Testimony
Before the Committee on Indian Affairs
United States Senate
June 15, 2005

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Youth Suicide Among American Indians and Alaska Native Youth

Statement of:

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Working with:
Bureau of Indian Affairs'
Office of Law Enforcement Services, District V

Statement of The Jason Foundation, Inc.
Hearing on
Youth Suicide Among American Indian Youth

Mr. Chairman and members of the Committee, good morning. I am Clark Flatt, President / CEO of The Jason Foundation and I am proud to be Jason's Dad. Thank you for this opportunity to share with you about The Jason Foundation and specifically our work with the Bureau of Indian Affairs' Office of Law Enforcement Services (BIA-OLES), District V in addressing the tragedy of youth suicide within the Native American and Alaska Native youth.

I have been asked to share with you my personal story, about the program we have begun nationally to address youth suicide, and specifically about our work with the BIA-OLES District V.

On July 16, 1997, my world as a parent changed drastically forever. I lost my youngest son, Jason – age 16, to a terrible *"Silent Epidemic"* in our nation today. This "Silent Epidemic" is the **THIRD** leading cause of death for our youth ages 15-24 in our nation and the **SECOND** leading cause of death for our college-age youth. We lose an estimated (including a percentage for mis-reported suicides) average of **100+** young people **EACH WEEK** in our nation to this "Silent Epidemic" – that is **ONE HUNDRED** families each week – dads, moms, brothers, sisters, grandparents, uncles and aunts – devastated by the loss of a youth to this "Silent Epidemic". This "Silent Epidemic" is youth suicide. To add to the staggering statistics surrounding youth suicide, the NHSDA reported in the year 2000 there were an average of over **2,700** suicide attempts **each day** by young people ages 12-17.

Although the tragic impact of youth suicide on our young people and families is obvious, you will probably not see a telethon to raise money for prevention or an "A" list celebrity making it their cause. We still have many hurdles in the forms of myths, half-truths, and stigma to over come. But as in the case of a national program of awareness and prevention of HIV-AIDS, it can be done effectively by public education.

As a parent, I attended as many PTO/PTA, community seminars, and church programs that I could to help me be a better informed parent on safety for my sons (I have an older son, John, who is a physician currently completing a Pediatric Neurology residency at Vanderbilt Children's Hospital). I learned about the dangers of drugs, alcohol, school violence, homicide, AIDS and sexual diseases, and even a section on bullying – but the **THIRD** most likely cause of death – suicide – was never mentioned let alone discussed about how to identify at-risk behavior / warning signs.

My family and a small group of friends decided that Jason's tragic death to this "Silent Epidemic" would not become just another "Silent Statistic" of youth suicide. A big part of youth suicide's danger is its "Silent" nature of taking a youth from a family / community and it not being talked about or addressed professionally.

In October 1997, we started The Jason Foundation, Inc. (JFI) a non-profit 501 (c)(3) organization with the mission to address this "Silent Epidemic" of youth suicide through education. Our initial program was to educate parents about the National Health problem of youth suicide in a professional manner. This educational seminar not only brought awareness of the problem, but introduced information concerning "warning signs", at-risk behavior, elevated risk-factors, and local resources available to help a parent with a son or daughter who may be struggling with suicidal ideation. However, it soon became obvious from requests by educators, youth workers, and youth themselves that a more comprehensive approach was necessary. JFI developed the "Triangle of Prevention" approach which provided programs for youth (they see the changes in their friends before anyone else), educators / youth workers, and parents. These programs and seminars provide awareness concerning the problem of youth suicide, information concerning "warning signs" / at-risk behavior / elevated risk factors, and local resources for assistance if needed. More information can be found about each program on our website – www.jasonfoundation.com. Today, our programs are in use in forty-eight states and five foreign countries. Our corporate office is in Hendersonville, Tennessee.

I was asked to comment on JFI's organizational structure, JFI's funding philosophy (especially use of non-federal funding), and our current work with the BIA on developing a youth suicide prevention model for Indian Country. I want to begin by commenting briefly on our organizational structure because it is the foundation for our funding success as well as our current project with BIA.

