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S. 1635, SEVENTH GENERATION PROMISE: INDIAN YOUTH SUICIDE PREVENTION ACT OF 2009

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

SEPTEMBER 10, 2009

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S. 1635, SEVENTH GENERATION PROMISE: INDIAN YOUTH SUICIDE PREVENTION ACT OF 2009

THURSDAY, SEPTEMBER 10, 2009

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

The Committee met, pursuant to notice, at 2:47 p.m. in room 628, Dirksen Senate Office Building, Hon. Byron L. Dorgan, Chairman of the Committee, presiding.

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

The CHAIRMAN. We will now call the hearing to order.

We are pleased today to have three witnesses join us. This hearing is on the subject of S. 1635, the Indian Youth Suicide Prevention Act.

We have the Honorable Yvette Roubideaux, who is the Director of the Indian Health Service, of the U.S. Department of Health and Human Services. We very much appreciate your being here.

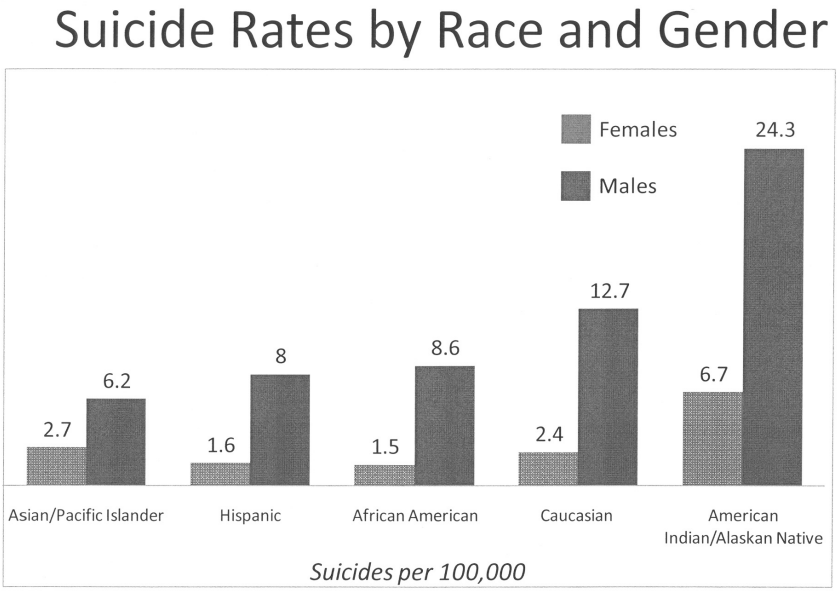
The Honorable Eric Broderick, who is the Acting Administrator of SAMHSA, the Substance Abuse and Mental Health Services Administration.

And Dr. Dolores Subia BigFoot, Ph.D., Associate Professor, University of Oklahoma at the Health Sciences Center, who will testify on behalf of the American Psychological Association.

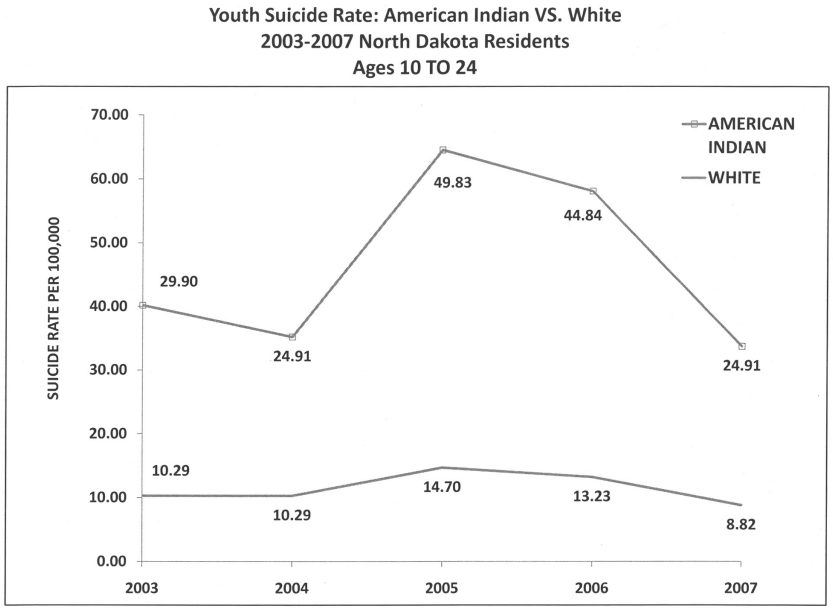
We appreciate very much your attendance.

Today we are going to hold this hearing to examine S. 1635, the Indian Youth Suicide Prevention Act. We believe this bill will help address the high rates of youth suicide on Native American communities and improve access, especially to mental health services. Suicide is hitting our Native youth like an epidemic in some areas of this Country. And it is critical, I believe, that we move quickly and respond aggressively.

The rate of suicide of Native American youth is not double, it is three and a half times higher than the general U.S. population. We have a chart that shows the suicide rates by race and gender in this Country. You will see the rates of suicide of American Indians.



Source: National Adolescent Health Information Center, 2006 Fact Sheet on Suicide: Adolescents & Youth Adults



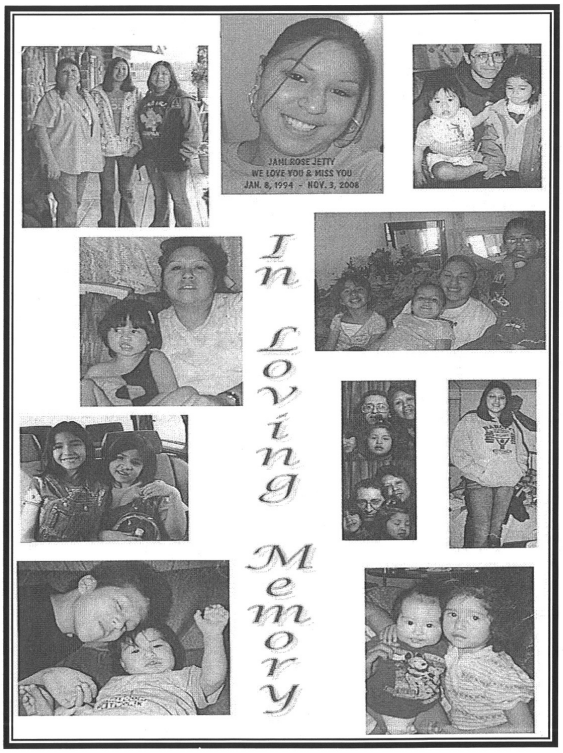
Source: North Dakota Department of Health, Division of Vital Records

Native American male and female teens have a higher rate of suicides than Asians, Hispanic, African American, Caucasians. In fact, the rate of Native American male youth is almost double that of the next highest racial group, which is male Caucasians. Chart

two shows the disparity in the youth suicide rates in my home State. The top line shows the rate of suicide for Native Americans 10 to 24. The bottom line shows the rate for Caucasians. Even when the incidence of Native American suicide is the lowest, the rate is still more than double that of Caucasian youth.

These charts show statistics. They fail, however, to show the cluster of suicides that can impact a community. The Standing Rock Sioux Reservation, which traverses North and South Dakota borders, had 53 suicide attempts this year, 10 of them which were completed. The members of this community are experiencing extreme trauma and need more resources and help.

This past February, when we held a hearing on teen suicide, a young woman named Dana Lee testified before this Committee about the loss of her little sister, Jami Rose. Jami Rose's picture is here on this chart, a beautiful little 14 year old girl from the Spirit Lake Nation in my home State of North Dakota. Last year, Jami took her life. Jami's mom had noticed that Jami seemed troubled. She took her daughter to the doctor, had her evaluated by mental health professionals from the Indian Health Service. The doctors dismissed her mom's concern and diagnosed her as being a typical teenager.



Jami Rose Jetty

Born: January 8, 1994
Died: November 3, 2008

Jami did not obtain the services she needed last November, and Dana Lee found her younger sister hanging in her bedroom.

Sadly, Jami's story is one we hear far too often in Indian Country. I have told the story often on the Floor with the consent of rel-

atives of Avis Little Wind. Actually, Avis was from the same reservation. She laid in a bed for 90 days in a fetal position. Her sister had taken her life, her mother was a substance abuser, her father had taken his life. And this young lady sort of dropped out and nobody noticed for three months that she wasn't in school. She was lying alone in bed in a dysfunctional family until they found her hanging in her closet at age 14. Hopeless, helpless, without the ability to get the services that we would expect for most teenage children in trouble.

We need to do much better than that, and that is the reason we have put together legislation to try to address these issues. This is all too silent an epidemic in this Country, and we aim to try to address it in a significant way.

I want to, because Senator Johanns has another hearing that he is supposed to be at, I want to, with the courtesy of my colleagues, call on Senator Johanns for a statement.

STATEMENT OF HON. MIKE JOHANNS, U.S. SENATOR FROM NEBRASKA

Senator JOHANNS. Mr. Chairman, thank you very much. And to my colleagues, thank you for the courtesy. I appreciate it. I, like all Senators, am learning that the biggest challenge we face is being in two places at once. So I do appreciate this.

I would like to offer a few thoughts on what we are doing here this afternoon. I think it is enormously important. I would like to address the challenges of providing mental health services to our Native American youth. I want to issue my strongest, without reservation, support of S. 1635, the Seventh Generation Promise: Indian Youth Suicide Prevention Act of 2009. In my home State, the State of Nebraska, we have four Native American tribes. They are just the most wonderful people. I have enjoyed working with them as a Senator and as a Governor and even as a mayor.

However, the suicide statistics in Indian Country would have to concern anyone. They deeply concern me. Native American young people have the highest suicide rate of any population group in the United States. The charts really do tell the story.

Alarmingly, the rate of suicide amongst Indian children in the northern Great Plains is 10 times higher, 10 times higher than the national average. Ninety percent of all Indian teens who commit suicide have a diagnosable mental illness at the time of their death. Yet more than half of these young people have never seen a mental health professional.

One effective way to reach these youth who are often in remote locations is through tele-medicine. A trained professional, through video conference, can do psychiatric assessments, complete diagnostic interviews, intervene with crisis counseling and provide needed mental health services. I could not be more pleased to be a sponsor of this important legislation. Key provisions of the legislation I believe will help transform how we deliver mental health services in this Country.

It is certainly a step in the right direction. For example, this bill authorizes the Department of Health and Human Services to carry out a project for tele-mental health services targeted to Native American youth. The goal is to provide mental health services to

those Indian youth who have expressed suicidal thoughts, have attempted suicide or who have mental health conditions that could increase the risk of suicide. The legislation would also address the barriers Indian tribes and tribal organizations face when applying for Substance Abuse and Mental Health Services Administration grants.

The legislation would require that this process be streamlined and take into account the unique obstacles that Indian tribes experience when applying for these grants. It would also give priority for youth suicide prevention grants to those Indian tribes and tribal organizations that have high youth suicide rates and prevent them from being disqualified from the grant application process, because they may not have the capability to extensively collect the data or have the advanced infrastructure in place to put that data there.

Finally, the bill would encourage the use of pre-doctoral psychology and psychiatry interns to provide mental health services in Indian Country where appropriate. Increasing the number of interns will help increase access to services, I believe, and serve as a valuable recruitment tool. My hope is that somebody who has this experience decides to stay in Indian Country.

With the impressive advancement technology in tele-medicine and with the tools that are at our disposal, living in an isolated rural area, which is oftentimes the case in all of our States, should not prevent a young person from getting services. I believe, again, that this is an important step in the right direction.

Mr. Chairman, I will wrap up and just say, I so appreciate your leadership on this, and the Ranking Member. I said at the first hearing I attended on Indian Affairs I thought this was one of our key issues to work on. I really think that if we can get started today, this will be a step, an important step in the right direction. Thank you.

The CHAIRMAN. Senator Johanns, thank you very much, and thanks for your work on and your attention to this issue. It is very important to this Committee.

I am going to call on others here for any statements. I am trying to determine, I believe we originally had a vote scheduled at 3:30. I am trying to determine whether that is the case. But let me call on Senator Barrasso, the Vice Chairman.

STATEMENT OF HON. JOHN BARRASSO,
U.S. SENATOR FROM WYOMING

Senator BARRASSO. Thank you very much, Mr. Chairman. These statistics are tragic. The personal stories compel action. It is inconceivable to me now that the Indian Health Service is reporting suicides among children as young as five years old.

I appreciate this legislation which attempts to address the lack of mental health services for these children, especially, as Senator Johanns talks about, through the tele-health services. According to the Indian Health Service, currently over 30 IHS and tribal facilities in 8 IHS areas are augmenting on-site behavioral health services with tele-behavioral health services.

This past spring, the previous director of the Indian Health Service testified before this Committee regarding the National Tele-Be-

havioral Center of Excellence. It was in the planning stages and was intended to provide increased access to video-conference-based behavioral health services. I hope, Dr. Roubideaux, that you can update us on the status of this Center of Excellence.

I look forward to hearing from all the witnesses on how this legislation can help provide an accountable system for addressing and preventing Indian youth suicide.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Barrasso, thank you very much.

Senator Udall?

STATEMENT OF HON. TOM UDALL,
U.S. SENATOR FROM NEW MEXICO

Senator UDALL. I just wanted to briefly, Chairman Dorgan, say thank you again for focusing on this issue, and thank you for focusing our attention on youth suicide in Indian Country.

The figures that you put up on North Dakota, those figures are very similar in New Mexico. We all know we have a national tragedy with this problem. Former Senator Gordon Smith, my cousin, also had a young son, Garrett. Garrett committed suicide while Gordon was in the Senate. Gordon used that tragedy to provide leadership and pass the Garrett Lee Smith Act, which has provided grants and momentum to bring some really thoughtful approaches to this particular tragedy.

So I thank you again for bringing our attention to this and really look forward to our leaders here giving us the way they see it and what they think we need to do. Thank you, Chairman Dorgan.

The CHAIRMAN. Senator Franken?

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

Senator FRANKEN. Thank you, Mr. Chairman.

I have an opening statement that I would like to enter into the record, without objection. Because I don't want to take any more time. I, like Senator Johanns, have to leave at a certain point and I apologize for that, because this is such an important and tragic subject. It is in Minnesota, as well.

So I would just like to thank the witnesses for being here, and I want to thank Senator Johanns for introducing the bill and his role in that, and you, Mr. Chairman, and you, Mr. Vice Chairman.

[The prepared statement of Senator Franken follows:]

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

Thank you Chairman Dorgan and Vice-Chair Barrasso for holding this timely and important hearing.

Mr. Chairman, I especially want to thank you—and Senator Johanns—for your leadership in introducing the *"7th Generation Promise: Indian Suicide Prevention Act of 2009."*

I look forward to working with both of you, and everyone on this Committee, to bring this legislation to the floor.

Over the years, this Committee has held a series of hearings on the issue of Indian youth suicide. I was moved by Chairman Dorgan's recitation of Dana Lee Jetty's testimony when he introduced the bill on the Senate floor last month. Ms. Jetty's testimony about the loss of her 14-year-old sister is just one more sobering reason why this legislation is so badly needed.

Across the country, American Indian teens commit suicide at a rate at least twice the national average. The rate is much higher in the Upper Midwest and Great Plains, where it is five to seven times higher than the national average.

In 2004—one of the most recent years data is available—three teens committed suicide on the Red Lake Indian Reservation in Minnesota; and a shocking 69 teems attempted it.

Even more shocking, in a survey of ninth-grade girls at Red Lake High school, 81 percent said they had thought about suicide at least once in their life; and nearly half said they attempted it.

Sadly, this problem is not just limited to a few reservations.

Clearly, it is a complex problem with no easy solution. I look forward to hearing from our panelists on how to best deal with this.

The CHAIRMAN. Senator Franken, thank you very much.

Dr. Roubideaux, I indicated when you took this job, and I was very pleased to support your nomination, that you inherited a pretty big task. But I appreciate your doing that, and today we asked you to come and talk to us about a very sensitive issue. It is difficult to talk about, and sensitive to talk about the issue of suicide, youth suicide. In some cases, some would perhaps sooner not have it discussed publicly. But the fact is, we must. We can no longer ignore this.

So let me ask you to begin. We appreciate very much your being here. Your entire statement will be a part of the record, I would say to all three witnesses. And we would ask that you summarize.

Dr. Roubideaux?

STATEMENT OF HON. YVETTE ROUBIDEAUX, M.D., M.P.H., DIRECTOR, INDIAN HEALTH SERVICE

Dr. ROUBIDEAUX. Thank you, Mr. Chairman, Mr. Vice Chairman and members of the Committee.

