



**Youth Suicide Prevention: Putting our Minds Together**  
A Think Tank Discussion on Research and Practice Implications for  
Native Youth Suicide Prevention

Sponsored by National Congress of American Indians (NCAI) Policy Research Center, National Indian Child Welfare Association (NICWA), and Georgetown University National Technical Assistance Center for Children's Mental Health

NCAI Mid-Year Session: Kewadin Convention Center, Spruce Room  
Sault Ste. Marie, Michigan  
Sunday, June 18, 2006  
Convening Notes

**Welcome by Sarah Hicks, Director, NCAI Policy Research Center**

**Goals of the session by Terry Cross, Director, NICWA:**

Need for conversation around emerging issues related to Youth Suicide Prevention. Youth suicide is an urgent issue in Native communities.

- SAMHSA will fund a summit in 2007 and today's think tank discussion is an opportunity for us to pull together key people and discuss issues for this upcoming summit.
- Convene a group of experts; share information with each other; support one another; coordinate between scholars, tribal leaders, researchers etc. We want to know about barriers people face in the work they do with Indian youth suicide prevention as well as about current data resources and gaps in this knowledge.

**People joining by phone conference and web:**

- Jacqueline Mercier, Executive Director, Native American Rehabilitation Association
- Dr. Paulette Running Wolf, Project Manager, Kauffman Associates
- Dr. Theresa Laframboise, Associate Professor of Education, Stanford University

**Additional official presenters in the room:**

- Dolores Subia Bigfoot, Assistant Professor, University of Oklahoma Health Science Center
- Dolores Jimerson, Director of Community Development for Children's Mental Health, NICWA
- Holly Echo-Hawk, Senior Mental Health Consultant, NICWA

**Welcoming remarks by the following:**

- Joe Garcia, President, National Congress of American Indians
- Jefferson Keel, Vice-President, National Congress of American Indians
- Jackie Johnson, Executive Director, National Congress of American Indians

Don Milligan, Executive Board Member, NICWA, said care providers need to learn signs, risks, and what to do about suicide. Care providers include many people in the community. NICWA is gathering the best information available about suicide.

**Additional opening remarks:**

NICWA is putting forth a resolution on suicide prevention to foster support by NCAI leadership to make this a more comprehensive approach to preventing suicide. Also, NICWA is helping to sponsor this think tank at this 2006 Mid-Year meeting. They are also assisting with the SAMHSA convening in 2007.

This is the very beginning step to pool resources and determine what tools, research, and curricula are available to address this work. We will be identifying gaps in our knowledge and to think about ways we can work together to address these needs.

The NCAI Policy Research Center is the bridge between elected tribal officials and the field. They are trying to help tribal leadership to make decisions that are based in the best available research. If no data is available, then involve research to advance work. The think tank effort is to bridge this gap.

NICWA has a MOA with NCAI and this allows NICWA to accomplish more at the legislative level. Our ability to influence legislation has to do with how well we coordinate and get the message across.

**Jacqueline Mercier, Executive Director, Native American Rehabilitation Association, 1st presenter**

Our youth have given the signal that our communities are troubled. Much of this is historical trauma. There is a heaviness coming over people talking about this topic. When we do this work, we recognize its critical nature. This triggers trauma for those doing the work and need to care for each other doing the work. NARA is a wellness organization. Yesterday, NCAI and the Urban Indian Health Board signed a MOA.

NARA had entered into agreement with nine tribes of Oregon to reduce suicide in the state. In Oregon, it is three times more likely for Indian youth to take their life than for youth of other ethnic backgrounds.

NARA is interested in the following:

- Creating sustainable tribal project with tribal groups
- Creating collaborative efforts
- Connecting to statewide efforts
- Building capacity of communities
- Supporting each tribal community to grow their own project

NARA created a statewide Elder's Council.

How do we support and create healing on a number of levels?

