

S. HRG. 112-616

**EMPOWERING NATIVE YOUTH TO RECLAIM THEIR  
FUTURE**

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**FIELD HEARING**

BEFORE THE

**COMMITTEE ON INDIAN AFFAIRS**

**UNITED STATES SENATE**

**ONE HUNDRED TWELFTH CONGRESS**

FIRST SESSION

—————  
AUGUST 9, 2011  
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## EMPOWERING NATIVE YOUTH TO RECLAIM THEIR FUTURE

TUESDAY, AUGUST 9, 2011

U.S. SENATE,  
COMMITTEE ON INDIAN AFFAIRS,  
*Poplar, MT.*

The Committee met, pursuant to notice, at 1:30 p.m. at Poplar High School, 400 4th Avenue West, Poplar, Montana, Honorable Jon Tester, Acting Chairman of the Committee, presiding.

**\*Due to audio technical difficulties; the following hearing transcript has [indiscernible] printed in place of a lot of missing text\***

The Committee apologizes for the inconvenience.

### OPENING STATEMENT OF HON. A.T. "RUSTY" STAFNE, CHAIRMAN, ASSINIBOINE AND SIOUX TRIBES OF THE FORT PECK INDIAN RESERVATION

Mr. STAFNE. Good afternoon, Senator Tester.

Senator TESTER. Mr. Chairman.

Mr. STAFNE. My name is Rusty Stafne, and I am Chairman of the Assiniboine Sioux Tribe, Fort Peck Reservation.

On behalf of the tribal council and the tribal membership, we welcome you to the Fort Peck Indian Reservation.

We also thank you for holding this hearing to address the epidemic levels of youth suicide on our reservation and the ways our community can empower our children to rise above this crisis and reclaim their future.

Senator, it is my honor to stand before you today. Please understand that I do so with a heavy heart. It is difficult for me to know where to begin or how to begin. You are familiar with the statistics. Yet, as you are aware, these numbers do not paint the full picture. We are under attack and our future is the target.

Like any nation facing such great threat to our most vulnerable citizens, we have acted to the best of our ability to combat this epidemic. But how can you fight what you cannot begin to understand?

Just over a year ago, the United States Public Health Service deployed six teams of behavioral health officers to help us better understand and join in the battle our youth are fighting. After the 12-week effort, final recommendations were made to the tribal executive board in October in Montana. Since then, our communities have worked tirelessly to implement these recommendations, and

keep those considering ending their lives from taking that final step. We have brought on skilled staff and involved multiple generations, collaborated with local school districts and heightened community awareness. We have tackled upstream issues such as bullying and boredom, while training parents and peers to recognize the signs and increase the available activities for youth across the reservation.

We have also developed response command and protocol for streamlining and minimizing response time in the event of another tragic attempt. Of course, in our communities, resources are always an issue. I would like to thank you, Senator, for your support in our application for a \$1.4 million grant awarded just two weeks ago to continue our efforts with the University of Montana and National Native Children's Trauma Center. It joins other grant funding we have relied upon to support these efforts.

We are doing all that we can. Yet at an agency level, a lack of communication, staffing shortages and budget shortfalls continue to hinder our efforts. Senator, we thank you for all your hard work and the support you have provided us in our time of need. But the threat of more lost young lives looms. Today I come before you as Chairman of the Assiniboine Sioux Tribes asking that the testimony shared here grows into productive collaboration and increased interagency communication.

There is much work yet to be done. Our people deserve healthy bodies and healthy minds. Our children deserve a future. Thank you.

[The prepared statement of Mr. Stafne follows:]

PREPARED STATEMENT OF HON. A.T. "RUSTY" STAFNE, CHAIRMAN, ASSINIBOINE AND SIOUX TRIBES OF THE FORT PECK INDIAN RESERVATION

Good afternoon, Senator Tester. My name is Rusty Stafne, and I am the Chairman of the Fort Peck Tribes. On behalf of my Tribal Council and our Tribal members, I would like to welcome you to the Fort Peck Indian Reservation and thank you for holding this hearing to address the epidemic levels of youth suicide on our reservation and the ways our community can empower our children to rise above this crisis and reclaim their future.

I would first like to recognize those who spoke before me. Vice Chairwoman Roxann Smith and Judge Roxanne Gourneau, thank you for selflessly sharing the stories of your sons. Even though unimaginable tragedy has touched your lives, you stand strong for your people. Nothing can bring your boys back, but your bravery reminds us that this is not a hopeless place. Thank you.

Senator, it is my honor to testify before you, but please understand that I do so with a heavy heart. It's difficult for me to know where to begin. You're familiar with the statistics, you cited them in your remarks. Yet even these numbers don't paint the full picture: we are under attack, and our future is the target. Like any nation facing such a grave threat to our most vulnerable citizens, we have acted to the best of our ability to combat this epidemic; but how can you fight what you cannot begin to understand?

Just over a year ago, the United States Public Health Service deployed six teams of behavioral health officers to help us better understand and join the battle our youth are fighting. After the 12-week effort, final recommendations were made to the Tribal Executive Board in October, 2010. Since then, our communities have worked tirelessly to implement these recommendations, to keep those considering ending their lives from taking that final step. We've brought on skilled staff, involved multiple generations, collaborated with local school districts, and heightened community awareness. We've tackled upstream issues such as bullying and boredom by training parents and peers to recognize the signs, and increasing available activities for youth across the reservation. And we've developed a response plan and protocol to streamline agencies and minimize response time in the event of another tragic attempt.

Of course, in our communities, resources are always an issue. I would like to thank you for your support in our application for a \$1.4 million grant awarded just two weeks ago to continue our efforts with the University of Montana and National Native Children's Trauma Center. It joins other grant funding we've relied upon to support these efforts—we are doing all that we can.

Yet at the agency level, a lack of communication, staffing shortages, and budget shortfalls continue to hinder our efforts. The IHS Behavioral Health Department here has no director, and its facilities are lacking. Repeated efforts to contact the Bureau of Indian Affairs and Indian Health Service for technical and financial assistance to build and implement "safe houses" across the reservation seem to have fallen on deaf ears, as neither agency has responded. Indian Health Service constant shortfalls impact these efforts as well. We cannot stress strongly enough the need for fully funded health services: to afford preventative and reliable behavior health services, treat substance abuse issues, and prevent early and unwanted pregnancies.

Senator, we thank you for all your hard work and the support you have provided us in our time of need, but the threat of more lost young lives looms. Today I come before you as a leader of my people asking that the testimony shared here grows into productive collaboration and increased interagency communication. There is much work yet to be done. Our people deserve healthy bodies and healthy minds. Our children deserve a future. Thank you.

Senator TESTER. Thanks, Rusty. Thank you.  
[Applause.]

Senator TESTER. Thank you very much. I appreciate everybody being here this afternoon on a glorious day in northeastern Montana.

Before I start, I would like to get comments from Walter White Tail Feather.

**STATEMENT OF WALTER WHITE TAIL FEATHER DIRECTOR,  
OFFICE OF ECONOMIC DEVELOPMENT, FORT PECK  
ASSINIBOINE AND SIOUX TRIBES; ON BEHALF OF HON.  
ROXANN SMITH, VICE CHAIRMAN**

Mr. White Tail Feather. Thank you. I bring the testimony of the Vice Chairman. So these are from her, Roxann Smith, Vice Chairman, Fort Peck Tribes.

One of the Fort Peck's needs to address [indiscernible]. We have [indiscernible] suicides among primarily our young people. My connection here is that I have lost a son and a cousin and some precious [indiscernible] for our communities. This very remote location that we live in is our home. Our families are here and they are [indiscernible] here. For the young people, there are not a lot of healthy activities for [indiscernible]. What we need is more opportunities for our youth to learn and prosper so that they can become productive members of our reservation.

The schools have done the best they can with what resources they have. However, some of our reservation schools have operating budget deficits. To alleviate this situation, they have been forced to downsize their counselors so that they can maintain their budget constraints.

Built into our tribe a youth program, the solution is to put funding priorities into those existing programs, not to reinvent the wheel. Everybody needs to participate.

At the Federal level, make existing grant funding opportunities more flexible to include youth activities as allowable costs. Our communities are impoverished, and in a lot of cases have little to look forward to. The outcome I would like to see is increased resources and collaboration within programs to provide outreach pro-

grams and collaboration with OPI, health providers and other entities. Perhaps a solution is to have a contract person that will be available to provide mental health and substance abuse counseling to local [indiscernible].

Health care providers must be available and visible in the community to earn the respect of our young people. Our community is small and everybody knows everyone. So it is imperative that our caretakers are clean and sober and have integrity in each of our communities. A possible solution would be to have a shelter workshop in a location where people may be productive members of our reservation. At this location, cultural teachings, counseling and recreation could take place with an emphasis on building esteem, hands-on crafts, horsemanship, hunting, et cetera. Families maybe included in the activities.

Organized recreation is another topic that we have [indiscernible] and since it is a healthy alternative to drinking and partying, it too can be incorporated throughout the [indiscernible]. We have a [indiscernible] oil and [indiscernible] opportunity knocking on our doors. And we need assistance on how to deal with the rush of people as well as opportunities coming our way. How will we protect our future without this [indiscernible] foster our communities [indiscernible] grow into the existing work force as well as future [indiscernible] these children that will lead them and [indiscernible] and [indiscernible] into the next generation.

So those are the words of the Vice Chair. And James Miller asked me to talk about my experience. I have never talked about it [indiscernible] for me. But I left home when I was 13 years old [indiscernible]. My parents wanted to get me away from the drugs and alcohol and that is where they sent me. Little did they know that that is where I encountered [indiscernible] high school [indiscernible].

I landed a job in Washington, D.C. And subsequently just lived that life there. There came a very serious point in my life when I, there was nothing to look forward to. Absolutely nothing. Even living in the city, [indiscernible] my friends, the job that I had. And there was a lot of [indiscernible] that was going on at the time. When I was a child, even here and in high school, I always wanted to find that party, the bright lights and the city.

And that is what goes on here, it happens here too. It got to the point where I didn't see anything [indiscernible] and I realized that the apartment that I was living in, I had a gas stove. And it got to the point where I said, I can just go to sleep. I don't ever have to wake up again, I don't ever have to deal with any of this. Nothing. And not being around my parents [indiscernible] my family. And the only reason I didn't do it was because my roommate at the time, he was in Boston. And it was his [indiscernible]. And I didn't want him to come back and find a body. And it [indiscernible] after that I turned myself in to rehab and it didn't work. I had to go back again [indiscernible].

So those memories are there. And there are some young people in the audience today, and you can survive anything, absolutely anything [indiscernible] if you want to. And you don't have to live that life.

And there is sometimes I got some calls from people who have, who know this about me and have asked my advice. I know what that feels like, when you are right at that point. There is some people who don't, they don't understand [indiscernible].

[indiscernible] allowing the chairman and all those people [indiscernible] eyes and everywhere else, there is hope. There is. It does get better. It absolutely does. Thank you.

[Applause.]

Senator TESTER. Thank you, Walter.

Roxanne Gourneau, Tribal Judge, could I get her to make a few comments?

**STATEMENT OF ROXANNE GOURNEAU, TRIBAL JUDGE, FORT PECK'S TRIBAL FAMILY COURT**

Ms. GOURNEAU. I know that I have two nieces in the audience, where are you? Will you come up for a minute, please.

I know that those of you who know me that I will [indiscernible] and that is two [indiscernible].

Senator, I am in mourning right now and I want you to know that, so I will weep. My son couldn't come today because I buried my son November 23rd, 2010, my only son. This is who he is. This is his family. My son was loved by many of you. My son took his life. But I want you, I am not going to stand here and tell you that things are great, and I want you to understand that our young, and I want you to know something, my son did not plan his death. His death was abrupt.

There are so many people across this beautiful reservation, [indiscernible] my son could have called anybody, anybody, and they would have been there. I am talking about friends and I am talking about children that would have saved his life. But Senator, I am telling you, what took my son's life was the public school systems. My son was [indiscernible] upon. In three hours, my son, who stood 6 foot 4 and 260 pounds and he was invincible, he was my boy, he was kind, he was generous, he was truthful and he was honest. He would give the shirt off his back.

And I want you to know, Senator, that I am here today to tell you anything you ask me. But we need regulations in the school systems. Let's don't pretend any longer for three decades that suicide is the second leading cause of death in the State of Montana and on our reservations, let's don't pretend any more. Let's don't pretend that we have titles that we have to speak in a certain way. Let's don't pretend any longer that our Native American children and [indiscernible] children that [indiscernible] and special ed. I don't want to pretend.

My son had a learning disability. They accused him of having chewing tobacco. My son was a contender for a state championship for wrestling. My son went to wrestling two years. Contrary to what people say, and my heart is beating just as hard as that drum, but contrary to what people say in that report, it was nay, I am not an alcoholic, Senator. I don't abuse drugs. I have been blessed by my tribe and by my people to make an income that is 10 percent of the nation.

And I can tell you, and I can't speak for other parents who have lost their children, but I can speak for me and I can speak for my

son, but I can tell you, Senator, they themselves love their children. They were middle class people. They weren't foster children. But I am telling you, Senator, that these [indiscernible] we didn't need a \$300 million report. What we needed was proper investigation for audit [indiscernible]. That is what we needed. We needed to head these problems off before they started.

I want to make a difference in the school systems. I have worked 30 years, Senator, and I have enjoyed opportunity and I have benefited in so many ways as an individual. And I am still very young in wisdom. But I have worked in the executive branch, I have worked in the judicial and the legislative. I have held the title of vice chairman, first vice chairman. I have been on the tribal council. I am presently a judge. I have worked in so many of the social programs and I graduated in this school.

So don't tell me, people, and don't let anybody say how poor this reservation is. This was a beautiful playground for my son. And he loved being Native American and he absolutely loved all people. But I am telling you, Senator, that days without recognition in the school what they did to my son and not contacting me was a direct result of my son taking his life. Those policies weren't placed by great wisdom. And I know that people have rumors out there that think differently. But that was my only son. Who in this reservation didn't know who I was? I made sure that that school knew my contact information. Why was my son targeted?

But it wasn't just my son. As many of you that sit her, you always said you have got to accept that is the way it is. I won't accept the death of my son. I won't. I will not celebrate him until I have closure. But it isn't for me, because he's gone now. It is for you and your children and your grandchildren. No other mother should feel how I feel. No other family, this family right here cries every day.

There is no such thing as substitution for love. As many of you [indiscernible] titles, you need to take the titles off and you need to do what's right. Be that leader. That is what we are asking you, Senator Tester. That is what I am asking you. I am asking you to be a leader for the State of Montana. And you have to ask yourself, what do we have in common. Your children, Senator. There is a severe expulsion and suspension rate, dropout rate, high suicide rate. These records have been on notice.

This isn't new information, folks, and I am telling you that. It is been here. Do you really think that anybody really cares that our children are taking their lives? They won't care until you start caring, until we start caring. Don't tell me about another policy. I don't want to hear about another policy. What I want, Senator, is, I work in a field, I know about this [indiscernible] act. We have been recently trained on the Adam Walsh Act. And you know what Adam Walsh is, you all do.

Many laws have been named because of an isolated situation for one person. Well, let me tell you, our tribe is being affected. And some of you know what manifest destiny means. Today we can't pick out the next 10 years' leaders because you can't be getting through the schools. Because their spirit is broken. Schools are where dreams are made. That is where they are at. How did it turn to be where it got today? Because that is what it is. They are de-

stroying them and they are breaking them. Nobody cares about the dropout rate. The children that need education.

Tribalizing education was done by this tribe, but nobody saw fit to pass it. We got so many dignitaries in this room that all you have to do is just do it. Senator Tester, what I am asking you, and I want you to understand my son's story and I want you to understand that morning he got up and he told me, he said, I love you, mom. I won't apologize for crying.

But I am not the only mother who walks with arms that hurt. And I am not the only family member who walks around and says, I need to know. But I know what you can do, Senator. You can remove tenure from the State of Montana. You can have accountability in the schools, access to equal education.

My son was a citizen of the United States. He deserved to be protected under the law. My son was a citizen of the State of Montana that should have enjoyed equal access and benefitted from education. My son is an enrolled member of a tribe, Turtle Mountain. He should have enjoyed the trust responsibility that guarantees education and protection. My son had a learning disability.

With all of that, my son should have never died. But he did. And so did many other children here. And it won't stop. It won't stop until somebody tells you the truth. And the truth is, you need accountability in the school systems. The feuds and the friction that is going on there, it is an atrocity. And everyone is going to tell you, and I know some of these fine folks out here are going to tell you that we need more money. And I am going to tell you I don't need any money. You need to roll up your sleeves and you need to be counted on. Because we have been paying for a long time, and it is time that you start stepping outside yourself and building an extension of our home. I am not going anywhere, I am going to die here. So Senator, these are the things that I ask of you. And I don't apologize for wearing my emotion on my sleeve. I haven't made any public speeches in a long time. But I am coming, and I want you to know, Senator, that I have filed a civil lawsuit against the State of Montana, the school board and the superintendent, just to begin with, for the gross, indifferent negligence that they demonstrated toward my son. And I can substantiate and prove every bit of it.

So thank you, Senator.

**STATEMENT OF HON. JON TESTER,  
U.S. SENATOR FROM MONTANA**

Senator TESTER. Thank you, Roxanne. And I want to thank everybody who's testified to this point. This is a field hearing of the U.S. Senate Committee on Indian Affairs. We are here today, and pleased to be here with the members of the Assiniboine Sioux Tribe of the Fort Peck Reservation and our distinguished panelists.

