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ADDRESSING TRAUMA AND MENTAL HEALTH CHALLENGES IN INDIAN COUNTRY

FIELD HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

AUGUST 17, 2016

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ADDRESSING TRAUMA AND MENTAL HEALTH CHALLENGES IN INDIAN COUNTRY

WEDNESDAY, AUGUST 17, 2016

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Bismarck, ND.

The Committee met, pursuant to notice, at 9:30 a.m. at the Lewis Goodhouse Wellness Center, United Tribes Technical College, Hon. Heidi Heitkamp, U.S. Senator from North Dakota, presiding.

OPENING STATEMENT OF HON. HEIDI HEITKAMP, U.S. SENATOR FROM NORTH DAKOTA

Senator HEITKAMP. Good morning. We're calling this hearing to order. I want to first thank all the tribal leaders, activists, providers, and community members for joining us today to discuss this critical issue. I want to thank the UTTC for hosting. I also want to recognize the staff of the Senate committee on Indian Affairs who have worked so closely with my office to make this field hearing happen. Today the Committee will examine, "Addressing Trauma and Mental Health Challenges in Indian Country". I am so honored to be hosting the field hearing in North Dakota to discuss how we can work together to address trauma in American Indian and Alaska Native communities. The U.S. and National Library of Medicine found implications of trauma on health, academics, and economic outcomes are significant. The average lifetime cost for a child exposed to non-fatal child maltreatment is over $200,000. This creates a significant cost and a need for services when 22 percent of Native American children suffer from post-traumatic stress. The costs are not only financial but impact Native American communities as a whole. Adults experience trauma in racism, poverty, poor nutrition, alcoholism, and suicide. In 2005 to 2008 data, the suicide rate for American Indians and Alaska Natives was 14.68, higher than the overall U.S. rate of 11.15. To mitigate the effects of trauma, the Department of Health and Human Services designated 4,000 mental health professionals to professional shortage areas across the country, many of which include Native American and Alaska Native communities. This shows that primary care providers generally have limited training in recognizing and diagnosing mental health disorders. Of the 53 counties in North Dakota, only six are identified as not having a mental health professional shortage. Of the 53 counties in North Dakota, only six have enough mental health providers. I hope that today we find some attainable proposals that will achieve Native American and Alaska

Native Communities that will benefit them across the nation, as well as focus on intervention models from the traumatic experience. I'm pleased and actually thrilled that I'm on this Committee, which I think speaks volumes to the history that we have in the Senate of Senators from North Dakota believing that this is an important issue. Senator John Hoeven has joined me here today to listen to this important testimony, provide questions, and take the message along with me back to Washington D.C. I turn now to Senator Hoeven for remarks.

STATEMENT OF HON. JOHN HOEVEN,
U.S. SENATOR FROM NORTH DAKOTA

Senator HOEVEN. Thank you, Senator Heitkamp. I'm pleased to be here with you. Thanks to all of you for attending. Thanks to our witnesses and UTTC for hosting this event on a very, very important subject. The purpose of the hearing is to discuss how Federal agencies can coordinate to provide services to Native American children who suffer from trauma and mental health issues. Trauma is defined as a series of events that cause physical and psychological stress reactions. Native American children experience abuse and neglect at higher rates than non-native children. As a result, they are more likely to experience trauma due to depression, substance abuse, homelessness, and poverty. Native Americans suffer from PTSD, post-traumatic stress disorder, at twice the rate of the general population in North Dakota. Between the years of 2006 and 2010 the suicide rate among Native American people was twice that of non-natives. As we all know, the devastating effects of trauma are all too common to Native American communities, specifically among the children. I'm committed to doing all I can to work with my colleagues and Senator Heitkamp to address this very serious concern. I believe the most effective way to address trauma in Native American communities is to prevent it from happening in the first place, especially for children. So we're working on trying to prevent trauma, and one example is the Native American Children Safety Act that ensures that foster children on the reservation are placed in safe homes. We need to take this step and other steps in a comprehensive way. Let's hear from our witnesses as to how we can address the very important issue and comprehensive approach working together. Thank you to Senator Heitkamp for organizing this very important discussion. Thank you.

Senator HEITKAMP. Thank you so much, Senator Hoeven. I want to now turn to our witnesses, some of whom we've seen many times in front of our committee in Washington D.C, I dare say this, maybe a little more friendly than what you've seen in the past. But I also want to thank those of you who have traveled from so far to provide this testimony at this field hearing and to open up this discussion that we did a couple years ago on trauma and realize that this is not a one off. This isn't something that we talk about today and not realize we need to continue that dialogue well into the future. Our first witness is Lillian Sparks Robinson. She is Commissioner of the Administration of Native Americans—Administration for Children and Families within the U.S. Department of Health and Human Services. I am pleased that she is here with us

today. I remind you your testimony is five minutes. I will introduce each of you before you speak.