Training with natural caregivers regarding:

- Recognition-early identification and linkage

- Media campaign
- Collect and analyzed data. Need data about what works for our communities to promote healing that needs to happen.
- Advanced research

Tribal youth are encouraging us to focus on strengths and they are concerned about how on the surface a lot of the pain and trauma is. You can have very deep connections very quickly with Indian youth. Mental health resources in tribes and counties are not so developed.

3 simultaneous efforts:

- Do treatment when have risk or mental health need
- Do intervention before something more serious
- Prevention

Some tribes have talked about the challenges of this effort. Culture is treatment and prevention. There are efforts to encourage cultural revitalization and to encourage people to embrace spirituality and focus on individuals, family, and community among the nine tribes in Oregon. When does hope fade to depression and depression fade to despair? Are we poised to intervene? Community despair represented by sexual abuse, abuse, etc. Need prevention for youth and more focus on protective factors. Prevention is helping communities think of economic opportunities, housing, education, and strengthening families and relationships. Clayton Small model (Clayton Small is a Trainer/Facilitator of Accessing Native American Training). Communities narrow down to what they want to do and are looking at a planning tool (each community picks models which work for them).

This work is related to the core work of NARA which is to raise the health status of people. We have health services, mental health services, and alcohol and drug services.

Part of our work is developing self-esteem mastery of one's life and to help people build life in way which works for them. It takes a lot of resources to do this.

We could create web based connections with communities throughout Oregon. Related to funding for the Garrett Smith project, communities are in process of overcoming isolation and three years not a long time to work on these issues. We propose three years for a planning grant and a five year implementation grant similar to Circles of Care. These are not issues we can overcome in three years. Need additional resources and people to coordinate efforts in each community.

We have a gap in knowledge related to how to talk about suicide prevention. On the surface, pain is there for Indian people. Part of grant is to talk about suicide prevention and engage youth in this effort. How do we have conversations in safe way and avoid problems in other communities?

Previously, we had a community forum following a suicide and the group was retraumatized. When do we talk about this suicide? How do we involve elders? At the IHS Indigenous Suicide Prevention project, the elders said to slow down efforts and to begin focusing on strengths and embrace life instead of contributing to retraumatization.

Related to a call to life, how do we write grant from strengths based perspective? How do we rebuild communities or help them rebuild themselves?

Regarding wrap around mental health systems, how do we fund these efforts? How can we all make a statement that we won't drink and use drugs and model this to our youth? If every community can do this, we can reduce suicide. Need to research the connection between hard liquor and suicide. Need for training and multi-level approaches. Where can the healing start?

Additional notes related to culturally specific preventions:

Issue around getting cultural preferences/practices established as best practices.

Research needs to catch up-impact SAMHSA, IHS, CDC, and NIH

Heart of organization is around sweats and talking circles

Training could happen for CHRs and families and schools

**Dr. Paulette Running Wolf, Ph.D. Project Manager, Kauffman Associates (KAI), 2<sup>nd</sup> Presenter**

Native Aspirations is a project to address youth violence, bullying, and suicide prevention/intervention for nine AI/AN communities.

Community Selection, 2 step process for participation in Native Aspirations:

- 1) Quantitative analysis to select 3 highest risk IHS regional service delivery areas
- 2) Regional stakeholder nominations to determine the communities most in need of project services

For quantitative analysis the following indices were considered:

Mortality, poverty index adjustment, per capita homicide rate, per capita suicide rate, per capita motor vehicle rate, relative funding for IHS area A & SA programs, and population of Native youth.

Identify nine high risk communities for suicide and bullying prevention and identify three highest risk IHS communities-Aberdeen, Alaska, and Billings

Demographics, per capita homicide rate, and a focus on population ages 15-24 years old

It is difficult to access IHS data to assist with program planning.

In Aberdine, Alaska, and Billings, Wyoming area, identified administrative stakeholders and identified four communities most in need. Regional BIA administrators, law enforcement administrators, and others in region to contribute.

