiences and effectively convey the intended messages. The *More Than Sad* films have been well-received by schools in general but I should note that they are expensive to make. Our funding came from a grant from the New York State Office of Mental Health, which was supplemented by gifts from several additional donors and by proceeds from our Out of the Darkness community walks. If a parallel package of educational materials were available for teens and educators in tribal communities, I can envision our chapters reaching out, as they do so well, to bring them to the appropriate communities across the country.

The second project is a DVD on Depression and Bipolar Disorder that educates patients with mental illness and their families about these illnesses. Like the previously discussed films, this DVD was made for a general population, but may be informative for Native Americans communities. Again, its relevance and resonance should be focus group tested with appropriate community members. In this case as well, developing a parallel product that specifically addresses these illnesses and perhaps others having high prevalence in tribal communities would be ideal, although would require special funding. I would like to emphasize that well-developed, appealing materials is in the long run a cost-effective way of educating and engaging youth, their parents, teachers, community leaders and other adults around the topic of suicide prevention. Investing in the development of culturally appropriate materials would represent a major step toward encouraging treatment for depression and other mental disorders and reducing suicidal behavior in these communities.

Third, AFSP has developed an anonymous, online interactive screening program for persons aged 18 and older, which would be extremely helpful for those Native Americans who have access to the Internet. It is possible it could also be accessed through use of online chat rooms. This program screens for stress, depression, alcohol and substance use, anxiety, eating disorders and suicide, and is currently being expanded to include PTSD and other conditions prevalent among veterans. Its purpose is to engage an individual through an anonymous online discourse that will lead to in-person evaluation and treatment. As part of this program, AFSP staff work closely with the schools, workplaces, veterans facilities and other sites that are using it, and would welcome the opportunity to discuss with tribal leaders how the program might be adapted to Native American communities.

*Question 2.* In your testimony you described the research and suicide prevention work of the AFSP and also your extensive work on youth suicide prevention and mental health issues.

Most of the AFSP efforts you discussed seem to be focused on screening and early detection. Once you have identified a child that should be referred to a mental health professional, how difficult is it to get that child into treatment?

Do you think a dramatic increase in access to mental health providers and other resources could help to turn around the tragic rates of suicide in Indian Country?

Answer. You note, rightly, that most of AFSP's efforts are on screening and early detection but you wonder about entry into treatment. As I read the testimony from various tribes that were sent to me before the committee hearing, I was struck by the complexity of getting a referral. In some tribes the route of the referral has to be approved by the governing council. It seems to me that the simplest thing for the tribes to consider is to refer all suspected problems to the individual's primary care doctors, who would be trained how to detect depression, substance abuse and other problems, how and when to treat and when to refer. Multiple studies indicate that when primary care doctors are taught to recognize and treat depression, the suicide rate goes down, significantly, in the community being studied. Other primary care providers such as nurse practitioners and physician assistants could also benefit from such training. I am sure each tribe has different resources, so it will vary. Certainly, as was told in the hearing, it would prevent the provider from not appreciating the seriousness of a distressed young woman with rope burns on her neck from attempted hanging and from only giving her a cursory evaluation and no treatment before sending her home.

I am also not clear why there are not AA and DA groups on the reservations. Clearly, that treatment is as successful as almost any we have for alcohol and substance abuse. I believe I was told by Jeremiah Simmons from The Mescalero NM tribe that they had an association with UNM medical school to give a medication for alcohol abuse to those members who have an addiction problem in their tribe and that it may be working.

I would think before one considers a dramatic increase in mental health resources to the tribes, one should do pilot testing of such a plan in two or three very different tribes. It may be that just having one full time mental health nurse practitioner in each site is the best answer. And unless the tribes are willing and able to tackle the alcohol and drug abuse problems that run in families, it may be that the problem cannot be solved.

*Question 3.* Today we heard testimony about the lack of data collection of both the incidence of youth suicide and prevention activities in Indian Country. In your testimony, Dr. Clayton, you emphasized the importance of collecting youth suicide data. Do you think the Indian Health Service and tribes should have more data collection activities as a part of youth suicide prevention efforts? How do you think they could improve this data collection?

How does the availability of data on suicide and availability of mental health services in Indian Country compare to non-tribal communities?