Good afternoon. My name is Dr. Yvette Roubideaux and I am the Director of the Indian Health Service. I appreciate the opportunity to testify on S. 1635.

As you know, the Indian Health Service plays a unique role because it is a health care system that was established to meet the Federal trust responsibility to provide health care for the 1.9 million American Indians and Alaska Natives it serves.

We are acutely aware that many American Indian and Alaska Native communities are affected by high rates of suicide. The most recent IHS data report that American Indian and Alaska Native suicide rate is 1.7 times that of the U.S. all races rate. Suicide is the second leading cause of death for Indian youth age 15 to 24, and is 3.5 times higher than the national average. American Indian and Alaska Native young people age 15 to 34 make up 64 percent of all suicides in Indian Country.

The current system of services for treating mental health problems of American Indians and Alaska Natives is a complex and often-fragmented system of tribal, Federal, State, local and community-based services. The availability and adequacy of mental health programs for American Indians and Alaska Natives varies considerably among tribes. The Indian Health Service Mental Health and Social Services program is a community-oriented clinical and preventive mental health services program that provides primarily outpatient mental health and related services, crisis triage, case management, prevention programming and outreach services.

As you know, suicide is a complicated public health challenge with many contributing factors and barriers to care in American Indian and Alaska Native communities. There are many reasons for the lack of access to care. Indian Country is predominantly rural and remote and local care may be limited. Rural practice is often isolating and challenging for its practitioners and even well-seasoned and balanced providers risk burnout. Many of the IHS tribal and urban mental health programs that provide services do not have enough staff to operate 24/7. Therefore, when an emergency or crisis occurs, the clinics and service units will often contract out such services to non-IHS hospitals and crisis centers.

Tele-health based behavioral health services are a promising strategy to address these access to care issues. We know that these services work and are acceptable to many, if not all, of our clinic populations. As a system of care, these services are either being used or are in planning stages in over 50 Indian Health System sites. Services being delivered range from settings including clinics, schools, youth and treatment centers.

We also have the methamphetamine and suicide prevention initiative, which is another coordinated program designed to promote the development of evidence-based and promising practices using culturally appropriate prevention and treatment to address methamphetamine abuse and suicidal behaviors in a community-driven context. IHS is using this funding to establish a national tele-behavioral health center of excellence to provide technical support nationally to programs attempting to implement such services.

We have preliminary indications that IHS programs are increasingly adopting and using these technologies. IHS is using Recovery Act funding to improve our telecommunications infrastructure, to increase the reliability and availability of appropriate bandwidth across the Indian Health system. We are investing in the infrastructure expansion support and maintenance needed to keep pace with potential service demands and to plan for the long-term success of this and any new Indian tele-mental effort.

We see many benefits of the use of tele-medicine for the treatment of youth suicide. It can connect many isolated programs in a web of support with a much larger array of services that is more cost-effective and convenient for patients. Such a system could potentially translate into 24/7 access to emergency behavioral health services in any setting with an adequate telecommunications service.

Such a system has other desirable consequences, such as filling gaps in provider coverage, allows providers with specialty interests to share their skills and knowledge with others in isolated locations, reducing provider burnout and professional isolation and improves recruitment for providers that can live and practice in urban areas rather that isolated locations. Families can also participate in care, even when at a distance from their youth.

We believe tele-health programs can become an integrated part of the IHS behavioral health services, strengthen our clinical expertise and expand access to needed behavioral health care. The additional services proposed in this legislation could help facilitate our ability to provide needed services.

In summary, we look forward to opportunities to work with this Committee to address the critical problem of youth suicide in Indian Country.

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

[The prepared statement of Dr. Roubideaux follows:]

PREPARED STATEMENT OF HON. YVETTE ROUBIDEAUX, M.D., M.P.H., DIRECTOR, INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee:

Good morning, I am Dr. Yvette Roubideaux, Director of the Indian Health Service (IHS). Today, I appreciate the opportunity to testify on S. 1635, 7th Generation Promise: Indian Youth Suicide Prevention Act of 2009.

As you know, the Indian Health Service plays a unique role in the Department of Health and Human Services because it is a health care system that was established to meet the federal trust responsibility to provide health care to American Indians and Alaska Natives. The IHS provides high-quality, comprehensive primary care and public health services through a system of IHS, Tribal, and Urban operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The IHS has the responsibility for the delivery of health services to an estimated 1.9 million federally-recognized American Indians and Alaska Natives. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our duty is to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

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

Background

Many American Indian and Alaska Native communities are affected by high rates of suicide. A wide range of general risk factors contribute to suicide. In the case of American Indian and Alaska Native young people, they face, on average, a greater number of these risk factors individually or the risk factors are more severe in nature for them. Research suggests that there are factors that protect Native youth and young adults against suicidal behavior. These factors are their sense of belonging to their culture, strong tribal spiritual orientation, and cultural continuity.

The soon to be published IHS "*Trends in Indian Health, 2002–2003*" reports:

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

On a national level, many American Indian and Alaska Native communities are affected by very high levels of suicide, poverty, unemployment, accidental death, domestic violence, alcoholism, and child neglect.[1] According to the Institute of Medicine, an estimated 90 percent of individuals who die by suicide have a mental illness, a substance abuse disorder, or both.[2] According to a 2001 mental health supplement report of the Surgeon General, "Mental Health: Culture, Race, and Ethnicity", there are limited mental health services in Tribal and urban Indian communities.[3] While the need for mental health care is great, services are lacking, and access to these services can be difficult and costly.[4]

Addressing Suicide Among American Indians

The current system of services for treating mental health problems of American Indians and Alaska Natives is a complex and often fragmented system of tribal, federal, state, local, and community-based services. The availability and adequacy of mental health programs for American Indians and Alaska Natives varies considerably across communities.[5] American Indian youth are more likely than non-Indian children to receive treatment through the juvenile justice system and in-patient facilities.[6]

IHS and SAMHSA work closely together to formulate long term strategic approaches to address the issue of suicide 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, CDC, NIMH, 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.

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

Suicide is a complicated public health challenge with many contributing factors, and barriers to care in American Indian and Alaska Native communities. Indian Country has communities every year where suicide takes on a particularly ominous and seemingly contagious form, often referred to as suicide clusters. In these communities, the suicidal act becomes a regular and transmittable form of expression of the despair and hopelessness experienced by some Indian youth. While most vividly and painfully expressed in these communities, suicide and suicidal behavior and their consequences send shockwaves through many communities in Indian Country, including urban communities. The pain only deepens when those seeking help for their loved ones in crisis, or those left behind as emotional survivors of such acts, are unable to access adequate care.

There are many reasons for a lack of access to care. Indian Country is predominantly rural and remote, and this brings with it the struggles of providing support

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

[2] Institute of Medicine (2002). *Reducing Suicide: A National Imperative.* Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., Bunney, W. E. (Eds.) Washington, DC: National Academies Press.

[3] 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.

[4] 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.

[5] Ibid.

[6] Ibid.

in settings where appropriate local care may be limited. Rural practice is often isolating for its practitioners. The broad range of clinical conditions faced with limited local resources challenge even seasoned providers. Some providers are so overwhelmed by the continuous demand for services, particularly during suicide outbreaks, that even well-seasoned and balanced providers risk burn-out.

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

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

Indian Tele-health Based Behavioral Health Services

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

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

The Methamphetamine and Suicide Prevention Initiative (MSPI) is another coordinated program designed to provide prevention and intervention resources for Indian Country. This initiative promotes the development of evidence-based and promising practices using culturally appropriate prevention and treatment to address methamphetamine abuse and suicidal behaviors in a community-driven context. IHS is using the MSPI funding to promote adoption of technologies on a larger, system wide basis. For example, in the California and Oklahoma Areas, programs will benefit from MSPI grants supporting increased access through tele-health service delivery.

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

We have been tracking visits to behavioral health clinics using tele-health technology, and have preliminary indications that IHS programs are increasingly adopting and using these technologies. Tele-behavioral health services require adequate and reliable bandwidth if they are to be sustainably implemented. Increasing bandwidth utilization strains the telecommunications infrastructure. IHS was fortunate

to be recipients of ARRA funding to improve our telecommunications infrastructure to increase the reliability and availability of appropriate bandwidth across the Indian healthcare system. Approximately $19 million of our Health Information Technology ARRA funding will be spent to provide new routers, switches, and basic telecom infrastructure to ensure current needs are met, as well as improve our ability to prioritize traffic over the network. ARRA funding is also supporting a mass procurement of state-of-the-art clinical videoconferencing equipment that will be distributed to Tribal, Urban, and Federal care sites depending on need later this fall. We are working to improve access to videoconferencing and bandwidth capacity to strengthen our telecommunications infrastructure. As one of my providers who is active in telemedicine told me, "My patients are very patient and are willing to tolerate surprisingly bad connections. But when my image freezes up with regularity I may as well be using the telephone." We are investing in the infrastructure expansion, support, and maintenance needed to keep pace with potential service demands and to plan for the long term success of this and any new Indian tele-mental effort.

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

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

It is important to note that the proposed services would require behavioral health providers including psychiatrists, psychologists, clinical social workers, and therapists in addition to the telemental health technology.

The behavioral health services discussed in my testimony today are available or will be available to some degree already at 50 federal and tribal sites, or are otherwise unavailable or irregularly available in the Indian health care system.

As described in my testimony today, IHS supports and indeed is already funding many of the activities included in the demonstration grant program outlined in, S. 1635, the 7th Generation Promise. These activities, including the National Tele-behavioral Health Center of Excellence funded by the MSPI, will also help us understand how to effectively deliver such services, and in particular, will provide more focused experience in providing services to Indian youth. We believe tele-behavioral programs can become an integral part of the IHS behavioral health services, strengthen our clinical expertise in using tele-health services and expand access to needed behavioral healthcare. We are working to augment the ability of the IHS Tele-behavioral Health Center of Excellence to promote and support such services across the Indian health system. The additional services proposed in this legislation could help facilitate our ability to provide needed services.

In summary, we look forward to opportunities to address the critical problem of youth suicide in Indian Country. We are committed to using available technologies including our growing national telecommunications infrastructure to help increase access to sorely needed behavioral health services. For Indian Health Service, our

business is helping our communities and families achieve the highest level of wellness possible.

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

The CHAIRMAN. Dr. Roubideaux, thank you very much for your statement and for being here.

Next we will hear from the Honorable Eric Broderick. Dr. Broderick is the Acting Administrator of the Substance Abuse and Mental Health Services Administration. Dr. Broderick?

STATEMENT OF HON. ERIC B. BRODERICK, D.D.S., M.P.H., ACTING ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. BRODERICK. Thank you, Mr. Chairman.

Mr. Chairman, Mr. Vice Chairman, members of the Committee, good afternoon. My name is Eric Broderick. I am the Acting Administrator of the Substance Abuse and Mental Health Services Administration within the Department of Health and Human Services.

Today I am honored to join Dr. Roubideaux as a witness at this hearing. I have known Dr. Roubideaux for a number of years, and I look forward to expanding our working relationship with the Indian Health Service under her leadership to expand and enhance the well-being of American Indians and Alaska Natives.

Mr. Chairman, I would like to also acknowledge the assistance of your staff, specifically John Hart, Erin Bailey and Rhonda Harjo for the assistance they provided us at SAMHSA in addressing and engaging issues of concern to Indian Country. Thank you for the opportunity to testify about suicide in Indian Country. As you have said, it is an extremely serious issue. The data are very clear, and bear our close attention.

I regret that since I last testified, as you pointed out, there has been a tragic cluster of suicide on the Standing Rock Sioux Reservation. Mr. Chairman, SAMHSA staff, accompanied by your staff, visited Standing Rock on the 20th of July of this year, met with Chairman His Horse Is Thunder, as well as members of the chairman's staff, other tribal leaders, reservation program coordinators and tribal community members. Based upon this visit, SAMHSA has submitted a report to this Committee. The report focuses on issues at Standing Rock and is consistent with the testimony I provided at previous hearings.

During our visit, the director of the Boys and Girls Club of the Grand River area of the Standing Rock Reservation reported that at Standing Rock, there is an unemployment rate of 74 percent, 85 percent of the tribal members live in poverty, violent crime is six times the national average and the high school graduation rate is 49 percent, compared with 76 percent nationally. These statistics provide a glimpse of the risk factors American Indians and Alaska Native youth face in their communities. We know that protective factors such as tribal culture, sports, recreation and academic programs can mitigate these risk factors. We also know that adequate mental health services and substance abuse services for those in need are extremely important.

Unfortunately, in many communities, these protective factors and essential health services are not always available. Federal, State and tribal governments must work together to address this problem, and we at SAMHSA are committed to the effort.

In order to create an opportunity for systematic feedback and guidance from elected tribal officials, we at SAMHSA created and staffed a tribal advisory committee comprised of elected tribal officials from across the Nation. The committee has been in place for two years and provides us with valuable assistance in working with tribal communities and understanding the issues of importance to Indian Country.

Additionally, over the past three years, SAMHSA has co-hosted with the Department of Justice Office of Justice Programs, Office of Violence Against Women, Office of Victims of Crime and the COPS program, as well as the Department of Interior, Department of Housing and Urban Development, the Small Business Administration and the HHS Office of Minority Health and the Indian Health Service nine technical assistance and consultation sessions. These tribal justice, safety and wellness conferences were created at the request of tribal leadership and provide the opportunity to both consult with tribal leaders on issues at the nexus of public health and public safety that are of concern to them as well as to provide technical assistance aimed at raising tribal grantsmanship capacity. Youth suicide has been raised as a concern at every one of these sessions.

I believe that this ongoing commitment to the development of tribal capacity is largely responsible for the doubling of SAMHSA grants awarded to tribes between 2006 and 2008. However, I also believe that much more can be done.

It has been our experience that giving blanket priority to certain groups, to specific drug types or to specific mental illnesses in a grant application process often fails to produce the desired results. As an alternative, I would like to share with you what has proven effective for us at SAMHSA. We understand the value of providing tribes and tribal organizations additional resources to develop infrastructure needed to submit competitive grant applications and to administer grants when funds are awarded. For example, in evaluating the Children's Mental Health Initiative, we have found that many American Indian and Alaska Native tribes were unsuccessful in competing for our Systems of Care grants because they did not have the infrastructure to draft or to plan for such new programs.

The Children's Mental Health Initiative provides funding to local communities, including American Indian and Alaska Native communities, to develop systems to care for children with serious mental illness. In response to that finding, SAMHSA developed the Circles of Care grants, which are three-year discretionary infrastructure grant programs for American Indian and Alaska Native tribes and tribal organizations to plan for and develop community-based systems of care for children with serious mental illness. There have been 16 tribes or tribal organizations who have received Circles of Care grants. Of those 16, 12 have been successful in becoming Systems of Care grantees and implementing the models they have developed as a result of their Circle of Care grants.

Mr. Chairman, when we consider ways to help tribal communities prevent youth suicide, I would recommend that we consider similar strategies to expand tribal capacity. Currently, fully one-third of our Garrett Lee Smith grants have been awarded to tribes and tribal communities. Eighteen of 54 grants now go to tribes. They have been successful and very competitive in that environment.

But to build upon that tremendous success of tribes, I would suggest that the Circles of Care grant model, relative to suicide prevention, is one worthy to consider. Creation of planning grants for suicide prevention would build upon SAMHSA's Native Aspirations program, as well as to develop much-needed capacity to develop programming and permit tribes to successfully compete for grants to implement those programs. These planning grants should target communities that currently do not possess the capacity to successfully compete for Federal grants. Not only would this approach direct resources to communities of extremely high need, it would also create the capacity for solid administration and implementation of those grants.

Thank you for the opportunity to testify, sir. I would be happy to answer any questions for the Committee.

[The prepared statement of Dr. Broderick follows:]

PREPARED STATEMENT OF HON. ERIC B. BRODERICK, D.D.S., M.P.H., ACTING ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee, good afternoon. I am Eric B. Broderick, D.D.S., M.P.H., Acting Administrator of the Substance Abuse And Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services and Assistant Surgeon General.

SAMHSA and the Indian Health Service (IHS) work closely together to formulate long-term strategic approaches to address the issue of suicide in Indian Country more effectively. For example, SAMHSA and IHS are actively involved on the Federal Partners for Suicide Prevention Workgroup. In 2001, the Office of the Surgeon General coordinated the efforts of numerous HHS agencies, including SAMHSA, IHS, the Centers for Disease Control and Prevention, the National Institute of Mental Health within the National Institutes of Health, and the Health Resources and Services Administration, along with 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. SAMHSA also helped facilitate and participated in a Federal Partners Committee on Telemental Health.