Aberdeen: Pine Ridge, Crow Creek, Cheyenne River

Billings: Fort Belknap, Fort Peck, Wind River

Alaska: Native Village of Savoonga, and Alakanuk, Noorvik Native Community

Process:

- Created a statement of work and evaluation design without OMB approval to get money out to the community. (\$50,000 per community and \$1,000 for community event)

- Had planning retreat, conducting introductory site visits to tribes and regional corporations. Conducted community mobilization trainings with 100% attendance rate. Conducted four community mobilization planning events.
- Identified community stakeholders and conducted interviews to identify their community readiness
- Communities are prepared to take on interventions but need to work on community awareness. Pool resources together to develop a comprehensive plan.
- Allowed for not just evidenced based interventions but also cultural based interventions.
- Have online reporting process for each project and final project report at end of 18 months. Also have a project monograph.
- Required resolutions-for reservation wide. Identified lead tribal contact and an oversight panel and identification of TOT training participants

#### Creation of Project Oversight Panel

Members may include:

- Tribal administrator (1)
- School administrator (1)
- Community member (1-2)
- Youth (1)

Responsibilities of supervisory panel:

- Assist in coordination and planning for the community mobilization training event
- Promote multi-agency collaboration, oversee project implementation, and monitor and approve project implementation budget

Developed a Memorandum of Understanding and implemented a project online reporting system.

#### Technical Assistance

Centralized Training of Trainers (TOT)

- Offered evidence and practice based intervention curricula
- Offered community mobilization and strategic planning training event
- Ongoing Project Implementation (one point: assistance with development of tribal media responses to suicide and violence incidents)

Don't just focus on suicide but also violence and bullying as these are risk factors of suicide.

Project evaluation, community readiness:

- Community readiness model-phone interviews with 4-6 community stakeholders
- Identifies community strengths and barriers
- Assists with comprehensive community-wide planning and efforts

Key Planning Components:

- 1). Community voice
- 2). Community readiness model
- 3). GONA (Gathering of Native Americans) Team Building Framework

Lessons learned:

- Community mobilization and planning events must be supported by leaders.
- Often multiple efforts occurring without cross-department or agency collaboration.
- Mean “community readiness” (3.0). Vague awareness: beginning recognition that there are these problems, but no motivation compounded by territorialism to do anything about it.
- Majority of communities have limited or no resource referral systems.
- None of the schools in the participating communities are conducting screenings.
- Tribal programs are often not aware of each other’s prevention efforts and have difficult collaborating

Key recommendations:

- Address the lack of collaboration and planning between schools, tribal programs, and tribal leaders (multi-agency training)
- Support the creation of well-planned “Resource and Referral” systems
- Support gatekeeper’s can engage in community training which will raise community awareness and understanding of the issues
- Support the use of community wide screening (Teen Screen with additional alcohol/drug questions)
- Create community based crisis response teams in every community, a cultural based response
- Assist tribal communities in establishing an evidence base for tribal culture/practice based prevention and intervention efforts

Tribes have a right to protect culture and protect safe interventions.

KAI Contact Information: Kauffman & Associates, Inc. 425 W. First Avenue (509) 747-4994.  
[www.kauffmaninc.com](http://www.kauffmaninc.com)

**Theresa Laframboise, Associate Professor of Education, Stanford University, 3<sup>rd</sup> Presenter**

Stress and Suicidal Behavior from a Native American Perspective-a cumulative stress model

This model allows us to incorporate historical trauma-includes acculturation stress (with emphasis in this country on war, immigration, technologically); historical life events; six-month life events; regular stress; predisposing mental disorder; poverty; invisibility of Native issues given current challenge of our government (minimization in light of what’s happening globally) and invisibility in urban areas; perceived discrimination

Need to do something proactively in schools so youth are not as vulnerable to these stressors and to deal with situations instead of wanting to opt out.

Cultural Buffers: cultural identity; traditional spiritual involvement; participation in traditional activities; community mindedness; perceived community support; filial obedience (young people can make a difference in the community by visiting family and identifying people who are more isolated)

Negative mental health indicators: psychological mechanisms; personal control; perceived community support; community mindedness; perceived social support; school belonging; life skills strategies; social problem solving orientation.

