One Sky Center
The American Indian/Alaska Native National Resource Center for Substance Abuse Services

Written Testimony of R. Dale Walker, MD, Director
One Sky Center: American Indian/Alaska Native National Resource Center for Substance Abuse and Mental Health Services
Oregon Health & Science University

Oversight Hearing on Teen Suicide
Before the United States Senate Committee on Indian Affairs
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Chairman McCain, Vice-Chairman Dorgan, and members of the Committee, I am R. Dale Walker, MD, Director of the One Sky Center, and Professor of Psychiatry, Public Health & Preventive Medicine at Oregon Health & Science University in Portland, Oregon. I am a Cherokee psychiatrist with qualifications and 25 years' experience in the addictions field. I direct the One Sky Center, the first national resource center dedicated to improving the prevention and treatment of substance abuse and mental health among Native people. I am honored and humbled to be able to provide oral testimony before you today.

I would like to thank the Committee for holding this important oversight hearing on youth suicide prevention. I would like to commend Senator Byron Dorgan for his advocacy efforts for drawing attention to this critical issue. I would also like to extend my appreciation to Senator Gordon Smith for championing the issue of mental health by introducing and enacting legislation in light of his own personal loss, his son, Garrett. There is a mental and behavioral crisis in Indian country today, and a vital need for preventive action.

The idea of a child—a sacred human being in tribal culture—ending their own life is an unthinkable act; often leaving loved ones in a state of great disbelief, shock, and denial. As we know, unfortunately, our Indian children are committing suicide across Indian country; in some communities, at alarming rates.

In some tribal communities, the topic and discussion of suicide is still considered taboo. However, due to this crisis, tribal people are asking for help. Thankfully, this is what brings us here today: to save our young ones, our next generation. Many questions have been raised about teen suicide, and the most important questions center around how to address it, and how to prevent it.

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1. Overview

In my presentation, I will offer our strategic assessment for your consideration.

Suicide, of course, is among several, causally related behavioral problems, including community conflict, family fragmentation, gangs, youth violence, alcohol abuse, abuse of illegal drugs like methamphetamine, and abuse of prescription drugs. Such physical illness as diabetes is causally related as well. Closely associated are demoralization, loss of vision, and clinical depression.

There are many valid theories about the causes (drivers) of that group of problems, including poverty, racism, lack of law enforcement, lack of skills learning, loss of culture, services deficiencies, and lack of community leadership.

- It is our judgment that extraordinary and extreme behavioral problems exist in many American Indian/Alaska Native communities.

- We believe that the critical point of leverage is improving the behavioral health of individuals, families and communities.

- We believe that improving the degree of collaboration and alignment among services will greatly improve the efficiency and effectiveness of services.

- We believe that it is strategic to intervene in crises/emergencies both to limit the amount of damage and to take advantage of the openness to change and action that crises/emergencies bring.

It is my hope that the assessments and recommendations presented today will be seriously considered as part of the Committee's efforts to reauthorize S. 1057, the Indian Health Care Improvement Act (P.L. 94-437), or be helpful to other committees with jurisdiction for potential legislative efforts related to mental health, substance abuse prevention, and treatment of American Indian and Alaska Natives.

I will also introduce the One Sky Center that I direct, our work, and a Substance Abuse and Mental Health Services Administration (SAMHSA) "emergency contract" that we are partnering with Kauffman and Associates, Incorporated titled, "Native Aspirations." We hope that the Committee will support as a first phase towards a demonstration project for suicide prevention.

2. The One Sky Center

The One Sky Center (www.oneskycenter.org) created in 2003, is the first national resource center dedicated to improving the prevention and treatment of substance abuse and mental health among Native people. The One Sky Center's mission is to promote best practices in substance abuse and mental health services for American Indians and Alaska Natives. The goal of the One Sky Center is to improve prevention

and treatment of substance abuse among native people. The objectives of the One Sky Center include (a) identifying culturally appropriate best practices in prevention science and treatment services designed for American Indians and Alaska Natives, (b) facilitating the implementation of evidence-based preventive programs and care systems for native people, (c) providing continuing education in substance abuse prevention and treatment so as to enhance the capabilities of educators and clinicians serving American Indian and Alaska Natives, and (d) recruiting native youth into education and health care training programs aimed at prevention and treatment of chemical dependency among American Indians and Alaska Natives.