The title of this hearing is Empowering Native Youth to Reclaim Their Future. We are here to acknowledge the devastating problem of youth suicide that occurs in Indian Country. And more importantly, as Roxanne pointed out, to find solutions to solving it.

Over the past year we have heard a lot of stories in the news about fights in Congress over the economy and celebrities who get themselves into trouble. But America's 24-hour news anchors forgot one painful story here in Montana. And we are here to acknowl-

edge that the rate of suicide for American Indian youth is far higher than any other ethnic or racial group in the United States. On some reservations, including this one and others in Montana, the incidence of suicide has been 10 times, 10 times the national average. Right here, the folks in this room know this much better than I, right here over the last year six children took their own lives. One of those children was only 10 years old. And there is more, at least 20 other members of the Fort Peck community attempted suicide. That is totally unacceptable in any community. Because these kids, as has been pointed out earlier, are our future.

Leaders in Montana, specifically at Fort Peck, have tried to do their very best to respond aggressively. The Chairman and his administration I think have done good work under difficult conditions. And so has Gordon Belcourt and Donnie Wetzel of the Montana-Wyoming Tribal Leaders Council. Their Planting Seeds of Hope project is helping every Montana tribe to build resilience in Native American youth. They are empowering tribes to prevent suicides.

This is also a good opportunity to remember a friend that left us all too soon. Darryl Red Eagle was a friend of mine and many of you folks in this room. Darryl was a council member for the Fort Peck Tribes from 2005 until he died in June. He was chair of the Health and Human Services Committee. In that role, Darryl was a tireless advocate for improving the health conditions of his people. I had the opportunity to visit with him many, many times. Those of you who knew him, you can imagine he was very vocal about the need to prevent native youth suicide.

Working together, we have taken some steps. Permanently reauthorizing the Indian Health Care Improvement Act means that better health care, physical and mental, is on the way for Indian communities. This bill opens up grants for tribes and organizations for suicide prevention efforts.

In fact, earlier this summer, as Chairman Stafne pointed out, Senator Boxer and I announced that the U.S. Center for Mental Health Services had ordered a \$1.4 million grant to address youth suicide and to promote activities that emphasize resilience and leadership on this reservation. That is a good start. But we need to do more.

In geographically isolated parts of rural America, including right here in Eastern Montana, resources aren't readily available. Recruiting health care professionals to serve frontier communities is very challenging. And in Indian Country, these challenges are compounded by poverty, inadequate infrastructure and sadly, a sense of hopelessness that should never afflict a 10 year old child, or any child for that matter. Hopelessness is not what this Country is about. We live in the greatest Nation in the world, where we work hard to make the future better for the future generations and have better opportunities than we have had. All America's kids and their families should have somewhere to turn, especially in places resources are slim and hope can be scarce.

Although resources are slim in many parts of Indian Country, you have something many others do not have, and that is the greatest strength in Indian Country, family, kinship. More than anything else, Indian families are a bond that not only help you

survive, but thrive. As community leaders and family members, we all have to do our part. Leaders make policy decisions and community members make role models. Role models include mothers and fathers, extended family and friends, teachers, business leaders and cultural figures. The Fort Peck community has a lot of good role models, a couple that I will just bring up. One of them is here today, a kid like April Youpee Roll. April grew up here, went to Harvard and interned in my Washington, D.C. office. April, congratulations on being a great role model.

Richard Dionne, a young man who grew up here, he resisted peer pressure and chose never to take a drink of alcohol or try a drug. After playing basketball in the Continental Basketball Association, he is now a guidance counselor for Native youth. And there are many, many more. And I wish we had time to talk about them all, but we don't.

But the point is that as a community, we have to give hope to kids. We have to give them the belief that they can become anything they want. That if they resist the peer pressure and the dangerous distractions, as was pointed out earlier here today, that they live in a country where their dreams can come true. As community members, we need to fight to make sure all our kids, no matter where they live, understand that hopelessness and despair doesn't belong in any community.

Another important step to addressing this tragedy is to make sure folks understand the story from Fort Peck Reservation, right here, is real. The more people understand the challenges facing many of our rural communities, many of our frontier communities, the better able we are to make sure that all of our young folks are able to live up to their fullest potential.

I am happy to welcome our distinguished panel to share their thoughts on this crisis. And we are going to do things a little bit different today. Usually at these hearings we hear from Administration witnesses first. That is not going to be the case today. We are going to hear from local witnesses first, witnesses from Montana, and then the agency officials will be on the second panel.

As always, we have limited time. Your complete statements will be entered into the record of the hearing. I would ask you to be concise and shorten your testimony to be as close to five minutes as you can, although I won't be too harsh on you if you run over a bit.

First we are going to hear from Deb Halliday. Ms. Halliday is Policy Advisor on Community Learning Partnerships in Montana's Office of Public Instruction. The committee invited OP to testify because schools are absolutely critical, as has already been pointed out, to solving this problem.

So if you want to start out, Deb, and we will go to Mr. Manning in a bit.

**STATEMENT OF DEBORAH HALLIDAY, MPA, POLICY ADVISOR,  
COMMUNITY LEARNING PARTNERSHIPS, MONTANA OFFICE  
OF PUBLIC INSTRUCTION**

Ms. HALLIDAY. Good afternoon. Thank you for inviting the Montana Office of Public Instruction to participate in this hearing. I look forward to sharing our work and our observations related to

the vitally important task of supporting and strengthening our American Indian youth.

Thank you, Chairman Stafne, for hosting the gathering. I too have in my mind today Councilman Darryl Red Eagle, who so deeply believed in the beauty and the promise of children and who worked so wisely to change how we do our work to better support American Indian youth.

I am here representing our State Superintendent, Denise Juneau, who is unable to attend today. I am also here to speak of the ground-breaking work we are doing in partnership with tribal governments, school districts, community members and families who truly improve the quality of education in our State's most struggling schools.

Under State Superintendent Denise Juneau's leadership, the Office of Public Instruction has launched an initiative called Montana Schools of Promise, which is working to significantly improve the quality of education in Montana's most struggling schools. Schools where a mere 15 to 25 percent of high school tenth graders showed proficiency in reading and dropout rates are double those of the general population.

In Montana, the most struggling schools are all located on our State's Indian reservations. Schools of Promise seeks to turn these schools around, providing intensive supports to all components of the school system and engaging community, family and tribal government in the effort.

Last year, the Schools of Promise received a substantial boost through a three-year U.S. Department of Education school improvement grant and we are now working intensively with four school systems, here in Fort Peck, on the Crow Reservation and the Northern Cheyenne Reservation. From the get-go, based on research, we knew that our efforts must be comprehensive and must include support for the mental health and well-being of students. It is common knowledge that students learn better when their mental health needs are met. This is particularly important in communities that are grappling with the long-term damaging effects of trauma, disruptive family environments and poverty.

Recent school improvement research clearly connect the students' well-being and their readiness to learn as central to the work of making schools better. Every child needs a trusting adult to turn to who will provoke and inspire that child to do their best. And that unmet health and mental health needs impair a child's learning process. From a brain physiological perspective, we now know that the brain itself cannot receive or retain new information if it is in a post-traumatic state: for example, when a student is re-experiencing or has not yet recovered from the traumatic event in their lives.

The Office of Public Instruction is addressing these challenges in several ways. We have partnered with the University of Montana National Native Children's Trauma Center, which you will hear about in a few moments, to support the adults working in schools so that they can better understand the critical role they play in a child's well-being and give them specific tools to do that better. We have brought mentoring and student advisory time into the school

day. We are working with schools to create a safer school environment.

We are also the recipient of a Montana Mental Health Trust grant. Through this two-year, \$600,000 grant, the OPI is partnering with tribal governments on the Fort Peck, Crow and Northern Cheyenne and with Indian Health Services, the Bureau of Indian Affairs, the State Department of Health and Human Services and public school districts on all three reservations to develop community-based school mental health wraparound services.

There is a lot of great work going on, and it is hard work. Yet we are seeing early results that are promising. After one year of our Schools of Promise work, all four school systems showed marked improvement in student test scores, such by as much as 15 points, and dropout rates are improving.

I will conclude my comments with a few observations, which I hope will help you in your discussions on how to best support the work being done to strengthen the American Indian youth. Number one, build on existing core community strengths. In every community, there is a small group of people working miracle every day. Many of those who work here at Fort Peck are here in this room. Find these folks, understand what they care about, how the community works when children return home from school, and office lights are turned off, the natural rhythms of life take over.

Number two, listen to what works. Montana is a rural, frontier State. We struggle with Federal policy and programs that are built with skyscrapers and city economies in mind. Here in Montana, we develop effective strategies that work in a vast, rural, poor State. Learn from that and take our lessons into the national debate.

And finally, we can't do it alone. The Office of Public Instruction is partnering with local communities, tribal governments, State and Federal allies. It is the only way we can see that lasting change will occur. The vast majority of funds we rely on to do this work comes from Federal funds. Keep them coming. Our State literally can't afford to fund the intensive work that needs to be done, and yet our communities and our Nation can't afford us to not do that work every day as best we can.

Thank you.

[The prepared statement of Ms. Halliday follows:]

PREPARED STATEMENT OF DEBORAH HALLIDAY, MPA, POLICY ADVISOR, COMMUNITY LEARNING PARTNERSHIPS, MONTANA OFFICE OF PUBLIC INSTRUCTION

Good afternoon. Thank you for inviting the Montana Office of Public Instruction to participate in this hearing. I look forward to sharing our work and observations as they relate to the vitally important task of supporting and strengthening American Indian youth.

Thank you to Chairman Stafne for hosting this gathering. I have in my mind today Councilman Darryl Red Eagle, who so deeply believed in the beauty and promise of children, and who worked so wisely to change how we do our work to better support American Indian youth.

I am here representing State Superintendent Denise Juneau, who is unable to attend today. I am also here to speak of the ground-breaking work we are doing, in partnership with Tribal Governments, school districts, community members and families to truly improve the quality of education in our state's most struggling schools.

Under State Superintendent Denise Juneau's leadership, the Office of Public Instruction has launched an initiative called Montana *Schools of Promise*, which is working to significantly improve the quality of education in Montana's most strug-

gling schools. Schools where a mere 15–25 percent of high school tenth graders are proficient in math and reading, and dropout rates are double those of the general population.

In Montana, the most struggling schools are all located on our state’s Indian Reservations. *Schools of Promise* seeks to turn these schools around:

1. Providing intensive supports to all components of the school system, and engaging community, families and tribal government in the effort.
2. Listen to what works. Montana is a rural, frontier state. We struggle with federal policies and programs that are built with sky scrapers and city economies in mind. Here in Montana, we develop effective strategies that work in a vast, rural, poor state. Learn from that, and take our lessons into the national debate. And finally,
3. We can’t do it alone. The Office of Public Instruction is partnering with local communities, tribal governments, state and federal allies. It’s t he only way we can see that lasting change will occur. Yet the vast majority of funds we rely on to do this work come from federal funds. Keep them coming: our state literally can’t afford to fund the intensive work that needs to be done, and yet our communities and our nation can’t afford for us not to do that work, every day, as best we can.

Thank you. I am happy to answer any questions.

Senator TESTER. Thank you, Deb. Thank you very much for your testimony. We will have some questions after we get done with the panel for each of the panel members.

Next we get to hear from Dick Manning. Dick is a Research Associate at the National Native Children’s Trauma Center at the University of Montana. Dick and the folks in his office have developed methods for tribal communities to address these strategies. He will share some of those recommendations with us.

On a side note, I will just tell you this. Dick is a special friend of mine. He’s one of those people that, from my perspective, looks at life from a different perspective and is able to find solutions that people like me don’t often see readily. So Dick, I want to thank you for being here today, and I look forward to your testimony. Once again, try to keep it as close to five minutes as you can.

**STATEMENT OF RICHARD MANNING, RESEARCH ASSOCIATE,  
NATIONAL NATIVE CHILDREN’S TRAUMA CENTER,  
UNIVERSITY OF MONTANA**

Mr. MANNING. Thank you, Senator, and thanks to Chairman Stafne.

I am here representing the National Native Children’s Trauma Center, whose director is Marilyn Zimmerman. She would be here today, but she is in Washington, D.C., presenting [indiscernible]. In other words, she got the short straw and had to go to D.C.

I would like to begin by saying first of all, we have been engaged in this community for seven years. We are very grateful to the tribal council. We would like to express that gratitude to the Chairman’s staff and the tribal council [indiscernible] in allowing us to learn from this community over the years [indiscernible] learning process. That engagement has greatly enriched our work with the work that we [indiscernible].

I would also like to thank Senator Tester, of course. I am very glad that he remarked today about that \$1.4 million grant. I can tell you, I personally had a hand in writing that grant. I saw it go through the bureaucracy and it clearly wouldn’t be here without the support we continually get from Senator Tester’s office and his

staff in negotiating this for us. It is very important work that goes on behind the scenes and is not often [indiscernible] it is a big deal.

Deb hit on some of the points I would like to hit on, and I would like to stress two points here today. The reports in the news, concrete examples that have grown out of our understanding, and by our work, I mean this community as a whole, that has been building as we struggle with these issues. Believe me, I use the word issue in plural. It is tempting of course to focus on the issue of suicide, headline-grabbing as it is. It is urgent that we do focus on it.

But we need to keep a few things in mind [indiscernible] this problem of suicide tends to be part of a lot of problems, a whole threat that is all tangled up, problems on problems, drug and alcohol abuse, assault and violence, poor academic performance, drop-outs, teen pregnancies. These problems kind of run together. We see them together and they are not speaking to individual cases [indiscernible] teen suicide. When we see them together we know we have a much larger problem than suicide, and we have to think about that.

We also have to think about causes. And again, there is no single cause. Causes themselves are very complex as well, and this is borne out by the research nationally. This is what we see on a community level when we work day to day. And those causes are not limited to but include things like child abuse, [indiscernible], absent parents, parents simply challenged by the difficulties [indiscernible] and in cases [indiscernible] historic [indiscernible].

This complexity of cause, in effect, dictates something very important and gives us our marching orders. Our marching orders are this: that no single agency, no single institution, no single level of government has a comprehensive solution. None of us can do it alone, we are all in this together. This virtually dictates that we have to learn to cooperate. Believe me, that is hard work. That is the work that has been going on.

This is not some platitude that we are just bearing lip service to. We have to learn to actively tear down the barriers between institutions so we can work together to solve this problem. We are all in this together.

Now, having set up those two principles, I want to report on good news, things that are happening, and we will get back to that \$1.4 million grant, and the way it worked. The way it worked, it did not begin with a grant-writing class. It began with a tribal consult declaring a state of emergency and then leading to the deployment of the Indian Health Service. The Indian Health Service deployed people to this community who did very hard State work. They researched and asked questions to find out what was going on.

Now, in lesser communities, the report that they generated would end up a shelf collecting dust as reports often do. That was not the case. We had already begun conversations with James Belcourt and under his leadership and tribal health people we understood that we needed that report as a way forward. So we took it as an information base. That information base, what we learned from that community or that Federal report told us as a university to do allowed us to write a grant that was far more compelling than we would have been able to do alone.

So it is that leadership, IHS, tribal health, tribal council and the schools, people working together, sharing information that allowed us to write a very strong grant and then the leadership of Senator Tester's office to make it happen. Those things [indiscernible] together.

That is probably [indiscernible] what is to us something we have learned. And this is a small thing [indiscernible]. During the IHS deployment, the people doing that work did a very smart thing and something we have a lot here today. They took kids aside and asked them what they thought we should do. They talked to children, they said, what do you need. Now, that sounds [indiscernible] be surprised at how often it doesn't happen. It happened in this case.

One of the things kids told us as a group, a common answer was, we had like more adult contact, one on one contact. So when we began our work in Poplar Schools in response to the initial suicide [indiscernible] schools and [indiscernible] university, we asked kids the same question, what do you need as a result of [indiscernible]. We got the same answer: we had like more one on one contact. We said, that sounds simple enough, let's do that.

So we started a mentorship program at Poplar Schools. We simply asked the kids to identify, identify an adult they trusted in the school. We took the kids' advice, someone you trust, a licensed therapist, a counselor, we don't care, just so you trust that person. The group we are talking about is 47 kids who were identified at risk for suicide. At risk. We are dealing with them intensively.

So those 47 kids went through the mentorship program and they also had a common history of assault. We had a lot of assault in that group. And then [indiscernible]. At the end of the mentorship, I am sorry, before the mentorship program, that group of 10 students had a rate of assault of .35, almost an assault every other month, .35 assaults per student per month. At the end of the mentorship program, it was .05. In other words, we effected a seven-fold decrease in assaults.

We have calculated out, if they do that mentorship program with every student in the school, and the school now has a rate of about 300 assaults per year, we would take that rate to about 116 by simple mentorship, checking into those kids three times a year, one on one adult contact. That is pretty good news. It is a simple program. It is the kind of thing that can be replicated and can be [indiscernible]. We think that justifies the kind of Federal investment that is being made [indiscernible] other people [indiscernible].

[The prepared statement of Mr. Manning follows:]

PREPARED STATEMENT OF RICHARD MANNING, RESEARCH ASSOCIATE, NATIONAL  
NATIVE CHILDREN'S TRAUMA CENTER, UNIVERSITY OF MONTANA

The National Native Children's Trauma Center and the Institute for Educational Research and Service, both at the University of Montana, thank you for the opportunity to present our information on this issue of vital importance, not just to this community, but throughout Indian Country and to the nation as a whole. Much of what you will hear in overall testimony today will focus on the severity of a single problem—teen suicide—here at Fort Peck. While we do not minimize that single problem, we would like to report that through seven years of engagement between our group at the university and this community, all of us have learned a great deal about some of the broader issues, again, of vital interest throughout Indian Country and to the nation as a whole. One of those lessons is that showing up matters.