Decrease depression, hopelessness, substance use, anger, and anxiety (negative mental health indicators)

Want to increase life skills, young people's sense of competence and well-being

American Indian Life Skills Development Curriculum:

This is a school-based intervention and thus look at measures for academic achievement-don't look at Grade Point Average

Strongest measures of success of interventions is attendance in schools and decreased tardiness

Had a number of lessons created before everything standardized. Implemented at Zuni, in school 3 days a week for a year.

Teachers had a choice about which lesson they could choose for their students. Each lesson could teach the same skill. Tension of academic freedom-lessons given by teachers. Each of the lessons teaches the same skill-can use one or multiple lessons depending on need.

Non-randomized groups of students are important. Groups were not equivalent. With the intervention, students move ideation. Groups had 31 people per group: matched students to deal with it statistically; randomized video tape role play (14 each)

Target Skills:

Suicide prevention (get youth to someone who can help), communication (use positive self-talk), depression management, stress management, anger regulation, and goal setting

Effectiveness:

- Found that intervention worked. Used scales for the self-report.
- With survey, found a decrease in hopelessness for kids in intervention class.
- reversed suicide attempt rate and completion. Zero completions noted since the implementation of the program in the 1980's.
- Program named a SAMHSA Program of Excellence in 2005
- This was deemed one of 10 effective programs by the National Registry of Effective Programs (2004)

Self-Efficacy Skill-how competent are you to manage stress and anger-asked kids this question

Kids in intervention could role-play helping a suicidal friend-have behavior on video and videos randomized

Sequoyah High School in Tahlequah, OK, Cherokee Nation, did intervention and Select implementation sites:

- Turtle Mountain Community Schools; Turtle Mountain Reservation, Belcourt, North Dakota
- Sequoyah High School, Cherokee Nation, Tahlequah, Oklahoma

- Prince Rupert School District, Tsimshian Nation, British Columbia
- East Palo Alto Middle School, East Palo Alto, CA

Tri-Ethnic Center Stages of Community Readiness (8 stages)-most communities at vague awareness stage. She is focused on last three stages: stabilization, confirmation/expansion, and professionalization

Level of promising practice-Future study use randomized clinical control trial then an outside group needs to do randomized clinical control trial. Then, outside group repeat. Level of evidence required v. expensive. Bring in professional interventionist. This is a rigorous process and difficult for communities to get excited about this.

This is very expensive to test intervention. Hard to give up mental health staff to do intervention in classroom. Used Ph.D. students do evidenced based work in Indian communities. Need to offer human resource training in Tribal College to be hired as interventionists.

Where to go from here?

After randomized trial conducted in middle schools this year, learned the Indian Life Skills Curriculum needs to be modified for students as the language is too advanced for them. Adapting curriculum this summer. Then conduct randomized control trial to do it right. With emphasis on No Child Left Behind, hard for high schools to give up time for instructional time with this curriculum. If schools emphasized social and emotional learning as fill in content, be flexible to bring these topics in whenever possible.

Ideal:

- Randomized clinical efficacy study
- 3 reservations (2 intervention, 1 control) geographically far apart
- 2 AI interventionists per site
- Middle school age students
- Comparing AILSDC vs. control classes
- Pretest, posttest, 6 month follow up survey

Pilot test-Pretest survey findings-Middle School Students:

- 8.1% at the critical level on suicidal ideation (400 possible subjects; recruited Oct. to Feb. and only had 125 kids signed consent forms.
- 75% of kids stayed in intervention from April to May and there was open door policy and could leave
- 19.6% attempted suicide (attempting at very early age-need to do evidence based work to show it was serious at the middle school level; asked how often they did it and if required medical attention).
- Attempt findings are two times the general population ages 15 +, 11-14 years attempt rate 8.3% vs. 19.6%

Of those who attempted:

-10.8% had attempted once

-5.9% had attempted twice

-2.9% had attempted 3 or more times

Recency of attempt:

2.9% attempted in last 6 months

6/9% had attempted with the last month

96.1% did not go to the reservation clinic, hospital, or see a doctor

On survey, had section on survey why they were attempting and they wrote in on section and school contacted parents (breaking confidentiality as explained to suicide attempters) and 50% of parents already knew of attempt. Researchers told the youth they would break confidentiality and the youth still reported attempt.

