

Demanding Results to End Native Youth Suicide
Testimony of Teresa D. LaFromboise
To the
United States Senate Committee on Indian Affairs
Senator John Barasso, Wyoming, Chairman

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Good afternoon Mr. Chairman and members of the committee. I am grateful for the opportunity to present testimony on a topic of urgent importance in Indian Country, that is, the need for effective interventions to reduce the exceedingly high rates of Native American youth suicide.

My name is Teresa LaFromboise. I am a Professor of Psychological and Developmental Sciences at the Graduate School of Education at Stanford University. I have been working in the field of American Indian/Alaska Native (AI/AN) youth suicide prevention since 1989.

The work began in response to a request from Mr. Hayes Lewis, the Superintendent of the Zuni Public School District, that I bring a team of educators and health promotion specialists from Stanford University to the Pueblo of Zuni to help community experts develop a culturally-grounded youth suicide prevention intervention.

Over the course of three years we worked in Zuni to develop life skills pedagogy and curriculum lessons, consult with the Zuni Board of Education and the Zuni Tribal Council, and conduct an outcome study to assess the psychological impact of the curriculum (LaFromboise & Lewis, 2008). This outcome evaluation demonstrated the following effects: less suicidal ideation and suicide attempts, less hopelessness, greater self-efficacy to manage anger, and greater effectiveness in helping a suicidal friend solve problems and go for help among participants in the Zuni Life Skills treatment group as compared to those in the no-treatment comparison group (LaFromboise & Howard-Pitney, 1995).

Today, I want to provide a brief overview of ongoing work associated with American Indian Life Skills (AILS) and introduce four other evidence-based interventions delivered in school settings that have produced favorable outcomes in youth suicide prevention. I will discuss some of the limitations of interventions that focus solely on psychological rather than social, cultural and spiritual issues that may be more relevant in Native American youth suicide prevention. Finally, I will offer some recommendations concerning how we might more effectively reverse the rates of youth suicide within tribal communities.

Promising Practices in School Based Suicide Prevention

When we were invited to develop an intervention in Zuni we were only allowed access to the Zuni High School. Thus we learned a lot about suicide prevention in schools. The rationale for schools adopting suicide prevention programs hinges upon recognition that a significant amount of suicidal behavior occurs among ostensibly, well-functioning students. School suicide prevention programs try to reach the greatest number of students through population-based

strategies to identify and assist the smaller number of students who are at risk. They primarily target an individual student's thinking and behavior. The ultimate goal is to help at-risk students receive psychological treatment before they become acutely suicidal.

Presently, there are five main types of suicide prevention interventions in schools: (a) awareness/education curricula, (b) peer leadership training, (c) skills training, (d) gatekeeper training and (e) screening. *Awareness/education curricula* focuses on increasing accurate knowledge about suicide, and encourages self-disclosure among peers to develop positive attitudes toward seeking help. *Peer leadership training* assists student leaders in learning to respond to suicidal peers and then to refer them to a “trusted adult” for further referral to treatment. *Skills training* fosters the growth of skills to support protective factors in the prevention of suicide (e.g., problem solving, self-regulation). Emphasis is also placed on the reduction of risk factors to prevent the development of suicidal behavior (e.g., depression, substance abuse, anger regulation). *Gatekeeper training* teaches school staff, students and their parents about symptoms of suicide, and additionally provides information regarding risk and protective factors in order to improve identification and referral of at-risk students to available resources. Lastly, *screening* programs assess suicidal ideation, depression symptoms, and other clinical mental health disorders (including multiple problems such as depression along with disturbed eating or binge drinking) in order to refer students displaying disorder to psychological services.

American Indian Life Skills

The success of the Zuni Life Skills Development Curriculum bolstered a more Native American generic version entitled the *American Indian Life Skills Development Curriculum (AILS)* which is available to any tribe or community that is searching for adolescent suicide prevention and life empowerment programs (LaFromboise, 1996).