Throughout our engagement here, working groups both large and small have traveled from the University in Missoula to this community on average every two months. But then we can't help but note and appreciate that the Indian Affairs Committee already knows this rule and proves it by showing up here for field hearings. We believe this community views this as a positive development.

All of what we have learned here with the help of this community cannot be adequately summarized in this short testimony, but in service of the Committee's work, we would like to emphasize two over-arching lessons that we believe ought to guide everyone's efforts in these issues. In addition, we would like to report an encouraging new finding that demonstrates how attention to these two fundamental points succeeds.

In convening this hearing, the Indian Affairs Committee, in fact, demonstrated the first important bit of knowledge by titling it: "Empowering Native Youth to Reclaim their Future." Everyone here today knows the headline-grabbing issue in this very school district has been a cluster of teen suicides, and the understandable urge is to do something now about that specific problem. In fact, our group from the university is engaged in exactly that, in doing something about suicide now. Nonetheless, as urgent as this issue is, the Committee's title urges us to not lose sight of the larger issues, and we agree. This is really about the future of Native youth, all youth. Teen suicide is not a single problem in isolation, but is part of a tangle of challenges that includes drug and alcohol abuse, family, community and gang violence, poor academic performance and a high drop-out rate, teen pregnancy, diabetes and obesity. Pulling a single thread will not untangle the larger Gordian knot of problems.

Likewise, our nation now has a solid body of science compiled by both the Centers for Disease Control and the National Childhood Traumatic Stress Network sanctioned by Congress in 2001. Our National Native Children's Trauma Center is a Category II Center in that national network, charged with addressing these issues on reservations throughout the nation. The overwhelming evidence from those efforts concludes that the knot of problems we face here and in impoverished communities nationwide stem from child abuse, neglect and domestic and community violence, and in the case of reservation communities, historical trauma. We do have some evidence that some forms of abuse are particularly damaging. For instance, our researchers expect to soon publish data indicating a particularly strong link between childhood sexual abuse and teen suicide. Nonetheless, this does not negate our primary lesson here, that the knot of problems is wound up in a knot of causes, and we make little progress in these issues unless we recognize the complexity of the total picture.

This presents a daunting challenge, but also leads to our second key point: Because the larger issue is a series of complex problems stemming from complex causes, no single agency, institution or bureaucracy can solve this alone. The hydra heads of challenges preventing Native youth from reclaiming their future must be dealt with by tribal health, social services, schools, juvenile justice and by families, especially families. The complexity dictates that all of these diverse elements and interests in the tribal community come together to share information and common strategy. We are all in this together. Federal, state, tribal, school district, and—yes, even academics from the university—must learn to cooperate in a common effort. That may be the most important lesson this community is learning and teaching the rest of us, not just that cooperation is necessary, but exactly how to tear down the barriers to cooperation so we can get to the hard work that faces us. These are not just platitudes; we have concrete examples of real success that stems from real cooperation.

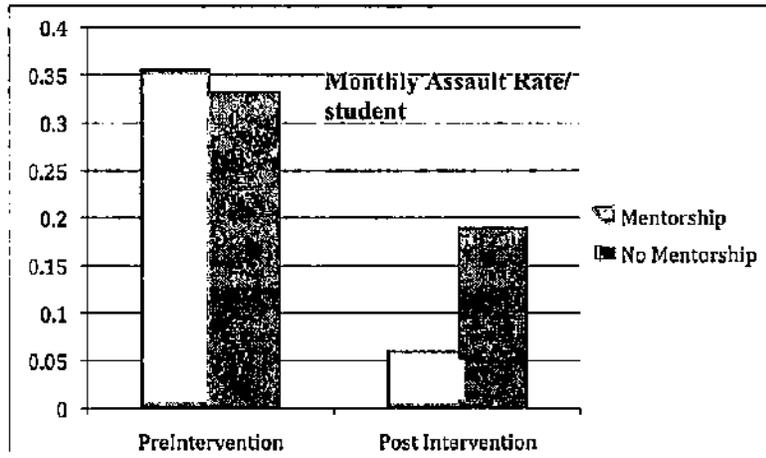
As you know, in response to the widely reported suicide cluster more than a year ago, the Fort Peck and Assiniboine Sioux Tribal Council declared a state of emergency in May of 2010, which triggered a deployment by the Office of Force Readiness of the U.S. Public Health Service and the Indian Health Service. IHS sent twenty-two officers, who rotated through the community in six separate teams, each in two-week deployments. The incident commander of the deployment was James Melbourne, Director of Tribal Health Service. This extraordinary effort led to a formal report from IHS, which could have, in a lesser community, been sent to a shelf somewhere to gather dust. Not here. Our group at UM had already begun working with Director Melbourne on these issues, and agreed to cooperate on a way forward, using the IHS report as an information base. We built on their knowledge. Cooperatively, we wrote an application for a \$1.4 million grant from the Substance Abuse and Mental Health Services Administration to pay for suicide prevention on the Fort Peck reservation. Senator Tester's office supported us and announced that our application was successful on July 28, and now a local agency—Tribal Health—a state university and a local school district will go to work fulfilling needs identified

by the federal IHS and the tribes. This is what we mean by interagency cooperation and shared information. Further, because of this structure and the spirit of cooperation, our university has agreed to waive any indirect costs, a burden that can run as high as 41 percent on federal grants.

Yet embedded in this is a development there is, we think, an even more revealing and encouraging bit of news. As part of its investigation, IHS took the rare and laudable step of actually interviewing the community's youth to solicit their ideas on how we might better serve them. The students gave us some common and revealing insights, and one of those was identifying a need for more meaningful adult contact, one-on-one relationships we might call mentoring. As part of the university's work at Poplar Schools, we repeated that question with a group of forty-seven students that screening had identified as being at-risk for suicide. We got a similar answer, so took the simple step of taking these children at their word. But in analyzing the data, we also noticed that a significant subset of the forty-seven also showed a pattern of assaulting other students and teachers, of violence. As we said, these problems are entangled, and often one problem like violence stemming from anger is a warning sign of another, like suicide.

Listening closely to what the young people were telling us caused us to do something very simple, but responsive: to begin a mentorship program. Each student identified someone on school staff that he or she could trust—a pivotal step—and in every case the identified staffer agreed to check in with the student at least three times during a school year—just three times. They talked about issues like academic progress and attendance, but more to the point, mentors took an interest in students' well-being. The program effected simple human contact between a student and a caring adult, not someone specially trained or licensed or delivering a particular therapy, just someone the student herself identified as someone she trusted.

The subset of ten students with a history of violence in the school, on average, accounted for 4.5 assaults per month in the two years and several months before teaming up with a mentor. That is, these kids, also at risk for suicide, accounted for a significant portion of the violence in the school. But more importantly, after these students participated in the simple program of mentoring, their assaults fell from an average of 4.5 per month to 0.71 per month. Conversely, three students identified as "at risk" of suicide and with a history of assault were denied parental permission to participate in the mentorship program. Their assaults decreased also, but not nearly as dramatically as those mentored. Seldom do those of us in this field see such a robust and dramatic result so quickly.



The bonus in all of this is that of the larger group of 47 students identified as "at risk," those who were mentored also showed significant gains in academic achievement. In fact, the difference between the two groups—mentored and not—amounted to the difference between earning enough credits to graduate and failing to do so, one of the more significant predictors of a student's future.

This is not to say this is a magic bullet that will solve the community's problems overnight, but there are a couple of points in all this worth emphasizing. The gains

shown here occurred as a result of an open exchange of information and knowledge among various agencies, particularly IHS, the Tribal Health Service and Poplar Schools. But they also occurred because Poplar Schools staff has spent many years learning to recognize and deal with at-risk youth. That is to say, the community has built capacity, and it has paid off.

Second, though, this is a cost-effective and simple program that rests on strengthening meaningful relationships between children and adults in this community, and now we have some evidence it works. It's the sort of work that can be easily and immediately replicated in similar communities with similar challenges, so the nation really can learn from Fort Peck. This, we think, helps justify the federal investment in this place and in these young people.

Senator TESTER. Thank you, Dick. We appreciate that.

Thank you for your comments, and I as I told Deb earlier, we will have questions.

Rounding out the first panel, we have Fanci Jackson, maybe the most important member of this panel. No offense to Deb or Dick. But the fact is that Fanci Jackson is a member of the Fort Peck Youth Council, and she is going to provide us a perspective from the youth side of things and what it is like growing up here on Fort Peck.

Thank you for being here, Fanci.

**STATEMENT OF FANCI JACKSON, MEMBER, FORT PECK  
YOUTH COUNCIL**

Ms. JACKSON. Hi, my name is Fanci Jackson and [indiscernible].

I don't mean to [indiscernible] but from my perspective, I [indiscernible]. I went [indiscernible] and I was a over there for a half a year. It was very hard, actually.

And the following year, it was really hard [indiscernible] no one knows how hard it is for you, you never tell anybody [indiscernible] because you are scared of what they will think of you. You are scared to tell anybody, because [indiscernible] you know people and you have to be [indiscernible] maybe [indiscernible] by that. And you don't want to do it and you get scared, you get terrified [indiscernible].

But my [indiscernible] at school [indiscernible] so mean, they call me mean names and make fun of me [indiscernible] call me a [indiscernible]. I really was [indiscernible] I felt [indiscernible] because all my friends were there, and we were all the same, we were no different. When I went to [indiscernible] and so easy problems [indiscernible] could do in five seconds [indiscernible] that I was too not smart [indiscernible] that I couldn't do anything. But in that school I felt so stupid, I felt, why am I here, they don't want me here. The teachers don't want me here, the students don't want me. So why am I here? I was afraid to go to school sometimes [indiscernible]. I was [indiscernible].

What I would like to bring to your attention is that we only got one [indiscernible] out of the whole year [indiscernible] had one B. I had straight As all across, distinguished honors and I got that B, it was the only one B I got for the last two years. I have never got a B [indiscernible]. I was proud, but scared [indiscernible] don't know [indiscernible] larger than happens [indiscernible]. Many of us don't have [indiscernible] hurts, even though we don't trust them. We don't tell a lot of people. Our friends see it, we see it but what do they do? They do nothing. They don't speak up. They don't

talk about it. When someone talks, when someone makes fun of you, when someone hurts you so bad you want to cry, we don't talk to anybody, because we are afraid.

And we don't know what to do. It is like [indiscernible] everybody embarrassment. You feel so embarrassed that you just want to cry and it hurts you so bad you don't know what to do. You are just sitting there [indiscernible] and you don't know what to say. So you just try to walk away but it just keeps coming back. They will keep following you and keep pushing you and pushing you and you still don't know what to do. And you are afraid [indiscernible] really hard.

But [indiscernible] that is why I tried to stand up for my friends when they get bullied by other people. I see that and I don't like it one bit. I hate when people bully people. The bullies don't see how people that are being bullied, how they feel. I see my friends cry [indiscernible]. I told [indiscernible] I don't know who it was, but I told one of [indiscernible] half hour I told them [indiscernible] and that they should just leave them alone [indiscernible] do something else. My friend cried for a whole half hour she was so hurt. She didn't know what to do.

And I was scared for her. Because sometimes bullying leads to suicide. A lot of my friends talk about it, suicide. They think, it is my way out. If I do this, I can get out of here, maybe it will be a better place. Maybe [indiscernible]. Only thing [indiscernible] we always think about getting out of here. When you are so deep down hurt that you don't know what to do or where to go, you don't think you have any other choice, you just want to die. But I am like, you really do, you want to leave this and you don't want to look back. That is when you are so deep down and you don't really care any more.

I have some friends, one friend that I was actually like that when I got depressed. When I got depressed, my dad passed away in August, his memorial is coming up this weekend on the 10th, he passed away [indiscernible] was so alone. I felt so alone in school, just knowing I had no one to talk to. I felt so alone deep down, I thought no one cared about me.

I got so depressed I started lashing out at my sisters, I got angry at them [indiscernible] over something that was completely not even important, maybe a pop, maybe she walked by me and maybe looked at me the wrong way. I would just get mad and then [indiscernible] my mom told me that [indiscernible] she thought [indiscernible] and I was really getting bad into it. I was lashing out. I started picking [indiscernible].

I thought if I leave [indiscernible] maybe I won't be alone, maybe I will see them then, he will care that I am there, maybe [indiscernible] see who I am. I felt so alone [indiscernible] and nobody talked to me. I told her [indiscernible] for maybe a few hours but [indiscernible]. I was hurting so bad nobody knew [indiscernible] just smile and act like nothing was wrong. I smiled for six months without telling anybody I was really, really depressed. I smiled through everything.

But then I just wanted to cry. Every day I was just tired, didn't want to get up. Every day [indiscernible] just looking at that [indiscernible] outside each [indiscernible] woke up and go to school [in-

discernible]. But then I thought of my mom, how much my mom loved me, how much my sisters loved me, how much my brother loves me, how much everyone loves me so much. And I couldn't leave them. What would they do without me? There is only one me. There is not going to be another me.

So there is never going to be [indiscernible]. And I thought that I could be [indiscernible]. But some kids just don't [indiscernible] just give up. They just don't think [indiscernible]. But [indiscernible] I want to what my friends wanted to do but I tried to stop them, because I know that I love them too much for them to go. Some of my friends, one did [indiscernible] very silent and I was very sad, I barely [indiscernible] but I was very said that he passed away. [indiscernible] no one [indiscernible] my cousins passed away in April [indiscernible] almost [indiscernible]. I was coming back from a field trip and then I get the call that [indiscernible] and I just cried. I didn't know what to do. He was 23 years old, he has his whole life in front of him [indiscernible]. He was my best [indiscernible] and I love him so much [indiscernible].

But sometimes being bullied doesn't mean being bullied in school but sometimes it can be outside of school. It can also be by family [indiscernible]. Sometimes [indiscernible] people you don't even know. You can get bullied everywhere, no matter what. He was bullied so much that he hung himself. And I walk by that garage every day, going to [indiscernible] and look in there wondering why, why did you have to leave, why. And it is all hurt so bad just knowing that he couldn't live any more. And knowing that I felt that way too. Then after [indiscernible] cried so much I wanted to kill myself, yes, but after I saw that, how many people got hurt by it, I wanted [indiscernible].

Most people get really [indiscernible] some of my friends. Some people I don't even know, I will be walking down the road and I will see someone, they are pushing a kid around. I mean, we are all human, we are all the same color. Sometimes we are [indiscernible] we can actually resolve the conflict, but they don't, no one does. They just watch these kids beat each other, they just watch these kids beat each other up all the time and no one stops it. No one speaks up. No one tells that kid that they are not supposed to do that to that child.

Because one day, what if tomorrow that little boy that got beat up [indiscernible] and that happens. It really does. I know it does. I have seen it happen. It [indiscernible] just knowing that your friend tomorrow [indiscernible] tomorrow is your friend that [indiscernible] yesterday [indiscernible] in the morning when I wake up and say hello [indiscernible] be there and say hello to him any more. He's gone.

You have to [indiscernible] that what if all these people are being hurt, no one looks at them, no one even sees them. Sometimes it is hard to see it. But they are hurt and you have to help them. If you don't help them, they are not going to be there tomorrow. There is only [indiscernible] what if tomorrow you don't see them. There is so many of them no one sees them. [indiscernible] but [indiscernible].

Senator TESTER. Thank you, Fanci. I appreciate that very much.

I would like to start with Fanci, if I might, it is kind of reverse order. Your testimony was very good, and you are right, there is only one you. And people need to understand that. And to give up, it talks about the dire straits, you could be there.

As you were giving your testimony, I was thinking about the peers that are around you, you talked about that, the family that is around you. Are you able to encourage, through the Fort Peck Youth Council, when people get bullied or for whatever reason and they get to feeling rejected, that there are people out there to go to talk to, kind of a support group, so to speak, to help them get back right with the world? Is that available to kids, whether you are in Poplar or Wolf Point or Frazier or wherever? Is there any kind of effort to try to make a group of your peers or a group of parents available?

Ms. JACKSON. Actually, I was just talked to my parents, but I don't know who to talk to about it. I mean, I didn't [indiscernible]. You don't think that anybody will believe you, you don't think that they will care.

Senator TESTER. But the fact is, there are people who care, right? You talked about your cousin.

Ms. JACKSON. Yes, [indiscernible] at the time I didn't [indiscernible].

Senator TESTER. Okay. That is fine.

Dick Manning, the grant that you spoke of, and you talked about working together, you talked about partnerships, the \$1.4 million grant, what kinds of programs do you think would be available to develop with this in the end? Where are you going to focus the effort?

Mr. MANNING. It is actually about the 6th of November, and in the first phase, that has already happened, the initial grant a year ago. That is almost like a triage, we zoom in and identify as rapidly as possible the kids who are at risk of suicide. And they tend to be in a cluster, they tend to be kids who knew the kid who completed suicide. For instance, they tend to be very angry about that, they didn't see that as [indiscernible] those kids almost on a triage basis as rapidly as possible.