JFI has built (and is building) a support system of national and local affiliations that work together sharing resources and talents for the awareness and prevention of youth suicide. It is this "affiliated network" that has enabled JFI to be successful – collaboration. Due to our National Clinical Affiliation with Psychiatric Solutions, Inc (PSI – Franklin, TN), JFI is quickly growing to provide our clinical based / supported programs nationally. We currently have twenty-six regional / state affiliate offices which provides all of JFI's programs and services to the service area – all of our programs and services are provided at no-cost to the school, church, youth organization, or community in those service areas due in large to our affiliation with PSI. We will have over fifty affiliated offices across the nation by summer 2006 which will enable us to reach even more youth and communities with our programs and services. This does not include our project with BIA which is growing rapidly. We also utilize regional clinical affiliates such as Vanderbilt Psychiatric Hospital, Lakeside Behavioral Health, Frontier Health, and Centennial / Parthenon Pavilion Psychiatric Hospital to support our programs and assist in research and development of programs.

As noted earlier, "Awareness" of the National Health Problem of youth suicide (as declared in 1999 by Surgeon General David Satcher) is the foundation / building block for an effective prevention program. JFI has enlisted three National Awareness Affiliates and a group of "individual" affiliates to help bring such awareness to youth suicide.

- **American Football Coaches Association (AFCA) – Waco, Texas:** Two years ago the AFCA announced a National Affiliation with The Jason Foundation to address the national health problem of youth suicide. This brought over 10,000 high school, college, and NFL coaches to the JFI / AFCA team to take on youth suicide. Today, we utilize over fifty high profile College and NFL coaches as "Ambassadors" for JFI / AFCA efforts in youth suicide awareness and prevention. These Ambassadors help through Public Service Announcements used to educate the public (print, TV, and radio), personal contacts, role models, and in "opening doors" to key individuals / corporations.
- **USA Wrestling (USAW):** USAW works with JFI as a National Awareness Affiliate through their membership and network of over 140,000 members nationwide. USAW is recognized as the governing body for all middle, high school, college, and Olympic wrestling in the nation. JFI and the USAW work closely in building awareness and expanding JFI's programs through its network of schools across the nation.
- **Wal-Mart, Inc.:** Wal-Mart signed as our National Corporate Affiliate in 2004. JFI is working with Wal-Mart to provide resources / educational materials to its 1.6 million associates and their families. We are also working on plans that will utilize Wal-Mart's 4,000+ locations across the nation to help educate and provide JFI materials to the communities they serve.
- **"Individual Affiliates" Group:** We are working with (and expanding) State Attorneys General in our programs. Currently, we have thirty-one AG's working with JFI in their states. Of the members of the Committee on Indian Affairs, we have eight AG's that have committed to working with JFI (New Mexico, Wyoming, Alaska, South Dakota, Idaho, North Carolina, Oklahoma, and Washington). In fact, our Chairperson for our Board of Directors is the Attorney General for the State of Tennessee, General Paul Summers. These AG's are very important in helping introduce JFI to the key people within their states and some have prevention programs in their divisions that work directly with JFI's programs and resources.

JFI believes that collaboration is not only the right thing, but is necessary for success in today's complex society. We are proud of our National Affiliates and all they do to help JFI with our mission. A big part of our success can also be found through our local / regional affiliations (clinical mentioned earlier). Local / regional affiliations such as with crisis intervention centers, Mental Health Associations, NAMI, state American Academy of Pediatrics, and many local mental health organizations have a huge part in the success and implementation of a youth suicide prevention plan.

Funding:

When JFI started, we spoke with many of non-profits about their funding strategies (both successful organizations and those who failed). We found many of those who failed had tied their funding to a few funding sources and that the majority of that funding

many times came from state and/or federal funding which at best can be uncertain due to budget cut backs and changes in priorities by government agencies. Our Board of Directors decided early on not to rely on government funding for the success of our programs, but to raise funds through public and private means.

Our first budget (for only two months in 1997) was $2,700 – all program expense. Our 2005 budget is $9.7 million and we are projecting our 2006 budget in excess of $13 million. Our revenue sources, cash and in-kind support, are 99.9% from corporate support / gifts, grants from private / public foundations, JFI fund-raisers, and individual gifts. We have only one governmental grant, a State grant from Tennessee for $77,500 to help with a special project with the Tennessee Department of Mental Health and Developmental Disabilities.

It is my belief that Corporate America and individuals will invest in an organization that is well run, frugal, and makes accomplishments. Our Administration Expense is less than 5% of our budget – 95% programs.