Girls attempt more often than boys. Girls with high rates of depression.

High numbers of students with learning disabilities who had higher suicide idealization rates.

Six risk factors:

- Negative problem orientation
- Financial strain
- Weak sense of belonging to schools
- Depression
- Hopelessness
- Previous history of suicide attempt (8 times more likely)

Knowledge Gaps, Impact of social and emotional learning on academic success:

- Interactive programs that enhance the development of interpersonal skills, behavioral and cognitive-behavioral self-control have greater impact on dropout and nonattendance, substance use, and conduct problems. Teachers stay longer.
- If focus on social and emotional learning, then academic gains do occur.

Classroom teachers afraid to do intervention work. How to help teachers with this type of work? In BIA schools, question, persuade, and refer method but don't utilize this model. How to implement in an environment concerned with NCLB legislation?

Knowledge gaps:

How do we begin to make a difference in kid's lives in how they can have hope in the future and not be bored and depressed? Need to do risk factor research. Other kids see TV and don't see new development in their communities. Positive development with Boys and Girls Clubs. Needs to be comprehensive approach. Kauffman group doing partnership work and this is exciting.

American Indian Life Skills Development Curriculum, University of Wisconsin Press, Chicago Distribution Center. (800) 621-2736, (800) 621-8476. Custserv@press.uchicago.edu.

**Comments, thoughts, and questions from participants:**

Suicide taboo and with Christian influence buried outside of cemetery. In terms of thinking about if we should use the word suicide, should we focus on suicide or on a positive reframing of the situation?

Could we use a different word than suicide and use a Native word which is more meaningful? We could use some word referencing the preservation of life or with the connotation of life. Zuni people did not want word suicide in title. This is about preserving life. Use Native American words for life. Address the stigma with suicide and mental health-destigmatize suicide. Put positive twist on seeking services.

As a practicing psychologist, when don't use words like death or suicide it keeps the stigma going. Kids given double-talk and caught in a power struggle. Don't talk about life skills; be realistic to address death, suicide, and life. With traditional teaching, recognize strengths and don't be afraid and talk about suicide, death, and the impact. Pull both together and use traditional words, positive strengths, and real words.

Nationally, an effort to destigmatize mental health and tribes not accessing SAMHSA resources. SAMHSA has initiated a national effort to transform mental health. Refer to grants as Transformation Grants (7 states have Transformation Grants to help them transform mental and behavioral services, reach those they are not reaching) Oklahoma has 13-14 million dollars to do this over 5 years. In Oklahoma, created Office of Innovation to create Transformation Agents and encouraging them to make sure tribal voice is prominent and recruit and hire tribal members as Transformation Agents.

Sioux Tribes not given SAMHSA grant as they were marked down for not participating in state initiatives to make them eligible for grant. But, the tribes weren't able to participate in state initiatives.

Is there data, by state and tribe, over last 10 years of incidence rates? Alaska has by region for the last 10 years and an Alaskan statewide plan.

IHS has information on suicide from tribes which choose to report. Some by state. Different states have kids count and some tribes don't give data. Inconsistent pool of data, scattered.

Child death review committees have good data (see near miss data too). Different states have different statistics, elements (data)

What is the policy approach to get a more consistent picture of what's going on?

NICWA CAN data analysis is a good model. Recommendation: need better handle on data.

**Dolores Subia Bigfoot, Assistant Professor, University of Oklahoma Health Sciences Center, 4<sup>th</sup> Presenter.**

Indian Country Child Trauma Center Programs:

Honoring Children-teach them about inappropriate sexual abuse behaviors they are already experiencing (underestimate the risk)

Honoring the Future-related to suicide prevention

SAMHSA is their funding source  
Revision of suicide prevention material  
In July 2006, revising material for middle school students  
Honoring children, honoring the future

Work with 80-90 tribes but only go into communities in which they are invited.  
Most of the work done with front line workers. This program is the tribes and want them to advertise it in the way that works for them. Want tribes to own it.