And that step, that [indiscernible]. The other thing you do with that is, you try to train staff to recognize. And some evidence based on steps that we have seen in other places, for instance, the staff now are very sensitive to a missing child. When a child is not in school on a given day, we are calling the house trying to find out. In some cases, if they get no response at the house they go, literally, they take it that seriously. We think, we think that we have prevented two completions as a result of that work.

But beyond that, as the effort continues, we can take it on a broader basis across the school and deal with some of the tougher issues that are out there, like bullying. Make people sensitive to bullying, take it seriously, it can happen. At least those kinds of things.

And we try to concentrate initially on that suicide problem. Then we go spread out to the broader community and the broader setting of problems [indiscernible.]

Senator TESTER. One more question. There is been recent legislation that talks about tele-health as a method to be used for issues

that revolve around mental health problems, psychological health, however you might want to put it. I just want to get your opinion. Is this an issue where tele-health can help? Tele-health, tele-medicine health. For instance, you have a health care professional in Boston, Massachusetts or Missoula, Montana or Billings or wherever talking to areas that are rural or frontier where you have a hard time getting health professionals, like right here.

Mr. MANNING. On a short-term basis, certainly. In this case, when we are worried about a suicide [indiscernible] I understand is not implemented but will be implemented in the spring. Suicide hot line [indiscernible] somebody to call in the [indiscernible]. But ultimately these issues resolve on something as simple as [indiscernible] and it really takes a village, the people who will support not somebody out [indiscernible] away. That first day it can be that. But ultimately, long term, one on one [indiscernible] works, it is the community support, it is creating an environment where people feel safe and welcomed [indiscernible].

Senator TESTER. Thanks.

Deb, we send our kids to school and they spend a lot of time in school. And so even though the family is hugely important in this, and it is critically important, I think part of Fanci's testimony revolved around that, are there things that the school districts are doing or can do as it revolves around mental health?

Ms. HALLIDAY. Absolutely. As I was saying earlier, to look at a school system and know that kids aren't getting their rightful access to a quality education, and not understand that they feel [indiscernible] safe to [indiscernible] flourish in a school environment, that is a very central piece of our work.

There are infrastructure pieces at schools. A lot of schools have school counselors who are trained to work with mental health. We have in our State a program where third party non-profit and for-profit mental health providers partner with the school systems to provide some care and then they go Medicaid for that, which is trying to get some of the challenges of getting services into a rural area.

I think this is a lot of work that can be done though around, as they were saying, relationship-building, encouraging teachers and staff to see themselves as a very important, safe, consistent adult in a child's life. And there is a lot of really great work that is happening in our State through something called Montana Behavioral Initiative, which is part of the Office of Public Instruction, that teaches adults in the school system how to just have a very consistent, caring way with kids. We are doing some of that work through the Schools of Promise work as well.

Senator TESTER. In areas where there is a real problem with teen suicide, and you talked about the role that counselors play, and what a critical role they can play, and the classroom teacher, as far as that goes. Does OPI have the resources or the ability, either one, to be able to give help to a school district where they are seeing an influx in problems?

Ms. HALLIDAY. Suicide particularly?

Senator TESTER. Yes, in suicide particularly.

Ms. HALLIDAY. Well, we are very strong local control State, so a tremendous amount of decisions of personnel and program and

budget are decided at the school board level. So this [indiscernible] one of our [indiscernible] legislation is going to be put forward was to require school districts to have baseline for what the anti-bullying policy would look like, the four components of it, definition, and that would be readily available to any parent or student who would want to know what the policy was. That was defeated.

But what we are doing anyway is creating a model bullying policy. I know that several of the public schools here in Fort Peck have been working, I think as a result of the IHS work [indiscernible] to try and revamp their bullying policies. But change really only happens when people change their behaviors. So I really, it resonated with me when Roxanne said, I don't want to hear about another policy, I want to know our kids are going to be loved and taken care of [indiscernible].

Senator TESTER. I want to thank you all for your contribution to this hearing. I very much appreciate your testimony and your forthrightness. We have some issues here that need to be dealt with, and we appreciate your leadership, whether it is leadership with our youth, or leadership in the capacity that you are in in your jobs. Thank you for that.

So I will release you now. In the meantime, I will ask Dr. Weahkee to come up, Ed Parisian to come up, and Dr. McKeon.

While they are getting set down, I will just tell you that our next panel represents the Federal Government's response to this crisis. They are going to tell us not only what they are doing, but also what communities throughout Indian Country can do to address this. We are going to first hear from Dr. Rose Weahkee, who is Director of Behavioral Health and the Indian Health Service. Rose has dedicated years to preventing these tragedies from occurring. We thank all three of you for being here today. We very much appreciate your presence at this Indian Affairs Committee hearing.

And we will hear from Rose first.

**STATEMENT OF ROSE WEAHKEE, Ph.D., DIRECTOR, DIVISION OF BEHAVIORAL HEALTH, INDIAN HEALTH SERVICE**

Ms. WEAHKEE. Thank you, Mr. Chairman, Senator Tester. Good afternoon. I am Dr. Rose Weahkee, Director of the Indian Health Service Division of Behavioral Health.

I am pleased and honored to have this opportunity to testify on the Indian Health System's response to youth suicide in Indian Country.

As you know, IHS plays a unique role in the U.S. Department of Health and Human Services to meet the Federal trust responsibility to provide health care to American Indians and Alaska Natives. In this ongoing effort to meet the health and behavioral health challenges, there is of course a trend toward tribal management and delivery of behavioral health services. Currently 54 percent of mental health and 84 percent of alcohol and substance abuse programs are tribally-operated. This evolution in behavioral health care delivery and management is changing the face of behavioral health services in Indian Country.

Where IHS was previously the principal behavioral health care delivery system, there is now a more diverse network of care provided by Federal, tribal and urban Indian health programs. This

“Indian health system” denotes this larger network of programs and the evolving care delivery system across Indian Country.

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 and the risk factors are more severe in nature. For years, several communities in Indian Country experienced suicide contagion, often referred to as suicide clusters. In these communities, the suicidal act becomes a regular and transmittal form of expression of the despair and hopelessness experienced by some Indian youth.

On a national level, American Indian and Alaska Native communities are also affected by very high levels of poverty, unemployment, accidental death, domestic violence, alcoholism and child abuse. American Indian and Alaska Native people suffer significantly from mental health disparities. While the need for mental health care is great, services are lacking and access to these services can be difficult and costly. The availability and adequacy of mental health programs for American Indians varies considerably across communities.

IHS has devoted considerable efforts to develop and share effective programs. Developing programs that are collaborative, community-driven and nationally supported offer the most promising potential for long-term success and sustainment. The IHS National Tribal Advisory Committee on Behavioral Health, which is made up of elected tribal leaders from each of the IHS areas, provides recommendations and advice on the range of behavioral health issues in Indian Country. The IHS Behavioral Health Work Group is the technical advisory group to IHS and is made up of mental health professionals from across Indian Country. They provide expert advice and recommendations for services and program delivery.

The Indian Health Service Suicide Prevention Committee was established and tasked with identifying and defining the steps needed to prevent suicide and suicide-related behaviors. The Indian Health Service methamphetamine and Suicide Prevention Initiative is a nationally coordinated pilot program, which supports 127 IHS, tribal and urban Indian health programs that are providing methamphetamine and suicide prevention resources to communities with the greatest need.

Just this past week, on August 1st, in partnership with tribes, IHS released the American Indian/Alaska Native National Behavioral Health and Suicide Prevention Strategic Plans. These strategic plans will foster collaboration and other key community resources.

Also, in November 2010 to February 2011, IHS, SAMHSA, BIA and BIE held ten suicide prevention listening sessions to seek input from tribes on how our agencies can most effectively work in partnership with tribes to prevent suicide. This information was used to form the agenda for the Action Summit for Suicide Prevention which was held just this past week with over 1,000 in attendance. The IHS and the Veterans Health Administration Suicide Prevention office have also developed a joint plan to address suicide among our Native veterans and their families. VA has also

participated in many of the suicide prevention listening sessions and also in the Action Summit last week.

Also, on December 30th, 2010, the National Action Alliance for Suicide Prevention announced an American Indian and Alaska Native task force to address the issue of suicide in Indian Country, and also to advance a national strategy for suicide prevention. Jointly leading this task force are Dr. Yvette Roubideaux, the Director for IHS, Mr. Larry Echo Hawk, Assistant Secretary of Indian Affairs, Department of the Interior, and Mr. McClellan Hall, the Executive Director of the National Indian Youth Leadership Program.

In summary, we look forward to addressing the issue of mental health care needs in Indian Country. Our partnership and our consultation with tribes has shown that we are working together to improve the health of American Indian and Alaska Native communities. As you heard today, together we can instill culture, language and spirituality, together we can instill hope.

Mr. Chairman, this concludes my statement. Thank you again for allowing me to testify. I would be happy to answer any questions that you might have.

[The prepared statement of Ms. Weahkee follows:]

PREPARED STATEMENT OF ROSE WEAHKEE, PH.D., DIRECTOR, DIVISION OF  
BEHAVIORAL HEALTH, INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee:

Good Afternoon, I am Dr. Rose Weahkee, Director of the Indian Health Service (IHS) Division of Behavioral Health. I am pleased to have this opportunity to testify on the Indian health system's response to youth suicide in Indian Country.

The IHS plays a unique role in the U.S. Department of Health and Human Services to meet the Federal trust responsibility to provide health care to American Indians and Alaska Natives (AI/AN). The IHS provides comprehensive health service delivery to approximately 1.9 million Federally-recognized American Indians and Alaska Natives through a system of IHS, Tribal, and Urban facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level, in partnership with the population served. The agency aims to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our goal is to promote healthy AI/AN people, communities, and cultures, and to honor the inherent sovereign rights of Tribes.

The IHS is responsible for providing mental health services to the AI/AN 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 services staffed by one or more mental health professionals. Many of the IHS, Tribal, and urban mental health programs that provide services are not open 24/7. 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.

In the ongoing effort to meet the health and behavioral health challenges, there is a trend toward Tribal management and delivery of behavioral health services in AI/AN communities. Particularly in the last decade, Tribes have increasingly contracted or compacted via the Indian Self Determination and Education Assistance Act, Public Law 93-638, to provide those services themselves. Currently, 54 percent of the mental health and 84 percent of the alcohol and substance abuse programs are operated by Tribes. This evolution in behavioral health care delivery and management is changing the face of behavioral health services in Indian Country.

Where IHS was previously the principal behavioral health care delivery system for AI/ANs, there is now a less centralized and more diverse network of care provided by Federal, Tribal, and Urban Indian health programs. The "Indian health

system” denotes this larger network of programs and the evolving care delivery system across Indian Country. Meeting the needs of this system will require an evolution in IHS and Tribal collaboration as well, particularly as Tribal programs take more direct responsibility for services and IHS supports them in doing so.

### Introduction

Suicide is a complicated public health challenge with many contributing risk factors. In the case of AI/ANs, they face, on average, a greater number of these risk factors individually or the risk factors are more severe in nature for them. In prior years, several communities in Indian Country experienced suicide contagion, 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.

The AI/AN suicide rate (17.9 per 100,000) for the three year period (2002–2004) in the IHS service areas is 1.7 times that of U.S. all races rate (10.8 per 100,000) 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 more frequently in those areas than the national average. Suicide is the sixth leading cause of death overall for males residing in IHS service areas and ranks ahead of homicide. AI/AN young people ages 15–34 comprise 64 percent of all suicides in Indian Country.<sup>1</sup> Suicide mortality rates have increased from 45.9 per 100,000 to 55.2 per 100,000 among AI/AN youth ages 15–24, comparing data from 2003–2005 to those from 1999–2001. Overall, suicide mortality is 73 percent greater in AI/AN populations in IHS service areas compared to U.S.—All races.<sup>2</sup>

On a national level, many AI/AN communities are also affected by very high levels of poverty, unemployment, accidental death, domestic violence, alcoholism, and child neglect.<sup>3</sup> AI/AN people suffer significantly and disproportionately from mental health disparities and lack access to culturally appropriate care. Each of these serious health issues has a profound impact on the health of individual, family, and community well being both on- and off-reservations.

According to a 2001 mental health supplemental report of the U. S. Surgeon General, “Mental Health: Culture, Race, and Ethnicity,” there are limited mental health services in Tribal and urban Indian communities.<sup>4</sup> While the need for mental health care is great, services are lacking, and access to these services can be difficult and costly.<sup>5</sup> The current system of services for treating mental health problems of AI/ANs 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 AI/ANs varies considerably across communities.<sup>6</sup> Navigating complex or fragmented combinations of Tribal, Federal, State, local, and community-based services can be confusing and discouraging, making it difficult to access care even if it is available. In addition, severe provider shortages are common.<sup>7</sup>

There are many reasons for a lack of access to care and services. Indian Country is predominantly rural and remote, and this brings with it the struggles of recruiting and retaining providers. Rural practice is often isolating for its practitioners. The broad range of clinical conditions faced with limited local resources challenges even seasoned providers. Some providers are so overwhelmed by the continuous de-

<sup>1</sup>Indian Health Service. Office of Public Health Support. Division of Program Statistics. *Trends in Indian Health, 2002–2003*. Rockville, MD: Indian Health Service.

<sup>2</sup>Unpublished data, Office of Public Health Support. Division of Program Statistics. Indian Health Service.

<sup>3</sup>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.

<sup>4</sup>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.

<sup>5</sup>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.

<sup>6</sup>Ibid.

<sup>7</sup>More Mental Health Resources Needed to Battle Teen Suicides in American Indian and Alaska Native Communities. (2010, May). *U.S. Medicine: The Voice of Federal Medicine*. Retrieved March 28, 2010 from <http://www.usmedicine.com/articles/more-mental-health-resources-needed-to-battle-teen-suicides-in-american-indian-and-alaska-native-communities.html>

mand for services, particularly during suicide outbreaks, that even experienced and hard working providers become at-risk for burn-out.

In addition to clinical care, the importance of public health and community- and culture-based interventions is becoming more widely recognized.<sup>8</sup> One factor that makes community- and culture-based interventions especially important is the role of historical trauma in the increased risk of suicide among AI/AN people. Historical trauma, exacerbated by re-traumatization of the community from the high rates of injury and death, continues to plague Indian communities.<sup>9</sup> Historical trauma is also linked to increased suicide risk because anger, aggression, and violence felt in response to experiences of victimization can be turned against oneself.<sup>10</sup>

### **Addressing Suicide in Indian Country**

Since 2008, IHS has devoted considerable effort to develop and share effective programs throughout the Indian health system. In particular, developing programs that are collaborative, community driven, and nationally supported, we believe, offer the most promising potential for long term success and sustainment. As an example of this, IHS regularly relies on Tribal leadership and expertise to collaborate on a range of behavioral health problems and programs.

The IHS National Tribal Advisory Committee (NTAC) on Behavioral Health, which is made up of elected Tribal leaders from each IHS Area, provides recommendations and advice on the range of behavioral health issues in Indian Country. From making recommendations on significant funding allocations and service programs, to developing long term strategic plans for Tribal and Federal behavioral health programs for the future, the NTAC is the principal Tribal advisory group for all behavioral health services to IHS. They ensure collaboration among Tribal and Federal health programs, provide Tribal input into the development of programs and services, and also provide the inclusive and transparent development of processes and programs so important to all our communities and programs.

The IHS National Behavioral Health Work Group (BHWG) is the technical advisory group to IHS. Comprised of mental health professionals from across the country, the BHWG furthers the agency priorities to strengthen partnerships with Tribes, improve quality and access to care for patients, and provide direct collaboration and input for accountable, fair, and inclusive services across the Indian behavioral health system. They provide expert advice and recommendations for services, programs, and intervention models, as well as long term strategic planning and goal development. As the national technical advisory group to the agency, they also work very closely with the elected Tribal leaders on the NTAC to provide collaborative links between the professional community and national Tribal leadership.

The IHS Suicide Prevention Committee (SPC) was established and tasked with identifying and defining the steps needed to significantly reduce and prevent suicide and suicide-related behaviors in AI/AN communities. It is the responsibility of the SPC to provide recommendations and guidance to the Indian health system regarding suicide prevention, intervention, and postvention in Indian Country.

### **IHS Methamphetamine and Suicide Prevention Initiative**

The IHS Methamphetamine and Suicide Prevention Initiative (MSPI) is a nationally-coordinated demonstration pilot program, focusing on providing targeted methamphetamine and suicide prevention and intervention resources to communities in Indian Country with the greatest need for these programs. IHS, Tribes, Tribal programs, and other Federal agencies concurrently coordinate the development and implementation of the MSPI project, which now provides support to 127 IHS, Tribal, and urban Indian health programs nationally. The strategic goal is to support Tribal programs in their prevention, treatment, and infrastructure development as they increasingly are delivering their own services. The MSPI implemented by IHS and its Tribal partners nationally, marks a significant milestone in suicide prevention efforts in Indian Country as well as Tribal and Federal partnerships for health that embraces the Administration's commitment to Tribal engagement and partnership.

<sup>8</sup>Grim, C.W. (2006, May 17). Testimony of Charles W. Grim, Director of the Indian Health Service, before the Senate Committee on Indian Affairs on Suicide Prevention Programs and Their Application in Indian Country. Washington, DC. Retrieved from <http://www.indian.senate.gov/public/files/Grim051706.pdf>

<sup>9</sup>Brave Heart, M. Y. H. and DeBruyn, L. M. (1998). The American Indian Holocaust: Healing Historical Unresolved Grief. *American Indian and Alaska Native Mental Health Research*, 8(2), 61.

