APPENDIX

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Greetings Honorable Chairman Dorgan, Vice-Chairman Barrasso, and Members of the Committee. Thank you for the opportunity to provide testimony to this committee and my perspective on the present status and progress toward preventing American Indian and Alaska Native (AI/AN) youth suicidal behavior.

I bring to you my perspectives as a Choctaw and Cherokee descendent, a mental health clinician with 25 years of experience working with American Indian clients, a faculty member from the Center for Rural Health at the University of North Dakota focused on rural and tribal mental health issues, an adjunct faculty in counseling psychology preparing future mental health professionals, a researcher of mental health and suicide prevention with American Indians, and a concerned mother and grandmother. I have worked in suicide prevention and crisis intervention for 20 years and developed a crisis intervention model that has been adopted across the state of Oklahoma. I have worked with Garrett Lee Smith campus, state, and tribal suicide prevention programs, Native Aspirations (which utilizes Dr. Theresa LaFromboise's American Indian Life Skills [LaFromboise, 1996] curriculum), Indian Health Service, and tribal programs focused on behavioral health. I walk in many worlds with regard to this issue: Native and Western with my bicultural identity; clinician, teacher, researcher, and consumer of mental health services; survivor of suicide; promoter of wellness, and prevention of suicide. I hope my testimony will assist the Committee in understanding the needs and potentials related to AI/AN youth suicide and promotion of positive AI/AN mental health.

You have received statistics from others highlighting the suicide rates of AI/AN youth as the highest in the nation and escalating in recent years (Broderick, LaFromboise, McSwain, Reid, Walker, 2009). Suicide in AI/AN communities is an epidemic and in need of the attention given a public health epidemic. A great deal has been addressed in recent years by the Garrett Lee Smith Memorial Act (P.L. 108-355). I have worked with campus, state, and tribal applicants and awardees of these grants and know the hard work that is being done to address youth suicide through the funds provided. I have worked with the Native Aspirations program and know that they are trying to address suicide prevention in some of the most ``at risk'' AI/AN communities in the country. I have also worked with the Suicide Prevention Resource Center and Suicide Prevention Lifeline and the great work they are doing to provide resources and support for suicide prevention. But this is clearly not enough.

Services

Mental health services available through Indian Health Service (IHS) and tribes are already stretched beyond capacity. As more youth are identified as suicidal or at risk we need more local services to address those needs. Many times youth must be transported hundreds of miles from home for inpatient treatment and then lack the aftercare services needed to transition to outpatient, and follow-up treatment when returned home.

When writing a grant a few months ago, I worked with Aberdeen Area IHS Behavioral Health staff to determine the ratio of mental health providers to AI population in the Aberdeen Area. The results were overwhelming: one psychiatrist per every 250,000 American Indians; one psychologist per every 17,000 American Indians; and one social worker or counselor per every 3,300 American Indians. Every county with AI reservations has been designated as Mental Health Professional Underserved Areas through the Health Resources and Services Administration (HRSA, 2008). The requirements for Mental Health Provider Shortage designations are 30,000: 1 for geographic areas or 20,000:1 for high need areas. Core mental health providers (CMHP; clinical social workers, psychiatric nurse specialists, clinical psychologists, and marriage and family therapists) rations 9,000:1 including psychiatrists or 6,000:1 CHMP and 20,000:1 for psychiatrists (HRSA, 2009). Indian Health Services behavioral health services are currently funded at about 25% of the actual need. Solutions to this problem includes passage of the Indian Health Care Improvement Act, increased funding for behavioral health services to AI/AN communities, minimal standards for providers of behavioral health services to ensure the protection of those receiving services, funding for training programs to increase the numbers of AI/AN behavioral health service providers, cultural competence training for providers of health, and behavioral health services in AI/AN communities. Resources to utilize American Indians into Psychology trainees and other trained, credentialed, AI/AN providers on an emergency basis help to assist with suicide emergency situations. Many of the youth involved in suicidal behaviors are in need of substance abuse services as well as mental health services. More funding for dual diagnosis services close to home for these youth are important in maintaining connection with families and receiving care for both issues at the same time.

Education/Training

The need for training includes increasing the numbers of AI/AN licensed mental health providers and trainings on cultural awareness, competence, and integration into services, prevention, and programs provided for AI/AN youth. There are approximately 250 AI/AN clinically trained psychologists (0.3% of 84,883), 865 AI/AN clinically trained counselors (0.5% of 100,533), and 150 school psychologists (0.4% of 37,893) in the U.S. (SAMHSA, 2004). Currently, there are American Indian/Alaska Native into Psychology programs at the University of North Dakota, Oklahoma State University, the University of Montana, and the University of Alaska-

Fairbanks. Utah State University has an unfunded American Indian Support Project. While these programs increase the number of AI/AN psychologists, there is a great need for more. The inclusion of clinical, counseling and school psychology programs would increase numbers and fill varied roles for mental health providers who receive the same licensure in states. To fill the gaps in the pipeline, mentoring programs to support AI/AN students between undergraduate and graduate programs would increase their competitiveness in applying to graduate programs and pre-doctoral internship programs; post-doctoral (pre-licensure) opportunities would provide clinical experiences with AI/AN clients and give those graduates work opportunities, helping them to get through the licensure process so they can work at IHS and tribal facilities.