STATEMENT OF HON. LILLIAN SPARKS ROBINSON, COMMISSIONER, ADMINISTRATION OF NATIVE AMERICANS—ADMINISTRATION FOR CHILDREN AND FAMILIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. ROBINSON. Senator Heitkamp and members of the Senate Committee on Indian Affairs, it is my honor to testify before this Committee on behalf of the Department of Health and Human Services (HHS) on the important topic of Addressing Trauma and Mental Health Challenges in Indian Country.

I am a member of the Rosebud Sioux Tribe, which is located in South Dakota. I serve as the Commissioner for the Administration for Native Americans, which is part of the Administration for Children and Families (ACF), as well as the Chair of the Intradepartmental Council on Native American Affairs (ICNAA).

Development of HHS-Wide Policy to Address Trauma. In my role as chair of the ICNAA, I have led meetings involving leadership from ACF, the Indian Health Service (IHS), and the Substance Abuse and Mental Health Services Administration (SAMHSA) to discuss how we may better lead collaborative efforts on an intradepartmental level to support improved outcomes in the health and emotional well-being of American Indians and Alaska Natives (AI/AN) and others in tribal communities. ACF, SAMHSA, and IHS were highlighted in the Committee's December 17 letter requesting HHS develop and implement an integrated and coordinated Federal approach to addressing complex trauma, including historical trauma in Indian communities and are the primary agencies bringing a trauma-informed lens to this work. We have examined the causes and effects of trauma, including historical and childhood trauma, with an intentional view toward better understanding and highlighting steps tribes themselves are taking to prevent and address the effects of trauma. We believe developing a comprehensive, integrated, and trauma-informed HHS-wide policy that is sustainable over the long-term requires collaboration not only across the health and the human services components of HHS, but also, with other Federal agencies and our AI/AN partners.

We are actively engaged in the development of an HHS-wide policy and are planning on releasing and implementing it within this calendar year. We are currently soliciting input from our tribal partners as well as incorporating substantive material from HHS Operating Divisions contributing to the Department's comprehensive trauma-informed policy. The policy will focus on moving tribal health promotion forward as well as learning from and incorporating AI/AN models of prevention, care, and healing in partnership with tribal leaders, experts, and communities.

Recently, I invited tribal leaders to a listening session held on August 9 to solicit input and recommendations to inform this important work. This listening session was held in Portland, Oregon in conjunction with the 2016 IHS American Indian/Alaska Native Behavioral Health Conference. We are tentatively planning additional listening sessions.

In addition, guidance and recommendations of tribal leaders in the development of the National Tribal Behavioral Health Agenda (TBHA), led by SAMHSA, has greatly informed the on-going development of our HHS-wide policy addressing trauma. The process for development of the TBHA was the result of SAMHSA's months of information gathering, discussion, analysis, validation, sharing, and revalidation of input received from Indian tribes and tribal leaders in coordination with the Indian Health Service's Office of Clinical and Preventive Services (OCPS) and the National Indian Health Board (NIHB). Development of the TBHA has been a strong collaborative effort among Indian tribes, national and regional tribal leaders, SAMHSA regional administrators and staff, and numerous Federal partners.

As you know, tribal leaders have consistently asked for support in addressing behavioral health issues affecting their communities as part of broader discussions of health and wellness. To bring a targeted focus to such issues at the outset of our work to develop Department-wide policy, in March 2016, we solicited and tribal leadership provided, through the HHS's Secretary's Tribal Advisory Committee (STAC), their recommendations on how we could approach the development of a comprehensive, integrated departmental policy to address complex trauma in AI/AN communities. Among the input we received were recommendations that we not only identify and understand the root causes of trauma, but that we make specific efforts to ensure that Federal partners are educated about models and approaches developed from tribal perspectives to more effectively prevent and address trauma in tribal communities including trauma affecting AI/AN children, youth, and families. Based on this and other feedback from tribes, we are encouraged to move beyond a deficits-based perspective and to reflect in our policy emphasis on protective factors and positive youth development strategies aimed at promoting resilience, which, we believe may have a larger impact on prevention than risk reduction strategies alone. Further, since the most effective trauma-informed activity is to prevent trauma from occurring, we are working to identify and promote interventions, such as home visiting, which address the intergenerational transmission of trauma and build on the strengths of young parents.

With our tribal partners, we are moving forward to develop approaches that focus on cultivating, strengthening, and lifting up the Native assets and cultural resources found in AI/AN Communities. One of the recommendations we heard through the STAC members was that our policy should acknowledge tribal elders as assets and resources. At a STAC meeting in June, we discussed the critical role of tribal elders in the development and implementation of policies addressing trauma, including strategies to foster resilience. Our colleagues in the Administration for Community Living (ACL), whose mission includes working with seniors and tribal elders, will be indispensable in our work to fully reflect tribal elders' roles in addressing trauma.

At the Departmental Fiscal Year (FY) 2018 Tribal Budget Consultation, Ms. Mirtha Beadle, the Director of the Office of Tribal Affairs and Policy at SAMHSA shared with tribal leaders that in HHS we take trauma and its effects very seriously and that it is

something that informs our work every day as part of an all-HHS commitment to Native Americans.