Answer. I absolutely believe that improvements are needed in collecting data on attempted and completed suicide in tribal communities, starting with mandated suicide surveillance in every tribe. The data from cancer registries and registries for other serious medical illnesses show that registries are important first steps in identifying the problem. These help to calculate trends and identify high risk groups as well as evaluate interventions. They provide a vital resource to estimate the incidence of known risk factors (such as mental illness, access to firearms, access and use of alcohol or other drugs, previous attempts) and protective factors (like whether a family member was available, they were brought in by police, what are their social supports). Unless we know the extent of the problem, we cannot begin to tackle it and we cannot measure a change if an intervention is initiated.

Although U.S. law requires that all sudden deaths are reviewed by a medical examiner or comparable official, I understand the law does not apply to Native American tribes. In all other deaths that are not sudden, a doctor must certify the cause of death. I do not know how Native Americans handle this. Anyway, that makes it possible to track suicides across the nation, region by region. Although there are undetermined deaths also, only a portion of them are probably suicide. And the CDC has designated 17 states (we are lobbying for funds for all 50 states) be trained to assess and record all violent deaths and acts of unexplained injury, including suicide attempts that occur in these states. The system is called the National Violent Death Reporting System (NVDRS). In most states this includes toxicology tests on the deceased. Such a system would greatly benefit Native American tribes. It would help to de-mystify the event, reduce stigma and call attention to the problem, both for individuals, families and caretakers responsible for them. The collaboration between Johns Hopkins and the White Mountain Apache Tribe is an example of how it can be done.

When I was young, some people thought cancer was contagious and avoided anyone with the diagnosis. As it became clear this life threatening medical illness was not contagious and registries were developed to help identify the problem and test newly developed treatments, the myths about the illness ended. We must do the same for the brain disorders that lead to suicide.

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RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN BARRASSO TO PAULA J. CLAYTON, M.D.

*Question 1.* Your written testimony suggests that young people who do not respond to initial treatment for mental health issues need to be referred to mental health and substance abuse specialists.

How would reach those young people who are referred to these specialists but refuse to go?

Answer. In all communities, non-compliance with recommendations regarding mental health treatment is an issue. Our experience is that young people are more likely to be willing to get treatment for depression, substance abuse and other mental disorders when they understand them to be medical problems rather than character disorders, and are supported to seek help by their peers and by respected adults in their community. Thus, broad educational efforts, aimed at changing attitudes as well as providing scientifically-grounded information, are necessary in the

effort to increase the willingness to get specialized treatment for mental health problems. Linking distressed youth to caring adults in the community can also be an effective way of cultivating support for help-seeking for mental health problems.

Compliance with recommendations from a primary care provider to seek specialized treatment is also furthered when treatments for physical and mental disorders are provided under the same roof, thus facilitating patients' access to services and communications among care providers, and reducing the shame associated with seeking psychiatric treatment.

Anonymous online screening tools, such as AFSP's Interactive Screening Program, are also useful in engaging reluctant young patients to seek mental health treatment. Our evaluation data show that for many such youth, anonymous online conversations with a local counselor were effective in addressing and resolving negative attitudes about treatment, fears of being stigmatized and other factors that pose barriers to help-seeking.

*Question 2.* The Committee has received testimony recommending more youth shelters, in particular, as places for young people to go when their lives at home become toxic. According to the testimony, for some youth, if they had had a place to go for the night, they would not have made a suicide attempt.

Do you have any other recommendations, such as ways in which to engage parents or other family members, so that Indian children feel secure in their homes?

Answer. Although I know little about youth shelters, the idea of creating them sounds solid. Here again, however, it would take a tribal commitment to make the use of them acceptable to the teens in the community. Since shame is always a problem, they would have to be presented as a wise choice for the teens that need help. Again, if there were suicide surveillance, it would be possible to learn whether more suicide attempts occur on weekends and then perhaps begin by making it available and acceptable first on weekends. Maybe the tribe could even encourage non-distressed youth to be present during the early months after it opened. Of course, there would also have to be appropriate physical and mental health assistance for those who come in, or at least the same familiar and wise counselor.

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RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. AL FRANKEN TO PAULA J. CLAYTON, M.D.