Kids underestimate risk and parents underestimate risk too (wear helmets, seat belts, diet leading to diabetes)

School don't want to address suicide. Some have a lack of knowledge to adequately address suicide. We do avoidance behavior well. Avoidance of mental illness, risky and suicide behavior.

Lack of knowledge in understanding the words (terms) youth use to describe their behaviors and thoughts (if saying I'm emo=they are feeling something, emotional). Kids do a lot of text messaging. Youth connect with other youth and not always savvy to connect with adults. Kids underestimate risk and do not share when other youth mention suicide. They are not sharing this information to other people.

Youth disconnected from their families. Do they eat breakfast together as a family? Do youth receive a morning greeting? Are kids greeted when arriving home? Do we eat dinner together? Need structured family time as this is important for families.

Traditional way-We greet the morning, greet our kids each morning, and have structured activities

Understanding collaboration of agencies, service providers, etc. (ideal and real)

We have a public health crisis and need to address it in a public health model by educating our leadership, community, decision makers a certain way. Need comprehensive approach. We created a shortened form for communities to assess themselves. Communities need to market themselves and their strengths. Help communities market themselves and provide info, data, and curriculum to themselves.

OKHSC-shorter community readiness survey

Link with CDC, NIH, and funding agencies to educate them so tribes can participate in research. Have NCAI start lobbying CDC and NIH and SAMSHA to be understanding of what it means to do research in Indian communities.

Identified best practices by age groups: kids need to know how to solve problems, decrease anxiety, deal with depression, cognitive reprocessing, and how to solve thinking errors.

When go to ceremony, stop and think this way (cognitive reprocessing)-think about this in a good way. When we help kids to do this, let's think about it in this way. Intrusive thoughts. Don't retraumatize kids. When we have kids talk about their trauma, we can help them say this really bothers me or I'm scared. We need to help kids prior to trauma narrative to not have intrusive thoughts, racing heart beats, etc. Otherwise, when they do talk about it, they are retraumatized and more susceptible to suicide. Need tools to learn how to not be traumatized.

Need to develop a directory to call experts in on different things. People who can really deal with suicide and organize programs there. Get beyond territorial issues

Need clearing house for suicide prevention.

Encourage tribal health boards to partner with NCAI to see mental health of children as a real priority and coordinate services with tribes and engage with youth about what it means to engage in high risk behavior. Need to look at local and national health plans and make children's mental health a priority. What it means for youth to engage in high risk behaviors. Sent away if no services locally. Kids don't tell people about problems as they fear being sent three hours away. They know they will be at home permanently if kill self because know they'll be buried at home.

If kid says they want to kill self, people need to react. Parents can have a tendency to diminish children's concerns. Be conscience of words we use and strengths of children.

Hope to explore the College of Public Health at OU. The OU Terrorism and Disaster program is developing 10 teams and research guidelines to assess what went wrong and what could be done differently. The Transformation Grants could be targeted by youth suicide prevention. Could build treatment teams in tribal communities.

Try to develop MOU among state, county, and tribes so they can support one another.

Suicide affects every other child in family and others in community.

Skills to assist youth:

- Recommend they breathe
- Have them ask, who do I need to go to?
- Equip children with tools with them all the time to do what they need to do. We push kids out there without the tools

We have intergenerational trauma. The families' response can be to provide traumatizing environments. We send kids back to traumatized survivors themselves.

IHS needs help and need to get money to tribes. There are so many workgroups working on suicide and meth and if coordinate correctly and link to funding sources. Need coordinated communication to go to NIDA, NIH, and NIAAA. IHS research office.

Need to recognize the symptoms. Families don't have tools and suicide can be traumatizing to whole families because they feel guilty.

Yellow ribbon campaign working in Indian communities too.