Our Recent Affiliation with BIA-OLES District V:

The national statistics on youth suicide are staggering. As tragic as those statistics / numbers are to the youth and families of our general population, when we look at the Native American and Alaska Native youth population, we see a rate **2.5 times higher** than the general population (which is staggering within itself). American Indians and Alaska Native youth have the highest suicide rates of all ethnic groups in the United States. Suicide is the **SECOND** (compared to third in general population) leading cause of death for youth in the Indian Nation. In Alaska, where the majority of tribes are located and Alaska Natives make up a significant part of the population, a 2001 Department of Health report showed suicide as the **#1** leading cause of death for ages 10-64. The report also reported that in Alaska, suicide attempts were the **SECOND** leading cause for non-fatal hospitalization for ages 10-14 (in front of sport, bicycle, and traffic accidents) and suicide attempts were **FIRST** for hospitalizations for ages 14-34.

In a recent study on American Indian youth living on a reservation or in a nearby associated town, it was found that 30% had serious thoughts about suicide – this compared to a national general population rate of 16.9%. As youth suicide has been portrayed as a "Silent Epidemic" in the youth general population – It is double its impact on American Native and Alaska Native youth.

Following a presentation about youth suicide that I presented in Los Angeles, I was approached by John Olivera, National Child Abuse Coordinator – BIA, about working together to develop a suicide prevention model for Indian Country. It seemed a good fit because of our successful collaborations with State Attorney Generals whose main purpose, like that of the BIA, is the protection of citizens within their areas. After some discussion and "brainstorming sessions" JFI and BIA-OLES District V signed an agreement to develop such a youth suicide prevention model first for District V and then to be shared with any BIA region wishing to participate.

In preparation, the first segment was to collect information both by the BIA and JFI about the problem of youth suicide from the communities it impacts. I visited the Crow

reservation in Billings, Montana. During my visit, I spoke with tribal leaders, youth workers, and Native American youth themselves. I was also able to visit with the local

IHS department. This visit truly opened my eyes beyond "printed statistics" concerning the problem of youth suicide in the Indian Nation and the challenges of resources.

We are proceeding to collect such "grass-roots" information by talking and visiting with local tribes. We will then begin to take JFI programs for schools, staff training Seminars, and parent training Seminars and make them more ethnic responsive for Native Americans and Alaska Native populations while maintaining the clinical based approached.

Before these programs to help identify at-risk youth can be put fully into place, we must address another challenge. I believe developing a program to identify at-risk youth is not a problem. We can do that now. The major challenge for Indian Country is what can be done for the young person once they are identified at-risk for suicide. The challenge is providing professional resources to help in treatment and counseling of these at-risk youth. There is no purpose and in fact may even be detrimental to identify someone who needs help if you cannot help them.

In my brief exposure to Indian Country and health services, IHS has done a noble job in mental health services with the resources provided. But limited resources and a seemingly almost unlimited geographical area to cover – the Crow Reservation I visited was over 2.5 million acres – makes mental health service delivery almost impossible. I was told by a local official that many times if a youth went to counseling at the local IHS facility, it would take almost two hours travel time one-way and including the session would account for six hours or more a day which most of the time was not possible for the family.

JFI and BIA-OLES District V are exploring two options to address the challenge of delivery of professional mental health services to Indian Country. We hope to collaborate with IHS also on this project and Dr. Perez of the IHS has indicated a desire to talk about such collaboration.

Option I: Utilizing a concept that is growing rapidly for rural American delivery of medical services (especially cardiac services) – TeleMedicine. We believe we can build a TeleCounseling Network that will provide professional mental health care to rural areas, especially reservations. It would involve trained local therapist working with a Psychiatrist via web conferencing (patient could be involved directly at times). JFI is currently using this technology to deliver our Staff Training Programs to rural areas and have found it very successful. It enables JFI to maintain quality of programs and the technology provides the service at a cost that is economically smart. This TeleCounseling Center could provide professional mental health services to even the most remote area as long a high speed internet capabilities exist. (We found recently that a remote island in Alaska that has a very high youth suicide rate and is only accessible by plane, had high speed internet due to its satellite connection to the states. I believe we will find this the case in many areas).