A National Steering Committee representing tribal governments, educators, clinicians, the Indian Health Service, the Bureau of Indian Affairs, the Addiction Technology Transfer Centers, and the Centers for the Application Prevention Technology as well as the Substance Abuse and Mental Health Services Administration (SAMHSA) advise the Center. The National Steering Committee strengthens existing linkages to the Addiction Technology Transfer Centers and the Centers for Application of Prevention Technology. It is a national resource center of, by, for, and steered by Indian people—a unique trait in a national resource center.

The One Sky Center's reach is extended by consultants and subcontractors located throughout the country including the Alaska Native Tribal Health Consortium, the National Indian Youth Leadership Project in New Mexico, and United American Indian Involvement in California. In addition to conferences, workshops, and coalitions, distance learning technology is used to facilitate technology transfer, technical assistance, and consultation. The Center continues the University's linkages with tribal colleges and universities to facilitate entry of American Indian and Alaska Native youth into education and health careers focused on substance abuse prevention and treatment. Two divisions within SAMSHA, the Centers for Substance Abuse Prevention and Substance Abuse Treatment, federally fund the One Sky Center. Please visit One Sky Center's website at www.oneskycenter.org for more information.

The SAMHSA grant supporting One Sky Center is its third and final year. It is my hope that SAMHSA will continue to fund the efforts of the One Sky Center, and the Committee will support us in that effort.

Evidence Based, Cultural Best Practices Movement

The IOM (2002) purports that evidence-based practice should integrate three key components: (1) best research evidence that includes clinically relevant empirical studies; (2) clinical expertise that comprises clinical reasoning skills focused on the context of the client's conditions, values, and expectations as well as the risks and benefits of specific interventions; and (3) client values or the preferences, concerns, and expectations of the client in the practitioner-client interaction. SAMSHA has incorporated the IOM evidence-based approach into a report regarding individuals with co-occurring disorders, an area of behavioral health care. SAMHSA asserts, "Many approaches to treating co-occurring disorders that do not meet strict standards of

evidence are nevertheless commonly accepted and believed to be effective based on the best available research, clinical expertise, individual values, common sense, and a belief in human dignity. It is incumbent on practitioners to use the best available approaches" (U.S. Department of Health and Human Services, 2002).

The One Sky Center is helping to lead a cultural movement toward identification, acceptance, and implementation of culturally appropriate substance abuse and mental health services that work in the American Indian and Alaska Native world. This activity spans awareness raising, coalition building, motivation enhancement, resource development (such as inventories of best practice), broad dissemination, training, and technical assistance.

An American Indian and Alaska Native Best Practices Consensus Panel met in October 2004 in Portland, Oregon. The small meeting was sponsored by the One Sky Center in collaboration with SAMHSA's Center for Disease Control and Prevention. The meeting provided a forum to discuss culturally appropriate, effective and promising practices in the areas of substance abuse prevention, substance abuse treatment, mental health, and co-occurring disorders for American Indian and Alaska Natives.

Meeting participants included senior scientists who are experts in the addictions and mental health fields, junior faculty-level American Indian professionals, community leaders, traditional healers, and a representative from SAMHSA's National Registry of Effective Programs and Practices. Participants reviewed the mainstream and American Indian and Alaska Native literature on best practices in substance abuse prevention and treatment, mental health and co-occurring disorders. Each of the four areas were discussed, incorporating science, community practice, indigenous knowledge, and traditional medicine practices into a culturally inclusive and relevant set of criteria to establish best practice approaches in American Indian and Alaska Native communities.

This dynamic panel meeting was the beginning of an on-going process to develop best practice approaches in tribal communities. Based on the literature reviews, discussions, and recommendations collected at this meeting, the One Sky Center will develop a set of papers for distribution to providers, educators and health policy organizations. A first draft of the monograph is expected this summer.

At the end of this month in San Diego, California, the National IHS/SAMHSA and Behavioral Conference on Alcohol, Substance Abuse, and Mental Health will be held. The One Sky Center will have a significant role at this conference. The One Sky Center will lead a one-day meeting of Best Practices, a follow up to the October 2005 meeting. The Center will also facilitate a Youth Panel to further discuss teen suicide and prevention with an impressive panel of tribal youth to hear their voices on the issues of teen suicide. Three of the youth are the three Standing Rock Sioux students who testified at the Senate Committee on Indian Affairs field hearing in Bismarck, North Dakota in May 2005.