While I am very pleased to be here today to talk about suicide rates among American Indians and Alaska Natives, I regret that since I testified the last time, the problem has not improved. I am saddened to note that we have faced yet another episode of suicides among American Indians and Alaska Natives, this time on the Standing Rock reservation where there have been ten recorded suicides, primarily among the younger population since January of this year.

Along with representatives of the Chairman, we visited the reservation on July 20 and met with Chairman Ron His Horse is Thunder as well as members of the Chairman's staff, tribal leaders, reservation program coordinators and tribal community members. Based on this visit, SAMHSA submitted a report to the Committee. The report repeats much of what I and the previous IHS Director have testified about in previous hearings, except due to the recent increased loss of youth to suicide, the report is specific to the Standing Rock Sioux Tribe July visit.

Despite the attention that suicide among American Indians and Alaska Natives deserves and gets, especially from the Committee and the Department, we, as a nation, continue to experience very high rates of suicide among Native Americans and Alaska Natives. In the case of Standing Rock, a cluster of youth suicide completions

devastated the reservation despite suicide specific funding from SAMHSA through the Garrett Lee Smith (GLS) State/Tribal Suicide Prevention Grants.

Program staff for the GLS grant, known as Oniyape, are deeply dedicated to their suicide prevention program. Community members told us that staff supporting this grant have their hands full just trying to intervene with the large number of youth and families most at risk for suicide.

Programs that help increase protective factors to offset the risk factors that exist among the tribe—such as sports, recreation, cultural, and academic support programs—are scarce on the Reservation. Where such resources do exist, inadequate financial and human resources limit outreach and activity level they can provide. During the recent crisis, the Boys and Girls Club of the Grand River Area of the Standing Rock Reservation served as the *de facto* crisis center for the community. It provided—and continues to provide—support, meetings with families, and grief counseling to the youth following the recent suicides. Parents and grandparents approached Club staff at work, on the street, and at their homes, asking if they could help their child or grandchild. Club staff made referrals, ensured the youth were involved in the Club's programs, checked in on the youth, and listened to and supported the adults.

With the suicide rates so high, tribal members report that many individuals at risk struggle with:

- Maintaining intimate relationships
- Trusting and being trusted
- Working in teams with others
- Persevering when problems arise
- Functioning as parents
- Holding a job—if jobs exist
- Stopping harmful behaviors such as alcohol and drug abuse or family violence.

These reactions only create a deeper sense of isolation, depression, and substance abuse which often lead to suicidal thoughts and actions.

This problem requires a public health approach that works to decrease risk factors and increase protective factors. This may very well take a concerted effort by the Federal, State, and Tribal Governments. It will take time.

In the meantime, we support programs such as the Garrett Lee Smith State/Tribal Grants and other efforts supported by the SAMHSA and the Indian Health Service and consider ways of intervening such as finding ways to support mental health and substance abuse services for American Indian and Alaska Native tribes and tribal organizations.

We provide technical assistance to tribes and encourage them to apply for funding. All of our grants, except those that are restricted by statute, are open to American Indians and Alaska Natives tribes and tribal organizations, and we have been working hard to increase funding to American Indian and Alaska Native tribes or tribal organizations. They may apply directly for discretionary funds without going through the State, and we have facilitated the application process.

As a result of this effort, the amount of funding to American Indian and Alaskan Native tribes and tribal organizations, especially with respect to suicide prevention, now totals over $60 million a year. Standing Rock has been very successful in competing and receiving grant funds from SAMHSA. Besides a Garrett Lee Smith State/Tribal grant, they also have a Circles of Care grant, an inter-departmental (HHS and Education) Safe Schools/Healthy Students grant, and a Targeted Capacity Grant for substance abuse treatment.

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

SAMHSA provides national leadership for suicide prevention, consistent with the National Strategy for Suicide Prevention. We have four major suicide prevention initiatives that I will highlight briefly today. These initiatives include the Garrett Lee Smith Youth Suicide Prevention Grant Program, the Native Aspirations Project, the Suicide Prevention Resource Center, and the Suicide Prevention Lifeline.

Garrett Lee Smith Youth Suicide Prevention Grant Program

As a result of the authorization provided by the Garrett Lee Smith Memorial Act (P.L. 108–355), SAMHSA has been working with state and local governments and community providers to further stem the number of youth suicides in our country.

In 2005, we awarded the first cohort of grants, 14 in all, under the Garrett Lee Smith Memorial Act State/Tribal Suicide Prevention program. These funds are available to help States/Tribes implement a State-wide/Tribe-wide suicide preven-

tion network. One of those first set of grants went to the Native American Rehabilitation Association in Oregon.

Awards were again made in 2006 and 2007, during which six Tribes/Tribal Organizations were awarded grants. In August 2008, 12 Tribes/Tribal Organizations received Garrett Lee Smith grants, totaling one-third of the number of grant awards. This is not only a direct result of outreach and technical assistance, but a true indication of the resolve of Tribes and Tribal Organizations to proactively seek Requests for Application and then put forward strong, viable applications. Additionally, it is important to note that many of the states which received grant awards are partnering with and/or reaching out to include suicide prevention efforts in their local tribal communities.

Among the newest cohort of grants the Tribes/Tribal Organizations awardees include: the Gila River Behavioral Health Authority Youth Suicide Prevention Project, The Gila River Indian Community, Sacaton, Arizona; Omaha Nation Community Response Team—Project Hope, Walthill, Nebraska; Mescalero Apache School Youth Suicide Prevention and Early Intervention Initiative, Mescalero, New Mexico; Wiconi Wakan Health & Healing Center, Rosebud Sioux Tribe, Rosebud, South Dakota; Circle of Trust Youth Suicide Prevention Program, The Confederated Salish Kootenai Tribes of the Flathead Indian Nation, Pablo, Montana; Preserving Life: Nevada Tribal Youth Suicide Prevention Initiative, Inter-Tribal Council of Nevada, Sparks, Nevada; Youth Suicide Prevention, The Crow Creek Sioux Tribe, Ft. Thompson, South Dakota; Tribal Youth Suicide Prevention Program, Oglala Sioux Tribe, Pine Ridge, South Dakota; Wiconi Ohitika Project, Cankdeska Cikana Community College, Fort Totten, North Dakota; Sault Tribe Alive Youth (STAY) Project, Sault Ste Marie Tribe Chippewa Indians, Sault Ste Marie, Michigan; Bering Strait Suicide Prevention Program, Kawerak, Inc., Nome, Alaska; and the Native Youth Suicide Prevention Project, Native American Rehabilitation Association, Portland, Oregon.

Overall, 54 states, tribes, and tribal organizations, as well as more than 50 colleges and universities, will be receiving funding for youth suicide prevention through this program. Again, it is important to note that with the new tribal grantees, one third of all of the Garrett Lee Smith State and Tribal grants will be going to tribes or tribal organizations.

Native Aspirations Project

SAMHSA funds the Native Aspirations project, which is a national project designed to address youth violence, bullying, and suicide prevention through evidence-based interventions and community efforts. Through the Native Aspirations project, a total of 25 American Indian and Alaska Native communities determined to be the most "at risk" develop or enhance a community-based prevention plan.

After a community is selected, the first step is an initial visit from Native Aspirations project staff members, who share information and help community leaders set up an oversight committee. The second step is the Gathering of Native Americans (GONA), a 4-day event designed to offer hope, encouragement, and a positive start. GONA events are based on each community's traditional culture and honor American Indian and Alaska Native values. GONA events are a safe place to share, heal, and plan for action.

Within a month of a GONA, Native Aspirations staff facilitate a 2-day planning event. At this event, participants receive training about prevention plans and decide which model to follow. They outline a customized plan based on actions that have worked for others. As the community finalizes and carries out its plan, Native Aspirations provides ongoing training, consultation, technical assistance, and budget support.

Suicide Prevention Resource Center

Another initiative is the Suicide Prevention Resource Center (SPRC) which is a national resource and technical assistance center that advances the field by working with states, territories, tribes, and grantees and by developing and disseminating suicide prevention resources. The SPRC was established in 2002. It supports suicide prevention with the best of available science, skills and practice to advance the National Strategy for Suicide Prevention (NSSP). SPRC provides prevention support, training, and resource materials to strengthen suicide prevention networks and is the first federally funded center of its kind.

The Suicide Prevention Lifeline

The last major initiative I will highlight today is the National Suicide Prevention Lifeline. The National Suicide Prevention Lifeline is a network of 141 crisis centers across the United States that receives calls from the national, toll-free suicide prevention hotline number, 800–273–TALK.

The network is administered through a grant from SAMHSA to Link2Health Solutions, an affiliate of the Mental Health Association of New York City. Calls to 800–273–TALK are automatically routed to the closest of 141 crisis centers across the country. Those crisis centers are independently operated and funded (both publicly and privately). They all serve their local communities in 49 states and operate their own local suicide prevention hotline numbers. They agree to accept local, state, or regional calls from the National Suicide Prevention Lifeline and receive a small stipend for doing so. (In Idaho, the only state that does not currently have a participating crisis center, the calls are answered by a crisis center in a neighboring state.) Every month, nearly 52,000 people have their calls answered through the National Suicide Prevention Lifeline, an average of 1,852 people every day.

When a caller dials 800–273–TALK, the call is routed to the nearest crisis center, based on the caller's area code. The crisis worker will listen to the person, assess the nature and severity of the crisis, and link or refer the caller to services, including Emergency Medical Services when necessary. If the nearest center is unable to pick up, the call automatically is routed to the next nearest center. All calls are free and confidential and are answered 24 hours a day, 7 days a week.

By utilizing a national network of crisis centers with trained staff linked through a single national, toll-free suicide prevention number, the capacity to effectively respond to all callers, even when a particular crisis center is overwhelmed with calls, is maximized. This also provides protection in the event a crisis center's ability to function is adversely impacted, for example, by a natural disaster or a blackout.

Further, by utilizing the national number 800–273–TALK, national public awareness campaigns and materials can supplement local crisis centers' efforts to help as many people as possible learn about and utilize the National Suicide Prevention Lifeline. In fact, SAMHSA has consistently found that when major national efforts are made to publicize the number, the volume of callers increases, and this increased call volume is maintained over time.

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

We are pleased that we have been able to work together with the American Indian/Alaskan Native Communities and also with the Department of Veterans Affairs (for veterans using the Lifeline) to help deliver the critically important messages that suicide is preventable, and that help is available. All Americans have access to the National Suicide Prevention Lifeline during times of crisis, and we are committed to sustaining this vital, national resource.

In addition to the four funding programs outlined above, SAMHSA has also provided funding for an expanded evaluation of Garrett Lee Smith-funded grant activities in the White Mountain Apache tribe, focusing on Emergency Department interventions and follow up with American Indian youth who have made suicide attempts. In this innovative approach, Apache paraprofessionals provide outreach in the community to each youth who has been reported to attempt suicide or to experience suicidal thoughts. By electronic means, these outreach workers are provided remote supervision by a child psychiatrist, psychologist and clinical team from the Johns Hopkins University Center for American Indian Health. In addition, last year, SAMHSA sponsored a meeting to examine the tragedy of suicide clusters in Indian Country.

These SAMHSA initiatives are an important start, but we know there is much more to be done to reduce the tragic burden of suicide in Indian Country. The problems confronting American Indian and Alaska Natives are taking a toll on the future these communities.

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

The CHAIRMAN. Dr. Broderick, thank you very much for being here.

Next we will hear from Dr. Dolores Subia BigFoot, Director of the Indian Country Child Trauma Center and the Project Making Medicine at the University of Oklahoma Health Sciences Center. She is testifying on behalf of the American Psychological Association.

You may proceed. Thank you for being with us.

STATEMENT OF DOLORES SUBIA BIGFOOT, PH.D., DIRECTOR, INDIAN COUNTRY CHILD TRAUMA CENTER AND PROJECT MAKING MEDICINE, UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

Dr. BIGFOOT. Chairman Dorgan, members of the Committee, this is both a personal and a professional effort. First, please allow me to express my appreciation for the opportunity to speak on behalf of the 150,000 members and affiliates of the American Psychological Association. My name is Dr. Dolores Subia BigFoot, and I bring goodwill from the Caddo Nation of Oklahoma in which I am enrolled, and from the Northern Cheyenne Tribe in Montana, in which my children are enrolled.

I am a child counseling psychologist by training and have devoted 35 years to addressing health disparities in its many different forms within our tribal nations. Thank you for convening this important hearing to discuss the need to reduce, to eliminate and to reveal the devastation of suicide within our American Indian and Alaska Native youth through the development of Federal legislation.

As the Director of Project Making Medicine and the Indian Country Child Trauma Center at the University of Oklahoma Health Sciences Center, I profoundly understand the need for safety for our youth. There are many diligent and dedicated people who are concerned and working to address this same need for safety and to provide appropriate mental health and other culturally-appropriate interventions that can help prevent suicide.

Project Making Medicine is funded by the Office of Child Abuse and Neglect, the Children's Bureau and the Indian Country Child Trauma Center was funded from 2003 to 2007 by the Substance Abuse and Mental Health Services Administration as part of the National Child Traumatic Stress Network. We currently remain a very active affiliate member of this network, which is an important Congressional initiative that works to raise the standard of care for traumatized children and their families.

It is also important to acknowledge the critical role of SAMHSA's youth suicide prevention and early intervention programs created under the Garrett Lee Smith Memorial Act. The rates of suicide among our youth has been drastically illustrated by the charts that were shown. They are disproportionately high and we must work to address these preventable, yes very preventable, tragedies.

Mr. Chairman, as I am sure you know, given your steadfast commitment to addressing this tragic problem, high suicide rates have significant impact on families, siblings, peers, and the community as a whole. While progress has been slow in understanding suicide from a cultural perspective, we know that both historical and current traumatic stressors in Indian Country affect our youth. I think that by the bill earlier referenced, regarding violence in Indian Country, it is very self-evident.

The self-harm responses that youth may exhibit are much like those of other individuals exposed to collective trauma, such as our combat veterans that are returning and their high rate of suicide, such as the first responders, firefighters and police officers, like those involved in the Oklahoma City bombing. I am aware of those

that committed suicide after that. And of course, those after 9/11. Tragedy has an impact. Trauma has an impact.

Despite the challenges facing our American Indian and Alaska Native communities, we remain optimistic and hopeful. Organizations such as the National Congress of American Indians, the National Indian Health Board, National Council of Urban Indian Health, along with tribes and the Indian Health Service, has been formulating best practices related to suicide prevention that will help our youth. These efforts focus on developing a better understanding of what would lead youth to consider suicide.

While we know that suicide typically occurs as a single individual act, suicide cannot be understood in isolation. Instead, we must consider the various precipitating factors, including child maltreatment, family violence, mental health problems, trauma, loss, grief and pain that are associated with feelings of hopelessness and the lack of safety among our youth.

Our youth are in desperate need of safe homes, safe families and safe communities. Chronic under-funding of tribal and urban programs and a lack of infrastructure and human resources, as described earlier, create barriers for our youth. We must provide appropriate resources and opportunities to immediately empower and support our population to build our capacity to address the needs of our youth.

Currently, there are insufficient numbers of psychologists and other mental health providers of Indigenous heritage. Two vital Federal initiatives in place to help address this problem are the Indians Into Psychology program and the Minority Fellowship program, funded by the Indian Health Service and SAMHSA, respectively. These programs have a strong history of success and are critical to building the ethnic minority pipeline. As such, it is important that increased funding is provided for these initiatives.

At the same time, while we work to build the sufficient professional workforce, tribal communities require immediate and innovative resources to meet the urgent needs of our youth and families. At the University of Oklahoma Health Sciences Center, we currently utilize a video-conferencing system through the internet in which we are training via real-time mental health providers in tribal communities. We have done this in the State of Washington, we have done it in California and Utah and Oregon and Alaska and across Oklahoma.

The National Child Traumatic Stress Network is also developing a sophisticated distance learning system that can help providers access the specific training they need. I strongly recommend the continued support and expansion of the National Child Traumatic Stress Network as an important resource to ensure that we have a national infrastructure of child trauma experts and providers who can meet the diverse needs of our youth.

We appreciate your efforts to develop the Seventh Generation Promise: Indian Youth Suicide Prevention Act of 2009. How well it is that we should think seven generations ahead.

This legislation aims to increase and enhance the provision of mental health care for American Indians and Alaska Native youth by decreasing disparities in access and improving quality of mental health care. We look forward to working with Congress, the Indian

Health Service, the Children's Bureau and SAMHSA as this proposal moves through the legislative process.