AILS is a universal, community-driven suicide prevention intervention emphasizing social cognitive skills training to reduce suicidal behaviors. *AILS* strongly emphasizes suicide as an action and behavior rather than the result of mental illness. It emphasizes an array of psychosocial skills necessary for effectively dealing with everyday life such as: emotional regulation, mindfulness, problem solving, and anger regulation. It focuses on 7 main themes: (1) building self-esteem; (2) identifying emotions and stress; (3) increasing communication and problem-solving skills; (4) recognizing self-destructive behavior and finding ways to eliminate it; (5) learning information about suicide; (6) helping a suicidal friend go for help, and (7) planning ahead for a great future.

A number of cultural considerations were considered in the design of this intervention. The curriculum is full of realistic situations that occur in AI/AN communities and homes. Lessons in *AILS* encourages culturally appropriate ways that students can express emotions like grief or anger. The preferred interventionist of *AILS* is a professionally trained community member. Additional community members are invited into *AILS* sessions at relevant times to share cultural teachings and model cultural coping perspectives.

Ideally, AILS is offered in a required course such as social studies or language arts. However, AILS has been taught in culture camps, local recreation and sports camps, tribal youth employment and training programs, Upward Bound, treatment centers, and tribal colleges. It has been adapted for AI/AN adolescents in urban and suburban settings. In addition, tribal communities such as the Spirit Lake Dakota tribe have adapted AILS to their local community values and norms.

Community members, teachers and behavioral health specialists from over 100 reservations have participated in AILS trainings. Currently, we are working on internet applications for providing on-going technical assistance to those who are implementing AILS following an initial 3-day Key Leader Orientation training.

Schools as Sites for Suicide Prevention

From my experience in this field and from systematic review of research on school-based suicide prevention programs, I have found a growing number of potentially effective mainstream programs that could be of help in reducing Native American youth suicide. I selected the following evidence-based programs to highlight today because they each have some history of implementation in AI/AN communities and they have been found to yield outcomes associated with the prevention of adolescent suicide with diverse populations (LaFromboise & Hussain, in press).

Sources of Strength (SOS). SOS is a universal program (meaning that it is offered to all students in a school) that emphasizes awareness/ education and peer leadership to reduce suicidal behaviors (LoMurray, 2005). Its curriculum includes suicide awareness, positive messaging, empowering activities and screening strategies. Peer leaders are trained in responding to students who display risk factors for suicide, directing them to a trusted adult for further support. Originally designed for youth living in rural areas near United Tribes in Bismarck, North Dakota to tackle issues related to suicide, such as violence and substance use, SOS was later modified for widespread use with students from diverse backgrounds across the United States. At a 3-month follow up, participants in SOS reported reduced suicide attempts and increased knowledge about suicide (Aseltine, James, Schilling, & Glanovsky, 2007).

Reconnecting Youth (RY). RY is a selected intervention utilizing a life-skills training approach which targets high school students who demonstrate poor academic achievement, are at risk for dropping out of school and exhibit maladaptive symptoms like aggressive behavior (Eggert & Nicholas, 2004). RY emphasizes the prevention of substance use and emotional distress while fostering resilience. Opportunity for social bonding is also achieved through intervention activities which form connections within the school and encourage parent involvement. Native American RY participants have reported reduced hopelessness and suicidal ideation immediately following the intervention and at 1-year follow up (LaFromboise & Malik, 2012).

Coping and Support Training (CAST). CAST is a selected prevention program adapted from RY that uses a skills-training approach with high school students following their referral to the

program based upon initial screening. *CAST* consists of 12 sessions given over 6 weeks administered by service providers (e.g., teachers, nurses). *CAST* focuses on mood management and school performance and emphasizes decreased involvement with illicit substances. Participants of *CAST* have demonstrated increased problem solving skills, perceived family support and self-control, and decreased symptoms of depression and hopelessness (Thompson, Eggert, Randell & Pike, 2001).

Good Behavior Game (GBG). *GBG* is a behavior management approach that has evolved into a universal, primary prevention program for elementary school students to teach self-regulation skills (Barrish, Saunders, & Wolf, 1969). The *GBG* socializes children into displaying cooperative rather than disruptive or aggressive behavior, both of which are risk factors for substance abuse and suicide. To play the *GBG* a teacher splits the classroom into two or more teams which are rewarded for being adaptive to academic social expectations (e.g., being on task for brief periods of time, not talking out of turn). Eventually they are expected to be cooperative for longer periods of time. The winner of the *GBG* is the team with the least amount of infractions.

