Testimony before the Senate Select Committee on Indian Affairs
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Good morning, Honorable Chairman Barrasso and Honorable Members of the Committee. Thank you for your invitation to personally testify before this committee and to present my views concerning progress in the area of preventing American Indian and Alaska Native (AI/AN) youth suicidal behavior.

I come before you as a professor of Counseling Psychology, a mother of an enrolled member of the Turtle Mountain Band of Chippewa, the developer and evaluator of a suicide prevention program entitled *American Indian Life Skills,* a researcher of ethnic identity and mental health, and a former elementary and secondary teacher in urban and reservation schools. I hope that my testimony will assist the Committee in taking stock of the potential for evidence-based family, school, and community interventions to prevent mental, emotional and behavioral disorders among AI/AN youth.

In the 21st Century, suicide continues to be a vivid manifestation of distress among Native people. Untimely death accounts for almost one in five deaths among American Indian and Alaska Native (AI/AN) youth 15- to 19-years of age. This proportion is considerably higher than that of youth from other ethnic groups or the general population (CDC, 2006). Completed suicide is 72% more common among AI/AN than the general population (Indian Health Service, 2001). The estimated rate of completed suicides among AI/AN youth ages 5 to 14 years is 2.1

per 100,000, compared to 0.8 per 100,000 for all U.S. youth in the same age group; the rate of completed suicides among AI/AN youth ages 15 to 24 years is 37.4 per 100,000, compared to 11.4 per 100,000 for all U. S. youth in the same age group (Indian Health Service, 2002).

In recent years federal efforts such as the Surgeon General's Call to Action and the National Strategy for Suicide Prevention (U. S. Department of Health and Human Services, 1999, 2001) have reflected the growing concern over youth suicide within the United States. Hearings on Indian youth suicide sponsored by this Committee have provided a forum for grass roots and professional people to advocate for greater attention and services for AI/AN youth who elect not to seek help due to stigma or embarrassment, who seem to lack regard for the lethal consequences of their behaviors, and whose suicidal intent goes unrecognized and thus unappreciated.

Funds appropriated through the Garret Lee Smith Act have served as a catalyst for the mobilization of suicide prevention programs in many AI/AN communities at highest risk for suicide. I have been fortunate to work with three SAMHSA funded programs for Indian youth suicide prevention whereby I designed a Training of Trainers program with staff from Native Aspirations (Joann Kauffman, PI) to train community members from 30 reservations in regional trainings in Wolf Point, MT, Rosebud, SD, Pine Ridge, SD, and Anchorage, AK. I was also supported by the Indian Country Child Trauma Center (Dee BigFoot, PI) to develop and field test a middle school version of the *American Indian Life Skills* on the Omaha reservation. As a consultant to the Helping Hands Project of the Puyallup tribe (Danelle Reed Inderbitzen, PI) I worked with mental health workers from the Puyallup Tribal Health Authority who worked in

tandem with 6th grade teachers at their tribal school to field test the middle school version of AILS. Through these experiences I got to know some incredible Native interventionists and witness directly the power of traditional healing in conjunction with effective convention psychological practices. However, I also observed the frustration of tribal leaders at the slowness with which these programs have reached AI/AN communities.

I realize that the psychological risk for suicidality includes co-morbidity with psychiatric and substance use disorders. However, as a counseling psychologist who studies learning and adaptation, I believe that decisions related to suicidal behavior among the majority of Indian youth may be attributed to direct learning or modeling influences (e.g., family, peer, extended family suicide attempts/ deaths by suicide) in conjunction with certain contextual sources (e.g., geographic isolation, perceived discrimination, historical trauma, acculturation stress) and individual characteristics (e.g., depression, PTSD). I also believe that many risk factors for suicide are similar to risk factors for other problematic behaviors such as alcohol and drug abuse or engaging in unsafe sex. When cast from this more social cognitive perspective, suicide is more likely to be seen as preventable.

SUICIDE PREVENTION INTERVENTIONS WITH AI/AN YOUTH

The goal of most prevention programs is to assist an individual in fulfilling their normative and developmentally appropriate potential including a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen their ability to cope with adversity (National Research Council and Institute of Medicine, 2009, p. 74). Five prevention programs targeting AI/AN youth suicide have been featured in noted reviews of suicide prevention (National Academy of Sciences, 2002; Goldston, Molock, Whitbeck, Murakami, Zayas, & Hall, 2008).