<sup>10</sup>Subia BigFoot, D. (n.d.) History of Victimization in Native Communities [Monograph]. Retrieved March 28, 2010 from <http://icctc.org/History%20of%20Victimization%20Issues-%20Final.pdf>

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, Tribal leaders developed a model and recommendations, which were accepted by IHS, for approaches and funding allocations. It was and remains a creation of close collaboration and partnership with Tribes. The program is 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.

The MSPI data currently available indicate that a total of 289,066 persons have been served through both prevention and treatment activities. Prevention activities include, but are not limited to evidence-based practice training, knowledge dissemination, development of public service announcements and publications, coalition development, and crisis hotline enhancement. There were 42,895 youth participating in evidence-based and/or promising practice prevention or intervention programs. There were 674 persons trained in suicide crisis response teams.

#### **American Indian/Alaska Native National Behavioral Health and Suicide Prevention Strategic Plans**

On August, 1, 2011, in partnership with Tribes, IHS released the American Indian/Alaska Native National Behavioral Health and Suicide Prevention Strategic Plans. These strategic plans will foster collaborations among Tribes, Tribal organizations, urban Indian organizations, and other key community resources. These collaborations will provide tools needed 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 American Indian/Alaska Native National Behavioral Health Strategic Plan is the culmination of over two years of close collaborative work, and contains three overarching strategic directions which are operationalized into 77 action steps, most of which are already in progress. It is the strategic framework for the continuing development of programs and services across the AI/AN behavioral health system, with an added emphasis on Tribal, Federal, and Urban program collaboration.

The American Indian/Alaska Native National Suicide Prevention Strategic Plan represents the combined efforts of Tribal, Federal, Urban, and other representatives across the country to develop strategic goals and objectives to address the ongoing suicide epidemic in so many of our communities. The suicide epidemic is the single most significant cause of concern across our communities and requires specific planning and program implementation, which this plan represents in eight strategic goals and 41 objectives.

The importance of including culture, cultural and traditional practices, and a variety of learning approaches is included in these strategic plans and should not be underestimated. AI/ANs see behavioral health as supporting their historic and continuing reliance on elders, languages, community, culture, and traditional practices as protective factors that restore balance and serve as both prevention and treatment.

#### **IHS Partnerships**

Strategies to address mental health and suicide include collaborations and partnerships with consumers and their families, Tribes and Tribal organizations, urban Indian health programs, Federal, State, and local agencies, as well as public and private organizations. This effort seeks to establish effective long-term strategic approaches to address mental health and suicide prevention in Indian Country.

IHS and the Substance Abuse and Mental Health Services Administration (SAMHSA) work closely together to formulate long term strategic approaches to address the issues 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.

IHS, SAMHSA, Bureau of Indian Affairs (BIA), and Bureau of Indian Education (BIE) held ten regional suicide prevention listening sessions across Indian Country over the last twelve months to seek input on how the agencies can most effectively work in partnership with Tribes to prevent suicide. The Tribal listening sessions provided important information on suicide prevention needs, concerns, programs,

and practices. This information was used to form the agenda for the Action Summit for Suicide Prevention held from August 1–4, 2011 in Scottsdale, AZ with over 1,000 in attendance. This collaborative work also paved the way for other Federal partners to join in the effort to prevent suicide among AI/ANs. For example, IHS and the Veterans Health Administration (VHA) Suicide Prevention Office have developed a joint plan to address suicide among Native veterans. VHA Suicide Prevention Coordinators participated in several of the listening sessions.

On September 10, 2010, Department of Health and Human Services Secretary Kathleen Sebelius and Department of Defense Secretary Robert M. Gates announced the creation of the National Action Alliance for Suicide Prevention. The Action Alliance is expected to provide an operating structure to prompt planning, implementation and accountability for updating and advancing the National Strategy for Suicide Prevention. On December 30, 2010, the National Action Alliance for Suicide Prevention announced three new task forces to address suicide prevention efforts within high-risk populations including American Indians/Alaska Natives. Jointly leading the American Indian/Alaska Native Task Force are Yvette Roubideaux, M.D., M.P.H., Director of the Indian Health Service; Larry Echo Hawk, J.D., Assistant Secretary of Indian Affairs, Department of the Interior; and McClellan Hall, M.A., Executive Director, National Indian Youth Leadership Project.

Tribes also look to SAMHSA for help in addressing youth suicides. Through its Garrett Lee Smith State and Tribal Grants, Tribes and Tribal organizations have received grants ranging from \$400,000 to \$500,000 a year to prevent suicide. 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, AI/AN communities determined to be the most “at risk” develop or enhance a community-based prevention plan.
- Supports the Suicide Prevention Resource Center which is a national resource and technical assistance center that advances the field by working with Tribes, States, territories, and grantees by developing and disseminating suicide prevention resources.
- Funds the National Suicide Prevention Lifeline, a network of 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 promoted 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.

### Summary

In summary, we look forward to opportunities to address the suicide and mental health care needs in Indian Country. For the IHS, our business is helping our communities and families achieve the highest level of wellness possible. IHS has devoted considerable effort to develop and share effective programs throughout the Indian health system. We believe developing programs that are collaborative, community driven, and nationally supported offer the most promising potential for long term success and sustainment. Our partnership and consultation with Tribes ensure that we are working together in improving the health of AI/AN communities.

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.

Senator TESTER. Thank you, Rose. We will have some questions a little later. Thank you very much for your testimony.

Next we are going to hear from Ed Parisian. Ed is the Billings Regional Director of the Bureau of Indian Affairs. Ed is responsible for improving upon many of the risk factors that contribute to youth suicide, primarily safe communities and violence issues. He will tell us how the new Tribal Law and Order Act is going to impact reservation communities and make them a better place. Thank you for being here, Ed.

**STATEMENT OF EDWARD PARISIAN, DIRECTOR, ROCKY MOUNTAIN REGIONAL OFFICE, BUREAU OF INDIAN AFFAIRS, UNITED STATES DEPARTMENT OF INTERIOR**

Mr. PARISIAN. Thank you, Senator Tester. I am pleased to be here to talk on the topic of empowering Native youth to reclaim their future. I also want to thank your staff.

American Indian and Alaska Native youth suicide is a devastating, serious problem in Indian Country. Data and research have shown that social factors such as poverty, alcoholism, gangs and violence contribute in the manifestation of suicide ideation, suicidal behavior and suicide attempts by American Indian youth in Indian Country. As the members of this Committee are aware, BIA programs assist tribal communities in developing their natural and social-economic infrastructures or provide services to fill infrastructure gaps.

For the BIA, suicidal events significantly impact law enforcement personnel since they are the most likely first responders to suicide events. There is also a significant impact on students, teachers, administrators and other school staff when handling suicide ideation, gestures, attempts and completions within the Bureau of Indian Education school system.

The BIE has developed a Suicide Prevention, Early Intervention and Postvention Policy to promote suicide prevention in BIE schools. The policy mandates specific actions in all schools, dormitories and the two post-secondary institutions and encourages tribally-operated schools to develop similar policies. These actions create a safety net for students at risk of suicide and promotes proactive involvement of school personnel and communities in intervention, prevention and postvention activities. There are also ongoing efforts to address these issues through partnerships with behavioral health and social services organizations at both the tribal and national level with SAMHSA and the Indian Health Service.

Within the Indian Affairs, BIA's Law Enforcement and Tribal Services programs, along with BIE continue to seek ways to collaborate and to support activities directed at suicide prevention and services coordination. The BIE utilizes the Youth Risk Behavior Survey, the Native American Student Information System, local BIA law enforcement and IHS data to develop interventions and track trends for program implementation and is committed to seeking out and enacting prevention strategies while ensuring a safe and secure environment for our students.

Indian Affairs' most direct action in youth suicide prevention is through the BIE, the Bureau of Indian Education. The BIE's Division of Performance and Accountability has been providing suicide prevention activities through funds provided by the U.S. Department of Education's Title IV Part A Safe and Drug-Free Schools and Communities program. Serving in a similar capacity as a State educational agency, the BIA is required to use these funds to provide technical assistance to the schools to reduce drug and alcohol abuse and violence by 2 percent annually. The BIE's DPA has provided technical assistance in the development and implementation of data-driven programs and evidence-based curriculum.

While the SDFS program has been discontinued, ongoing technical assistance and monitoring is provided by regional school safe-

ty specialists to ensure schools are compliant with intervention strategies and reporting protocols to further ensure student safety. BIE's partnering with other Federal agencies, including SAMHSA and IHS and the Department of Education has enabled BIE to address the unique needs of students within these schools in the areas of behavioral health and suicide prevention efforts.

Additionally, BIE schools and dormitories use NASIS to track and identify specific behavior trends to develop interventions to address school-specific behavior issues. BIE has developed two technical assistance training sessions that include both a basic and coaching level course. The basic course covers initial program development, policy development, best practices and implementation and the coaching level course focuses on adult wellness issues and youth development. The framework of the session is based on Native resiliency and cultural practices that support a positive school climate.

On November 12th, 2010, Larry Echo Hawk, Assistant Secretary, Indian Affairs, Yvette Roubideaux, Director, Indian Health Service, and Pamela Hyde, Administrator of SAMHSA, announced to tribal leaders that BIA, IHS and SAMHSA would sponsor listening sessions to hear the needs and concerns regarding youth suicide in Indian Country. The purpose of the listening sessions were to gather tribal input on how we can best support the goals and programs of tribes for preventing suicide in tribal communities.

The listening sessions began on November 15th, 2010, and ended on February 10th, 2011. Over this four-month period, BIA, IHS and SAMHSA met with several tribes from all the BIA regions. We held these listening sessions in Indian Country to gain first-hand knowledge from the American Indian and Alaska Native communities to see how best we can all, as partners, prevent youth suicide and to identify specific needs expressed by tribal community leaders, clinicians, practitioners and youth.

Information gathered from these listening sessions was used at the Action Summit for Suicide Prevention held in Scottsdale, Arizona last week from August 1st through 4th. I attended the Action Summit, along with other Indian Affairs staff and key leadership in the Office of the Assistant Secretary. A lot of what we have heard this afternoon about, we can't do it by, just one tribe can't do it, one office, I just can't do it, one of the messages I took from that was that it is going to take a community. It is going to take all resources. We have to give up a little bit here and a little bit there, and we have to put our resources together if we are going to make this happen. We can't have ownership, it has to be flexibility on our resources. That way we will prevent duplication. This is one of the major things that I took away from that conference. It is one of the things we have heard across the Country from the listening sessions that they held.

I kind of got a little bit off of my testimony, but it is there for the record, Senator. And I will end because I feel my hook coming. I will be happy to answer any questions that you may have.

[The prepared statement of Mr. Parisian follows:]

PREPARED STATEMENT OF EDWARD PARISIAN, DIRECTOR, ROCKY MOUNTAIN  
REGIONAL OFFICE, BUREAU OF INDIAN AFFAIRS, UNITED STATES DEPARTMENT OF  
INTERIOR

Good Afternoon Mr. Chairman, Mr. Vice Chairman and Members of the Committee, my name is Edward Parisian and I am the Regional Director for the Bureau of Indian Affairs (BIA) Rocky Mountain Regional Office in Billings, Montana. I have served in this capacity since April 1, 2008. I am pleased to be here today to provide the Department's statement on the topic of "Empowering Native Youth to Reclaim Their Future," which relates to American Indian and Alaska Native youth suicide prevention.

American Indian and Alaska Native youth suicide is a serious problem in Indian Country. Data and research have shown that social factors such as poverty, alcoholism, gangs, and violence contribute in the manifestation of suicide ideation, suicidal behavior and suicide attempts by American Indian youth in Indian Country. See *To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults*, 2010 Publication by Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services.

According to the Centers for Disease Control (CDC) data on "Leading Causes of Death by Age Group, American Indian or Alaska Native Males—United States, 2006," suicide was the second leading cause of death for ages 10–34. The same 2006 data from the CDC for American Indian or Alaska Native females showed that suicide was the first leading cause of death for ages 10–14, the second leading cause of death for ages 15–24, and the third leading cause of death for ages 25–34. Additionally, SAMHSA in its 2010 publication, *To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults*, states that young people account for forty percent (40 percent) of all suicides in Indian Country.

As the members of this Committee are aware, BIA programs assist tribal communities in developing their natural and social-economic infrastructures (i.e., tribal governments, tribal courts, cultural vitalization, community capabilities, etc.) or provide services to fill infrastructure gaps (i.e., education, law enforcement, social services, housing improvement, transportation, etc.). For the BIA, suicidal events significantly impact law enforcement personnel since they are the most likely first responders to suicidal events. There is also a significant impact on students, teachers, administrators and other school staff when handling suicide ideation, gestures, attempts and completions within the Bureau of Indian Education (BIE) school system. The BIE has developed a Suicide Prevention, Early Intervention and Postvention Policy to promote suicide prevention in BIE schools. The policy mandates specific actions in all schools, dormitories and the two post-secondary institutions; and encourages tribally-operated schools to develop similar policies. These actions create a safety net for students at risk of suicide and promotes proactive involvement of school personnel and communities in intervention, prevention and postvention activities. There are also ongoing efforts to address these issues through partnerships with behavioral health and social services organizations at both the tribal and national level with SAMSHA and the Indian Health Service (IHS).

Within Indian Affairs, the BIA's Law Enforcement and Tribal Services programs, along with the BIE, continually seek ways to collaborate and to support activities directed at suicide prevention and services coordination. The BIE utilizes the Youth Risk Behavior Survey, Native American Student Information System (NASIS), local BIA Law Enforcement and IHS data to develop interventions and track trends for program implementation and is committed to seeking out and enacting prevention strategies while ensuring a safe and secure environment for our students.

The Office of Justice Services (OJS) in the BIA has partnered with numerous health and social service programs to assist in educating and presenting at schools, seminars, workshops and community events to the youth and the community on suicide prevention. Corroborated by statistics from the Resource Patient Management System (RPMS), BIA Law Enforcement has seen a history of high rates of suicide completions in the Great Plains Region alone. The statistics show that, in this region, there were 24 American Indian suicide completions in 2008, 36 in 2009, 15 in 2010 and 6 so far in 2011. The majority of these suicide completions were for individuals in the age range of 15 to 24. In the Great Plains Region, OJS has signed a Memorandum of Understanding (MOU) with the "Circles of Care" program. The Circles of Care program provides youth prevention activities for families, which are held in their tribal communities. During these events BIA Law Enforcement participates by setting up an educational booth designed to interact with families and other service agencies and provide information on suicide prevention. The OJS will

continue to gather statistical data and identify youth suicide trends within Indian Country, as well as look for ways to expand suicide prevention training with other stakeholders in the future.

Indian Affairs' most direct action in youth suicide prevention is through the BIE. The BIE's Division of Performance and Accountability (DPA) has been providing suicide prevention activities through funds provided by the U.S. Department of Education's Title IV Part-A Safe and Drug-Free Schools and Communities Program (SDFS). Serving in a similar capacity as a State educational agency, the BIE is required to use these funds to provide technical assistance to the schools to reduce drug and alcohol use and violence incidence by two percent, annually. The BIE's DPA has provided technical assistance in the development and implementation of data driven programs and evidence-based curriculum.

While the SDFS program has been discontinued, ongoing technical assistance and monitoring is provided by regional School Safety Specialists to ensure schools are compliant with intervention strategies and reporting protocols to further ensure student safety. BIE's partnering with other federal agencies, including SAMHSA and IHS and ED, has enabled BIE to address the unique needs of students within these schools in the areas of behavioral health and suicide prevention efforts.

Additionally, BIE schools and dormitories use NASIS to track and identify specific behavior trends to develop interventions to address school specific behavior issues. BIE has developed two technical assistance training sessions that include both a basic and coaching level course. The basic course covers initial program development, policy development, best practices, and implementation, and the coaching level course focuses on adult wellness issues and youth development. The framework of the session is based on Native resiliency and cultural practices that support a positive school climate.

On November 12, 2010, Larry Echo Hawk, Assistant Secretary—Indian Affairs, Yvette Roubideaux, Director, Indian Health Service, and Pamela Hyde, Administrator, SAMHSA, announced to Tribal Leaders that BIA, IHS and SAMHSA would sponsor listening sessions to hear the needs and concerns regarding youth suicide in Indian Country. The purpose of the listening sessions were to gather Tribal input on how we can best support the goals and programs of tribes for preventing suicide in Tribal communities. The listening sessions began on November 15, 2010 in Window Rock, Arizona on the Navajo Nation and concluded on February 10, 2011 in Arlington, Virginia at the United South Eastern Tribes (USET) Annual Conference. Over this four month period, the BIA, IHS and SAMHSA met with several Tribes from all of the BIA Regions. We held these listening sessions in Indian Country to gain first-hand knowledge from the American Indian and Alaska Native communities to see how best we can all, as partners, prevent youth suicide; and to identify specific needs expressed by tribal community leaders, clinicians, practitioners, and youth.

The information gathered from these listening sessions was used at the Action Summit for Suicide Prevention held in Scottsdale, Arizona last week from August 1–4. I attended the Action Summit, along with other Indian Affairs staff and key leadership in the office of the Assistant Secretary for Indian Affairs. The Action Summit was jointly sponsored and attended by BIA, BIE, IHS and SAMHSA to discuss what we heard during our joint listening sessions with Tribes, their members, and especially the tribal youth. One of the goals of the Action Summit on Youth Suicide was to develop policy and future action items to address youth suicide and prevent youth suicide in Tribal communities.