*Question 1.* I learned a sobering statistic recently—a study of American Indian teens in Minnesota found that more than one-quarter believed they had only a 50 percent chance of living to age 35, compared to 10 percent of white teens. This statistic seems to show how difficult life is overall for these teens.

Dr. Clayton, can you please discuss the role of poverty in the youth suicide problem?

Answer. As you know, poverty contributes to access to health care, quality of health care, quality of education, and unemployment. All of those may shorten life span so if young people live in poverty, their assessment of the future may not be unfounded. The most important factors that can change that future for youth who are born into poverty are a first-rate education and access to first-rate health care. This must include mental health care. But as AA informs, in addition, the individual must also take responsibility for themselves and admit he or she needs help. In the case of teens, it is the family, the community, or an appropriate substitute for the family that needs to make that decision. Certainly, surveillance that includes the school teachers, police force and designated adults would also provide a valuable network to engage these teens in treatment.

The American Foundation for Suicide Prevention (AFSP) would like to thank each of you, as well as all members the Senate Committee on Indian Affairs for your interest and leadership on suicide prevention in Indian Country. Our entire AFSP team at our national headquarters in New York City, in our Washington DC public policy office and all of our Chapters throughout this great nation pledge our support to do whatever we can to assist you and our tribal communities to prevent suicide through education, research and treatment.

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RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO HUNTER GENIA

*Question 1.* In your written testimony you discussed the Tribe's mental health program in great detail and the extensive behavioral health programming available through the Tribe. When did the Tribe begin supplementing the mental health pro-

gram with tribal funds? Do you still find that more mental health resources are needed in your community?

Please describe the activities specific to youth suicide prevention that are ongoing on the Reservation.

Answer. The Saginaw Chippewa Indian Tribe was supplementing the mental health program since at least the year 2000 if not longer. I began working for the Saginaw Chippewa Indian Tribe in the year 2000.

More mental health resources are certainly needed in the way of prevention and residential services for our young people. Our Behavioral Health program provides an expansive amount of resources and outreach to our community that could be deemed youth suicide prevention. This occurs on the prevention, intervention, and treatment levels in our program. There is also a saying in Indian Country, "Culture is Prevention" we believe that to be true as well here on our reservation. Having pride and self esteem is also in direct correlation with a strong healthy cultural identity. An emphasis on prevention and mental health occurs year around with a tremendous amount of community activities. The Saginaw Chippewa Indian Tribe has made a commitment to doing what we can for our community members. However, there are still too many health issues to address without proper funding.

*Question 2.* What is the biggest contributing factor to the high need for mental health services and how can it be prevented in the future?

Answer. I believe we haven't recovered as an Indian community or tribe from some of the policies and practices that have contributed to the traditional values and roles that governed our families and tribes. We are talking one to two generations removed from our families who attended the boarding schools that assisted in stripping away our traditional practices, languages and families. As a race of people who have had to adapt to another cultures values, this created a hardship for many families and communities where it tore apart intact tribal communities and systems. What replaced these cultural and traditional rich values were unhealthy behaviors that turned into alcoholism, depression, trauma, violence, helplessness, and hopelessness. These are the same health issues we are still dealing with today.

Our biggest challenge in recruiting mental health care providers is the low number of Native Americans in the field of social work and counseling. With 50% of the total US Native American population being adults only a small percentage move onto seek a higher degree education. A small percentage of that are going into the social work and counseling fields. We are very fortunate that we have a small turnover of mental health providers for our tribal program. This can be attributed to the tribe's generosity and care towards the workers health and wellness.

*Question 3.* What resources would a tribe need to develop a Youth Treatment Center in their community?

Answer. We do not operate a youth treatment center. We do have an adult residential substance abuse treatment program. A youth treatment center is an idea the tribe is looking at providing as well. If we were to operate a youth treatment center I believe we can model after the traditional Native American (Ojibway, Ottawa, and Potawatomi) values of the Seven Grandfather Teachings. These seven teachings promote love, respect, honesty, bravery, courage, humility, and truth. We would surround the youth with these teachings and provide activities that promote the Medicine Wheel which reinforces the development of positive physical, emotional, mental, and spirituality of an individuals being.