We cannot be silent and so I will add, my own family loss, my beautiful, precious son of 33 years died 10 months ago today. His death certificate does not say suicide. However, his self-harm behavior created a situation in which injury resulted in his death. The outcome was the same. He was traumatized by someone outside the family that I have no knowledge about until he informed me as an adult. And by that time, as we tried to untangle all of the webs that tore at his heart, tore at his spirit, tore at his mind. It was very difficult.

So his death was a result of self-harm. He chose not to seek medical care and knew that he would die. There are many of those in similar situations beyond what we see in terms of the statistics that are taking their own lives, and it is not reported as a suicide.

Mr. Chairman, members of the Committee, I am honored. My family is honored and my tribe is honored by this invitation to join you today. But especially my son, Bryce Buffalo Man BigFoot is honored that his mother can voice his cry that help is so desperately needed. The American Psychological Association and the Psychology Committee looks forward to continuing to work with you and the tribal communities to ensure that our youth receive the mental and behavioral health care that they urgently need and deserve.

I must also acknowledge and honor the warrior woman that sits here and her diligence in bringing so much to this table and to our communities. So I honor you.

I am willing and open and eager to answer any questions you have.

[The prepared statement of Dr. BigFoot follows:]

PREPARED STATEMENT OF DOLORES SUBIA BIGFOOT, PH.D., DIRECTOR, INDIAN COUNTRY CHILD TRAUMA CENTER AND PROJECT MAKING MEDICINE, UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

Chairman Dorgan, Ranking Member Barrasso, and members of the Committee, please allow me to express appreciation for the opportunity to speak on behalf of the 150,000 members and affiliates of the American Psychological Association. My name is Dr. Dolores Subia BigFoot and I bring good will from the Caddo Nation of Oklahoma in which I am enrolled and from the Northern Cheyenne Tribe in Montana in which my children are enrolled. I am a child psychologist by training and have devoted 35 years to addressing health disparities in its many forms within our Tribal Nations. Thank you for convening this important hearing to discuss the need to reduce, eliminate, and reveal the devastation of suicide with our American Indian and Alaska Native (AI/AN) youth through the development of federal legislation.

As Director of Project Making Medicine and the Indian Country Child Trauma Center at the University of Oklahoma Health Sciences Center, I profoundly understand the need for safety among our AI/AN youth. There are many diligent and dedicated people who are concerned and working to address this same need for safety, and to provide appropriate mental health and other culturally appropriate interventions that can help prevent suicide. Project Making Medicine is funded by the Office of Child Abuse and Neglect, Children's Bureau, and the Indian Country Child Trauma Center was funded from 2003–2007 by the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Child Traumatic Stress Network. We currently remain a very active affiliate member of this Network, which is an important congressional initiative that works to raise the standard of care for traumatized children and families. It is also important to acknowledge the critical role of SAMHSA's Youth Suicide Prevention and Early Intervention Programs created under the *Garrett Lee Smith Memorial Act.*

Physical, mental, and behavioral health problems continue to affect the AI/AN communities at alarming rates. I am particularly concerned about the disproportionately high prevalence of mental and behavioral health problems among our nation's AI/AN population, including suicide and suicidal ideation. The statistics regarding suicide in the AI/AN communities are astonishing. Research indicates that American Indians account for nearly 11 percent of total suicides in the United States. The suicide rates among youth are also deeply tragic. Of the approximately five million people who are classified as AI or AN in our country, 1.2 million are under the age of 18, which comprises 27 percent of this group. This is particularly significant because in 2006, suicide was the second leading cause of death for AI/AN individuals between the ages of 10 and 34. Furthermore, among AI/AN youth attending Bureau of Indian Affairs schools in 2001, 16 percent had attempted suicide in the 12 months preceding the Youth Risk Behavior Survey.

From 1999 to 2004, AI/AN males between the ages of 15 to 24 had the highest rates of suicide as compared to other age or ethnic groups, 27.99 per 100,000. This age group accounts for 64 percent of all AI/AN suicides. Unfortunately, more than half of all persons who die by suicide in AI/AN communities were never seen by a mental health provider.

Mr. Chairman, as I am sure you know given your steadfast commitment to addressing this tragic problem, high suicide rates have a significant impact on siblings, peers, family members, and communities as a whole.

It is also important to acknowledge the cultural aspects associated with suicide in our AI/AN communities. While progress has been slow in understanding suicide from a cultural perspective, we know that both the historical and current traumatic stressors in Indian Country affect our youth. The self harm responses that they may exhibit are much like those of other individuals exposed to collective trauma, such as service members/veterans, prisoners of war, and first responders (e.g., firefighters, police officers).

Despite the challenges facing our AI/AN communities, we remain optimistic and hopeful. The National Congress of American Indians, along with Tribes and the Indian Health Service, has been formulating best practices related to suicide prevention that will help our youth. These efforts focus on developing a better understanding of what would lead youth to consider suicide. While we know that suicide typically occurs as a single individual act, suicide cannot be understood in isolation. Instead, we must consider a variety of precipitating factors, including child maltreatment, family violence, mental health problems, trauma, loss, grief, and pain that are associated with feelings of hopelessness and a lack of safety among our youth.

The unfortunate and often forgotten reality is that there is an epidemic of violence and harm directed towards this very vulnerable population. AI/AN children and youth experience an increased risk of multiple victimizations. Their capacity to function and to regroup before the next emotional or physical assault diminishes with each missed opportunity to intervene. These youth often make the decision to take their own lives because they feel a lack of safety in their environment. Our youth are in desperate need of safe homes, safe families, and safe communities.

Chronic underfunding of tribal community programs and a lack of infrastructure and human resources create barriers for AI/AN youth. We must provide appropriate resources and opportunities to immediately empower and support our population to build their capacity to address the needs of our youth. Currently, there are an insufficient number of psychologists and other mental health providers of Indigenous heritage. Two vital federal initiatives in place to help address this problem are the Indians Into Psychology Program and the Minority Fellowship Program, funded by the Indian Health Service and SAMHSA, respectively. These programs have a strong history of success and are critical to building the ethnic minority pipeline. As such, it is important that increased funding is provided to these initiatives to meet the current mental and behavioral health needs of our population. At the same time, while we work to build a sufficient professional workforce, tribal communities require immediate and innovative resources to meet the urgent needs of our youth and families.

At the University of Oklahoma Health Sciences Center, we are currently utilizing a video conferencing system through the Internet in which we are training via real time mental health providers in tribal communities in Washington State. In the past, we have trained via Internet tribal providers located in Alaska, California, Utah, and across Oklahoma. The National Child Traumatic Stress Network is also developing a sophisticated distance learning system that can help providers access the specific training they need when working with AI/AN youth and families. I strongly recommend the continued support and expansion of the National Child Traumatic Stress Network as an important resource to ensure that we have a na-

tional infrastructure of child trauma experts and providers who can help to meet the diverse needs of our youth.

This past June, we traveled to Anchorage, Alaska to provide a Mental Health First Aid training for individuals from the villages or Native corporations who were interested in developing basic skills in assisting those experiencing mental or behavioral health problems, including suicide risk. Unfortunately many village providers and other village helpers who expressed interest in the training were unable to attend given the lack of transportation resources. With telehealth capability, such barriers might be overcome to enable the delivery of critical mental health and suicide prevention education and training in remote or less accessible areas and to large groups of community members.

We appreciate your efforts in developing the *7th Generation Promise: Indian Youth Suicide Prevention Act of 2009*. This legislation aims to increase and enhance the provision of mental health care to AI/AN youth by decreasing disparities in access and improving quality of mental health care. We look forward to working with Congress, the Indian Health Service, the Children's Bureau, and SAMHSA as this proposal moves through the legislative process.

Mr. Chairman, Ranking Member, and members of the Committee, I am honored, my family is honored, and my tribe is honored by this invitation to join you here today. The American Psychological Association and the psychology community look forward to continuing to work with you and the tribal communities to ensure that our youth receive the mental and behavioral health care that they urgently need and deserve. I would be pleased to answer any questions.

Attachment

Trauma Exposure in American Indian/Alaska Native Children

Dolores Subia BigFoot, PhD, Sadie Willmon-Haque, LCSW, and Janie Braden, B.A.

American Indian/Alaska Native Children

- 4.4 million American Indian/Alaska Native[1] (AI/AN) persons in U.S.; 1.5% of the U.S. population (1).
- 562 federally recognized tribes, 225 Alaska Native entities
- About 27 percent of the American Indian and Alaska Native population was younger than 18, compared with 25 percent of the total population (2).

What is Trauma in Indian Country[2]?

A unique individual experience associated with a traumatic event or enduring conditions, which can involve an actual death or other loss, serious injury, or threat to a child's well-being (3), often related to the cultural trauma, historical trauma, and intergenerational trauma that has accumulated in AI/AN communities through centuries of exposure to racism, warfare, violence, and catastrophic disease (4).

How Trauma is Experienced in Indian Country

- A single event (car accident, rape);
- Prolonged experience (historical events such as the removal from homelands, ongoing sexual abuse);
- Cumulative effects (high rates and exposure to violence, such as domestic violence and community violence);
- Personal events that impact several generations (boarding schools, massacres, forced relocation, early losses);
- Youth suicides and multiple suicides;
- Violent deaths (homicide; suicide; unintentional injuries); and
- Multiple victimization (two or more different types of victimizations).

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[1] American Indian and Alaska Native are terminology to designate the Indigenous People of the United States with the following terms used interchangeably with tribes, Native, Native people, and Indigenous people.

[2] "Indian Country" is defined by Chapter 18, Section 1151 of the United States Code. In simple terms, Indian Country is any land granted by treaty or allotment to Native American nations, tribes, reservations, communities, colonies, or individuals and recognized by the federal government. There are about 285 federally recognized reservations, colonies, and communities in the United States. Reservations may consist of two or more traditional tribe s because of relocation dating from the 1800's.

Oppression and Limited Infrastructure Increase Vulnerability of AI/AN Youth

Lack of Mental Health Services

- 100 AI/AN mental health professionals available per 100,000 AI/ANs, compared to 173 per 100,000 for Caucasians (5).
- More than 55% of AI/ANs rely on Indian Health Service (IHS) alone for their health care needs (6).
- Only 28% of AI/ANs have private health insurance (6).
- Most adolescents with substance use disorders are referred to one of 12 Indian Health Service funded residential treatment facilities which are often geographically distant from their own communities (7).
- Cultural traditions are the preferred method of healing for mental health or substance abuse problems for many AI/ANs (8).

Education

- AI/ANS are overrepresented in special education with significant variations among states; for example, 39% of AI/AN students in Florida have some type of disability where no AI/ANs in the District of Columbia were identified (9).

Poverty

- In 2006, 40% of AI/AN children lived in poor families (10).
- AI/AN children live in single parent families at the highest rates in the U.S. (2).
- The adolescent birth rate for AI/ANs (69/1000) is higher than the national rate (49/1000); births to AI/AN women younger than 20 years of age (1 in 5) is higher than the national rate (1 in 9) (11).
- While representing less than 2% of the U.S. population, it is estimated that AI/ANs constitute 8% of Americans who are homeless (12).

High Death Rates

- In 2003, AI/ANs were 1.5 times more likely to die from unintentional injuries (56.9 per 100,000) compared to all races combined (37.2 per 100,000) (13).
- AI/AN infant mortality rates were 1.6 times higher than non-Hispanic Caucasian rates (13).
- In 2001, AI/ANs had the highest rate of sudden infant death syndrome (SIDS) of all racial/ethnic groups (124.2 per 1,000 live births), 2.2 times higher than the rate for all populations (55.5 per 1,000) (13).

Victimization

- Victimization rate of AI/AN children is 20/1000 compared to 10/1000 of non-Hispanic Caucasian children (14).
- Compared to their peers, AI/AN children are at 2.5 times greater risk of experiencing trauma (10).

Chronic Health Problems

- AI/AN children are 2.2 times more likely to have diagnosed diabetes than Caucasian children (15).

- AI/AN adolescents have two to four times the rate of sexually transmitted diseases (STDs) compared to Caucasians nationally and twice the proportion of AIDS compared to their national counterparts (16).

Major Mental Health Problems and AI/AN Youth

Suicide

- In 2001, the suicide rates for AI/AN youth were three times greater than for Caucasians of similar age (19).
- In a survey of AI/AN adolescents (n=13,000), 22% of females and 12% of males reported having attempting suicide at some point (20).
- AI/ANs age 15 to 24 have the highest rate of suicide, 30.7 for AI/AN males and 10.5 for AI/AN females (21, 22).
- The suicide rate among American Indians age 15 to 24 years is more than 3 times higher than that of other young people in the United States (37.4 and 11.4 per 100,000, respectively; Indian Health Service, 2004). Research indicates that 14% to 30% of American Indian adolescents, particularly high school students, attempt suicide (Blum, Harmon, Harris, Bergeisen, & Resnick, 1992; Borowsky, Resnick, Ireland, & Blum, 1999; Freedenthal & Stiffman, 2004; Grossman, Milligan, & Deyo, 1991; Howard-Pitney, LaFromboise, Basil, September, & Johnson, 1992), compared to 4% to 10% of adolescents in the general population (Resnick et al., 1997; Substance Abuse and Mental Health Services Administration, 2002).

Depression

- AI/AN youth have higher rates of mental health and substance use problems than other ethnic groups (17).
- Psychiatric disorders may be common among AI/AN adolescent detainees at a juvenile detention center (18). Of 150 AI/AN youth, 49% had at least one alcohol, drug, or mental health disorder, 12.7% has two disorders, and 8.7% has three or more disorders (18).
- Depression among AI/AN children ranges from 10-30% (5).

PTSD

- In a sample of AI/AN youth, an average of 4.1 lifetime traumas reported, with threat of injury and witnessing injury being the most common form of trauma exposure (23). About 10% of AI/ANs youth in this study met the diagnostic criteria for posttraumatic stress disorder (PTSD) (23).

Child Abuse and Neglect

- Alcohol abuse, related to child abuse and neglect, is more likely to be reported for AI/AN families (24).
- Nationally, when substantiation rates for abuse or neglect of Caucasian children are compared with rates with other children, AI/AN children are twice as likely to be substantiated as abused or neglected (25).
- While AI/AN children represented 1% of the total population under the age of 18, they were 2% of the foster care population in 2000 (25).
- Approximately 1 substantiated report of a child victim of abuse or neglect for every 30 AI/AN children (26).
- For every 1,000 AI/AN children in the U.S. population, 16 were in foster care in 2000, compared with on average, 1 in 7 for all races in the U.S. population (25).

- Among women who had children placed in substitute care by child welfare, AI/AN families were the only group that seemed to have more negative child welfare outcomes (e.g., longer length of stay in substitute care and placement outcomes) (27).
- Violence is more likely to be reported among AI/AN families, both as an element of abuse and/or neglect and in general (24).

Domestic Violence

- AI/AN women are more than 2.5 times more likely to be raped or sexually assaulted than women in the U.S. in general (28).
- In 2005, 39% of adult AI/AN women were victims of intimate partner violence (29).

Substance Abuse

- Tobacco use is considerably higher among AI/AN than Caucasian youth (30).
- Substance use and substance use disorders among AI/AN adolescents are significantly higher than non-AI/AN peers (31, 32).
- 50% of AI/AN youth in treatment for substance abuse have significant untreated psychiatric comorbidity (33).
- Parental histories of problematic substance use and childhood traumatic events are associated with substance use among AI/ANs (34).

See References at www.icctc.org

Resources:

Indian Health Service Suicide Prevention Program
http://www.ihs.gov/NonMedicalPrograms/nspn/

University of North Dakota, Center for Rural Health
http://ruralhealth.und.edu/projects/

Indian Country Child Trauma Center
Center on Child Abuse and Neglect,
University of Oklahoma Health Sciences Center
PO Box 26901 OUCP 3B3406
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The CHAIRMAN. Dr. BigFoot, thank you very much for being with us and for your testimony. I know that the spirit of your son would be very proud of his mother today for being with us.

I think this issue is so difficult, it is especially more difficult when it requires a discussion of a loved one. I have, well, first of all, I have some experience, having walked into a room and found a friend who had taken his own life. So I know something about the shock and the trauma of walking into a room and seeing a friend who has taken his life, something that you never, ever, ever forget.

It is especially tragic when it is a child, because that is someone whose life is in front of them and extinguished because of feelings of helplessness and hopelessness. So what we are trying to think through is, what causes all of this? We understand that part of the roots reflect the difficulties of living in third world conditions. You don't have to go to a third world country to see third world conditions. It too often exists here in America on Indian reservations. I have gone to a reservation where there was a cluster of teen suicides and just sat around a large table with a group of teenagers, no other adults present. And I said, just tell me about your lives. Many of you knew the young kids that took their own lives. Tell me about them, tell me about what you think.