GBG has demonstrated long-term effects (following elementary school-age participants on into adolescence) on decreased impulsive/disruptive behavior, substance use, drug addictions, and lower rates of suicidal ideation and suicide attempts (Kellam et al., 2008). By incorporating the program into the classroom at an early age, there is a high cost-effectiveness ratio.

Lessons Learned

From having either carefully reviewed, implemented or tested each these programs, I found that it is very difficult to influence schools to engage in primary prevention. "School administrators and teachers working in public schools serving Indian populations are so bent upon meeting the high stakes demands of testing and Adequate Yearly Progress (AYP) that they have no time to do more than the minimum expected when it comes to responding to the emotional and cultural needs of Native American students" (Testimony of Hayes A. Lewis, Youth Suicide in Indian Country, February 26, 2009, p.4). It takes advocacy from community champions (e.g., tribal council members, members of prevention committees and parents) to influence school administrators to adopt programs sensitive to the social emotional needs of youth.

Most of these interventions rely on the referral of at-risk students to psychological treatment before they become acutely suicidal. However, many rural AI/AN communities have limited school counseling services or behavioral health services. When formal mental health services are staffed by AI/AN behavioral health specialists those services are in high demand. When they are staffed by service providers from outside the community they may be underutilized due to the stigma of seeking help from those who seemingly represent the group that marginalizes and oppresses them. The ultimate effectiveness of the prevention program, to save lives, relies on youth initiating or completing care.

I also found that most individually focused "off the shelf interventions" do not address key perceived contributions to AI/AN suicide such as historical oppression, intergenerational

trauma, prejudice and discrimination and other forms of collective disempowerment. Thus the protocols upon which these interventions were tested are either short lived or, in the best case scenario, modified to address more relevant social justice issues in Indian Country.

Finally, those AI/AN communities, who actually implement programs such as the ones I have just reviewed and who find them intuitively "helpful," are often reluctant to engage in further assessment of their effectiveness within their own community. I believe that this type of assessment would be helpful in guiding decisions about modifications to the intervention to better meet local community needs and norms or concerning whether or not to continue efforts toward sustaining the intervention overtime.

Recommendations

I respectfully offer the following recommendations to strengthen tribal capacity to improve service delivery to prevent Native youth suicide based upon my observations, research, and training experiences.

Expand the number of empirically-validated suicide prevention interventions and evaluate their adaptation and implementation in diverse AI/AN contexts.

School-based suicide prevention programs began in 1984 in reaction to a significant escalating trend in suicidal behavior among adolescents in many Western industrialized countries. Considering the relatively new introduction of prevention intervention to this complicated problem, issues with customized delivery that target specific variables such as ethnic/racial group background, cultural involvement, and tribal diversity still need significant innovation and evaluation.

Make a commitment to continue to support the dissemination of valued community-driven approaches to suicide prevention across Indian Country.

There is a sense of urgency among tribal leaders to preserve cultural ways of knowing before the knowledge keepers are gone. Research indicates that communities with higher levels of political and cultural engagement have lower suicide rates. Certain individual protective factors for Native youth suicide prevention include cultural identity and engagement in cultural activities as well as school completion. This presents a window of opportunity for collaboration between community leaders and prevention scientists to develop services that reflect community priorities and practices and to mobilize available support systems to prevent suicide.

Encourage and support research on the interaction of community-level processes, family systems, and individual psychology that affect the well-being and resilience of Native youth.

Historically suicide prevention has focused on the treatment of the individual and that type of intervention should continue but not at the cost of ignoring the gestalt of the disorder. Specific

efforts have evolved for the last decades or two on economically viable, rapidly deployed and clinically efficacious efforts to target not only the individual but the larger system- from social media to society and everything in between. Let us continue that momentum.

Tribal communities have practiced "integrated care" among individuals and families for generations but usually without adequate resources. Let us support continuation of those cultural practices and healing traditions.

Thank you for providing this opportunity.

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