Funding for staffing and an appropriate facility would be instrumental to making a youth treatment center a reality. Health leadership internally within the tribe is also very important. A shared and supported vision within the tribal leadership is very important. The latitude, respect, and recognition of modalities and cultural processes that promote a healthy cultural self esteem and identity are desired is needed from funding administrators and grantors. The access to recovery (ATR) grant, which is a SAMSHA grant, is a great example of recognition of cultural processes that are valued within a grant process.

*Question 4.* What can we do for American Indian you to prevent mental health and substance abuse issues before they begin?

Answer. I believe in short that healing and wellness is needed in every tribal community. Universal truths within tribal communities means that trauma, substance abuse, mental health, domestic violence, sexual assault, and many more health disparities are so elevated in most tribal communities. Community member participation is needed in order to be able to identify risk and protective factors. Native Community wellness initiatives such as Gathering of Native Americans (GONA) should occur on every reservation in order to scratch the surface of issues in a fun, friendly, safe, and culturally sensitive manner. This would be followed by a strategic planning on a grass roots community level that community members would need to buy

into and follow through with action steps. Resources on a federal level need to cut back on the red tape for acquiring such resources and make them accessible for tribes. The healing of tribes needs to come from within each tribe. Assistance from outside the tribes can occur on a complimentary level but the control, pace, and solutions need to be identified with the tribal community members at the table. Native American tribes need to be at the helm of solutions and allow us to control our own destiny.

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RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO NOVALENE GOKLISH

**1. In your testimony, you discussed how the White Mountain Apache developed the first tribally-mandated suicide surveillance and follow-up systems in the United States. Other witnesses also talked about the need for adequate data collection and suicide reporting in Indian Country. You have done some great work implementing this reporting system on your Reservation. Can you describe how you think the suicide surveillance system gives you a clearer picture of the types of services needed on the Reservation?**

The surveillance system allows the Tribe to understand and respond in real time to the problem of suicide on our Reservation. Data from the surveillance system provide estimates of incidence and prevalence, trends in age, community of residence, gender, methods, severity of suicide risk, use of drugs or alcohol, intent to die, and referrals made and completed. We also can look at incidents by individual, family or community—in order to devise public health responses to the problem. In general the suicide surveillance system provides data to inform our health care service needs and to formulate treatment and prevention strategies.

To provide you with a specific example of how the system activates our public health response, we have identified that youth, ages 20-24, are the most likely to attempt and die by suicide among our people, but youth 15-19 are the most likely to attempt, with 10-14 year olds youths at second highest risk for attempts. Further, unlike in other populations, males are as likely as females to attempts. Thus, current evidence based suicide prevention interventions have been adapted for male and female 10-19 year olds. Further, our surveillance system includes an in-person interview with every individual identified through our surveillance system. At follow-up, we gather more detailed information regarding determinants of suicidal behavior and how we can intervene. For example, since 2006, we have learned 40-50% or youth 10-24 years of age were using substances at the time of their suicide attempt and the primary reasons for attempts were fights with family/significant others, or triggered by the death of a loved one (often by suicide). These data emphasizes the need to address substance use on our reservation, as well as targeting preventions strategies at interpersonal and communication skills, and within family and peer groups who've lost a loved one by suicide. In addition, we learned many youth who attempted suicide are not in school. Thus our interventions are devised for family-based, rather than school-based outreach. This finding is also informing parallel efforts to keep our children in school. Finally, our follow-pu revealed that a proportion of youth hospitalized for self-injury report that they did or do not have intent to die, but rather are cutting or burning themselves as a form of non-suicidal self-injury to relieve internal and external stressors. We are now developing prevention and outreach strategies to assist youth who are using non-suicidal self-injury as a maladaptive coping strategy.

**2. How do you envision a suicide surveillance system like this being implemented throughout Indian Country?**

Tribal governments have a unique opportunity to mandate suicidal surveillance as part of their public health reporting system. Given the high incidence of suicide in Indian Country and the unique characteristics and cultural contexts of suicide among Indian youth, there is much knowledge to be gained by collecting tribal-specific and cross-tribal data. Shared lessons could inform the entire field of youth suicide prevention, as we are working in communities where children have the highest risk of suicide and are the hardest to reach. Successful interventions with Indian youth have high potential to work with other youth living in low income, highly stressed communities.