It is an extraordinary lesson to learn from the mouths and the minds of young people, to hear about their existence and their concerns. So there are a number of things, I think, that play a role here. One of the things that I think is a bright spot are the youth clubs and the youth centers and so on that are doing unbelievable work with very little funding and very little accolades for what they do.

We are trying today to think through, what is it we can do. Let me just tell you one more story, then I will ask you some questions. I held a hearing once in Bismarck, North Dakota. It was on the subject, again, an extraordinarily difficult, sensitive subject, and that was child sexual abuse. A young woman testified from one of our reservations. She was in her mid-twenties. And she had been hired on that reservation to work on these issues.

And she was the recipient, then, of the complaints. She began to testify at this hearing. She described that on her desk was a pile of complaints of child sexual abuse that had not been investigated by law enforcement. And she began to describe that just taking one of those complaints and talking to one of those children and finding a need to take one of those children to a professional somewhere in a medical facility, that in order to do that, she had to try to find a way to beg or borrow a car in order to have the transportation to get this person to a professional.

At that point in the discussion she just began to sob and weep, I am talking about the woman on the, in this case, the Spirit Lake Nation. She just couldn't continue, thinking about the impossibility of her job. She quit her job several months later.

But the point is, somewhere stacked in those files was, I am certain, tragedy occurring with a young child, not even investigated. So when we ask the question, what leads to this feeling of hopelessness and helplessness, what leads to suicide, there are many causes, but not the least of which, in my judgment, is just the lack of basic resources that exist routinely and are expected to exist routinely by parents in most other areas in our society. When someone is missing from school 90 days, somebody, somebody is going to track them down, some professional in that school district. But when there are not enough people around to do that job, kids get lost. That is what happened to 14-year-old Avis Little Wind.

Dr. Broderick, you indicated that the time previously, when you testified before this Committee related to fast-forwarding to this point, there has not been any improvement on the subject of Indian teen suicide. Can you expand on that and if that is the case, obviously the question is why?

Dr. BRODERICK. Mr. Chairman, as you know, it is an extremely complex topic that requires, I mean, it has taken a long, long time and much tragedy, much trauma to get there. Standing Rock is an excellent example. We have worked, we at SAMHSA and I know the Indian Health Service as well, have worked closely with the community. They currently have a Garrett Lee Smith suicide prevention grant and yet they still experience a suicide cluster, in spite of the investment of resources. And it tells me that what is needed is a holistic approach that cuts across both public safety and public health programs to address the fundamental needs and the fundamental causes that Dr. BigFoot so eloquently described.

We know that people who have experienced trauma, be it intergenerational trauma or trauma as children are at extremely high risk. Unfortunately, children in Indian communities are oftentimes subjected to such trauma. So I believe that if we use Standing Rock as a case study, in spite of the investment of some resources and establishment of close working relationships with that community, those children still remain at risk. It speaks to the need for a dedicated effort to address the multiple causations and the multiple risk factors that go to contribute to the high rates of suicide that we see.

So I think it calls for not only a redoubling of our effort, but the need to look at all the causes and all the complexities that exist in those communities that have existed there for a long, long time to actually break that cycle.

The CHAIRMAN. Dr. Roubideaux, thank you for your testimony. You are relatively recently nominated and confirmed to your post. But tell me, do you think the issue is substantially additional resources? Condense for me your testimony, if you would, to a couple of paragraphs. What do you think, if you had your choice today and could make that choice, would be the couple of things you think would most affect our ability to reduce the rate of teen suicide on Indian reservations?

Dr. ROUBIDEAUX. I think that the first thing that we need to do is to make sure that we are not all working in isolation on this problem. We have great partnership with SAMHSA, we have a great partnership with our tribes. And working with the local schools, the local justice systems, the local community programs, I really believe that that is going to be one of the major ways to address this problem. We can't solve the problem alone. We have to have partners in this effort.

I am really excited about our new meth and suicide prevention initiative. Now we have 129 new meth and suicide prevention initiatives across the Country that involve work with tribes and the local IHS and other community partners to try to address this problem.

The other major thing we need is just increased access to services. Many of our behavioral health programs are staffed with one clinical psychologist. Many of them have vacancies. And we really do need to find a way to get more access.

I am pleased that the legislation includes the tele-behavioral health and the tele-mental health. Because that is a way that we can increase access to psychiatric and psychological care through a network of resources using technology, so that we could potentially provide 24/7 crisis care if needed. So I think this is an enormously heartbreaking and complex problem. But I think there are things that we can do, if we all put our resources together.

The CHAIRMAN. Are you fighting inside the institution for better funding? I mean, you are part of a process by which you send recommendations up to OMB and then it goes to the White House and then they decide what you are going to have and then you have to come here to this table and say, I support this number, despite the fact it may not be your number at all. You may strongly, profoundly disagree, but you come to support it. That is the way the budget process works. But the first side of that is to be very aggressive, to say, here is what we need to address these issues, one of them being, for example, teen suicide, here is the money, the funding we need for these programs to address teen suicide. You are new to this process, but I assume you fully understand the early role that you will play in this budget process?

Dr. ROUBIDEAUX. Absolutely. I understand the stakes are high and that we play an important role in trying to help understand what resources are needed to adequately and effectively meet the health needs of this population. I am proud to say that for the new budget process, we started by looking at our tribal recommendations for our budget. And I am really pleased with the support that I am seeing in the new Administration and in the Department, as people are trying to understand what our budget needs are. Again, I am also pleased with the support of the President, with his pro-

posed Fiscal Year 2010 budget, a 13 percent increase, which is the highest in over 20 years.

So I am doing my best to be an advocate for the people we serve.

The CHAIRMAN. I should say, Dr. Broderick, thank you for sending the resources you did down to the Standing Rock Reservation, along with the staff of this Committee. That was very, very helpful. We are continuing, and I know with you, continuing to monitor what is happening there.

Dr. BRODERICK. I think, if not today then very shortly, Standing Rock will sign an agreement with the Native Aspirations program to become one of the communities that are involved in Native Aspirations. That is a direct result of your intervention and our trip there. So we are seeing the dedication of additional resources to that community.

The CHAIRMAN. Dr. BigFoot, describe for me, if you would, the child trauma center that you are directing.

Dr. BIGFOOT. The child trauma center is hope. What we have done is we have taken evidence-based practices and culturally adapted them for the treatment of trauma. We have culturally adapted Trauma Focus, Cognitive Behavioral Therapy to Honoring Children, Mending the Circle. We have culturally adapted Parent-Child Interaction Therapy to Honoring Children, Making Relatives. The treatment of Children with Sexual Behavior Problems, we have culturally adapted it to Honoring Children, Respectful Ways, which has two components. One is a treatment component, one is a prevention component.

And then we have taken the American Indian Life Skills Development, in conjunction with Terese LaFramboise, to revise it for lower grades. Because we also discovered that children very, very young, in middle school and younger, were having thoughts of suicide. So we wanted to be able to implement a curriculum that was for younger ages. Then as part of that, we have the Honoring Children, Honoring the Future, which is a suicide intervention and prevention efforts that we have undertaken through the Indian Country Child Trauma Center, which includes consultation to tribes and training. It includes the accessing of resources.

For example, yesterday I was in the State of Washington where they were having an incredible conference with State and tribal agreements as part of the innovation center that is funded by SAMHSA. So I had a presentation on suicide, and one of the things that I did as part of that presentation was bring up the Indian Health Service suicide prevention website, and looked at all the resources that were on there. I had a room full of tribal members from all different tribes in Washington State, and they had no idea of the numerous resources that were available to them, even the simple screening that was on that website that you can access and get training in.

So being able to help tribes look at what the resources are, and I think we have numerous kinds of resources, we have the American Indian Life Skills, we have the different programs like Native Aspirations, we have multiple different programs. But a lot of times, tribal communities are not aware.

The other thing that we do is to assist tribal communities in that healing process so that they can become more proactive. So we help

with healing camps, talking circles, different kinds of culturally-based interventions that are directed to the general population. Because one of the things that we need to recognize is that our tribal communities have always had healing ways.

And even though I am a trained professional, I still am highly respectful of the fact that our tribal communities have ceremonies that are still viable to help to renew and regenerate and heal some of the loss and grief and some of the trauma that individuals and tribes have been faced with. And part of this, in terms of the project Making Medicine funded by the Office of Child Abuse and Neglect of the Children's Bureau is to take these evidence-based practices into tribal communities.

So the culturally-adapted treatment programs were developed under the Indian Country Child Trauma Center funded by SAMHSA. But now we have made a wonderful link to be able to deliver those training interventions to licensed professionals. The problem we have is that we can train about 20 participants a year, and we have to do booster training and we need to do other kinds of things to support. If we only do 20 a year, we are not doing it very sufficiently. But we really try to help tribal communities to build their capacity.

The CHAIRMAN. Thank you very much. It sounds like a really important program that is affecting and improving the lives of a lot of people. Thank you for your work.

I just received a note that a vote is going to start in one minute on the Floor of the Senate. So it worked out pretty well that I could have an opportunity to hear all of the testimony and have all of you be here. We will continue. As you know, Senator Johanns, Senator Barrasso, myself, Senator Tester and many others are very concerned about this issue. We wanted to have an initial discussion today. We intend to proceed with these discussions on the issue of youth suicide. We will continue to work with all of you. We would like to get our legislation enacted this year and try to move forward to make some significant improvements.

So we thank you for testifying. We will hold the record open for any additional submissions for two weeks. This hearing is adjourned.

[Whereupon, at 3:40 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF RENO KEONI FRANKLIN, CHAIRMAN, NATIONAL INDIAN HEALTH BOARD (NIHB)

On behalf of the National Indian Health Board (NIHB), I am writing to submit these comments for the written record of S. 1635 – 7th Generation Promise: Indian Youth Suicide Prevention Act of 2009. Each component of S. 1635 addresses some of the hurdles such as access to care, funding and workforce needs when it comes to deliver the much needed services and treatment in order to prevent suicide among our American Indian and Alaska Native (AI/AN) youths.

We support the creation of the demonstration project to use telemental health services in suicide prevention and intervention for AI/ANs youths. The telemental health project is an innovative way to deliver the services needed in remote tribal communities. However, many Tribes and Tribal organizations that could benefit from this type of project lack the technology now to compete for such grants. We suggest creating additional grants to assist Tribes and Tribal organizations in acquiring and establishing the initial technology in order to support the telemedicine.

We also commend Senator Dorgan for incorporating a provision to address the Substance Abuse and Mental Health Services Administration (SAMHSA) grants process. Some tribes are successful in securing SAMHSA awards. Recent examples include the Kiowa Tribe of Oklahoma and Montana Wyoming Tribal Leaders Council in receiving SAMHSA awards to develop and enhance services to prevent suicide among young people. However, many Tribes and Tribal organizations lack the infrastructure or resources to compete with other entities in securing SAMSHA grants. We applaud the efforts here to require the Secretary to give "priority consideration to the applications of Indian tribes and tribal organizations that serve populations with documented high suicide rates regardless of whether those Indian tribes or tribal organization possess adequate personnel or infrastructure..." This language will be the first step in giving more tribes an opportunity to compete for SAMHSA grant.

We also recommend further expansion of the ability of Tribes to seek grant resources by including Tribes in the definition of "affected states." While the intent specifies that no Tribe shall be required to apply for the funds through a State, it may be more prudent to direct the Agency to include Tribes for granting purposes in any program or project that benefits the target population in the application process. In lieu of States entering into a partnership with the Tribe,

treating the Tribe as a State would more readily create service delivery to the affected population. Creating mechanisms for Tribes to participate in programs in this manner eliminates an extra bureaucratic step in receiving the funds.

NIHB appreciates the emphasis on recruitment of pre-doctoral providers. In prevention efforts, many Tribes must utilize "lay professionals" who receive certification through non-traditional certification process. This inclusion should make FTCA considerations in ISDEA contracting less contentious in negotiation. This is necessary language and creates pathways for suicide prevention providers, like those certified by Upper Midwest Council on Addictive Disorders, to work for the communities that they live in.

Thank you for your consideration. If you have any questions or need additional information, please do not hesitate to contact NIHB's Executive Director, Stacy A. Bohlen, or Government Relations Director, Jessica Burger .

PREPARED STATEMENT OF THE NATIONAL CONGRESS OF AMERICAN INDIANS (NCAI)

On behalf of this country's tribal nations, the National Congress of American Indians (NCAI) is pleased to present testimony on S.1635, the *7th Generation Promise: Indian Youth Suicide Prevention Act of 2009.* The recommendations that we are making are in support of passage of this legislation. We look forward to working with this Committee to ensure that the critical programs and initiatives authorized and supported by this body are implemented effectively by tribal governments.

NCAI is the oldest and largest American Indian organization in the United States. NCAI was founded in 1944 in response to termination and assimilation policies that the United States forced upon the tribal governments in contradiction of their treaty rights and status as sovereign governments. Today NCAI remains dedicated to protecting the rights of tribal governments to achieve self-determination and self-sufficiency.

Background

Suicide has become an epidemic in Indian Country. Native youth are taking their lives at extreme rates. The occurrence of suicidal clusters indicates that Native youth are clearly hurting, and this necessitates an emergency action. For the past 16 years, suicide has been the second leading cause of death (behind unintentional injuries) for Indian youth aged 15-24. The highest rates of youth suicide occur in the Alaska, Aberdeen, and Tucson areas, with rates nearly six to eight times greater than the national average. Although these targeted areas are in critical need of immediate response and resources, we thank the Senate Committee on Indian Affairs for expanding the Indian Youth Telemental Health Demonstration Project to all of the tribes and tribal organizations currently experiencing high rates of suicide through this legislation.

Because our communities are so small, the effects of a suicide are never contained solely within the immediate family. Suicide affects everyone in Native communities. When those who have been affected the hardest are unable to access quality behavioral health care, matters only worsen.

There are prevalent factors in Indian Country that often result in suicide. These factors include depression, alcoholism, and domestic violence- all of which occur at higher rates in Native communities. Attempted suicides are often associated with being female, depression, substance abuse, loss of a family member to suicide, availability of firearms, and a history of physical or sexual abuse. The strongest factor correlated with an attempted suicide is having a friend attempt or complete a suicide. The loss of a friend or family member can often lead to the tragic suicidal clusters that disproportionately plague Native communities.

Until Native communities become safer environments, these alarming suicide rates will persist. Native communities must continue to crack down on substance and domestic abuse in order to safeguard these youth and their futures from potentially dangerous situations. Unfortunately, public safety and law enforcement services suffer from the same chronic underfunding as most other services in Indian Country.

Tribal leaders from all across Indian Country recognize youth suicide as a major problem. Two years ago, Bill Martin, President of the Central Council Tlingit and Haida Indian Tribes of Alaska asked the NCAI to create a tribal leaders task force to address the growing pandemic of youth suicide in Indian Country. Since then, the Suicide Prevention Task Force has been held annually at NCAI Conventions. This Task Force works alongside federal partners and sister tribal organizations in order to more comprehensively address this issue.

The NCAI Suicide Prevention Task Force is responsible for making sure that tribes have the most up-to-date, effective resources for their communities. It also provides an update from partners on the work accomplished over the past year to address youth suicide. The next meeting of the Task Force will be on October 11, 2009, at NCAI's Annual Convention in Palm Springs, California. The Task Force will discuss S.1635 and develop strategies for its successful passage in this Congressional session.

Recommendations

The mental health and substance abuse services currently offered by the Indian Health Service (IHS) are extraordinarily underfunded as are the rest of the IHS programs. This dearth of services provided coupled with an inadequate number of culturally competent providers, is the most pertinent issue to be confronted now.

NCAI has identified some promising responses to address the expanding crisis. These responses include:

- preventative approaches, such as telehealth-based behavioral health services and early diagnosis;
- utilizing the services of pre-doctoral psychology and psychiatry interns; and
- integrating mental and behavioral health throughout the health delivery system.

Telemental Health Services:

Telemental health, which is the provision of mental health services from a distance through the use of telecommunications technologies, is an innovation that helps make available mental health services to rural and frontier populations. These services can be delivered in a number of settings, including rural primary care clinics, hospital emergency rooms, community mental health centers, schools, and nursing homes. Telemental services are bridging the mental health services gap and creating opportunities that have oftentimes been limited in rural areas.

Telemental health services have the potential to dramatically change the lives of Native youth and tribal communities. The majority of our communities are located in rural and remote locations, often with no access to mental health care workers. Telemental health services can deliver child- and youth-specific behavioral services to clinics, schools, and youth treatment centers no matter the distance or the location.