Option II: (excluding many areas of Alaska because of terrain issues) We propose having a mobile counseling center – a customized RV – that would on a regular basis

provide counseling services to areas of a reservation. It would be staffed by 1-3 therapists. Our initial plans would be dividing a reservation into four divisions and having the Mobile Counseling Center in each division one day each week for four days. The fifth day, it would be at the local IHS clinical center for updating with the local Psychiatrist and determining referrals as necessary. This would provide mental health services closer to the communities and would be cost effective in the delivery of these services.

This is not as optimal as building a clinic in each division of a reservation, but would be much better than current service availability for remote areas. It would provide initial professional counseling for youth identified as at-risk for suicidal ideation as well as for other mental / emotional issues and could be effective immediately.

We are working on the programs and options of delivery of services and would welcome the help of the Senate Committee on Indian Affairs and IHS / SAMHSA to join in this effort.

In summary:

1. We are working with BIA and all interested parties to develop programs and seminars for youth suicide awareness and prevention for Indian Country. These programs will focus on school-based curriculum, youth seminars, staff training seminars, and parent training seminars.
2. We are exploring two options on solving the problem of delivery of professional mental health counseling services especially to the remote reservations. The options include TeleCounseling utilizing web conferencing technology to provide professional counseling consultation for local therapist and developing a Mobile Counseling Center that would take therapists on a regular basis to areas of reservations. Both of these options will deliver quality professional mental health care and treatment. Clinical backup and provision of services are critical to a successful youth suicide prevention program

Recommendations:

I was asked to comment on if I were on the Senate Committee hearing today, want recommendations I would like to see put forward:

1. I would also like to ask your help in making the availability of government grants more streamlined and easier to apply for funding. Many good local and regional organizations that provide the lion's share of services in many cases cannot make their way through the maze of paperwork that is required and therefore we see the funding funneling to the same organizations who have built a professional grant department. If we are to be successful in addressing youth suicide in the nation and in Indian Country, it will be because of such "grass-root" organizations that are trusted and part of the communities they serve. Funding needs to be more readily attainable and a higher percent actually making it to the populations it was intended to reach and help.
2. To encourage the IHS and BIA to work collaboratively on the issue of youth suicide awareness and prevention in the Indian Nation. Each organization brings with it a unique resource in successfully addressing this tragedy of youth suicide. The IHS is instrumental in the delivery of mental health services. Their current network of hospitals and clinics need to be a major part of the answer for professional counseling assistance for at-risk youth. However, many times they are not brought in a case until a suicide attempt has been made…and this may be

too late for many. The BIA is directly involved in the daily life of the communities they serve. They have a unique opportunity to help identify at-risk youth before a suicide attempt is made because of this community involvement and/or since they investigate all suicide attempts – can be a tremendous referral resource for at-risk youth.

3. This "collaboration" of BIA and IHS partner with developed public / private organizations that provide programs on youth suicide awareness and prevention to "ethnically customize" the programs for Native American and Alaska Native youth, educators / youth worker, and parents. Funds do not need to be spent "re-inventing the wheel" of prevention programs, but in customizing them to meet the ethnic needs of Indian Country.
   JFI hopes to explore through our relationship with BIA copying our National Clinical Affiliation manner of Affiliate Offices to deliver programs with IHS. This would place a functional JFI Affiliate Office for programs with each hospital / clinic serving reservations across the nation. This would tie in directly with mental health services provided by IHS.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to share with you and the committee about my son, The Jason Foundation and our mission, and our work with BIA in addressing youth suicide in Native American and Alaska Native youth. I will be happy to answer any question you may have.

Sincerely,
Clark Flatt
President / CEO
The Jason Foundation
www.jasonfoundation.com

The Jason Foundation

AFCA
AMERICAN FOOTBALL COACHES ASSOCIATION

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Larry Kehres	**Mount Union College**
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Tommy Tuberville	**Auburn University**
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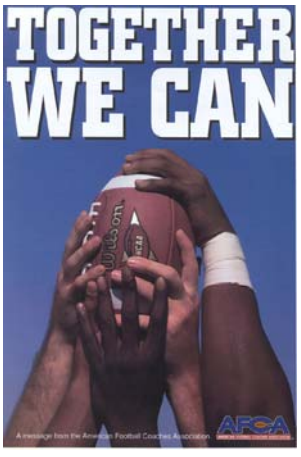

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