The White Mountain Apache and Johns Hopkins' work on developing a tribal community-based surveillance system has produced many replicable tools for dissemination, including:

1) Sample tribal resolutions and a Policy & Procedures manual for management of the suicide surveillance system.
2) A comprehensive suicide behavior data collection form that includes state-of-the-art nomenclature to describe suicide behavior, severity, key demographic characteristics and referral status.
3) An adapted Suicidal Ideation Questionnaire, scored at the follow-up visit that is used to identify imminent risk, with a protocol to triage imminently suicidal youth to immediate care.
4) A training program protocol for Native paraprofessionals, whom we call "Case Managers," to collect the forms from tribal health and human service agencies, enter the data, and follow-up.
5) A secure web-based data management system that has the potential to aggregate de-indentified data and maintain confidentiality of all individuals for whom an incident report has been entered.

The White Mountain Apache Tribe, in partnership with Johns Hopkins Center for American Indian Health mental and public health experts, is prepared to provide consultation and training to tribes to adopt and adapt our surveillance system. We have the capacity to do webinars and distance education in order to save travel costs; however, we are also willing to travel to regional sites to provide in-person training, which is very useful when dealing with such a sensitive problem.

Further, our surveillance registry form has been designed to be compatible with the Indian Health Service RPMS system, such that data gathered could be entered into electronic charts, so health care providers are aware that patients are at risk for suicide. Eventually, the tracking system we have designed could be shared by IHS and tribal behavioral health services.

**3. Are there specific thoughts, lessons or recommendations you would have for the Indian Health Service and Tribes about how to go about implementing such a program?**

1) The tribal consultation process and community buy-in are critical. The highest level of tribal leaders—including the Tribal Council, Health Boards and all relevant governing bodies engaged in making health and human service decisions must be involved in adopting and legislating a surveillance system. It has also been helpful for us to create a "High Risk Coalition" comprised of leaders from all health and human service agencies who are involved with suicidal individuals (i.e., police, fire, social services, division of health, etc.). The Coalition meets on a monthly basis to review cases and trends, and participate in honing prevention and triage strategies.

2) Our Tribe and the local IHS have a close working relationship, and our local IHS fully participates in providing suicidal behavior registry data from their patients to the Tribe's suicide surveillance system. National leadership from IHS would be key to engage early in this process, to develop policies such that other local IHS Service Units would participate similarly to the Whiteriver PHS Service Unit.

3) Tribes or the partnering IHS Service Unit must dedicate personnel to the management of the local surveillance system. Resources used to employ personnel to manage this system are well spent, and d we believe save incalculable emergency care and law enforcement dollars, and extreme human suffering. Well-trained Native American paraprofessionals are the provider of

choice, as they can navigate the cultural and social mores of their communities and are affordable, maintainable and sustainable in Indian communities.

4) The start-up of a surveillance system takes extensive community training and outreach so that agency representatives and community members are aware how to use surveillance forms. In addition, maintaining the system requires ongoing community in-services.

5) It would be ideal if there were a commitment from tribes, IHS and the federal government that the goal of the surveillance system is far more than just data collection. The most important component is our follow-up protocol with every incident. We have trained paraprofessional case managers who verify the event, gather more information about severity and circumstances, and triage at-risk individual and families to appropriate treatment and community services.

**4. You described how the White Mountain Apache suicidal reporting system tracks suicidal behavior as well as risks for suicide, such as alcohol and substance abuse, self mutilation, etc. These figures are reported to a centralized suicide prevention task force. It seems there could be some hesitation for youth to report these behaviors if they are being tracked in a broader database. What was the initial reaction to your tribally mandated reporting? Was there push back from some in the community about tracking so many personal statistics in a database system?**

Typically, youth do no self-report. It is another community member who completes a report on the person at risk. For youth, it is typically a school professional or family member who makes the report. Some youth will fill out reports on peers and some individuals complete forms on themselves.

Our Tribe has suffered such tragedy from suicide that there has been very little hesitation about the development and implementation of this system. The essential component is that Apache paraprofessionals are trained and employed to follow up on every incident and will go to homes, schools, neighborhood, wherever is needed, to meet with the individual at risk. The system has created a sense that our tribal leaders and community care, and that the system is being managed professionally and discreetly.