Telemental health services would provide much-needed preventive programs that would be very beneficial for Native youth. Such services include:

- training and support for members of the community who work with Indian youth;
- medical advice and training for health care providers; and
- psychiatric assessments, diagnostic interviews, and therapies.

NCAI believes that the grants awarded through the Indian Youth Telemental Health Demonstration Project provide a powerfully effective means of combating the epidemic rates of suicide in Indian Country. Through the utilization of these services, tribes will have the capacity to decrease the number of youth suicides in their communities.

Among the outstanding benefits of telehealth capabilities is the training of much-needed mental health providers throughout Indian Country. Professional training via the Internet will assist in the following ways:

- identification of suicidal tendencies;
- crisis intervention and prevention; and
- emergency response skill development.

Furthermore, this type of training will help build and expand networking with state and local health service providers. The distance learning programs currently in operation show great promise. It is imperative that these programs continue to grow throughout Indian Country.

Pre-doctoral Psychology and Psychiatry Interns:

While the use of telehealth services is a crucial element in addressing mental health disparities in Indian Country, there is also a chronic shortage of mental health service providers on the ground within the communities. In order to address this disparity, NCAI recommends the recruitment of psychology and psychiatry interns. Generally, interns are more flexible about where they serve. Indian Country internships would be far more attractive to those beginning their professional lives than to professionals who are already comfortably established in less remote communities.

Integration of Mental and Behavioral Health:

Early diagnosis and intervention is another key element in successfully decreasing the high rates of youth suicide in Indian Country. But in order to do this, mental and behavioral health services must be integrated within the overall health care delivery system. A comprehensive behavioral health prevention and treatment program within

the current health care delivery system benefits tribes and tribal organizations immensely. Tribes will then have the capacity to develop, implement, and coordinate suicide prevention activities with other community-based programs. This includes the identification, prevention, education, referral and treatment services tribes need in order to curb the rise of suicide among Native youth.

Conclusion

The opportunities for tribal governments under the proposed *Indian Youth Suicide Prevention Act* have the potential to transform mental and behavioral health services for tribal youth and families in several significant ways. Increasing the use of telemental health services and training, fostering the recruitment of psychology and psychiatric interns, and integrating mental and behavioral health services are some of the most important. NCAI thanks the Senate Committee on Indian Affairs for making this epidemic a priority.

NCAI strongly supports this legislation. NCAI also believes that increasing the collaboration between the Department of Health and Human Services and the Department of Education is an important element in the implementation of programs serving Native communities. As we have seen in other federal programs, tribal governments are ready to apply their expertise and knowledge of their community to develop the most effective programs for their youth. We thank you for the opportunity to share our recommendations regarding the alarming rise in Native youth suicide rates. We appreciate this Committee's support and leadership in these crucial matters.

PREPARED STATEMENT OF GWENDOLYN PURYEAR KEITA, PH.D., EXECUTIVE DIRECTOR, PUBLIC INTEREST DIRECTORATE, AMERICAN PSYCHOLOGICAL ASSOCIATION (APA)

On behalf of the 150,000 members and affiliates of the American Psychological Association (APA), I would like to thank you for the invitation to testify before the Senate Indian Affairs Committee on September 10 regarding the ***7th Generation Promise: Indian Youth Suicide Prevention Act of 2009.*** We appreciate the opportunity to comment further on the critically important issue of suicide prevention in Indian Country, and to specifically discuss some of our association's initiatives to address this most serious tragedy in our country.

APA is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. Comprising researchers, educators, clinicians, consultants, and students, APA works to advance psychology as a science, a profession, and as a means of promoting health, education, and human welfare

APA is working on a number of fronts to address the high suicide rates among American Indians and Alaska Natives (AI/AN). We advocate for strong federal funding of programs that seek to address the mental and behavioral health needs of underserved populations, including AI/AN. These programs include the Garrett Lee Smith Memorial Act's (GLSMA) Youth Suicide Early Intervention and Prevention Strategies and the Campus Suicide Prevention programs as well as the Graduate Psychology Education Program (GPE), the Indians Into Psychology Program (InPsych), and the Minority Fellowship Program (MFP).

The Youth Suicide Early Intervention and Prevention Strategies program, also known as the State/Tribal Youth Suicide Prevention Grants and authorized as part of GLSMA, is available to States, public or private non-profit entities or federally recognized Indian tribes or tribal organizations to combat youth suicide at the critical, early ages. Many of these grants have been awarded to tribes, tribal councils, American Indian schools, and colleges/universities serving American Indian communities.

The grants provide support for a three-year period and promise a significant financial contribution and focus on public-private partnerships for promising Statewide or tribal suicide prevention initiatives. The Campus Suicide Prevention program, also authorized as part of

GLSMA, provides competitive grants to institutions of higher education to support education and outreach activities to students and the broader campus community related to mental and behavioral health, including suicide prevention. These grants have also provided much-needed resources to American Indian communities. As an association, APA was involved from the very earliest stages in advocating for the creation of the *Garrett Lee Smith Memorial Act* programs. Our members lent their expertise in crafting legislative language as well as devoting strong advocacy efforts to ensure passage of this vital law.

The GPE program is a small but highly effective program that supports psychology education and training, and links that training and service provision to high-need areas throughout the country, including American Indian communities. GPE is the nation's only federal program dedicated solely to the education and training of psychologists. The activity is authorized by the *Public Health Service Act* [P.L. 105-392 Section 755 (b) (1) (J)] and funded under the "Allied Health and Other Disciplines" account in the Labor, Health and Human Services, and Education Appropriations legislation.

Established in 2002, the GPE Program provides grants to accredited psychology doctoral, internship and postdoctoral training programs to support the training of psychology graduate students with other health professions while they provide supervised mental and behavioral health services to vulnerable populations, such as older adults, children, the chronically ill, and victims of abuse and trauma, especially in rural and urban underserved communities. There have been GPE grants in American Indian communities and these grants have provided support as well as direct services to those in need.

The InPsych Program was established to more effectively address the disproportionate prevalence of behavioral and mental health issues within the AI/AN populations. This important initiative addresses four major issues: insufficient number of mental health professionals in American Indian communities; insufficient number of AI/AN mental health professionals; substandard availability of quality mental health services in Indian country; and insufficient cross-training in mainstream psychology.

The Program is designed to recruit AI/AN undergraduate students into psychology programs, and recruit and train American Indian graduate students into clinical psychology programs. The ultimate goal of the program is to increase the number of trained AI/AN clinical psychologists to meet the disproportionate mental and behavioral health needs of the AI/AN population. Training and recruiting AI/AN to provide behavioral and mental health services to reservations substantially increases the utilization rate of these services and improves their quality by assuring the provision of services by culturally competent trained professionals.

The MFP is administered by the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration. This vital program has succeeded in educating ethnic minority mental health professionals and in producing leaders in the mental health field. To date, 1,650 individuals have received fellowships across the disciplines of psychology, psychiatry, nursing, social work, and marriage and family therapy.

Recipients of this fellowship provide leadership in service delivery to minority populations in a variety of settings, including hospitals, clinics, neighborhood health centers, counseling centers, schools, universities, federal and State government agencies, and correctional facilities. In addition, fellows have provided leadership in mental health recovery efforts during critical moments such the tragic events of 9/11 and Hurricane Katrina.

The MFP program promotes diversity among health professionals trained to work with ethnic and racial minorities and helps to reverse and eliminate disparities in mental health services and increase the quality of those services to minority populations by training minority mental health professionals to provide culturally competent, accessible mental health and substance use services for diverse populations. The Program represents a cost-effective way to address some of our most serious public health challenges.

Individual APA members are also making meaningful contributions in addressing the mental and behavioral health needs of Americans Indians. For example, Tami DeCoteau, Ph.D., is one of many APA members who are committed to improving the mental and behavioral health needs of Americans Indians. Dr. DeCoteau is an enrolled member of the Turtle Mt. Band of the Chippewa Indians. She is currently the training director for the Standing Rock Psychology Internship program. Dr. DeCoteau works collaboratively with the Standing Rock Sioux Tribe and Indian Health Services to provide culturally sensitive mental health services through the training of predoctoral psychology interns. Through her work, she is making a significant difference in her community.

In addition to the individual work of our members and our own efforts as an organization, APA also works in coalition with various organizations committed to promoting the health and well-being of special populations, including AI/AN. For instance, APA is a member of the Mental Health Liaison Group, the National Child Abuse Coalition, the Campaign for Mental Health Reform, and the National Consortium for Child and Adolescent Mental Health Services. As an active member of these coalitions, we have focused collective attention and have dedicated efforts to addressing the unique issues facing the AI/AN communities, including suicide prevention.

In closing, we would like to thank you once again for the opportunity to share with you some of our current initiatives to address the tragedy of suicide among American Indians. We welcome the opportunity to work with you on this and other critical issues impacting the American Indian community. For further information, please contact Annie Toro, J.D., M.P.H., in our Government Relations Office.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO DOLORES SUBIA BIGFOOT, PH.D.

1. **Youth Suicide:**
   - As a child clinical psychologist, what do you believe are the biggest barriers to addressing tragic rates of youth suicide in Indian Country?

In my personal and professional opinion, and not representing any polices of any organizations, the biggest barriers are:

- there is not a comprehensive approach to address the precipitating trauma and mental health issues that leads to suicide ideation, attempts, or completions;
- the lack of understanding the relationship surrounding violence, trauma, and lack of safety that precedes suicide;
- the misguided focus on criminalizing youth who find themselves in the juvenile justice system when most youth have been repetitively victimized and their needs are largely unmet;
- the lack of understanding that when community members become desensitized to escalating violence and violent acts, the next step of harm, even self harm becomes acceptable and fatalistic;
- the difficulty in implementation of culturally appropriate evidence-based prevention and treatment approaches by programs and agencies when resources are fully developed and readily available;
- the strong focus on preventing and treating deficits and problems without equal attention to the promotion of resiliencies and strengths in individual American Indian and Alaska Native youth, families, and communities.
- the lack of sufficiently trained professionals and support by administration to address mental health issues with effective interventions even when the interventions are readily available,
- the intense siloing of programs within the American Indian and Alaska Native community makes it difficult to collaborate across formal and informal sectors of the community;
- the lack of involvement of tribal and village citizens in the processes of needs assessment, strategic planning and implementation of activities;
- the multiple demands at the tribal and community leadership level which makes it extremely difficult to prioritize psychosocial needs;
- the lack of economic development and infrastructure in vulnerable and poverty stricken American Indian and Alaska Native communities;
- the need to address suicide as a public health issue rather than primary mental/behavioral health focus, that would lend to community awareness, community readiness, and advance the community role of ownership and participation; as well as data collection;
- the breakdown of family structure and support, which in turn grows into the next generation's lack of coping skills, confusion about identity, and inability to communication appropriately; and

- the need to define the terminology of Medical Examiners or Forensic Scientist for determining probable causes of death and race of individual; when terms such as accident, unknown, or inconclusive are used, the lack of specific cause interferes with proper data collection or results in inaccurate and/or loss of numbers regarding intentional injuries, and also can be reflected in the incorrect identification of race.

- What are the most important activities that some organizations are engaged in to address youth suicide rates among American Indians and Alaska Natives?

  According to the public information available on various websites and the activities I am most familiar with, I can describe the following:

  - The APA has been very diligent about addressing health disparities among all disadvantage groups. Specifically, the APA-accredited training programs for psychology provide financial and mentoring support through the Minority Fellowship Programs (MFP), as well as support for the Indian into Psychology (INPSYCH) programs that training American Indian and Alaska Native graduate students in psychology. APA has a formal policy on recruitment and retention of AI/AN students into psychology. APA monitors health-related policy action. For example, APA has supported and will continue to support the passage of the IHCIA, and it is formulating a position on the recent Health Care Reform bill as it effects health disparities among all at-risk populations.
  - APA sponsored my testimony at the Senate Committee on Indian Affairs, as well as prior testimony by APA members at other hearings on suicide and health disparities.
  - APA recognizes that behavioral health disparities are a result of complex interrelated phenomenon, such as self-harm, self-injury, substance abuse, depression, anxiety, domestic violence, and suicide.
  - APA publications have raised awareness of the issue of suicide and self injurious behaviors (APA Monitor, 2009; Mental Health Care for Urban Indians, 2006).
  - APA has collaborated with other professional associations and organizations (NCTSN, APSAC, First Nations Behavioral Health, Society of Indian Psychologists, OneSky Center) to support mentoring and recruitment of American Indian and Alaska Native students into psychology and to create a better understand of the policy change necessary for effective programs and interventions.
  - A major problem is the lack of consistent funding over a lengthy period of time to establish and sustain viable programs that community members will have confidence in and is accessible for prevention, intervention, and support.

- **Telemental Health:** As the director of Project Making Medicine and the Indian Country Child Trauma Center, you work with telemental health programs and other youth suicide prevention efforts implemented in Indian Country. Can you elaborate on the telemental health work in Indian Country?

  As an affiliate of the National Child Traumatic Stress Network, I am familiar with the following activities: The NCTSN sites working with the American Indian and Alaska Native populations have used a variety of interventions and adaptations (including telemental health services) to address substance use, depression, and suicide. For example, an affiliate member of the NCTSN in New Mexico has extensive experience participating in

telepsychiatry services in partnership with the Indian Health Service (IHS) and the State of NM. This center has also recently been awarded a new grant within the IHS Albuquerque Area to develop a "Center of Excellence" for telemental health. Through their University of New Mexico Center, they connect to IHS regional offices, local schools, and school-based health centers to support supervision, consultation, and patient/family interviews. More information about this program can be found at: http://hsc.unm.edu/som/psychiatry/crcbh/Telehealth%20Activities.html.

Our Indian Country Child Trauma Center (NCTSN affiliate) at OUHSC developed an innovative telemental health approach where master trainers at our Oklahoma site coach therapists in training via the internet during live sessions with parents and their children who are located on reservations across Indian Country (www.icctc.org).

- What are the barriers you see to implementing successful telemental health services in Indian Country?

  We have been working to establish a method to train mental health providers with the use of a telemental health network. Our site at the Indian Country Child Trauma Center at OUHSC, is not the only site working to build a telemental health connection. According to the testimony given by Indian Health Service (02/26/09), there are approximately 30 sites utilizing a telemental health network; however they are not all functioning at the same consistent, reliable clinical level. There are small independent connections in place to support fluctuating programming of telemental health services delivered at a specific location. Not all have sufficient logistics, consultation, training, monitoring, coordination, IT support, compliance, security, equipment, facility, and client contact. These independent efforts are often very limited and disconnected from a system wide implementation of which all of Indian Country could benefit.

  The barriers are:
  - Lack of a systematic implementation nationwide for telemental health in Indian Country
  - Lack of sufficient funding for a system to be implemented, established at sites, and functioning at a productive state. It is estimated that it would take $2M annually to build and maintain the system.
  - It is ineffective and counter-productive to provide funds for separate sites to develop a network independently or even when there is a requirement to collaborate since this approach lacks the needed nationwide coordination and implementation (manual development; IT capacity; logistic coordination). Most sites would be working on establishing the same methodology with potentially different criteria for implementation. It would be best to build the system nationwide followed with local customization for services. The local sites should not have to 'reinvent the wheel' in the start-up phases of programming.
  - Many tribal and Native health sites have a simple video conferencing system, but there is a great lack of understanding of what a comprehensive, functioning telemental health network design needs to reach full, effective capacity. Videoconferencing is simply the technology that allows service capacity to be

coordinated – but we still need the mental health expertise accessible, service, support, security, billing, staff, and the coordinating function.

- States regulate medical services and have different and often conflicting regulations for how cross-state telemedicine care should be managed. Some Tribes and Native organizations are located within more than one state and thus, need to consider application for and maintenance of multiple state medical licenses for providers. This is cumbersome and costly. Federal providers are able to provide services across state lines without this added complexity. Again this re-enforces the need for support for a nationwide approach.
- There are changes needed in the federal system of care to promote sustainability such as improving the ability to bill for tele-health based services and reduce cross-state licensing complications. It is important to note that Medicare and the Veterans Administration reimburses for tele-mental health sessions offered by videoconferencing.
- A central limitation to the expansion of tele-mental health services is the lack of experienced clinical personnel to staff service delivery. The expansion of tele-mental health cannot be separated from the number of clinical staff available to provide services. It is necessary to develop the telecommunications infrastructure but much more is needed for a functioning tele-mental health based service. Consequently, the Indian Health facilities using tele-psychiatry have often not been able to expand services beyond their current levels because there is insufficient funding to increase the professional positions to staff the services. There is a need for HHS and SAMHSA to support programs in carrying out the grants and cooperative agreements through technical assistance and training.
- The training and supervision of paraprofessionals who live in American Indian and Alaska Native communities has not been considered seriously. The workforce needed to address Indian Country's complex needs cannot be built largely on professionally trained behavioral health providers.
- There is no current infrastructure that could support the implementation of a telemental health network plus allow for 3th party payment.