In summary, the BIA, BIE, IHS, SAMHSA, other Federal agencies, and Indian tribes must continue to work together to address all aspects of suicide prevention and response. I want to thank this Committee for its continued concern for the wellbeing of Indian children, teens and young adults, especially on the subject of suicide prevention. I am happy to answer any questions you may have.

Senator TESTER. Thank you, Ed. I always appreciate your being here. Thank you very much.

Last but certainly not least, we will hear from Dr. McKeon, of the Substance Abuse and Mental Health Services Administration. Dr. McKeon will tell us about his agency's work to reduce the two most important risk factors involved with youth suicide, and those are mental health and substance abuse. So with that, Dr. McKeon, you can go forward. Please begin.

**STATEMENT OF RICHARD T. McKEON, Ph.D., LEAD PUBLIC HEALTH ADVISOR, SUICIDE PREVENTION TEAM, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Mr. McKeon. Thanks, Senator Tester. Thank you for allowing SAMHSA to testify at this important hearing on prevention of suicide among American Indian and Alaska Native youth.

I serve as the lead public health advisor on suicide prevention at SAMHSA. I am pleased to testify here, along with my colleagues at the Indian Health Service and the Department of Interior, as well as the tribal leaders, tribal youth and others.

The problem of suicide in Indian Country is a shared and urgent concern. Efforts to reduce suicide and suicide attempts among American Indian and Alaska Native youth must be a shared effort.

Today I will share with you some of the efforts SAMHSA is undertaking to reduce suicide and suicide attempts in Indian Country, both through SAMHSA-led programs as well as work we conduct in conjunction with other Federal, State and tribal partners. You all know the tragic statistics. In 2007, suicide was the second leading cause of death among American Indian and Alaska Native youth age 10 to 24, with rates of suicide significantly higher than for other ethnic groups.

According to unpublished Indian Health Service data, suicide mortality is 73 percent greater in American Indian and Alaska Native populations in IHS service areas compared to the general U.S. population. American Indians and Alaska Natives have the highest rates of suicide, Senator, at least until the age of 40.

SAMHSA's number one strategic initiative is prevention of substance abuse and mental illness. Included in this initiative is the prevention of suicide and suicide attempts. The prevention of suicide is a public health issue and necessitates a comprehensive public health approach.

SAMHSA is addressing youth suicide through a range of efforts, including the National Action Alliance for Suicide Prevention, a new Tribal Behavioral Health formulary grant program, grants to tribes through the Garrett Lee Smith Memorial Act youth suicide prevention program, implementation of the Indian Healthcare Improvement law, the Native Aspirations program, technical assistance provided by the Suicide Prevention Resource Center, and 24/7 crisis support through the National Suicide Prevention Lifeline.

Also through the recently signed memorandum of agreement between HHS, the Department of Justice and Department of Interior as required by the Tribal Law and Order Act, and inclusion of requests that States engage in tribal consultation as part of their plans submitted to SAMHSA in conjunction with the new Uniform Mental Health and Substance Abuse Block Grant Application.

You also heard how we spent just last week, over 1,000 people came together to work together and to learn together at the Action Summit for Suicide Prevention that was jointly hosted by IHS, Bureau of Indian Affairs, Bureau of Indian Education and SAMHSA. The most important thing that the research and the efforts showed was the effort to learn from each other. No one of us can do this alone. We can't start from the beginning, we have to learn from [in-

discernible] of what has been helpful [indiscernible]. So that was the important part of what happened last week.

Let me also reference National Action Alliance for Suicide Prevention, which was launched September 10th, 2010 by the United States Department of Health and Human Services, Kathleen Sebelius, and former Defense Secretary, Robert Gates. The National Action Alliance is a public-private collaborative effort to promote suicide prevention in the United States, to implement and to update United States national strategy for suicide prevention. The private sector co-chair is former U.S. Senator Gordon Smith, who tragically lost his own son to suicide, and the public sector co-chair is the Secretary of the Army, John McHugh. Members of the National Action Alliance include but are not limited to SAMHSA Administrator Hyde, Department of Interior Assistant Secretary Larry Echo Hawk, McClellan Hall from the National Indian Youth Leadership Project. In addition, IHS Director Roubideaux serves as ex officio member of the Action Alliance.

You have heard about the task force that was set up as part of the National Action Alliance to focus on [indiscernible] specific suicide prevention for tribal youth, regarding suicide prevention, intervention and postvention strategies, including positive youth development.

The President's fiscal year 2012 budget for SAMHSA proposes a new grant program entitled Behavioral Health—Tribal Prevention Grant, which is intended to increase SAMHSA's efficacy in working with tribes and tribal entities. The program will focus on the prevention of alcohol abuse, substance abuse, and suicides in the 656 federally-recognized tribes. Recognize the Federal obligation to help tribes deal with physical and behavioral health issues, SAMHSA will work in consultation with tribes and [indiscernible] partners to establish a single coordinated mental health and substance abuse prevention effort for all federally-recognized tribes. SAMHSA will also consult and work closely with tribes and tribal leaders to develop a comprehensive, data-driven planning process to identify and address the most serious issues in each tribal community.

You have heard about the Garrett Lee Smith Memorial grant that we have recently received. [indiscernible] 19 tribes and tribal organizations receiving multi-year grants to address suicide prevention among tribal youth. This year, in the last two weeks, 21 additional tribal grants have been made for a total of 40 tribal grants [indiscernible].

Let me just mention the innovative work in the grant that we have done here at Fort Peck. That grant has done a number of things that includes innovative efforts from a program called Sources of Strength. Promising results are coming from [indiscernible] as well as efforts and follow-up to address people being discharged from emergency departments.

Thank you for this opportunity to share with you efforts SAMHSA is making with respect to our American Indian and Alaska Native youth suicide prevention. I will be happy to answer any questions you may have.

[The prepared statement of Mr. McKeon follows:]

PREPARED STATEMENT OF RICHARD T. MCKEON, PH.D., LEAD PUBLIC HEALTH ADVISOR, SUICIDE PREVENTION TEAM, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Akaka, Ranking Member Barrasso and Senator Tester, thank you for inviting me to testify at this important hearing on the prevention of suicide among American Indian/Alaska Native (AI/AN) youth. I am Dr. Richard McKeon and I serve as the lead Public Health Advisor on suicide prevention at the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). I am pleased to testify along with my colleague at the Indian Health Service (IHS) and tribal leaders, as well as AI/AN youth. The problem of suicide in Indian Country is a shared concern and efforts to reduce suicide and suicide attempts among AI/AN youth must be a shared effort.

SAMHSA has played an integral role in the nation's efforts to reduce suicide in Indian Country and I want to acknowledge the tremendous efforts of SAMHSA's Deputy Administrator Eric Broderick who has testified before this Committee several times related to suicide prevention. Dr. Broderick will be retiring later this month after 38 years of services in the U.S. Public Health Commissioned Corps. He brought his passion, leadership and skill to IHS and SAMHSA and will be greatly missed.

Today, I will share with you some of the efforts SAMHSA is undertaking to reduce suicide and suicide attempts in Indian Country both through SAMHSA-led programs, as well as work we conduct in conjunction with other Federal, State, and tribal partners. As you know all too well, the rate of suicide among AI/AN individuals is higher than the national average. In 2007, suicide was the second leading cause of death for AI/AN youth aged 10–24 with rates of suicide significantly higher for AI/AN youth aged 15–24 (20.04 per 100,000) than for the national average (11.47 per 100,000) (CDC, 2010.) Injuries and violence account for 75 percent of all deaths among Native Americans ages 1 to 19 (Wallace, 2000). Overall, according to unpublished Indian Health Service (IHS) data, suicide mortality is 73 percent greater in AI/AN populations in IHS service areas compared to the general U.S. population.

SAMHSA's number one strategic initiative is Prevention of Substance Abuse and Mental Illness. Included in this initiative is the prevention of suicide and suicide attempts. The prevention of suicide is a public health issue and necessitates a public health approach that works at the primary, secondary and tertiary levels. In line with SAMHSA's Prevention strategic initiative, the Administration is addressing AI/AN youth suicide through a range of efforts including: the National Action Alliance for Suicide Prevention; a new Tribal Behavioral Health formulary grant program; grants to tribes through the Garrett Lee Smith Memorial Act (GLSMA) youth suicide prevention program; implementation of the Indian Healthcare Improvement law; the Native Aspirations program; technical assistance by the Suicide Prevention Resource Center (SPRC); 24/7 crisis support through the National Suicide Prevention Lifeline; the recently signed Memorandum of Agreement between HHS (with SAMHSA as the lead agency), the Department of Justice (DOJ) and the Department of the Interior (DOI) as required by the Tribal Law and Order Act; and inclusion of requests that states engage in tribal consultation as part of their plans submitted in conjunction with the new Uniform Mental Health and Substance Abuse Block Grant Application.

In order to highlight the plethora of activity around efforts to prevent suicide and suicide attempts among AI/AN individuals, just last week in Scottsdale, Arizona over 1,000 individuals came together for The Action Summit for Suicide Prevention hosted by IHS, Bureau of Indian Affairs (BIA), Bureau of Indian Education (BIE) and SAMHSA. The title of the Summit was "Partnering with Tribes to Protect the Circle of Life," and objectives for the event included strengthening tribal, Federal, State and community partnerships; creating an opportunity to collaborate, network, and share effective strategies on topics in suicide and substance abuse prevention in Native American communities; and providing the most up-to-date research related to suicide and substance abuse in Indian Country.

#### **National Action Alliance for Suicide Prevention**

On September 10, 2010, the National Action Alliance for Suicide Prevention (NAASP) was launched by the U.S. Department of Health and Human Services Secretary, Kathleen Sebelius, and former Defense Secretary, Robert Gates. The NAASP has a private sector Co-Chair, former U.S. Senator Gordon Smith (R-OR), and a public sector Co-Chair, Army Secretary John McHugh. Members of the NAASP include, but are not limited to, the Surgeon General, Regina Benjamin; the SAMHSA Administrator, Pamela Hyde; Department of Interior Assistant Secretary of Indian Affairs, Larry Echo Hawk; HHS Assistant Secretary for Health, Dr. Howard Koh;

and National Indian Youth Leadership Project Executive Director, McClellan Hall. In addition, the IHS Director, Dr. Yvette Roubideaux, serves as an *ex officio* Member of the NAASP. Mr. Echo Hawk, Mr. Hall and Dr. Roubideaux serve as the leaders of the NAASP AI/AN Task Force which will establish specific priorities for Tribal youth regarding suicide prevention, intervention, and postvention strategies, including positive youth development. The Task Force also helped develop the agenda and strategy for the National Suicide Prevention Summit and will also do so for the Alaska Suicide Prevention Summit for AI/AN communities, leaders, service providers, educators, and law enforcement.

#### **Behavioral Health—Tribal Prevention Grants**

The President's FY 2012 Budget for SAMHSA proposes a new grant program titled Behavioral Health—Tribal Prevention Grant (BH-TPG), which is intended to increase SAMHSA's efficacy in working with tribes and tribal entities. The BH-TPG represents a significant advance in the Nation's approach to substance abuse and suicide prevention, based in a recognition of behavioral health as a part of overall health. The program will focus on the prevention of alcohol abuse, substance abuse and suicides in the 565 Federally-recognized Tribes. Recognizing the Federal obligation to help Tribes deal with physical and behavioral health issues, SAMHSA will work in consultation with Tribes, establishing a single coordinated mental health and substance abuse program for all Federally-recognized Tribes. SAMHSA also will consult and work closely with Tribes and Tribal leaders to develop a comprehensive, data-driven planning process to identify and address the most serious behavioral health issues in each Tribal community.

Tribes will be allowed to use a set percentage (determined after consultation with Tribes) of the Behavioral Health—Tribal Prevention Grant funds for a combination of service and service-related activities, development and dissemination of prevention messages, and provider development and linkage building to support the Tribes in achieving outcomes. Funding for infrastructure activities will enable the Tribe to build service capacity. The Tribe will present data to support how the allocation will support infrastructure and/or provision of services. In carrying out these activities, the Tribe will be required to use comprehensive, evidence-based programming, and/or proven successful programming, based on either mainstream science or proven Tribal traditions. Up to 20 percent of the grant funds may be used to fund key support and development activities, such as operation of a Tribal prevention advisory group, support for a Tribal community coalition, access to an epidemiological work group, training and technical assistance to communities, data collection and evaluation, and oversight and monitoring of activities. The details of the funds distribution will be determined in consultation with Tribes.

#### **Garrett Lee Smith Grants**

Since passage of the GLSMA (P.L. 108-355) in 2004, 19 tribes have received multi-years grants to address suicide prevention among tribal youth, with 21 additional tribal grants to start this year. This number represents 39 percent of the total State and Tribal Youth Suicide Prevention Grants authorized by the GLSMA. These grants have provided the tribes funding to help implement a tribe-wide suicide prevention network. The first tribal grantee was the Native American Rehabilitation Association in Oregon, which was one of three GLSMA grantees in the first cohort to be awarded additional evaluation funding. They will use the funding to enhance their evaluations to maximize what could be learned from their important suicide prevention activities.

One of the Nation's most innovative systems for intervening with youth at risk for suicide, the White Mountain Apache's suicide prevention program (funded by SAMHSA through the GLSMA grant program), includes the evaluation of two culturally adapted interventions that target youth who have attempted suicide. These interventions are linked to a unique tribally mandated suicide surveillance system that identifies youth who have exhibited suicidal behavior. The interventions focus on in-home follow-up with youth who have attempted or thought of attempting suicide and were treated and discharged from emergency departments. The first intervention, New Hope, is an emergency department-linked intervention conducted over one to two sessions. The sessions comprise of a locally produced video and workbook curriculum that develops a safety plan for the youth and problem-solves barriers to their engagement in treatment. The second intervention, Re-Embracing Life, was adapted from the American Indian Life Skills Development Curriculum and consists of nine curricular sessions conducted weekly in home or office settings. The intervention targets problem solving, anger/conflict management, self-destructiveness, emotional regulation, coping, social interactions, and help-seeking behaviors.

In the most recent cohort of GLSMA grantees which were announced over the last 2 weeks, I am pleased to note that SAMHSA provided funding for the “Sister National Empowerment Partnership” which will be administered by the Fort Peck Tribal Health Service and the University of Montana. This grant of \$480,000 per year for 3 years will be utilized to design and deploy a comprehensive system of youth suicide prevention on the Fort Peck Reservation in northeast Montana. The partnership will build on existing work in response to a devastating suicide cluster in 2010. Particular attention will be given to needs identified in a deployment report by the U.S. Public Health Service in response to a state of emergency declared by the Fort Peck Tribes in May 2010. During the period identified in the report, the suicide completion rate on the reservation was three times the Montana average and more than six times the rates for the nation as a whole. The goals of the grant include increasing the number of primary health care and mental health providers trained to assess, manage, and treat youth at risk for suicide; increase the number of youth, school staff, parents and community members trained to identify and refer for care a youth at risk for suicide; to increase the number of youth receiving mental health and substance abuse services by improving access to care; and to promote the National Suicide Prevention Lifeline in all activities.

In addition, the Confederated Salish & Kootenai Tribes in Pablo, Montana also received a GLSMA grant in Fiscal Year (FY) 2011. Finally, I would like to note that this year funds from the Prevention and Public Health Trust Fund established by the *Affordable Care Act* (ACA) will be utilized to enhance SAMHSA’s youth suicide prevention efforts and all four of these \$1.44 million grants have been awarded to tribes or tribal entities.

#### **Implementation of the Indian Youth Suicide Prevention Provisions of Indian Health Care Improvement Reauthorization and Extension Act of 2009**

On March 23, 2010, as part of the ACA, President Obama also signed into law the *Indian Health Care Improvement Reauthorization and Extension Act of 2009*. Title VII, Subtitle B includes provisions related to Indian Youth Suicide Prevention. SAMHSA is dedicated to undertaking measures to improve the process by which Indian tribes and tribal organizations apply for grants. One such example is that SAMHSA does not require tribal entities applying for agency electronically.

In the FY 2011 cohort of GLSMA State/Tribal grantees, 21 of 37, or 57 percent, grantees are tribes, tribal organizations, or entities that have indicated the grant will be used specifically for AI/AN youth suicide prevention activities. SAMHSA has made significant efforts to take into consideration the needs of Indian tribes or tribal organizations. Furthermore, SAMHSA does not require any Indian tribe or tribal organization to apply through a State or State agency for any of the agency’s grant programs.

#### **Native Aspirations Program**

SAMHSA has funded 49 tribal communities through Native Aspirations (NA), a national project designed to address youth violence, bullying, and suicide prevention through evidence-based interventions and community efforts. NA is unique among SAMHSA suicide prevention programs in that it is based on the concepts and values that reflect the AI/AN community: that solutions to AI/AN youth violence, bullying, and suicide must come from and be embraced by the community; leadership must be involved and invested in the solution; it is up to the community to determine the approaches that would be most effective for them; traditional approaches that are used in non-AI/AN communities in America don’t always work in AI/AN communities; and that the community Elders are crucial to the success of the project.

To date, nearly 200,000 Tribal members in 20 communities and 2,100 Alaska Natives in five villages have been provided specialized technical assistance and support in suicide prevention and related topic areas for these communities. In addition, over 750 community members were trained in prevention and mental health promotion in these communities.