Our partnership with Johns Hopkins has allowed us to maintain the highest standards of confidentiality and data security. The community is aware of Johns Hopkins partnership, and because of our 30-year history doing cutting edge research, this partnership provides reassurance about the quality and confidentiality of the data collection and management system. Johns Hopkins provides HIPAA and human subjects confidentiality training to all Apache paraprofessionals who are involved in data collection, follow up and triage. In addition, our staff care deeply about the community and their work, and are excellent ambassadors for the utility of the system.

**5. During the hearing we have heard about the lack of mental health care providers in tribal communities and the struggle for communities to maintain adequate health care services. What are the main challenges you face in recruiting mental health care providers on your Reservation?**

Like all Tribes, our Tribe has had difficulty recruiting and retaining professional mental health care providers. From an outsider's perspective, our reservation is geographically isolated from metropolitan areas. Our schools are stressed, and if providers have families, they have to consider where to send their children to school.

Besides having too few funded positions for mental health professionals (i.e., until this year, we have no full-time staff with child psychiatry training on the reservation for many years), our providers get burnt out quickly. Their caseloads are unreasonable and the problems of our people can be acute because by the time they get to treatment their crises have escalated.

Because we are under-resourced, there are long waits for mental health treatment, which makes our community members lose trust and faith in the system. Our people can manifest frustration about the responsiveness of the system which will affect their relationship with the providers they see. There are immense transportation issues, so often Apache community members will miss their clinical appointments, which may provide another source of frustration and burn out for the providers and patients. Further, there are cultural differences between western medicine and Apache (and other tribal) views of mental health and disease, and general differences in social interactions. If the providers are outsiders, they may struggle initially establishing a positive relationship with a new patient.

**6. In your testimony, you discussed how Elders and members of the Apache community are involved in your programs. Do you envision these individuals as being a part of the mental health team?**

Yes, absolutely, with an important point of explanation. Both our elders and our Apache case managers are NOT providing mental health "treatment"—in terms of the way "treatment" is understood from a western clinical perspective. We are providing triage, education, community awareness, and adjunctive services.

The most important role our White Mountain Apache Elders Council as well as community leaders comprising our Community Advisory Board have played has been in the design and implementation of our youth suicide prevention work. Both groups have provided critical input and feedback on all suicide prevention intervention studies that have occurred in the community. Recently, both groups were essential to the selection and adaptation of two evidence-based interventions addressing youth suicide for replication and evaluation on the Reservation. These groups provided mentorship and guidance on the restructuring of intervention content and delivery. Specifically they incorporated local beliefs and values about suicide into the program, how the whole community is affected by a suicide, and what resources exist for youth and families post-attempt. They also suggested the inclusion of a family member in the youth-focused interventions and directed for the programs to be delivered in the home. Members of these groups have their finger on the pulse of the health and well-being of the community. They are a crucial connection to understanding the depth and context of mental health morbidity in the community, and we believe a necessary component of all current and future mental health programming. Harnessing the local wisdom and experience of these individuals helps to ensure we are capitalizing on all of the strengths and resiliency that already exists in our community.

**7. Do you think incorporating Elders in your program has put more of a focus the on Apache cultural values and changed the way that the youth view suicidal behavior?**

The Elders play a crucial role in addressing suicidal behaviors for youth—emphasizing that it is unnatural to end one's life prematurely; that all challenges are life's lessons to make you a stronger person; and that our Apache families and communities care and can help. They have also provided strong counter-suicide messages about the sacredness of Apache life and the importance of every life to maintain the wellness of the whole.

As opposed to the general U.S. population, suicide rates among our Elders are the lowest of all age-groups. We believe the Elders have a unique knowledge and perspective that has protected them against suicide and premature death; we also believe their way of life is teachable and can become our youth's reality. Currently the Elders engage regularly with high-risk youth through school-based workshops, after-school programming, and with the larger community through public service announcements and monthly talk shows on the local radio station. All youth-focused programming emphasizes Apache cultural traditions and values. School-based workshops have underscored the Apache value of respect: respecting yourself, your community, your family, your environment, your health, and doing whatever is necessary to preserve the harmony and balance in your life. Through these workshops, Elders have shared stories and lessons learned in their own life and serve as clear examples to youth of how to live a happy and prosperous life. After-school programming has focused on the teaching of traditional crafts and foods and field trips to sacred locations on the Reservation. Radio talk shows have reinforced these messages and increased awareness and visibility of suicide prevention activities in the community. Our goal is to promote local protective factors through the work of the Elders to prevent youth suicide and other high risk behaviors and to continue teaching these values to the new generation of Apaches.