Traditional Health Practice

Traditional health practices include procedures such as Circles of Care, Sweat Lodges, use of botanical medicines, and specific programs like the *Red Road to Recovery*, a model that has helped thousands of American Indians lead clean and sober lives (Thin Elk 1992). Traditional Health Practices (THP) offer American Indian/Alaska Natives communities a variety of culture-based activity, health related ceremonies, philosophy, healing practices and a healthy alternative lifestyle.

Traditional health concepts include harmony as a source of health and disharmony as a source of disease. THP sees health as a process involving internal causes that create or attract disease.

Traditional health delivery contexts include cultural symbols, facility decoration, provider dress, and provider interaction style. THP addresses alcohol abuse, intentional and non-intentional injury with a special emphasis on auto related injury, diabetes and other health outcomes related to alcohol.

As a treatment intervention, the THP model focuses on the role of culture, tribe and society at large play in understanding and treating the individual's health situation. Historical trauma, cultural conflict, language, exposure to tribal culture and identify formation help determine health or lack of it.

As a prevention model, THP focuses on social support and social capital for an individual who is so often socially isolated. A major prevention intervention is supporting cultural renaissance among Indian peoples. Another major prevention intervention is assisting tribes to regain control over their circumstances: legal rights, property, institutional authority, and local self-governance.

The Surgeon General's *Report on Mental Health: Culture, Race, and Ethnicity* (DHHS 2001b) acknowledged that culture counts in the prevention and treatment of substance abuse and mental illness. Therefore, there is a need for culturally relevant practices to address the issues of behavioral health in Indian country.

Because of the complex historical, cultural, familial, economic, and legal foundation of American Indian reservations and Alaska Native villages, tackling the task of providing proactive behavioral health services for Native youth and their families is equally complex. Knowledge of behavioral health issues of Native children and youth is necessary. However, just as important is a deep appreciation and understanding of Native culture and the experiential grasp of Native life on tribal reservations and villages. Only by blending this knowledge, knowing, and experience within the behavioral health framework, will inroads be made to Native American communities to reduce the risk factors that contribute to youth violence and suicide and to heal devastated families and communities. In other words, to respond to the behavioral health needs of Native youth, children, and families, a culturally tailored and community

specific approach combined with evidence-based best practices in behavioral health must be initiated at a community level in Indian Country.

3. Behavioral Health Overview

Among today's Native youth and young adults, suicide, violent crimes, substance abuse, and school violence each are running rampant. During a 12-week period from November 2004 to February 2005, eight young Native American adults committed suicide in separate events on the Standing Rock Sioux Reservation in North Dakota and South Dakota. All but one suicide was related to alcohol. Each young adult used hanging as the method to die.

A few weeks later and only 300 miles away on the Red Lake Reservation in Minnesota, a 17 year old killed his grandfather and grandfather's partner in the family home in his Ojibwa community. Then he went to school and took the lives of two adults and five of his classmates. Then he killed himself.

Unfortunately, these two recent, tragic stories are not rare in Indian Country. In fact, suicide, homicide, violence, and substance abuse each run rampant amongst today's Native youth and young adults. The three leading causes of death for American Indians and Alaska Natives, ages 15 through 24 years of age between 1994 to 1996 were: (1) accidents; (2) suicide; and (3) homicide. In 2002, suicide rates of Native American male teens (ages 15 through 19) were highest of any ethnicity in the U.S. at 22.7 per 100,000; a rate three times higher than the national average (7.4 per 100,000) for this age group (Child Trends DataBank, 2002).

The violent crime rate in every age group below age 35 was significantly higher for Native Americans than the general population of the U.S., according to the U.S. Department of Justice (2004). In addition, the rate of violent crime victimization of Native Americans, ages 25 to 34 was more than 2.5 times the rate for all persons of the same age. When violent crimes were reported, about 62% of Native American victims experienced violence by an offender who was using alcohol, compared to 42% for the national average.

Alcohol abuse is also a common and historical health problem. Statistics in 2002 indicated that Native Americans have higher rates of illicit drug, marijuana, alcohol, smokeless tobacco and tobacco use than Whites in any age group throughout the U.S. (U.S. Department of Health and Human Services, Office of Minority Health). SAMHSA (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, Office of Applied Statistics, 2002) reported that the average age of first alcohol use was earliest for Native Americans (mean, age 15.1 years old) than any other ethnic group.