2. **Collaborative Indian Youth Suicide Programs:** S. 1635 emphasizes the importance of consultation and collaboration between youth suicide programs. Recently, federal agencies have begun to form partnerships and networks to exchange data and information in order to maximize youth suicide prevention. For example, the national Strategy for Suicide Prevention is a partnership between Indian Health Service, Centers for Disease Control and Prevention, Department of Defense, Substance Abuse and Mental Health Services Administration, and other agencies.
   - What if any partnerships or collaborative efforts are you aware of and do you feel they are helpful to the overall effort to suicide prevention in Indian Country?

   As I reviewed the resources developed through partnerships and collaborative efforts, many organizations have participated including APA, in addressing suicide and suicide interventions. There are several publications that can guide the continued partnerships and collaborative efforts. The report, a supplement to the 1999 first-ever Surgeon General's

report on mental health, highlights the role culture and society play in mental health, mental illness, and the types of mental health services people seek. It states that even when effective, well-documented treatments for mental illnesses are available, racial and ethnic minorities are less likely to receive quality care than the general population. Overall, only one in three Americans who need mental health services actually receives care. A critical consequence of this disparity is that racial and ethnic minority communities bear a disproportionately high burden of disability from untreated or inadequately treated mental health problems and mental illnesses. Striking disparities in access, quality and availability of mental health services exist for racial and ethnic minority Americans, according to the report of the Surgeon General released in 2001, *Mental Health: Culture, Race and Ethnicity*. Also in that year, U.S. Department of Health and Human Services issued the National Strategy for Suicide Prevention. The Office of the Surgeon General coordinated the efforts of numerous agencies, including SAMHSA, CDC, NIMH, HRSA, IHS, and other public and private partners to develop the first, comprehensive, integrated, public health approach to reducing deaths by suicide as well as suicide attempts. This effort was also pursuant to Congressional resolutions -S.Res 84 and H.Res 212 which declared that suicide was a national problem, requiring a national strategy to prevent its occurrence. In 2003, the President's New Freedom Commission on Mental Health reiterated the call for full implementation of the National Strategy for Suicide Prevention. Another publication in 2004 was the "Cultural Diversity Series: Meeting the Mental Health Needs of American Indians and Alaska Natives," written by Spero Manson with assistance by many others. In this publication he addresses the issues facing this population plus awareness of barriers to services (http://www.nasmhpd.org/general_files/publications/ntac_pubs/reports/native%20american%20FINAL-04.pdf). The One Sky Center has a publication titled, "A Guide to Suicide Prevention (2006) which contains the strategies currently available. Along with all these efforts, current initiatives include the SAMHSA Suicide Prevention programs, grants aimed to improve public and professional awareness of suicide and suicide prevention with the Garrett Lee Smith Memorial Act (GLS) that funds GLS State/Tribal Youth Suicide programs. To build on this effort, The Indian Health Service has a web page titled, American Indian and Alaska Native Suicide Prevention Website (http://www.ihs.gov/nonmedicalprograms/nspn/) which lists numerous efforts and products developed by several programs and organizations or individuals, including members of APA. We need to utilize the resources, consider information coming from individual communities concerning needs and resources, and select those strategies to implement that are a strong match for each community. It is very clear that one organization alone cannot meet the stated needs as described in the Surgeon General Report http://mentalhealth.samhsa.gov/cre/fact4.asp. Equally important are collaborated efforts of the Suicide Prevention Resource Center between many partners (http://www.sprc.org/library/phasp.pdf.) and the utilization of the resources developed to address suicide.

- Who may be providing technical assistance to existing Indian Health Service and Tribal programs for youth suicide prevention?

  According to the APA website, in 2002, Psychologists in Indian Country was established within APA Division 18, Psychologist in Public Service, to provide a network and advocacy forum for psychologists working in American Indian and Alaska Native communities. Member of this APA Division, have described that IHS and tribal health professionals have the opportunity to consult and seek assistance from APA colleagues on multiple concerns including youth suicide. Especially effective is the utilization of the listserv which offers immediate and constant connections among all of its members

to seek and discuss the issues needing immediate attention. This APA network has been instrumental in distributing announcements for crisis teams and deployments into Indian Country when suicides occur or other major crises arise. More information about this can be found at http://www.apa.org/about/division/div18.html.

- Do you have further recommendations for ensuring that government agencies and other organizations work together on youth suicide prevention programs and data collection in Indian Country?

As state by Manson (2006) there is a need for high quality, accurate data that illuminates needs, causal and correlated events, and resources. Tribes and Indian health programs usually lack the infrastructure and/or experience to collect and analyze such data. He suggested that more opportunities should be created for states to collaborate with American Indian Tribes and Alaska Native communities for enhanced data collection. There has been great concern about the lack of systematic data collection from federal agencies, individual tribes, Bureau of Indian Affairs, and Indian Health Service. What is collected is not uniform or collected annually or at regular intervals. For example, the rates for AI/AN adolescent with inappropriate sexual behavior are not available at any level. Most youth who have attempted suicide or youth with a history of residential treatments have indicated that many were victims of inappropriate sexual contact/assault from peers or adults. Many times youth from residential treatment centers are sent directly to residential schools without any follow up or assessment. It is impossible to estimate how many youth are in need of specialized care when data is not available. These are the youth that are at risk for suicide.

3. **Pre-doctoral Psychology and Psychiatry Intern Programs:** S. 1635 includes a section which encourages American Indian Tribes to utilize pre-doctoral psychology and psychiatry interns. Intern programs allow Indian Country to utilize mental health providers still in training that can see patients under the supervision of a licensed health professional.
    - Do you think the initiation of pre-doctoral intern programs will help increase the number of patients accessing care and serve as a recruitment tool for psychologist and psychiatrists?
        - There is a significant need for more mental health providers in the field; the inclusion of pre-doctoral psychology interns and psychiatry residents is important. In building the infrastructure for professionals in training to participate, details must be addressed on the specifics of the program and the funding support necessary to establish the program (financial, clinical supervision, APA accreditation, employee benefits, travel support, state licensure, etc.). For example, if a site is not APA-accredited, it could jeopardize an intern's qualifications for licensure. This is similar to a hospital being accredited for billing procedures or meeting professional standards of operation. Potential trainees would want reassurance that their service would not be detrimental to their professional development and would be a significant recruitment incentive. Soliciting advice from current program directors and former interns or residents would be helpful in solidifying how to operationalize the implement for pre-doctoral interns and psychiatry residents. Creating a positive training experience with sufficient compensation would increase the potential for skilled professionals to remain at sites.

- Given the shortage of mental health professionals nationwide what else do you think IHS and Tribes can do to attract good psychologists?

  Allow me to focus on the need for therapeutic behavioral health services. There are varied levels of therapists that can be attracted to Indian Country; however certain attention should be given to the current and critical problems facing psychologists considering a career within American Indian Tribes, urban centers, or Alaska Native communities:

  A) Position requirements: Psychologists are typically trained to be not just clinicians but also researchers, administrators, and clinician supervisors. Most positions are limited to clinical service which does not utilize the vast skills which psychologists have been trained. Also, most tribes and urban programs advertise for master level therapists. NARCH and NIH-funded research would benefit if PhD level psychologists were involved at the tribal level. This is not possible when the position is limited by a payback agreement restrictions or a description focusing only on clinical services.
  B) Salary limits: Tribes and urban programs typically inform psychologists that they are over trained and are not willing to offer compensation in line with their skill.
  C) Payback programs: Individuals recruited by the Minority Fellowship Program and INPSYCH programs should not be penalized by Indian Health Service once they become psychologists. Currently there are inconsistent policies being administrated by the IHS Payback Program. Also the Payback Program has placed some former recipients into credit default who have willingly met their payback obligation but IHS misapplied different criteria for the payback contracts. Additionally they are not responsive when asked for clarification on the inaccurate interpretations of federal law regarding the payback agreements. IHS Payback Program has been very punitive in its relationship with the recipients of scholarships within its program.
  D) Post-doctoral Fellowships: Provide more opportunity for funding for post-doctoral fellowships to get the necessary clinical supervision for licensure, more specialized training in evidenced-based approaches, and more opportunity to build a network of support for addressing professional isolation and the management of difficult cases.
  E) Discrimination in APA clinical programs designation: There has been a changed in eligibility of which graduate programs in psychology qualify for scholarship money for their students. I graduated from a counseling psychology program at the University of Oklahoma that is APA-accredited program; which is the same accreditation for clinical psychology programs. However, counseling psychology graduate students are not eligible for the same financial support as clinical psychology students. This exclusion discriminates against graduate students who are meeting the same qualification in a graduate program from benefiting from the funding sources available but limited to clinical psychology students.
  F) Master Level Therapists: Increase the opportunity for BA/BS level individuals to acquire master level clinical training. Many students are eager to progress beyond the initial degree but need financial support.
  G) Do not over burden currently employed psychiatrists and psychologists by allow them respite care that does not penalize them.

- There are a few pre-doctoral sites currently functioning that offer culturally-specific training for pre-doctoral students to work in American Indian and Alaska Native settings. One is the Standing Rock Sioux Tribe Internship and Postdoctoral Programs directed by Tami De Coteau, PhD.; another is the Indian Health Care Resource Center in

Tulsa, Oklahoma, that will have 2 pre-doctoral interns starting next year (2010-2011 internship year). They are part of Northeastern Oklahoma Psychology Internship Program (NOPIP). Here is the link to the accreditation site for internship at the Association of Psychology Postdoctoral and Internships Centers (APPIC) http://appic.org/directory/program_cache/1105.html which provides the protocol for applying for post-doctoral and internship sites.

The focus on pre-doctoral and psychiatric interns is important; as the details are considered, it is important to address specifics of the program and the funding support necessary to be able to provide such services. Currently there is not sufficient detail, authority, or encouragement with funding or resources to operationalize the program into practice. When considering funding and resources for internship training programs, issues such as student compensation and benefits, culturally-proficient clinical supervision, training needs, and promoting accredited programs are essential to increase recruitment and retention. Current programs would be a helpful resource to use in developing the methods for implementing this effort.

Response to Written Questions Submitted by Hon. Tom Udall to Dolores Subia BigFoot, Ph.D.

4. What role do you see for a community-initiated, high-school program that addresses the challenges in learning effective coping and problem solving skills for American Indian and Alaska Native youth, say one that would include classroom curriculum for skill building, peer education, and interventions specifically tailored to tribal beliefs?
    - The efforts with the community at the high school level are critical; however, the programs that emphasize learning skills and developing supportive personal networks should be initiated much earlier. Many discussions with people in the tribal and village communities stress that prevention programs are needed in the elementary and middle school grades. Students as early as in 6-7-8 grades are expressing the desire toward self-injury and self-harm; by the time they are in high school they have "rehearsed" many times over their thinking and behavior that killing one's self is the only solution. Evidence-based curricula, such as the American Indian Life Skills Development with family involvement, does make a difference. We have programs that are effective, we need to implement them earlier and have community-trained interventionists who can provide the supportive network for young students and their families. On the Omaha Reservation in Nebraska, with the Kiowa Tribe in Oklahoma, and in various tribal communities in Oregon, the American Indian Life Skills intervention has been established, either in the schools as part of the health class, at Boys & Girls Clubs, or just by parents using the workbook at home with their children. The benefit of structured curricula, is to provide a framework that is sequential and consistent with the message---"youth are worthwhile." We know what works, we need to reach youth earlier and be more consistent in the delivery of the interventions for the duration of several years. Many programs are not sustainable after federal funds end because there are not sufficient private businesses or organizations in tribal communities that can support services needed. We need a long period for implementation to allow the curriculum to be institutionalized in schools or youth organizations. The 3-year period of implementation does not allow sufficient time for the buy-in of the intervention across sectors in a given community for wide-spread sustainability.

5. What do you see as the role of families, businesses, community leaders, and others as we create a protective environment for our children to strengthen mental health and reduce risk factors for mental illness and suicide?

There needs to be a higher level of accountability to decrease the level of violence and trauma; we need to feel as tribal communities and parents that we have a right to parent our children in safe and healthy communities. Unfortunately, we are focusing on incarceration, containment, and criminal behavior. More attention is being directed toward juvenile detention then school achievement and retention. The detention-focused message is a message that hope is lost and all paths leads toward negative outcomes. The Adverse Childhood Experience Study (ACE Study, CDC-2005) has confirmed that events such as violence, substance abuse, child maltreatment, physical and sexual assaults, and other earlier child hood experiences affect positive mental health from adolescence into adulthood. According to the President New Freedom on Mental Health (2002), most American Indian and Alaska Native youth receive inadequate mental health care in the juvenile detention system. We need a better method for caring for AI/AN youth outside the juvenile detention.

A public health approach to address behavioral health is needed. American Indian and Alaska Native societies, small and large, have acquired gloomy attitudes and misunderstandings that are not life- or culturally re-affirming. Our American Indian and Alaska Native communities would greatly benefit from social marketing and media campaigns that raise vital issues of trauma reactions and advocating for trauma and violence reduction. Youth involved in developing campaign materials, especially those that involve technology, are excellent resources toward engagement and building a positive knowledge base.

I realize that suicide prevention and intervention is an ongoing process that is building momentum. On February 26, 2009, the Oversight Hearing on Youth Suicide in Indian Country received testimony from family survivors of suicide, tribal leaders, developers of suicide strategies, and researchers. I am anxious; I want more to be done even when I see the building the collaborations among key players is occurring. I would like the Senate Committee on Indian Affairs to continue to review the recommendations of the February 26 Hearing while they consider the input from my perspective. The resources that were provided during that Hearing are invaluable.

How do you suggest creating an environment of hope, where our youth have optimism, confidence, and feel valued – that their lives matter, that they can attain their dreams, that there is a future for them worth living for? How we can think more comprehensively about recreating an environment where our American Indian and Alaska Native youth would be less at risk for mental illness and suicide in the first place?

We are focusing on intervening after the fact; significant dollars which are going toward incarceration, detention, and juvenile justice should be shifted toward prevention and treatment. Several tribal juvenile detention centers are being built; the saying applies, "if you build it, they will come." Newly constructed facilities will soon reach capacity, resulting in more misguided decisions to increase prison space again. We are incarcerating and trying to contain traumatized youth because we are overwhelmed by their destructive and illegal behaviors; we are not addressing the underlying causes.
Focus on supporting critical care families; Multi-Systemic Therapy (MST) works with adolescents with their numerous and compounding issues, including dysfunctional and destructive family

relationships. It is expensive initially, but the family is supported over a period with intense interventions that allows for family stability and fewer negative outcomes in the future.
Focus on supporting families at risk: Safe Care and similar evidence-based home visitation programs provide intensive training, consultation, supervision, and support to the interventionists. This quality of program supports the staff resulting in decrease turnover and the common situation of being overwhelmed by needy and demanding families.
Focus on school age children and their parents: American Indian Life Skills Development (or similar evidence-based intervention) is an effective curriculum that can be incorporated into many school curricula or provided at youth based organizations (Boys and Girls Clubs, Unity). Encouraging parental participation has been successful and necessary with any program involving youth. Implementation requires training, clinical consultation, and administrative supervision that supports the institutionalization within the school or program for long term stability and sustainability to be achieved.
Focus on the community: Utilize community based programs, such as Mental Health First Aid (an approach developed out of an Indigenous effort) to train and assist community members in understanding and in responding appropriately to stressful events in their communities. In addition, community members need assistance in addressing their own personal and family trauma; this can be done in a variety of ways. SAMHSA, CDC, and other federal agencies have supported programs such as the Gathering Of Native Americans, the Healing Journey Accord, Adult Children of Alcoholics, and other initiatives directed at health disparities and understanding. The problem is that the events are usually short-term or a one-time effort; more should be in place pre-and post when PTSD surfaces after attending community gatherings to address trauma. Trauma responses are not new; historically, tribes utilized healing ceremonies to address trauma. Healing and supportive ceremonies (spiritual connections) are still effective. Cultural camps held in Montana (Flathead, Ft. Peck, Northern Cheyenne, Ft. Belknap) have been very successful in addressing mental health, grief, trauma, lost, substance abuse, suicide, and child trauma. Unfortunately, only one camp was recently established and the other sites are no long functioning.
Focus on the Tribe: There have been several initiatives in Indian Country, including Health People 2010, or Healthy Indian Country Initiative, which is critical for planning and coordinating how Tribes may approach a particular issue. A few Tribes have a coordinated and developed "State of Tribal Nation Strategic Plan" to address over all issues and solutions; however not all Tribes are addressing the coordinating and developing of all the various programs' goals in a systematic and collaborative effort. It would be helpful to have all tribal programs develop their program goals in consideration of what the overall tribal goals are for their respective communities.
Focused on building enterprise in tribal communities: As stated in one study, Long-term Poverty Affects Mental Health Of Children (*Science Daily*, Feb. 9, 2006): "children in low-income families start off with higher levels of antisocial behavior than children from more advantaged households." And if the home remains poor as the children grow up, antisocial behavior becomes much worse over time compared to children living in households that are never poor or later move out of poverty." (http://www.sciencedaily.com/releases/2006/02/060206171449.htm) Building financial literacy and entrepreneurship among youth is critical.