These include: The Zuni Life Skills Development Curriculum (LaFromboise & Howard-Pitney, 1994), the Wind River Behavioral Program (Tower, 1989), the Tohono O'odham Psychology Service (Kahn, Lejero, Antone, Francisco, & Manuel, 1988), the Western Athabaskan Natural Helpers Program (May, Serna, Hurt, & DeBruyn, 2005), and the Indian Suicide Prevention Center (Shore, Bopp, Waller, & Dawes, 1972). These programs incorporate positive messages regarding cultural heritage that increase self-esteem and sense of mastery among AI/AN adolescents and focus on protective factors in a culturally appropriate context (LaFromboise, 1996). They also provide a strong grounding for adolescent pro-social behaviors through close ties with extended family involvement and resilient elders. They integrate traditional healing practices and tribal leaders in the prevention effort and encourage youth to use traditional ways of seeking social support (May, et al., 2005).

These programs privilege AI/AN ways of knowing, behavioral expectations, attitudes and values and encourage youth to be embedded in cultural practices. For the most part, suicide prevention programs that incorporate cultural teachings and traditions into the psychological intervention have been received by AI/AN communities and some are found to have promising outcomes. Research has shown that enculturation is positively related to protective factors such as academic success and prosocial behaviors and is negatively related to depression.

One of the complexities in implementing interventions across tribal groups is the extent of major cultural differences among more that 560 different tribal groups. However, researchers who struggle with the problem of lack of generalizability of prevention programs are exploring efforts to identify common elements among tribes with closely related traditions that could be

incorporated into prevention programs on a wide scale basis (See Mohatt et al., 2004; Allen et al., 2006).

POTENTIALLY EFFECTIVE PREVENTION INTERVENTIONS FOR AI/AN YOUTH

Within mainstream society and a few cultural groups there has been considerable evidence for the positive effects of family, school and community based prevention interventions to increase the resilience of youth and reduce their risk for mental, emotional, and behavioral disorders. A report highlighting the impact of these interventions just released by the National Academy of Sciences (2009), entitled *Preventing Mental, Emotional and Behavioral Disorders among Young People,* features interventions designed to prevent common correlates of suicidal ideation (e.g., depression, substance abuse, interpersonal conflict, constricted thinking). Many of these interventions focus on strengthening families, improving social relationships, and reducing aggressive behavior and school-based violence. I believe that some of these prevention programs could provide a mechanism for hastening suicide prevention efforts in Indian Country.

I cannot make this presentation to the Committee without advocating for the expansion of social emotional learning in AI/AN schools. I realize that schools are often overloaded with other academic-related priorities. However, social emotional development programs in schools have been found to have a positive impact on academic outcomes, especially among elementary school-age children. Research by Durlak and colleagues (2007) indicated that the effects of social and emotional learning programs were equivalent to a 10 percent point gain in test performance. Students who also participated in this intervention demonstrated improvements in school engagement and grades.

Unfortunately, few of the interventions showcased in this report have been implemented in Indian Country. Evidence has been found for long-tem results of some prevention interventions with African American and Latino/Latina youth. No doubt that given the unique cultural and historical context of AI/AN communities, there is resistance to the mere transporting of evidence based prevention interventions onto interventions with AI/AN youth. However, it would seem important for AI/AN researchers and clinicians to join other researchers and clinicians to better assess whether these recommended prevention interventions are generic enough to be effective with AI/AN communities. If not, they might work together to culturally adapt the evidence based prevention interventions while maintaining the critical core content and dosage of the intervention.

RECOMMENDTIONS

1. Allocate federal funds for a technical assistance center to provide training in effective prevention interventions and assist in their implementation in AI/AN communities on a wide-scale basis.
2. Encourage the expansion of AI/AN community-based research collaboration.
3. Evaluate and disseminate in AI/AN communities interventions already proven effective for the prevention of mental, emotional, and behavioral disorders with other populations.
4. Require cultural competence in terms of knowledge of relevant risk and protective factors of suicidality among educators and mental health professionals working in AI/AN communities.
5. Increase the availability of AI/AN people in medicine, education, psychology, social work, and public health training programs to assist in and advance prevention efforts.