**Dolores Jimerson, Director of Community Development for Children's Mental Health, NICWA, 5<sup>th</sup> Presenter.**

We know our children are sacred and we are all related and what I do impacts our earth and all. We have a relational worldview.

Pinpoint with each community when this changed and historical trauma began. It began with European contact and introduction to boarding schools-deal with unresolved grief and historical trauma see violence as a result. Got out of balance. Cumulative losses-want to go be with those ahead. Suicide not seen as evil, but normalized because experience so much death.

Have Indian on Indian violence too.

SAMHSA 1984, Systems of Care based on CASSP grants to plan and the tribes were left out. Tribal communities operate in a relational world view instead of a linear world view. Tribes need more time to plan. Three year planning initiatives to develop System of Care and partnership with everyone in community. Included elders and grassroots level people. Engage entire community. What are the gaps which exist in our community? What resources exist to come up with a plan?

NICWA contracts with SAMHSA. To make the language relevant to tribes, talk about being bi-cultural. Communities call it “families out of harmony” or “in temporary disharmony” instead of DSM4.

Have holes in the soul-experience pain. We take something to alleviate pain by getting really numb and hurting ourselves.

When have one loss after another, don't get to recover from one loss before another happens. You get numb and suicide is seen as norm and not evil thing to do.

With our communities, NICWA is being told as restorative justice approach truth and reconciliation. It makes us angry our children were stolen from us. We need to talk about pain and reconcile it. It is hard to write about what it works. Doing the naming ceremony and sweat lodges, use what has historically helped your family. We see case after case kids getting better due to ceremonies. Talk about the pain and combine western and traditional ceremonies.

Help mobilize communities-Circles of Care is a planning grant. Tribal communities to redefine process and bring in elders and spiritual advisors to the table. The Blackfeet community graduated in 2004 created an elders group. They talk about intergenerational trauma, use their own evaluators, put own team together, and hire their own staff.

Doing research within their own communities and use research in a way to move community forward. The community owns their data and can express their sovereignty. System of Care coordinates services so as to not lose kids.

Many referrals come from public schools. Need to have communities work with schools to identify family dynamics, historical trauma, etc.

Traumas vary from tribe to tribe.

NCAI could help with educating about sovereignty to make sure done in a culturally responsive way. Tribes should keep a strong voice and talk about what it is working in Circles of Care initiatives. To apply for Systems of Care grants, need to be tribe or state. Thus, need to advocate for urban centers to apply as we need community partners to apply. Two urban sites (qualify for

Circles of Care but not Systems of Care, have to advocate to state or have TG partner to apply and allow urban to implement).

We want:

- Youth guiding process
- Services based in our homes and schools
- Continuous quality improvement
- Discretionary money
- What's working (ensure future \$)

### **Holly Echo-Hawk, Senior Mental Health Consultant, NICWA, 6<sup>th</sup> Presenter**

Suicide is a lonely event. At IHS meeting recently, a participant talked about suicide as not being about death. Kids don't want to die they just want to stop the pain. It is about not feeling you have control to change self, family, or community. It is about need for comfort and natural ways to calm ourselves and regroup. There is a need for problem solving and for confidence. It is about self-medicating to escape. We need to understand the language our young people use. Need language to understand pain, hope, and dreams (generational issues). Need for coordination and to not reinvent the wheel. Need to develop and coordinate the data. Find the link with the dollars.

A policy summit-when there is a trauma and there are community needs, policy can direct \$ to the problem.

From IHS data, have suicide ideation 1995-2005, by age, attempts, and completions by age

Ideation from ages 15-19

Tribal suicide completion-this is only the data of tribes reporting to IHS. There are more suicides.

Substance abuse too? Adult focus too?

The SAMHSA Policy Academy Initiative is funded by the Child, Adolescent and Family Branch of SAMHSA Center for Mental Health Services.