## Response to Written Questions Submitted by Hon. John Barrasso to Novalene Goklish

**1. Your written testimony notes that many tribal youths do not regularly attend schools and that their families are not involved with their schools. As a result, you say that your tribe has adapted for home outreach the life skills curriculum that is typically provided in schools to help students develop coping and problem-solving skills. Can you explain how you bring this program into the home, particularly when the child or family has not sought help?**

At the end of our follow up visit with high-risk youth identified by our surveillance system, we ask their permission to contact their parent or guardian to discuss the possibility of delivering a home-based prevention curriculum. If the youth agree (which is the vast majority), we then contact their parent or guardian to ask if we can meet with him/her and his/her child to explain the home-based intervention and see if they would like to participate. Currently, if youth and parents are interested in participating, we go through an informed consent procedure, because currently we are collecting pre, mid and post intervention data on the effectiveness of the home-based intervention to prevent youth's suicide risks. This work is currently being supported by a Garrett Lee Smith grant from the Substance Abuse and Mental Health Services Administration, and carried out with youth who have made a suicide attempt. Youth and a parent or family member are recruited into the program after the youth has made an attempt and parents and youth have completed informed consent. It is explained during informed consent that the goal of the program is to problem-solve the youth's barriers to engaging in treatment and complete a 3-month life skills curriculum. It is also explained that the youth have a choice of receiving the curriculum in their home or at a local project office. The majority of youth in the program select their own home for the program as they cite it as more comfortable, relaxed, and easier to focus on the content of the curriculum. Anecdotal results of this pilot to date indicate that the program is well-received and youth are eager to work with program staff in their own home.

We have a long history of doing home-based infectious disease prevention and behavioral health promotion intervention research with Johns Hopkins. Home-based intervention is culturally preferred and highly feasible among my Apache people and other tribes.

## Response to Written Questions Submitted by Hon. Al Franken to Novalene Goklish

**1. Ms. Goklish, I'm heartened by your description of the case managers who seem to make a real difference in your community. This concept of using community members as a resource seems incredibly wise, and is similar to the "Cultural Counselors" that Red Lake now employs at their high school. Can you please discuss how we could expand the use of lay people to address mental health issues in tribal communities?**

We believe that lay, paraprofessional workers have a fundamental role in the mental health system of our and other Tribal communities. We have a track record (documented by many peer reviewed publications) of using lay behavioral and mental health workers for intervention delivery to affect positive significant change in teen parenting skills, maternal and child health, behavioral and mental health outcomes, substance abuse, and youth suicide surveillance. Because of the lack of resources and poor continuity of care in our community, lay mental health workers have been crucial in providing case management services, health education, psychosocial support, crisis management, referral, and triage to treatment. The utilization of lay health workers has enabled us to capitalize on local talent and resources, overcome a lack of resources and ability to maintain professional mental health providers, empower and build the human resource capacity our community, and provide an innovative systems approach to addressing health disparities in our community in culturally appropriate ways.

Specifically, we believe that the use of lay workers is appropriate and well-suited to the areas of: case management, health education, psychosocial support, crisis management, referral, triage to treatment and prevention. We also believe that the development of Native paraprofessionals as part of the mental health systems on reservations will be extremely cost effective, and lead to greater numbers of Native Americans pursuing professional mental health degrees. (Native American mental health professionals will be easier to recruit and retain in Indian communities.) A formalized system of training and accreditation needs to be developed and institutionalized of mental health paraprofessionals. We believe that IHS, perhaps in partnership with Johns Hopkins Center for American Indian Health, could create a training program for individuals from a variety of backgrounds and education levels that serves to streamline the knowledge and skills necessary for paraprofessional mental health workers. These workers would supplement activities of local IHS and outpatient facilities, and could provide adjunctive home-based services like we are currently doing in our community. We also believe reservation communities could stand as a model for how mental health paraprofessionals can effectively become an essential part of any mental health care delivery system, particularly in low income, under-resourced and cross-cultural communities.

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