Paralleling the high rates of suicide, violence, and substance abuse in Native youth and young adults is the increased amount of violence occurring at public schools and Bureau of Indian Affairs schools (U.S. Department of Education and U.S. Department of

Justice, 2004). Last year, 22.1% of Native students reported being threatened or injured with a weapon on school property; the highest rate of violence experienced by any ethnic student group. In the same report, violence rates of other ethnic
Youth dropped but Native youth reported the biggest growth in violence (increasing nearly 9 percentage points). This reported violence was demonstrated by 24.2% of Native high school students being involved in a physical fight on campus last year and 12.9% Native youth taking a weapon to school.

These soaring rates of school violence, suicide, and substance abuse among Native youth are not stand-alone statistics but point toward the excessive amounts of poverty, domestic violence, child abuse and neglect, and historical trauma in Indian Country. Poverty continues to be the most troublesome social, educational, and health disorder in Native American communities (Cornell & Kalt, 1992). In 2000, the U.S. Census Bureau reported that one in four Native Americans experience poverty (26%); a rate that is more than double for the general U.S. population (12%). Domestic violence is noted with the homicide mortality rate for Native American females ages 25 to 34 years old being 1.5 times that for the U.S. general population (U.S. Department of Justice, Office of Justice Programs, 2004).

Similarly, Native children and youth oftentimes experience family disruption, neglect, and abuse because Native Americans have a rate of prison incarceration about 38% higher than the national rate (U.S. Department of Justice) and a higher use of substance abuse than other ethnic groups (U.S. Department of Health and Human Services, Office of Minority Health, n.d.). In addition, the historic trauma of Native Americans based on centuries of cultural oppression, loss of traditions, and racism severely affect the wellness and health of Native communities. The long-term effects of these underlying conditions have resulted in high rates of physical, mental, and behavioral health disorders for Native youth and children and their families that have been passed on from generation to generation.

4. Strengthening of Systems For Delivering Behavioral Health Services

The U.S. maintains a unique moral and legal obligation to provide health services to American Indians and Alaska Natives. This obligation is based upon the U.S. Constitution, numerous Indian treaties, federal laws, Supreme Court rulings and Executive Orders. The federal government carries out this responsibility primarily through the Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services. Health care, including behavioral health services, is provided to IHS eligible populations through a regional system of twelve Area Offices, each composed of community specific service units. Severe limitations on funding, however, have resulted in a system of rationed health care, where preventive services less a priority than access to acute care.

The provision of adequate behavioral health services in Indian Country continues to be challenging. A report released by the U.S. Commission on Civil Rights (2004) on the health disparities and health care services of Native Americans indicated that robust

social, cultural, structural, and financial barriers serve as roadblocks for Native Americans to receive adequate health care. The most typical barriers of the Indian Health Services (IHS) included racial and ethnic bias by health care providers; geographical location of health care facilities; wait times at facilities and for treatment; turnover rates, recruitment, and retention of health care providers; and the rationing of health services for Native Americans.

One Sky Center recommends strengthening and increasing the capacity of behavioral health services in American Indian/Alaska Native communities. We encourage the Committee's efforts to reauthorize S. 1057, the Indian Health Care Improvement Act (P.L. 94-437), or be helpful to other committees with jurisdiction for potential legislative efforts related to mental health, substance abuse prevention, and treatment of American Indian and Alaska Natives.

5. Coordination of Services

In addition, fragmentation of behavioral health services in Indian Country is commonly demonstrated by separate federal, state, and local agencies focused on suicide, substance abuse, education programs, and mental health and social services instead of an integrated, comprehensive behavioral health system. Often times, these systems do not interface or communicate well, defeating the logical, community-based, effective behavioral health care planning and implementation needed in Native communities (Walker, 2005). More specifically for the behavioral health needs of Native youth and their families, a well-functioning, integrated system involving community stakeholders and agency partnerships is crucial. Together schools, social services, mental health programs, law enforcement, and tribal leadership can be instrumental in collaborating and coordinating effective behavioral health programs for Native youth and for healing and recovery of Native communities.

Schools are a key service in the matrix of services. The role of the U.S. government in Indian education dates back to the 1800s. In 1879, the Indian boarding school, Carlisle Indian School, in Carlisle, PA was established. With the goal of assimilating Indians into the culture of white men, these boarding schools suppressed indigenous languages, cultures and dress in an effort to "Kill the Indian, save the Man" (Cohen). This history complicates the challenge of enhancing the capacity of schools to promote health in that critical setting and critical age group.