Gives \$ to Georgetown and they develop policy academy

Georgetown Policy Academy: previously failed when including tribes; fund states or U.S. territory; funded for 7 people; usually 120 people total including faculty have plenary sessions and seminars

From 1999-2005, no tribes were applying. In 2005, they set aside funding for a delegation of 7 tribal people to do cultural critique of Georgetown process. Met in Albuquerque and determined this academy has to focus on suicide prevention, healing, etc. The participants thought was most pressing issue facing Indian Country. Could expand the number of tribal delegations? Included \$100,000 plus for a tribal policy summit. Have NCAI, National Indian Health Board, NICWA, etc. Geographically diverse. Three day event in May of next year somewhere in U.S.

SAMSHA said they have other money for other policy academies to direct to tribal people. Could have more delegations or one in 2007 and 2008. Could expand to child, youth, and adult focus. Suicide, mental health, and substance abuse. Need to think about who should be at table (best at

Indian Country on these topics)? Families/tribal members? Must read articles on suicide? Key topic areas? How to deal with key trauma areas-front line responders? If this is to have ripple effect, how do we share results of this after summit is over?

Bigfoot's program has shown parent/child therapy (evidenced based intervention) and culturally based interventions can be the same thing. Use clinical outcome measures in Native project – evidenced based interventions can be done-address this at a policy level at the summit. Funding outside of SAMHSA? Yes, discussions to target additional private foundations such as the Robert Wood Johnson Foundation, corporate sponsors, the Carter Center, and the Center for Medicaid Medicare Special Populations money. Key tribal council people from around the country? (Have tribal elected officials on steering committee). Bring in youth to this summit too. Do have parents on steering committee but need youth. NICWA has emerging youth involvement component. Meet with NCAI youth council and MOA with NICWA for youth advisement. Find some survivors. There are young people helping each other stay alive-survivors of losing someone. Need therapy there at gathering as this conversation triggers intergenerational grief. Situate people with counseling background and a safe room to watch for breathing, people going flush, crying. Have traditional healer in there with sage healing to leave the emotional part and then go back in or go rest and care for selves. SAMSHA will step aside and tribal people run this and Indianize the segments. Identify elders and traditional healers. Need law enforcement there as they are the first responders and as they are holding youth in detention centers because no other options.

Summit can be vehicle to coordinate efforts.

### **Participant comments:**

4000 people had 23 suicides this year alone in Canada. If it is a sensational issue, create organizations to respond. Holistic approach and what we do and say does affect someone. Prayerful. Not a day we don't think about how carefully we move forward. A number of years ago, participant wanted to host a suicide prevention gathering and wanted money to fund it. Participant said he'd come from a business background and he focused on empowerment and business accounting. He talked about challenges instead of problems. Don't call yourself positive instead of negative. Weak communities produce weak leaders because of weak fathers. Need to bring people involved in business (economic development), arts, healers, and law enforcement to the table so as to take a holistic approach or stay isolated. It's Father's Day, having a happy fatherless day for all have no fathers.

Try to do these briefings and don't want a bandwagon effect (create new organizations to deal with a hot issue vs. holistic approach) and how to include comments such as even that we should try to not have too much hope as we only have a certain amount of money. Need people with many skill sets, from many sectors to participate in youth suicide prevention.

We are trying to bridge and create toolkits. In your community, are you using policies and infrastructure to deal with this problem? What would the expectations, standards, and available tools be? Create a toolkit for tribal leaders to turn this around.

At NICWA, asking what is our role and how to work with foster parents caring for children who were traumatized?

Going back to statement about expectations not being too high. If tribal people willing to take lead, it is important to trust tribal communities to know what to do (when they choose to take the lead). Work we do today is the manifestations of the prayers of our ancestors. We are the answers. Pay attention to the voice from within (find it in voices of those we work with). We'll find the way. To trust them to know what to do? Always remember the work we do today are the prayers of our ancestors and what we need to do to help our youth is to listen to spirit of ancestors and to prayers of those who are suffering now. This is new territory to do this kind of linkage and bringing partners together to bring people together.

National Congress of American Indians could be the fiscal agent for SAMHSA expansion money, multi-year. NICWA, Georgetown University partnering. Youth/parents vs. policymakers. In head vs. heart.