#### **Suicide Prevention Resource Center**

SAMHSA funds the Suicide Prevention Resource Center (SPRC), which provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies, and to advance the National Strategy for Suicide Prevention. SPRC supports the technical assistance and information needs of SAMHSA State/Tribal Youth Suicide Prevention and Campus Suicide Prevention grantees and State, Territorial, and Tribal (STT) suicide prevention coordinators and coalition members with customized assistance and technical resources. SPRC has two senior tribal prevention specialists available to provide technical assistance to those seeking information, evidence-based programs and

awareness tools specifically geared for suicide prevention among AI/AN individual. Included on SPRC's Web page dedicated to AI/AN suicide prevention is a SAMHSA funded guide titled, "*To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults.*"

#### **National Suicide Prevention Lifeline**

The National Suicide Prevention Lifeline (Lifeline) 1-800-273-TALK (8255) is a 24-hour, toll-free, confidential suicide prevention hotline available to anyone in suicidal crisis or emotional distress. By dialing 1-800-273-TALK, the call is routed to the nearest crisis center in our national network of more than 150 crisis centers. The Lifeline's national network of local crisis centers, provide crisis counseling and mental health referrals day and night.

The Lifeline has a Native American Initiative that includes objectives such as:

1. Establishing and maintaining working relationships between crisis center staff and key stakeholders in tribal communities.
2. Developing and delivering cultural awareness and sensitivity trainings as per the direction of the designated tribal community for crisis center telephone workers.
3. Strengthening the effectiveness of the local Reservation referrals for suicide prevention supports by identifying relevant, available resources in the tribal community.
4. Promoting culturally sensitive social media and educational materials in tribal communities, as determined by tribal stakeholders.
5. Identifying similarities and differences that can inform serving Native American communities on a national level in a culturally and respectful manner.

In Montana, the Fort Peck, Blackfeet, Northern Cheyenne, Crow, Fort Belknap, Flathead and Rocky Boy reservations are served by Lifeline's Voices of Hope crisis call center.

#### **Tribal Law and Order Act**

As you are aware, through the Tribal Law and Order Act of 2010 Congress sought to engage new federal partners to build upon previous efforts in addressing alcohol and substance abuse in Indian country. As a result, the Secretary of Health and Human Services, the Secretary of the Interior, and the Attorney General, recently signed a Memorandum of Agreement (MOA) to, among other things:

1. Determine the scope of the alcohol and substance abuse problems faced by American Indians and Alaska Natives;
2. Identify the resources and programs of each agency that would be relevant to a coordinated effort to combat alcohol and substance abuse among American Indians and Alaska Natives; and
3. Coordinate existing agency programs with those established under the Act.

The MOA specifically takes into consideration that suicide may be an outcome of, and has a connection to, substance abuse. To accomplish the above stated goals, SAMHSA sought to establish an Interdepartmental Coordinating Committee (Indian Alcohol and Substance Abuse Committee) to include key agency representation from SAMHSA, IHS, Office of Justice Programs, Office of Tribal Justice, BIA, BIE, and the Department of Education. The Administration on Aging and Administration for Children and Families within HHS are also represented on the IASA Committee. The IASA Committee has created an organizational structure to include workgroups to carry out its work.

#### **Uniform Block Grant Application**

On July 26, SAMHSA announced a new application process for its major block grant programs the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant (MHBG). The change is designed to provide states greater flexibility to allocate resources for substance abuse and mental illness prevention, treatment and recovery services in their communities. One of the key changes to the block grant application is the expectation that States will provide a description of their tribal consultation activities. Specifically, the new application's planning sections note that States with Federally-recognized tribal governments or tribal lands within their borders will be expected to show evidence of tribal consultation as part of their Block Grant planning processes. However, tribal governments shall not be required to waive sovereign immunity as a condition of receiving Block Grant funds or services.

Included within the MHBG application SAMHSA notes that States should identify strategies for the MHBG that reflect the priorities identified from the needs assessment process. Goals that are focused on emotional health and the prevention of mental illnesses should be consistent with the National Academies—Institute of Medicine report on “Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.” More specifically, they also should include Strategies that implement suicide prevention activities to identify youth at risk of suicide and improve the effectiveness of services and support available to them, including educating frontline workers in emergency, health and other social services settings about mental health and suicide prevention. Finally, the uniform application requests that States attach to the Block Grant application the most recent copy of the State’s suicide prevention plan. It notes that if the State does not have a suicide prevention plan or if it has not been updated in the past 3 years, the State should describe when it will create or update its plan.

#### **Conclusion**

Thank you again for this opportunity to share with you the extensive efforts SAMHSA is undertaking with respect to AI/AN youth suicide prevention specifically, as well as other efforts relating to tribal behavioral health issues. I would be pleased to answer any questions that you may have.

Senator TESTER. Thank you, Dr. McKeon. You can hand the mic down to Rose. In the meantime, I want to thank you for your testimony. As with everybody who testified today, your entire testimony will go into the official record. So thank you very much.

Rose, past Indian Affairs Committee hearings have revealed that tribal communities are sometimes unwilling to talk about suicide, especially youth suicide. Has that been in your experience, and if it has, is it better to talk about it or is it better to keep quiet?

Ms. WEAHKEE. Yes, that has been brought up, and even just this past week at the Action Summit for Suicide Prevention, that was addressed as one of the issues from tribal communities speaking at the Summit. So it is important for us to work jointly with the tribe elders and traditional practitioners in the community to help us address the issue of suicide.

But it is important and something that we have been hearing from tribal communities is that there needs to be more communication and more awareness to all systems throughout the tribal health system, through the education system, law enforcement, first responders, to parents and grandparents, and to peers. So if someone does come to them with thoughts of suicide, that they know what to do to respond to that issue.

Senator TESTER. Okay. Does talking about it or not talking about it affect suicide clusters, and if so, how?

Ms. WEAHKEE. I think that is one of the myths, that talking about suicide will increase the number of suicides. It is important for us to bring education and awareness and be able to learn how we can respond when someone is coming to us, maybe expressing that they want to harm themselves. That is a skill that we are trying to develop and awareness we are trying to bring with the suicide summit that was held last week, and the one that we will be holding in Alaska next month, to bring more awareness about how to deal with that.

Senator TESTER. Are you familiar with a program the Montana-Wyoming Tribal Leadership Council is doing called Planting Seeds of Hope?

Ms. WEAHKEE. Yes, absolutely.

Senator TESTER. One of their goals is to train gatekeepers in every community. Can you tell me what a gatekeeper is and why it is important?

Ms. WEAHKEE. A gatekeeper is and can be anyone in the community. It can be a peer, it can be a teacher, it can be a parent, someone that that young person or that youth may come in contact with that could be trained about how to listen and know what to do, understand what the risk factors are, understand what suicide is and basically how to intervene. So we have a lot of gatekeeper training programs that are out there, and a lot that we shared last week. And they need to be developed and they need to be trained. Native HOPE is one of those gatekeeper programs that many of our tribal communities are implementing. So the short answer is yes it is important.

Senator TESTER. So those would be people that a student or an adult could go talk to if they are having some issues, being bullied or whatever?

Ms. WEAHKEE. Yes, absolutely. But I also want to stress the point, I think one of the things that we heard from our youth, our youth panel last week, is that we need to listen and that we need to reach out more as adults. A lot of our youth are afraid, I think we heard that here today.

Senator TESTER. We sure did.

Ms. WEAHKEE. Sometimes it is scary for a youth to come to an adult and explain when something like that is happening, for whatever reason. So it is very important for us as adults to go to our youth and listen to them.

Senator TESTER. Okay. Thank you, Rose.

Ed, we passed Tribal Law and Order Act last Congress. It was, I think, a pretty good piece of legislation. I want to know from your perspective, it was supposed to reduce violence in Indian Country. Have we been into the program long enough where we can say it has worked or it hasn't worked or do we need more time?

Mr. PARISIAN. I am trying to think about how to answer this, because I am not the expert when it comes to law enforcement. But I am familiar with the program, and the meetings that we have attended. I know that they are in the planning process. I am not sure if it is made that big a difference yet. I think that it is going to need some time, particularly training, education, more involvement from the tribal side, so that it would work. But the program, I do believe, will make a difference.

Senator TESTER. Good.

Dr. McKeon, you talked about suicide prevention grant programs. Whenever grant programs are brought up, from my perspective, I am always wondering if they are skewed against rural communities. I would say for, but typically they are skewed against them. So I guess specifically, with the programs you referenced, specifically to Indian Country, how can we be assured that the playing field is level as it supplies to access to those grant dollars for frontier Indian communities?

Mr. McKeon. That's a very important point. SAMHSA has worked hard to try to maximize the availability of these grants to tribal communities. Currently with the new awards that were just made, 40 percent of the grants that have been awarded through

the State and tribal component of the Garrett Lee Smith Memorial Act have gone to tribes and to tribal organizations.

We have tried to do a couple of things to try to help tribes be competitive in that process. One is our Native Aspirations program, which looks at risk factors for violence, bullying and suicide and how to [indiscernible] focus on the planning effort. Nine of our Native Aspirations communities have gone on afterwards to successfully compete for Garrett Lee Smith Memorial grants.

Also, we make sure to have specific technical system session when the requests for applications or grants are [indiscernible] for tribal communities and to make sure that there are no barriers around things like electronic access, which could disadvantage tribal communities in some places.

Senator TESTER. Okay. Thank you.

We are pressed for time, because we are over by about 20 minutes already. This is an important issue. I want to thank all of you for your testimony and your commitment, as well as the previous panel, to the issue.

As I have said to the tribal council earlier today, this is about, all these hearings, whether they are in Washington, D.C. or whether they are in Poplar, is about gathering information and utilizing information to make a difference. We heard some pretty moving testimony here today from people who have been directly impacted by horrific events, quite honestly. And we also heard some good testimony from folks up here about what works, and maybe what doesn't work, and some of the issues that we need to address, whether it is bullying, or it is working together in partnership, getting everybody on the same page or whatever it might be, moving forward.

We have those on record and we can utilize them and staff will be moving over those and hopefully we will be able to come up with some things in Washington, D.C. that is not going to solve the problem but will help solve the problem. Because I do believe, as many people have testified today, communities play such an incredibly important role with their buy-in. It is absolutely critically important.

I want to thank the folks here at Poplar High School for the use of the venue. Very, very nice. I want to thank Chairman Stafne for not only his testimony but for his hospitality. I want to thank all the participants who participated today.

I want to thank all of you for coming to this hearing. You need to know that the hearing record will remain open for two weeks. And this doesn't apply just to the folks who are here, this applies to all of you and your neighbors. The hearing record will be open for two weeks. If you would like to contribute your comments, the easiest way to do it is to get on the internet, providing you have access to it, *indianaffairs.gov*, and we can take your input to the testimony at this hearing, you can add to the testimony if you so choose. It is one of those things. Technology can help make a difference.

I want to thank you all for being here once again. I very, very much appreciate the participation, very, very much appreciate the heartfelt testimony. And with that, this Indian Affairs Committee meeting is adjourned.

[Whereupon, at 3:00 p.m., the hearing was adjourned.]

## A P P E N D I X

PREPARED STATEMENT OF ANNIE BELCOURT-DITTLIFF, PH.D., MISSOULA, MONTANA

Honorable Senator Tester and Committee Members,

Suicide is clearly one of the most significant problems facing Native American communities in Montana. I would first like to take this opportunity to thank Senator Tester for the work he has done to address this problem. Native Americans in Montana are nearly twice as likely to take their own lives (21.4 per 100,000—Native Americans in Montana versus 11.0 per 100,000—U.S. rate). This rate is even higher in specific Native reservations in our state. This is unacceptable. We must all join together to improve the health and hope of our native communities and youth. As we have seen, the youth are the population most at risk. However, as we all appreciate our children and youth are our most important resource and hope for healthier communities in the future.

Reducing the problem of suicide among our Native American communities in Montana will require collaborative efforts aimed at improving our collective understanding of the problems associated with suicide and potential solutions. I have multiple connections to the tribal communities and I am personally committed to improving the overall health of Native American communities. I was trained as a clinical psychologist and completed my doctorate at the University of Montana in 2006. I went on to complete an internship year at the Denver Veterans Affairs Medical Center and a 4-year postdoctoral faculty position at the Centers for American Indian and Alaska Native Health concentrating on posttraumatic stress and mental health disparities (suicide, trauma, PTSD, depression, and cultural factors) in Native American populations. My research and clinical practice experiences have focused upon mental health disparities, trauma, depression, anxiety, posttraumatic stress reactions and disorders, risk factors, and resiliency.

I write to you today from both a professional and a personal perspective. As a researcher and faculty member in the state of Montana, I am interested in advancing knowledge, science, and practice to improve health disparities facing American Indians. I know the vital importance of science, intervention, and community collaboration in this process. My comments reflect my beliefs that we must all invest in quality collaborative intervention, prevention, science, education, and health care practice within our Native communities. My comments reflect these beliefs and commitment towards working to address the problem of suicide. While some Montana reservation communities have received a lot of recent media attention, it is important to note that the problem of youth suicide has been impacting every Native American community in Montana. As such, it is important that each community receive access to scientific, clinical, educational, and prevention opportunities.

In addition to my role as a researcher and clinician, I also write today as a family member of a Native youth lost to suicide. This is a devastating loss for our family and I can tell you that I personally would have done anything to prevent this loss from happening. My nephew fell through the cracks that have become all too evident within our reservation health care and educational systems. I cannot bring him back, but I can work to honor his brief life through the work that I do advocating for science, practice, education, and policy efforts aimed at preventing suicide. I feel that it is important to advance our knowledge regarding the impact of trauma and poverty within our Native American communities. I also feel that it is important to invest in prevention efforts that promote resiliency, sobriety, education, physical health, and improved access to mental health care within our Native communities. We can all do more to work to prevent any other families from experiencing the loss of family members to suicide.

Federal agencies, Tribal leaders, community members, healthcare providers, researchers, elders, youth, and academic partners need to work toward improving the health and hopes of our Native youth. The growing crisis of suicide facing our Native communities in Montana and the nation demands that we all take a stand and work to prevent any more losses.

I include below responses to recent questions posed in a regional suicide prevention listening session held in conjunction with key federal agencies. The responses were created in collaboration with the Montana-Wyoming Tribal Leaders Council. I hope that the responses help to generate potential ideas for how to improve our collective response to suicide within Montana's Native communities. It is with great hope that I look to your leadership to provide us with innovative solutions to the problem of suicide within our Native communities.

Please let me know how I can help in these efforts.

*Question 1.* What can federal agencies do together to help communities reduce suicide and suicide-related problems in Indian country?

Answer. Policy and legislation needs to prioritize suicide prevention, risk identification, referral, mental health access, education, inter and intra agency collaboration, and funding for Native communities. Mental health needs to be funded more adequately for both reservation and urban communities to target Native youth who are most at risk. Funding needs to directly address the needs of those most at risk: Native youth, rural reservation populations, and those experiencing mental health problems are primary examples of vulnerable populations. Primary high risk is associated with Native American males who have a history of substance abuse, physical or sexual abuse, incarceration, relationship problems, and academic problems. Working with educators, mental health professionals, and academic partners to advance early detection and prevention efforts is one example of innovative work that needs to occur. These efforts need to occur at both the community and individual level. Mental health problems are compounded by the rural nature of reservations and the stigma that can be attached to mental disorders. As a result, prevention and intervention efforts need to focus on reducing barriers to accessing mental healthcare including improving access options, improving confidentiality, improving available mental health services, improving community mental health services, improving public health information availability and access, and reducing stigma. In addition, substance use is frequently a proximal antecedent to suicide; consequently, treatment options need to be improved for all Native youth and community members. In most completed suicides, hopelessness paired with alcohol and drug use is the most frequently identified risk factor for self-harm and suicide completion. We must work to increase both individual and community protective factors (self-esteem, social support, cultural factors and beliefs, traditional medicine and traditional healer access, mentorship, sobriety, and familial support). We must also work to decrease poverty, discrimination, trauma, substance abuse, and crime. What has been done toward addressing these issues in the past has not been sufficient.

Funding to increase protective and resiliency factors and simultaneously decrease risk factors should be prioritized. Information should be shared between federal agencies, health care agencies, communities, Tribes, and Native researchers to work to address risk and protective factors for Native Americans in Montana. The Rocky Mountain Tribal Epicenter and collaborative efforts should be supported as a continued part of Tribal data and information technological resources. Indian Health Services must provide surveillance data to the Rocky Mountain Tribal Epicenter and individual tribes. We are all accountable for the health and well-being of Native youth and children. We must all work toward reducing the stress and trauma that our most vulnerable Native Americans face and this will require collaboration and perseverance.

- Legislation that would allow school systems to acquire and provide or refer children who exhibit bullying behaviors or signs of maltreatment (peer or familial) to therapy rather than punishment or expulsion. Provide incentives to schools for implementing programs that institute healthy relationship building, character development and values clarification in a systematic way.
- Funding that would support such an alternative program and supplement regular educational structures including summer camps, after school or weekend activities that are designed to increase character and social skill development.)
- Educated Leadership—mandatory training and education on best practices (for health promotion and disease prevention) as well as how to talk and how not to talk about the issue at hand as well as the underlying causes or feelings.
- Contagion risk-Media in Montana require training in available guidelines available from the American Psychological Association to avoid or mitigate potential risk associated with sensationalized media depictions of suicide in Montana.
- Information technology- could provide telemedicine and telepsychiatry options as well as instruction and education to tribal communities. Building the clinical and educational capacity of tribal communities would reduce the isolation confronting many tribal communities, educators, and health providers. We must es-

establish ways to develop community support and technological access to our most rural reservations. Youth need access to information and options about healthy living options and educational opportunities.

