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**Written Statement of**

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**On behalf of the**

**American Psychological Association**

**Before the**

**Senate Committee on Indian Affairs**

**on**

***The 7th Generation Promise:***

***Indian Youth Suicide Prevention Act of 2009***

**September 10, 2009**

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 national 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 *7<sup>th</sup> 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.