The conditions in Indian Country are several degrees from the norm for safety and wellbeing compared to historically when Indigenous people were thriving populations. Much of this has its roots in a multitude of cultural and individual assaults. In the recent past, progress has occurred;

however, there is still significant movement that needs to occur to return more fully to that previous norm of cultural balance and safe surroundings.

DISCLAMINER: The content of this written response is the opinion of Dolores Subia BigFoot, PhD, and does not reflect the policies of OUHSC, ICCTC, APA, NCTSN, IHS or any other program or organization. A reference list is available upon request and resource links are available at www.icctc.org.

I wish to thank many who responded to my call to comment or who reviewed these written words of limited wisdom.

This is being submitted with heartfelt remembrances of
Bryce Buffalo Man BigFoot (1975-2008) and the other
cherished children who left much too soon and
for their voices of silent thunder to which we need to heed.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY THE COMMITTEE FROM DR. ELLEN GERRITY

Dr. Ellen Gerrity, Associate Director
Duke University-UCLA National Center for Child Traumatic Stress

Committee Follow-up Questions for Dee Bigfoot, Ph.D.

Telemental Health: As the Director of Project Making Medicine and the Indian Country Child Trauma Center, you work with telemental heath programs and other youth suicide prevention efforts implemented in Indian Country. For example, in your testimony, you discussed the National Center Child Traumatic Stress Network and this program's telemental health efforts.

- ***Can you elaborate on the telemental health work at this Network?***
- ***What are the barriers you see to implementing successful telemental health services in Indian Country?***

Question 1: Can you elaborate on the telemental health work at this Network?

A central feature of the National Child Traumatic Stress Network (NCTSN) is the distance learning and web-based resources that provide education and training opportunities for providers who deliver services to children and families affected by trauma. The National Center for Child Traumatic Stress (NCCTS) coordinates these efforts and provides the infrastructure for these online services, as well as the in-person Learning Collaboratives that are supplemented by tele- and videoconference. These services provide many long-distance supports for the therapeutic services that take place at the Network Member Centers.

Background on the NCTSN: Established by the U.S. Congress in 2000, the NCTSN is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families in the U.S. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the CMHS/SAMHSA-funded initiative serves as a national resource for developing and disseminating evidence-based interventions, public and professional education, and trauma-informed services to children and their families. Together with the NCCTS, the 100+ member centers--including currently funded and affiliate (unfunded) members--work collaboratively within the Network and in their communities to create and support sustainable, mutually beneficial relationships with governmental and non-governmental bodies, comprising a dynamic range of international, national, tribal, regional, state, county, city and other local community partnerships.

The NCTSN has several funded and affiliate member Centers on tribal lands, as well as other Centers who work collaboratively with AI and AN children and families. Through the NCCTS Core Data Set (CDS), the National Center is tracking the impact of trauma on AI/AN children. For example, of the 247 AI/AN children currently enrolled in the CDS, only about half had been receiving any services from any child-serving system prior to

treatment at the NCTSN program. The most commonly reported traumas experienced by the children were traumatic loss, having an impaired caregiver, and domestic violence, and most (85%) had multiple trauma exposures. Most of the children had problems in many areas of life (home, school, relationships), and suicidality was reported for 10%. The predominant mental health issues documented at the baseline CDS interview for AI/AN children were PTSD, traumatic bereavement, depression, attachment problems, and general behavioral problems.

Telemental Health Resources and AI/AN Issues: A major part of the work of NCCTS is provided through the NCTSN website (www.nctsn.org), the NCTSN Knowledge Bank (resources related to AI/AN issues are at http://kb.nctsn.org/SPT/SPT--BrowseResources.php?ParentId=239), and the NCTSN Learning Center (http://learn.nctsn.org) where online training opportunities, speaker series, and informational resources can be accessed on a variety of trauma topics. Established in 2009, the NCTSN Learning Center has registered over 5200 participants to date, and participants can view any of the 65 Speaker Series presentations by child trauma experts that have been produced and archived, and receive free CE credits. Currently, 7 topical Speaker Series, including one on culture and trauma, are offered, with several more in development. A presentation by Dr. Bigfoot is one of many presentations on culture-related issues; she spoke on "American Indian Youth: Current and Historical Trauma." Dr. Bigfoot's presentation has been viewed by several hundred Network members and other participants, and remains accessible on the NCTSN website.

The sites working with the AI/AN populations have used a variety of interventions and adaptations (including telemental health services) to address substance use, depression, and suicide. For example, an affiliate member of the NCTSN in New Mexico has extensive experience participating in telepsychiatry services in partnership with the Indian Health Service (HIS) and the State of NM. This center has also recently been awarded a new grant within the Albuquerque area of the IHS to develop a "Center of Excellence" for telepsychiatry. Through their Center, they connect to IHS regional offices, local schools, and school-based health centers to support supervision, consultation, and patient/family interviews. Through this work, the NCTSN can gather more information about the elements of telepsychiatry that are most effective for AI/AN children and families, and those who work in partnership with them. More information about this program can be found at:
http://hsc.unm.edu/som/psychiatry/crcbh/Telehealth%20Activities.html.

In addition to information provided by Dr. Bigfoot, additional information about NCTSN experiences with the challenges of telemental health-related services is included in response to Question 2 below. For further information about telemental health at the NCTSN, visit the NCTSN website at www.nctsn.org or contact Dr. Ellen Gerrity, NCCTS Associate Director at Duke University, at egerrity@psych.duhs.duke.edu.

Question 2: What are the barriers you see to implementing successful telemental health services in Indian Country?

In addition to information provided by Dr. Bigfoot, other NCTSN members who have experience with providing support services related to telemental health services for

children and families in Indian Country, provided details about specific challenges and barriers to the use of telemental health services, as follows:

- Trust and Stigma: A critically important element to successful telemental health is the establishment of trust between the provider and the individual receiving services. For these technological services to be effective, the individual needs to know and trust the person providing the service. The issue of trust is related to stigma, which can be a powerful communal issue in Indian Country, as are confidentiality and privacy. These cultural issues are critically important to the success of telemental health service delivery. Network members emphasized that the most serious barriers are cultural and less an issue of structure (such as connectivity issues). In Indian Country, work is dependent on relationships, and an essential component is the face-to-face experience. Therapeutic work requires regular personal contacts, long-distance travel, and "visiting," and the more this can happen, the more likely success can be achieved. The personal contact is essential.
- Both in-person therapy and telemental heath services rely heavily on necessary follow-up services that are supported by technology, such as telephone, video link, other internet-supported communication, and perhaps even for follow-up telemental health therapy, once the relationship is established. These tools can be used to provide clinical consultation with mental health professionals on topics related to trauma therapy as well as suicide, anxiety and grief. These efforts are supplemented with long distance contact, tele-consultation, supervision, problem-solving discussions, etc. Teleconferencing and videoconferencing have been helpful for these purposes.
- In the geographic regions of these Centers, many people are tech-savvy in their personal and professional lives. However, connectivity is very variable, with some places (such as schools and tribal colleges) sometimes having very good internet connectivity, and other, more rural areas having poor internet connectivity. This is an area that needs continued improvement.
- Other significant barriers include very spotty and often non-existent cell phone coverage. Although efforts to improve this problem are underway in related economic stimulus efforts, the infrastructure of cell phone coverage is a critical element in achieving success with tele-mental health services. This connection is very important for supervision and consultation efforts, health-behavior check-ins, and preventive work with clients or patients.
- It is also important to note that the law and standards of professional practice are lagging with regard to tele-practice and tele-supervision, and this is a concern when working with clinicians within or across states. The issue remains about how various kinds of clinical responsibility and associated issues work in telemental health situations.

WRITTEN QUESTIONS SUBMITTED BY THE COMMITTEE TO HON. ERIC B. BRODERICK, D.D.S., M.P.H. *

Questions from Senator Dorgan:

1. **SAMHSA Work in Indian Country.** S. 1635 calls upon SAMHSA, as the agency dedicated to substance abuse and mental health, to enhance the mental health care provided to Native American communities.

   - Do you think that S. 1635 will assist SAMHSA and Indian Country in addressing the mental health needs throughout Native American communities?
   - What other tools do you think are needed to assist SAMHSA change the disturbing trend in youth suicides among Native Americans?
   - S. 1635 suggests that SAMHSA monitor suicides in Indian Country, while respecting tribal sovereignty and consultation requirements. How would SAMHSA go about fulfilling this requirement? Would this requirement fit better within an agency other than SAMHSA, such as the Centers for Disease Control and Prevention or the Indian Health Service?

2. **Youth Suicide Risk Factors and SAMHSA Grants.** Several important risk behaviors associated with suicide are more prevalent in Indian Country, making the population more at risk. Some of these risk factors include alcohol and substance abuse, gang activity, isolation, high unemployment, domestic violence and barriers to effective mental health services.
   - Currently 18 Indian tribes receive Garrett Lee Smith grants for suicide prevention. Do you think programs funded by Garrett Lee Smith grants have been successful at addressing the multiple risk factors affecting suicide rates?
   - Do you think more comprehensive programs are needed through SAMHSA to address the vast risk factors for suicide? Please explain.

3. **Priority for Indian Tribes.** A section of S. 1635 requires that SAMHSA grants for youth suicide be prioritized for Indian tribes and tribal organizations with high youth suicide rates. The bill says that the priority should be given regardless of resources or infrastructure. The goal is to protect disadvantaged Tribes. For

* Response to written questions was not available at the time this hearing went to press.

example, there are tribes which lack access to the internet necessary to apply for grants electronically or disease data tracking capability to fulfill the grant expectations and requirements.

The federal government has an obligation to provide health care to Native Americans regardless of their telecommunication abilities or other infrastructure. The relationship with tribes is a government-to-government relationship.

- Since, data shows that Native Americans, especially the youth, suffer disparities in substance abuse, mental health and the incidence of suicide much higher than other populations, do you feel it is justified to give tribe's and tribal organization priority?
- Would giving Indian tribes' priority, regardless of infrastructure, be a way to ensure Native Americans receive the services they need? If not, what would you recommend?

4. **Pre-doctoral Psychology and Psychiatry Intern Programs.** S. 1635 includes a section which encourages Indian tribes to utilize pre-doctoral psychology and psychiatry interns. Indian Country faces extreme shortages of mental health professionals. Intern programs allow Indian Country to utilize mental health providers still in training that can see patients under the supervision of a licensed health professional. The initiation of pre-doctoral intern programs will help increase the number of patients accessing care and serve as a recruitment tool for psychologists and psychiatrists.

   Standing Rock has implemented a pre-doctoral psychology intern program and has been able to triple their patient load as a result. In addition, multiple interns have agreed to stay on and continue to practice mental health on the Reservation when they are licensed. The Veteran's Administration has also seen success with intern programs.
   - Do you see a potential for pre-doctoral health programs improving health care provided to Indian Country?
   - Do you see SAMHSA getting more involved in implementing intern programs?

Questions from Senator Udall:

1. What role do you see for a community-initiated, high-school program that addresses the challenges in learning effective coping and problem solving skills

for Native youth, say one that would include classroom curriculum for sill building, peer education, and interventions specifically tailored to tribal beliefs?

2. What do you see as the role of families, businesses, community leaders and others as we create a protective environment for our children to strengthen mental health and reduce risk factors for mental illness and suicide?
3. Reducing administrative barriers for Tribal leaders to apply for and receive grants for youth suicide prevention, as well as on other issues, will help increase grant programs for Native communities. You might have noticed other ways, such as targeted technical assistance, that might strengthen the quality and competitiveness of grant applications from Tribes. Can you identify other strategies to improve the success rate of Native Peoples' grant applications?
4. What have we already learned from previous suicide prevention programs for Native youth that may inform our thinking about other suicide prevention strategies and mental health promotion for AI/NA's?

WRITTEN QUESTIONS SUBMITTED BY THE COMMITTEE TO HON. YVETTE ROUBIDEAUX, M.D., M.P.H. *

Questions from Senator Dorgan:

1. **IHS and Youth Suicide.** In 2003, the IHS began a suicide prevention initiative which includes: IHS Suicide Prevention Committee (SPC), a working group, website, annual conference and other efforts. Also IHS has an Emergency Medical Services and Preparedness Division which supports Indian communities by implementing the IHS Emergency Response to Suicide Model during a rise in incidence of suicide in an Indian community.

   This year there have been suicide clusters identified in North Dakota and South Dakota. On the Standing Rock Sioux Reservation there have been 53 attempted and 10 completed suicides this year. Also, on the Cheyenne River Sioux Reservation there have been 3 completed suicides in the recent weeks.

   - As a clinician, researcher and now IHS Director what do you believe are some of the causes of the high suicide rates in Indian Country and how do you plan to address this disturbing trend?
   - In your testimony, you talked about protective factors Native youth have against suicide, like the feeling of belonging to a Tribe and cultural tradition. How do we expand and build upon these protective factors?
   - What do you believe will be the biggest challenge to implementing programs and responding to suicides in Indian Country?
   - Do you have suggestions for S. 1635 which could improve IHS' response?

2. **Telemental Health Demonstration Project.** S. 1635 includes a demonstration project for telemental health services at the Indian Health Service. The demonstration project will award up to five grants, for four years each, to Indian Tribes and tribal health organizations for youth suicide prevention activities. There is an authorization for $1,500,000 for each of the fiscal years the grants would be carried out.

* Response to written questions was not available at the time this hearing went to press.

- Judging from what you have learned from the existing telemental health services at 50 IHS and Tribal facilities, do you think this demonstration project for youth will be successful?
- What additional resources does IHS need to expand telehealth programs, such as this demonstration project?

3. **Consultation and collaboration with SAMHSA.** The telemental health demonstration project section of S. 1635 requires IHS to consult with SAMHSA in the development and implementation of the demonstration project.
   - Aside from collaborating with SAMHSA, what other types of partnerships do you think would be helpful in preventing youth suicide in Indian Country?
   - Do you think collaboration between SAMHSA and other Department of Health and Human Services (HHS) agencies, like the Federal Partners you discussed in your testimony, is beneficial to preventing youth suicide in Indian Country?
   - Do you have further recommendations for ensuring that government agencies and other organizations work together on youth suicide prevention programs and data collection in Indian Country?

4. **Pre-doctoral Psychology and Psychiatry Intern Programs.** S. 1635 includes a section which encourages Indian tribes to utilize pre-doctoral psychology and psychiatry interns. Indian Country faces extreme shortages of mental health professionals. Intern programs allow Indian Country to utilize mental health providers still in training that can see patients under the supervision of a licensed health professional. The initiation of pre-doctoral intern programs will help increase the number of patients accessing care and serve as a recruitment tool for psychologists and psychiatrists.

   Standing Rock has implemented a pre-doctoral psychology intern program and has been able to triple their patient load as a result. In addition, multiple interns have agreed to stay on and continue to practice mental health on the Reservation when they are licensed. The Veteran's Administration has also seen success with intern programs.

   - In your testimony, you discussed the issues IHS faces in recruiting and retaining mental health providers to Indian Country. Are you aware of the programs that currently exist at the Veteran's Administration and at Standing Rock where pre-doctoral psychology and psychiatry intern programs exist?

- Do you see a potential for expanding these types of pre-doctoral health programs as a way to improve heath care in Indian Country by increasing the ability to recruit and retain mental health providers? Do you see IHS getting more involved in implementing intern programs?

Questions from Senator Udall:

5. What role do you see for a community-initiated, high-school program that addresses the challenges in learning effective coping and problem solving skills for Native youth, say one that would include classroom curriculum for sill building, peer education, and interventions specifically tailored to tribal beliefs?
6. What do you see as the role of families, businesses, community leaders and others as we create a protective environment for our children to strengthen mental health and reduce risk factors for mental illness and suicide?
7. Beyond the scope of the proposals specifically in this bill, can you comment on what the IHS is able to do to reduce the risk factors that contribute to suicide in our Native youth?

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