- Cross-agency coordination and collaboration—must come from the top down as well as from communities. Schools and Tribal colleges and health professionals as well as Tribal leaders or health committees need paid on-the-job time to ensure information sharing and collaborative initiatives.
- Data sharing—The reporting system is inadequate and the problem of agency “silos” only exacerbates the problem. The relationship between state, federal, and tribal entities needs to be improved in an equitable manner that does not serve as a detriment of the Tribes. Currently, the Indian Health Service does not have a data sharing agreement with the Rocky Mountain Tribal Epicenter. This limits surveillance data available to tribal communities in Montana.
- Accountability—If this does not become everyone’s issue, then it will continue to belong only to those who are already isolated and most at risk. If we are going to be genuinely accountable to each other we each must hold ourselves accountable for finding effective remedies for this horrific situation.

*Question 2.* What is the best way for federal agencies to coordinate suicide prevention activities with tribal groups? For example, in what ways can we assist in addressing the problem (i.e., prevention, response, mitigation, and recovery)?

*Answer.* The best way to coordinate suicide prevention activities with tribal groups is to work with all key stakeholders within diverse aspects of tribal communities and leadership. This collaborative process must be directed to identify best practices for prevention, response, mitigation, and recovery. Tribal leaders, mental health providers, educators, researchers, administrators, community members, tribal youth, and academic partners are examples of key groups that require representation at the Billings area level. Federal agencies should consider creating positions (ideally led by Native personnel with expertise in mental health) specifically devoted to suicide prevention, response, and recovery. However, these individuals would need to be very active in coordinating the response of all stakeholders not just one component of the tribal community. A note of caution: the last thing we need is to have this position bogged down by excessive bureaucratic barriers. The immediacy of the problem should guide the immediacy of our collaborative response. Federal funding agencies need to make solid commitments and be required to expedite and support the suicide prevention efforts at an agency level. The problem is occurring now and the solution must therefore occur now. Every day that passes signifies the loss of more members of our Native communities. Tribal communities have recommended the use of immediate crisis response teams comprised of mental health providers and trained community members (who are well supported to prevent burn-out and just being overwhelmed). Other ideas include establishing safe houses for youth; improving access to crisis mental health services including daily walk-in hours for those in crisis; law enforcement training in mental health identification and referral; training for educational providers (teachers, principals, coaches, and aids); and improving after-school and alternative activities for youth (skateparks, basketball open gyms, extra-curricular events, and healthy options for activities). These activities should also have available information about healthy coping and available help for those who may be in crisis.

*Question 3.* What are some ways that we can improve communities’ understanding of suicide as a “public health issue?”

*Answer.* Work with educational systems on each reservation or urban center to work to educate teachers, families, students, and communities about the public health aspects of suicide and ways to cope with stress, trauma, and loss. Grants that work to promote public health education would be a good idea to develop collaboratively with communities. Involving communities and youth in these efforts is critical. Engaging communities in empowering and creative ways is critical to ensure the success of these efforts. More focus needs to be placed upon what it means to be a healthy and successful member of Native communities. Traditional culture, beliefs, and practices are all positive aspects that can promote resiliency and healthy coping. Too often, we fall victim to petty jealousy and or political pressures and end up focusing on negative aspects of communities or individuals. We must all work to promote resiliency, protective factors, and mental health within our youth and communities. Native spirituality, traditional medicine, and cultural practices are important factors that could be incorporated into any public health initiatives.

*Question 4.* Are there ways technology could be used to address gaps in services or community education?

Answer. Telehealth and telemedicine should be explored, particularly for our rural communities in Montana. Many of our most rural and remote reservation communities appear to experience more risk for suicide. Any innovative ways to establish support for individuals, communities, and providers in rural settings would be helpful. We also need to create a sense of community and systematically cultivate the perspective that life can improve for our Native youth. We need a nationwide “It gets better” effort analogous to the efforts being made for the LGBT youth in this country. Identifying health Native American role models could help improve community pride and hope for youth. Feelings of sadness and hopelessness can happen to anyone, we have to work to create a sense of hope for youth in particular. We also need to look at creating healthy opportunities to develop community for our isolated and rural reservations. One idea is to create an online community that has access to mental health educational material and health mentors. Hobbies, creative arts, music, theater, games, astronomy, learning about taxonomies are just a few of the activities that are virtually unavailable on the reservations, this is prime example of how Poverty can stifle imagination and consume all one’s energy or interest. Poverty is too often the direct result of a lack of employment opportunities, hiring youth to come up with safe activities might spark imagination.

*Question 5.* In what ways can federal agencies better support and help sustain local programs? Specifically, what technical assistance and program evaluation support is needed to illustrate program success and extend successful programs? How is success measured?

Answer. Programs that do not adequately involve communities, families, and youth do not have sustainability. In addition, adequate funding for long-term programs and to support key personnel is required. Short-term grant funded programs that do not include a meaningful community collaboration do not have good chances of continued success. In addition, Native Mental Health providers, physicians, and educators need to be increased. Native youth need to have healthy and successful role models within their communities. Success can be measured quantitatively and qualitatively. Including communities and Native professionals in the evaluation and technical assistance aspects of programming is vital.

*Question 6.* How can the various disciplines work collaboratively to address suicide within your communities?

- Healthcare
- Law enforcement
- Tribal governments
- Federal government
- State governments
- County systems
- First responders
- School personnel (BIE and Public Schools)
- Families and communities

Answer. All can and should work collaboratively to prevent youth suicide and improve our collective response to those at risk. The problems identified associated with suicide risk are complex and involve each of the identified disciplines. Improving knowledge of risk factors and available mental health options can help to integrate education, health, and familial resources to improve early identification and treatment for Native Youth at risk.

*Question 7.* What are some of the specific challenges to addressing suicide in your region?

Answer. Montana is a very rural and isolated state. It also has very limited options for mental health care access. The poverty faced by our Native communities can be quite extreme. Unemployment and poverty are severe in many reservations and these factors increase the risk experienced by all members of Native communities. Substance use problems, trauma exposure, inadequate healthcare access, and extremely limited access to mental healthcare are all additional barriers to Native Americans in Montana. Treatment programs should be expanded and professional interventions for all behavioral health issues (including obesity). These efforts require additional resources. Educational disparities in Montana are significant and translate to increased area of risk. Drop-out rates are very high among Native Youth and very few make it through college. These factors all need to be improved to promote suicide prevention here in Montana.

*Question 8.* What are some of the community strategies that have worked to prevent suicide?

Answer. In the past, I have observed that there have been stronger links between healthy older mentors in the community and youth. Ceremony, language, familial

support, peer support, sports, extracurricular activities, and access to community-wide event access (pow-wows, sobriety events, open supervised gyms, cultural educational events/activities, rodeo, skate parks, and other events aimed at youth) have been helpful in prevention. Poverty on many reservations limits access to the opportunities and these could be helpful areas to invest in for the future.

*Question 8a.* What can we learn from tribes that have been implementing successful prevention and intervention models?

Answer. Planting the Seeds of Hope and the Montana Suicide prevention initiative have exemplified important programs working within tribal communities, but they are relatively short term grant funded initiatives that will disappear when the grant period ends and they are not funded to be comprehensive prevention programs. Engaging communities, individuals, and leadership have all marked successful efforts. Collaborative efforts between key agencies, scientists, and healthcare providers demonstrate promise of improving suicide prevention in this state.

*Question 9.* How can federal agencies work collaboratively to promote youth success, wellness, and resilience (i.e., bullying prevention)?

- What makes certain youth resilient and some youth high risk?

Answer. I grew up on the Blackfeet reservation and went on to obtain a doctorate from the University of Montana. I can tell you that when I was a youth I was probably considered high risk (as was the majority of our high school population), but I was able to build upon the resiliency factors within my life to create a good life for me and for my children. The primary factors that helped me succeed were family support, social and community support, having stable and healthy parents, traditional cultural beliefs and spirituality, and access to educational opportunities and academic scholarships. My family and children have been my primary protective factor. I think that efforts to support building a safe and supportive environment for our children to learn within— such as bullying prevention and mentorship programs can help to improve resiliency. Matching healthy mentors with youth can be a powerful force to promote health and suicide prevention. We need to develop a system to identify those most at risk to connect them with the mental health services they may need. Cultivating connections is a key component of this process. I feel strongly that the solutions to our problems reside within our communities, but we must be creative and persistent in our quest to develop healthier communities.

*Question 10.* What steps need to be taken to develop a comprehensive strategy that addresses suicide in your community?

Answer:

- Identify Key stakeholders (community, leadership, youth, mental health providers, academic partners, Native providers, and federal agency representatives)
- Build strategic plans and implementation timelines
- Create early identification, screening, and referral programs on each reservation
- Increase mental health access and educational opportunities for youth
- Increase Native healthcare providers and partnerships between tribal colleges, high schools, and Universities
- Increase Native researchers working to promote suicide prevention
- Funding for Native youth suicide prevention programs
- Creation of support networks for those at elevated risk

JOINT PREPARED STATEMENT OF MARILYN BRUGUIER ZIMMERMAN, DIRECTOR,  
NATIONAL NATIVE CHILDREN'S TRAUMA CENTER AND RICHARD VAN DEN POL,  
DIRECTOR, INSTITUTE FOR EDUCATIONAL RESEARCH AND SERVICE, UNIVERSITY OF  
MONTANA

The National Native Children's Trauma Center and the Institute for Educational Research and Service, both at the University of Montana, thank you for the opportunity to present our information on this issue of vital importance, not just to this community, but throughout Indian Country and to the nation as a whole. Much of what you will hear in overall testimony today will focus on the severity of a single problem — teen suicide — here at Fort Peck. While we do not minimize that single problem, we would like to report that through seven years of engagement between our group at the university and this

community, all of us have learned a great deal about some of the broader issues, again, of vital interest throughout Indian Country and to the nation as a whole. One of those lessons is that showing up matters. Throughout our engagement here, working groups both large and small have traveled from the University in Missoula to this community on average every two months. But then we can't help but note and appreciate that the Indian Affairs Committee already knows this rule and proves it by showing up here for field hearings. We believe this community views this as a positive development.

All of what we have learned here with the help of this community cannot be adequately summarized in this short testimony, but in service of the Committee's work, we would like to emphasize two over-arching lessons that we believe ought to guide everyone's efforts in these issues. In addition, we would like to report an encouraging new finding that demonstrates how attention to these two fundamental points succeeds.

In convening this hearing, the Indian Affairs Committee, in fact, demonstrated the first important bit of knowledge by titling it: "Empowering Native Youth to Reclaim their Future." Everyone here today knows the headline-grabbing issue in this very school district has been a cluster of teen suicides, and the understandable urge is to do something now about that specific problem. In fact, our group from the university is engaged in exactly that, in doing something about suicide now. Nonetheless, as urgent as this issue is, the Committee's title urges us to not lose sight of the larger issues, and we agree. This is really about the future of Native youth, all youth. Teen suicide is not a single problem in isolation, but is part of a tangle of challenges that includes drug and alcohol abuse, family, community and gang violence, poor academic performance and a high drop-out rate, teen pregnancy, diabetes and obesity. Pulling a single thread will not untangle the larger Gordian knot of problems.

Likewise, our nation now has a solid body of science compiled by both the Centers for Disease Control and the National Childhood Traumatic Stress Network sanctioned by Congress in 2001. Our National Native Children's Trauma Center is a Category II Center in that national network, charged with addressing these issues on reservations throughout the nation. The overwhelming evidence from those efforts concludes that the knot of problems we face here and in impoverished communities nationwide stem from child abuse, neglect and domestic and community violence, and in

the case of reservation communities, historical trauma. We do have some evidence that some forms of abuse are particularly damaging. For instance, our researchers expect to soon publish data indicating a particularly strong link between childhood sexual abuse and teen suicide. Nonetheless, this does not negate our primary lesson here, that the knot of problems is wound up in a knot of causes, and we make little progress in these issues unless we recognize the complexity of the total picture.

This presents a daunting challenge, but also leads to our second key point: Because the larger issue is a series of complex problems stemming from complex causes, no single agency, institution or bureaucracy can solve this alone. The hydra heads of challenges preventing Native youth from reclaiming their future must be dealt with by tribal health, social services, schools, juvenile justice and by families, especially families. The complexity dictates that all of these diverse elements and interests in the tribal community come together to share information and common strategy. We are all in this together. Federal, state, tribal, school district, and ---yes, even academics from the university --- must learn to cooperate in a common effort. That may be the most important lesson this community is learning and teaching the rest of us, not just that cooperation is necessary, but exactly how to tear down the barriers to cooperation so we can get to the hard work that faces us. These are not just platitudes; we have concrete examples of real success that stems from real cooperation.

As you know, in response to the widely reported suicide cluster more than a year ago, the Fort Peck and Assiniboine Sioux Tribal Council declared a state of emergency in May of 2010, which triggered a deployment by the Office of Force Readiness of the U.S. Public Health Service and the Indian Health Service. IHS sent twenty-two officers, who rotated through the community in six separate teams, each in two-week deployments. The incident commander of the deployment was James Melbourne, director of Tribal Health Service. This extraordinary effort led to a formal report from IHS, which could have, in a lesser community, been sent to a shelf somewhere to gather dust. Not here. Our group at UM had already begun working with Director Melbourne on these issues, and agreed to cooperate on a way forward, using the IHS report as an information base. We built on their knowledge. Cooperatively, we wrote an application for a \$1.4 million grant from the Substance Abuse and Mental Health Services Administration to pay for suicide

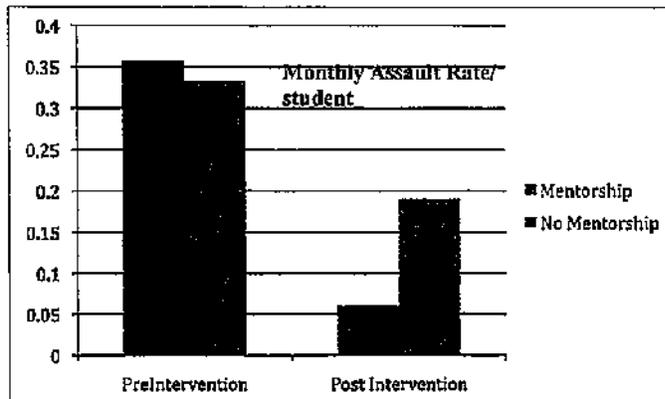
prevention on the Fort Peck reservation. Senator Tester's office supported us and announced that our application was successful on July 28, and now a local agency — Tribal Health — a state university and a local school district will go to work fulfilling needs identified by the federal IHS and the tribes. This is what we mean by interagency cooperation and shared information. Further, because of this structure and the spirit of cooperation, our university has agreed to waive any indirect costs, a burden that can run as high as 41 percent on federal grants.

Yet embedded in this is a development there is, we think, an even more revealing and encouraging bit of news. As part of its investigation, IHS took the rare and laudable step of actually interviewing the community's youth to solicit their ideas on how we might better serve them. The students gave us some common and revealing insights, and one of those was identifying a need for more meaningful adult contact, one-on-one relationships we might call mentoring. As part of the university's work at Poplar Schools, we repeated that question with a group of forty-seven students that screening had identified as being at-risk for suicide. We got a similar answer, so took the simple step of taking these children at their word. But in analyzing the data, we also noticed that a significant subset of the forty-seven also showed a pattern of assaulting other students and teachers, of violence. As we said, these problems are entangled, and often one problem like violence stemming from anger is a warning sign of another, like suicide.

Listening closely to what the young people were telling us caused us to do something very simple, but responsive: to begin a mentorship program. Each student identified someone on school staff that he or she could trust — a pivotal step — and in every case the identified staffer agreed to check in with the student at least three times during a school year — just three times. They talked about issues like academic progress and attendance, but more to the point, mentors took an interest in students' well-being. The program effected simple human contact between a student and a caring adult, not someone specially trained or licensed or delivering a particular therapy, just someone the student herself identified as someone she trusted.

The subset of ten students with a history of violence in the school, on average, accounted for 4.5 assaults per month in the two years and several months before teaming up with a mentor. That is, these kids, also at risk for suicide, accounted for a significant

portion of the violence in the school. But more importantly, after these students participated in the simple program of mentoring, their assaults fell from an average of 4.5 per month to 0.71 per month. Conversely, three students identified as "at risk" of suicide and with a history of assault were denied parental permission to participate in the mentorship program. Their assaults decreased also, but not nearly as dramatically as those mentored. Seldom do those of us in this field see such a robust and dramatic result so quickly.



The bonus in all of this is that of the larger group of 47 students identified as "at risk," those who were mentored also showed significant gains in academic achievement. In fact, the difference between the two groups — mentored and not — amounted to the difference between earning enough credits to graduate and failing to do so, one of the more significant predictors of a student's future.

This is not to say this is a magic bullet that will solve the community's problems overnight, but there are a couple of points in all this worth emphasizing. The gains shown here occurred as a result of an open exchange of information and knowledge among various agencies, particularly IHS, the Tribal Health Service and Poplar Schools. But they also occurred because Poplar Schools staff has spent many years learning to recognize and deal with at-risk youth. That is to say, the community has built capacity, and it has paid off.

Second, though, this is a cost-effective and simple program that rests on strengthening meaningful relationships between children and adults in this community, and now we have some evidence it works. It's the sort of work that can be easily and immediately replicated in similar communities with similar challenges, so the nation really can learn from Fort Peck. This, we think, helps justify the federal investment in this place and in these young people.