The lack of coordination includes conflicting policies among multiple school jurisdictions and lack of coordination with health services. Policies from higher levels, myopic perspectives of local staff, and lack of strategic planning drive the lack of coordination.

The nightmare of having a Columbine School scenario on an Indian reservation has now become a reality. The countermeasures include integrating substance abuse, mental health and social services into comprehensive behavioral health programs. Many tribes and tribal organizations, including the National Indian Health Board, support integrating programs which are nurturing, fulfilling, accountable, and responsible. These

local efforts and federally supported programs offer an opportunity for wellness and balance in tribal communities.

One Sky Center recommends identifying coordination of services as a key objective for interventions supporting American Indian/Alaska Native communities to overcome the complex of problems such as suicide, youth violence, and substance abuse. An emergency/crisis is one of the few times that enough momentum can be generated to overcome some of these barriers to coordinated service.

6. Emergency/Crisis Intervention Program

Clusters of suicides or homicides create a community trauma. Survivors and those who provide care for them, as well as community leaders are in shock and often too overwhelmed to continue to function. This precipitates lasting damage to the community and its capacity to support healthy lives, which leads to further problems. This trauma needs immediate treatment, itself. But the emergency/crisis also creates an opportunity to initiate fundamental improvements—it motivates people, enables examination of causes and contexts, and calls for a plan to prevent reoccurrence.

We recommend three culturally relevant, community specific approaches for addressing community health issues and healing in the aftermath of emergencies/crises (or in anticipation of them). The *Community Suicide Prevention Assessment Tool* (Walker, 2005b), *Community Readiness Model* (Thurman, Pleated, Edwards, Foley, & Burnside, in press), and the *Gathering Of Native Americans* (GONA; Center for Substance Abuse Prevention, 1992 have been successful in Indian Country. All of these approaches have been implemented and successfully worked with behavioral health issues in Native communities including partner violence, substance abuse, HIV/AIDS prevention, suicide, and other community health issues. One Sky Center used this approach in the Standing Rock and Red Lake incidents.

Of the three tools, *The Community Suicide Prevention Assessment Tool* serves as a mechanism to collect and evaluate information about a community and its contributing factors related to the behavioral health of individuals, families, and the Native American community as a whole. The *Community Readiness Model* approach and the *GONA* forum are used primarily in a community participatory process for planning action and activities to address the behavioral health needs of the community. The common features of the Community Readiness Model and the GONA comprise: (1) empowering community members to address the community health and social issues that they face on a day-to-day basis; (2) honoring the values, beliefs, and knowledge of each Native community and its members; (3) addressing many segments and parts of a community (e.g., individuals, leaders, organizations) because of their interconnectedness with the health or social issue; and (4) generating and maintaining culturally relevant solutions, resources, and healing in a collective and community specific manner, i.e., a large group forum.

All of the community specific tools including The Community Suicide Prevention Assessment Tool, the Community Readiness Model approach, and the GONA forum are detailed below.

The Community Suicide Prevention Assessment Tool was developed by OSC by modifying two other community-based assessments, the Native Community Assessment, developed by the Canadian Task Force on Preventative Health Care in 1994 and the Suicide Prevention Community Assessment Tool published by the Suicide Prevention Resource Center. The CSPAT used by OSC focuses on gaining a comprehensive, integrated picture of the contributing factors and the overall community functioning and capacity as it relates to the behavioral health of individuals, families, and the Native American community as a whole. The framework encompasses a gathering of information regarding each community's history, culture, government, demographics, geographic features, economic resources and status, social characteristics, recreational opportunities, and health status, services, and facilities. Community specific information is acquired through several mechanisms including meetings with key informants and community leaders, semi-structured individual interviews with community stakeholders (e.g., mental health counselors, school principals), documents of relevant organizations and agencies, (e.g., Indian Health Service, tribal government, local school district), and databases records (e.g., U.S. Census data). Through the analysis of this community specific information garnered from multiple sources, recommendations then emerge and are presented to the community that focus on the behavioral health of the targeted group. The Community Suicide Prevention Assessment Tool and process has allowed Native communities to gain a clearer and integrated picture of their respective community as it relates the behavioral health needs of individuals, families, and the overall community and to set the stage for developing a plan toward community healing and health.