In addition to training mental health providers, cultural competence and awareness training needs to be a requirement for all health service providers in Indian Country. It is critically important that those providing services can relate to the cultural values of the people they serve to increase the likelihood of AI/AN people in need of services seeking out the help that is available. If culturally appropriate programs, media, and services are not available, the resources are less likely to be used by those who need them most. In addition, a strong cultural identity has been found to be protective against depression (Gray, et. al, 2008).

While the need for services and well-trained professionals is evident, another area of need is the training of community members, first responders, and school personnel to recognize, assist, and support youth prior to reaching a suicidal state. Programs such as Question, Persuade, Refer (QPR) (Quinette, 1999) have been adapted for Indian Country and focus on suicidal behavior recognition and intervention. Mental Health First Aid is a program like a first aid program focused more generally on mental health issues, recognizing symptoms, crisis situations, intervening in a crisis, and supporting a person throughout any treatment or follow-up (MHFA, http://www.thenationalcouncil.org/cs/press_public/mental_health_first_aid_2/about_the_program/mhfa_course_description). This program has shown increased willingness for participants to intervene in the case of a mental health emergency, greater feelings of confidence in their abilities to do something in a mental health emergency, and reduced stigma regarding mental health issues by those completing the training (http://www.mhfa.com.au). Funding for programs like this in Indian Country, where there are great distances to travel for services and need for support locally, can help to increase capacity for supporting those in crisis within the community.

Research

Although we hear a great deal about evidence-based practices, there is virtually no research on evidence-based treatment with AI/AN populations (Miranda, et. al, 2005) and only two suicide prevention programs being studied to establish their efficacy: American Indian Life Skills and Sources of Strength (LaFromboise, 1996; LoMurray, 1998). There is very limited research on the assessments used to measure effectiveness of programs with AI/AN programs. These

measures must be tested before the results of efficacy of programs that utilize them can be tested to provide accurate information on the use of programs with AI/AN populations. To give the needed attention to this work, funds through NIMH, NIDA, and NIAAA are needed to address levels of research to measure, and provide evidence-based practices in AI/AN populations. Interfaced data and a national registry through IHS for suicidal behaviors and treatment, to provide data informing continuity of care across systems for inpatient, outpatient, dual diagnosis, and other supportive services, is necessary. Establishing a mandatory reporting system, such as the kind used for reporting child abuse, could help to identify troubled youth before they actually attempt suicide and subsequently get them access to prevention services.

Technology/Infrastructure

In remote areas of Alaska and throughout Indian Country, a technology infrastructure is needed, from electronic health records (EHR) that interface across IHS, tribal, Veterans Affairs, private, and public health systems, to telemental health programs that allow for services and billing of psychiatric and mental health services across state lines and licensure jurisdictions. Blue ribbon panels to address the issues of access across service systems of EHRs, and funds to support the development of the interface of these systems, are needed. Demonstration projects in telemental health are needed to find how these systems can provide better care and address the issues of licensure and access to services across state lines. Infrastructure funding is needed to provide adequate technological support for the distance services, including video and audio connections for youth located in residential treatment facilities to their families at home who may not be able to visit them while they are in treatment. This helps to maintain their connection to family and loved ones during a stressful time in their lives.

Summary

In summary, my recommendations to this committee cover four general areas: mental health services, education and training, research, and technology and infrastructure.

Mental Health Services

1. Passage of the Indian Health Care Improvement Act;
2. Increase funding to Indian Health Service to increased the number of credentialed mental health professionals providing services in Indian Country;
3. Increase funding of Indians into Psychology and Indians into Medicine to increase the numbers of AI/AN providers in Indian Country;
4. Increase funding of loan repayment programs to recruit and retain qualified mental health service providers in Indian Country; and
5. Fund aftercare treatment programs and circle-of-care services for transition and follow-up treatment for AI/AN youth.

Education and Training

1. Fund and require cultural competence training for service providers in Indian Country;
2. Increase funding and scope of Indians into Psychology and Indians into Medicine programs to more locations and include clinical, counseling and school psychology programs as part of Indians into Psychology;
3. Fund enrichment programs for AI/AN students between undergraduate and graduate programs to make them stronger applicants for graduate and medical school;
4. Fund clinical placement, internship, and post-doctoral residency programs for AI/AN students for experiences working with clients in Indian Country, and jobs in transition while working toward licensure; and
5. Provide funding for programs such as Mental Health First Aid that help to build community capacity and reduce stigma related to mental health issues and crises.

Research

1. Funding for research on assessment materials used to determine efficacy of treatment programs with AI/AN populations;
2. Funding for research to determine evidence-based treatments for AI/AN populations;
3. Promote and fund the interface of data and a national registry through IHS for suicidal behaviors and treatment, to provide data informing continuity of care across systems for inpatient, outpatient, dual diagnosis, and other supportive services; and
4. Establish a mandatory reporting system to gather data, plan programming, and get youth needed services before they complete a suicide.

Technology/Infrastructure

1. Fund interfacing of electronic health records across IHS, tribal, Veterans Affairs, private, and public health care systems;
2. Establish a blue ribbon panel to address the issues of access across service systems, as well as technology-based services across state lines, and licensure issues;
3. Fund demonstration projects in telemental health to find how these systems can be of greatest assistance in Indian Country; and
4. Fund infrastructure to connect service providers, families, and patients for communication and treatment planning with support networks while in residential treatment.

Source: Jacque Gray, Youth Suicide in Indian Country, Committee on Indian Affairs, Hearing 111-36, February 26, 2009 (Appendix 79-85). Available at: https://www.govinfo.gov/content/pkg/CHRG-111shrg47726/html/CHRG-111shrg47726.htm.