The Community Readiness Model originally developed at the Tri-Ethnic Center for Prevention Research at Colorado State University provides an easy method for assessing the level of readiness of a community, related to a specific prevention and/or intervention of a health or social issue (Thurman, Plested, Edwards, Foley, & Burnside, in press). To gain a clear picture of the community, the model proposes six primary dimensions including Community Efforts (programs, activities, policies); Community Knowledge of Efforts; Leadership; Community Climate; Community Knowledge About the Issue; and Resources Related to the Issue. The model addresses nine development levels of community readiness that must be worked through in order for the community to generate, implement, and maintain efforts to reduce the health or social problem. The nine developmental stages include: (1) No Awareness; (2) Denial; (3) Vague Awareness; (4) Preplanning; (5) Preparation; (6) Initiation; (7) Stabilization; (8) Confirmation/Expansion; and (9) Professionalization. By identifying the community's developmental stage to address the social or health problem, the community may then develop and apply culturally appropriate and effective strategies involving multiple community systems and within community resources and strengths.

The Gathering of Native Americans (GONA) which operates on the principle that primary prevention should be implemented from within the community rather than from the top down was developed in 1992 as a culturally specific prevention curriculum within the Community Partnership Initiative of the

Center for Substance Abuse Prevention, (SAMHSA). There are four themes to the curriculum that correspond to indigenous values that are core resiliency factors for native people. These values: Belonging, Mastery, Interdependence and Generosity are the framework for a collaborative planning process to address substance abuse issues in Native communities. The model is easily adaptable to specific tribes and tribal regions allowing local coordinators to integrate their traditional stories, songs and ceremonies into the curriculum. The curriculum has proved so valuable as a healing and planning tool in native communities, the Indian Health Service and the Office of Juvenile Justice contributed to funding of local and regional GONA trainings. Recently, IHS funded a publication of a shorter, revised GONA manual. The curriculum has been adapted to address other issues in Native communities throughout the nation, including: domestic violence, diabetes, HIV, and gang prevention.

One Sky Center recommends a program of intervention into Crises/Emergencies in Indian communities using a protocol worked out well in advance.

Today's Native youth and Native communities are experiencing more and more tragedies related to suicide, school violence, violent crimes, and substance abuse. Underlying social, economic, and health conditions in Indian Country such as poverty, domestic violence, child abuse and neglect, and historical trauma continue to deter the safe and healthy development of Native youth, children, and families. Responding to the behavioral health needs of Native youth is imperative in order to prevent youth violence, suicide, and substance abuse and in turn, help Native communities heal and recover.

More evidence-based, culturally-tailored, and community-specific approaches for addressing Native youth's behavioral health issues and Native communities' planning and healing are required to build pro-social and help seeking behaviors of Native youth and their families. Tribal leaders, school officials, behavioral health providers, and community stakeholders in Native communities must direct Native youth toward healthy and save lives. Coordination among services is needed to make them efficient and effective in dealing with behavioral health needs. A powerful intervention around crises and emergencies will facilitate these changes.

Conclusions

It is safe to conclude that the Indian health community, a majority of federally-recognized tribes, and most Indian health organizations generally agree that the Indian Health Care Improvement Act reauthorization or any other moving legislative initiatives must include provisions to enhance or improve the delivery of mental health services for American Indian and Alaska Native communities. The alarming health disparities, domestic violence, suicide, and major crimes committed on Indian reservations are

escalating, and show no signs of relenting unless crucial federal programs are fully funded, which includes critical mental health programs for American Indian and Alaska Natives.

Tribal communities are taking a leadership role in addressing the myriad of needs associated with behavioral health problems. Building upon that local leadership and initiative offers a strategic opportunity to improve coordination of local and federal services, to bring services up to critical level of capacity, and to get going a renaissance in American Indian and Alaska Native communities. One Sky Center has been honored over the past two years to help empower tribal communities with the tools and resources to be pro-active in creating their own better futures.

The One Sky Center is willing to offer its expertise in the areas of substance abuse treatment and prevention, mental health, and best practices if the Committee should seek guidance on those matters. The One Sky Center is qualified to offer insight, experience, and recommendations addressing these problems for the Committee's consideration.

Both HHS and SAMHSA have seen the wisdom and advantages of cross agency support and funding for strategic nation-wide efforts. As the Nation's only National Resource Center in behavioral health for this population, it is our sincere recommendation that resources be directed to SAMHSA through HHS for a five year demonstration project to bring the full efforts of all federal and state agencies together to address the issues related to suicide and violence for all American Indian and Alaska Native communities across the nation. The demonstration project approach will allow model programs to develop in all regions of the country. They can be integrated with other native and nonnative communities.

The basis for this demonstration project could build upon the Native Aspirations project to be funded by SAMHSA. SAMHSA has issued a request for an "Emergency Contract" to provide a proactive, community-based effort to bring mental health assistance to children, youth, and families living on American Indian reservations and in Alaska Native villages. This proposal responds to the SAMHSA request, and provides a structured approach to engaging Native communities to collaboratively identify strategies to decrease factors that contribute to school violence and suicide and to increase protective factors that support healthy, safe environments for children and their families.

The partnership between the One Sky Center and Kauffman and Associates, Incorporated, a 100% American Indian owned contracting firm, presents an opportunity for the Substance Abuse Mental Health Services Administration (SAMHSA) to utilize two entities, each uniquely qualified, with excellent track records across Indian Country to address the serious problem of preventing American Indian and Alaska Native youth suicides, homicides, school violence and disruptive behaviors in and around schools.

The goal of the Native Aspirations project is to reduce risk behaviors, such as acts of violence and suicidal gestures, and increase pro-social and help seeking behaviors

among American Indian and Alaska Native youth in high-risk communities. Because of the complex historical, cultural, familial, economic, and legal context of Native youth, their families, and communities, providing behavioral health services to reduce high-risk behaviors is equally challenging. Consequently, to respond to SAMHSA's Native Aspirations Project, the One Sky Center (OSC) and Kauffman and Associates, Inc. (KAI) have developed a culturally tailored and community specific approach combined with evidence-based behavioral health best practices to meet the objectives, tasks, and requirements of the contract.

The approach that OSC and KAI will use in the Native Aspirations Project includes a four-step community-based protocol including: (1) Community Selection; (2) Community Assessment; (3) Community planning; and (4) Community Implementation. First, the Community Selection process will enable OSC/KAI to identify approximately 22 high-risk Native communities through the use and analysis of qualitative information and quantitative data gathered through multiple sources. Second, the Community Assessment will involve project personnel visiting each identified community and examining contributing factors and overall community functioning and capacity as it relates to the behavioral health needs of Native children, families, and communities.

The Community Assessment focuses on each community's history, culture, government, demographics, geographic features, economic resources and status, social characteristics, recreational opportunities, and health status, services, and facilities. Next is the Community Planning process that will be conducted through a Gathering Of Native Americans (GONA) forum utilizing the Community Readiness Model allowing each community's stakeholders to formulate a plan that will direct it toward improving the behavioral health of Native youth, their families, and the overall community. Finally, the Community Implementation process will involve providing on-site supervision, training, and consultation to the tribal communities regarding behavioral health evidence-based interventions and service coordination.

The project staff of Native Aspirations will include skilled personnel and experts from OSC and KAI in the areas of behavioral health, community assessment and facilitation, Native culture and ceremony, project management, evaluation and research, and database management. In addition, approximately 14 consultants specializing in Native behavioral health issues of children, families, and communities will be engaged throughout the Community Assessment, Community Planning, and Community Implementation phases of the project.

Through this Emergency Contract, SAMHSA has provided an opportunity for OSC and KAI to respond to the behavioral health needs of Native youth in order to prevent youth suicide, violent crimes, substance abuse, and school violence and in turn, help Native communities heal and recover. Evidence-based, culturally-tailored, and community-specific approaches for addressing Native youth's behavioral health issues and Native communities' planning and healing are required to build pro-social and help seeking behaviors of Native youth and their families. Tribal leaders, school officials, behavioral

health providers, and community stakeholders in Native communities must direct Native youth toward healthy and save lives.

Recommendations

1. Strengthen and increase the capacity of behavioral health services to levels available in the broader community.

2. Create a powerful mandate to align and coordinate policies and services at the federal and local levels—a mandate powerful enough to overcome the enormous “silo” tendencies of all agencies. .

3. Creation a long-term intervention program for communities going through emergencies/crises, to deal with the crisis and to seize the opportunity, which a crisis provides.

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