Beyond our work to develop a written HHS policy to effectively address trauma in AI/AN communities, others in the Department and I are working with Federal agency partners through the White House Council on Native Americans Affairs, an interagency body established to improve coordination of Federal programs, to develop a Federal Government-wide approach to improve our capacity, coordination, and collaboration in addressing the wellness of AI/AN communities.

Ongoing Work to Address Trauma—Since receipt of the Committee's letter, my colleagues and I have worked hard to reach across agencies to identify trauma-informed work already being done in the Department and ways we as champions for AI/AN children, youth, families, and communities, can coordinate this work better. We are focused on ways we can more effectively take advantage of the Department's health and human services assets.

I would like to share with the Committee and participants in this field hearing the three-pronged framework HHS is pursuing.

Increase Awareness and Understanding. The initial step is to improve information available to key staff across HHS about the extent and impact of trauma in tribal communities and opportunities to more effectively improve well-being. This prong will be supported by increasing Federal staff access to webinars and informational materials and encouraging greater engagement with tribal leaders and representatives. Resources and discussions are intended to build staff knowledge about cultural, practice, and evidence-based opportunities for creating and/or supporting systems that are trauma-informed.

Among some examples of specific HHS activities to increase Federal staff awareness and understanding of trauma and its effects are:

The development of the ACF Principles for Working with Federally Recognized Indian Tribes; a set of principles designed and intended to foster AI/AN well-being by providing a framework for Federal leadership, partnership, and compassionate and effective human services delivery. These principles are intended to guide the internal management of ACF in its partnership with people in Federally-recognized tribes.

The launching of the ACF Trauma Network, which is a community of practice for ACF staff designed to share lessons learned and promising practices and to strengthen the agency's ability to support trauma-informed programmatic work. The ACF Trauma Network will host an internal training on issues of trauma and resilience in AI/AN communities, currently scheduled for October 2016. This program will address research on protective factors and positive youth development strategies that may have a larger impact on prevention of negative health outcomes than risk reduction strategies. Representatives from the Center for American Indian Health of the Johns Hopkins School of Public Health will share with ACF leadership and staff strength-based interventions developed and evaluated with the White Mountain Apache and Navajo communities; interventions that have now been scaled to 75 tribal communities across 15 states, and two non-Native communities.

Each year, SAMHSA, through its Tribal Training and Technical Assistance Center, hosts a training program focused on improving the Agency's work with AI/AN people. The training includes experiential exercises to assist SAMHSA staff gain greater awareness and understanding of intergenerational and historical trauma and their effects on tribal communities. The training is delivered in a format that allows SAMHSA staff at all levels to participate during the three-day program. Webinars are also offered throughout the year to improve knowledge about trauma-related issues in tribal communities and opportunities for addressing them.

Home visiting helps expectant families and those with young children provide stimulating learning environments and nurturing relationships. Beginning in 2013, the IHS Community Health Representatives Program also partnered with the Center for American Indian Health of the Johns Hopkins School of Public Health to implement Family Spirit, an evidence-based, culturally tailored home-visiting program as a core strategy to support young families. Six pilot sites received intensive on-site training and technical assistance. Using lessons learned from the pilot project, IHS and Johns Hopkins will expand Family Spirit for implementation in other tribal communities beginning in 2016. Since 2010, ACF has been operating the Tribal Home Visiting Program, part of the Maternal, Infant, and Early Childhood Home Visiting Program. The Tribal Home Visiting Program is an unprecedented expansion of culturally responsive services for vulnerable AI/AN families and children. The program serves some of the most vulnerable families who experience multiple challenges often attributed to historical trauma. The program has served a total of 1,523 families and provided nearly 20,000 home visits through 25 funded grantees in 14 states. There are currently 15 rural grantees, three urban grantees, and seven grantees in a mix of rural and urban settings.

IHS provides comprehensive training options to build a workforce that is trauma-informed and responsive. Topics cover historical trauma, adverse childhood experiences, early screening and assessment of trauma, treating complex trauma, trauma informed care services and programming, and many others. Training is available online through the IHS TeleBehavioral Health Center of Excellence.

This year's IHS AI/AN National Behavioral Health Conference was planned around the theme, Creating Trauma Informed Systems in AI/AN Communities. The conference was held in Portland, Oregon, from August 9–11, 2016, with 550 registrants over 35 breakout sessions, 90 presenters, and more than 45 continuing education hours offered at no cost to participants.

Improve Coordination and Collaboration. HHS is developing a comprehensive, integrated policy on actions that support healing from trauma and advance trauma-informed practices through programs that contribute to improving the health and well-being of tribal communities. As part of our work with the other agencies on these issues, we are developing a template for creating complementary policies across Federal agencies that support trauma-informed practices. The intent is to: (1) strengthen support systems across health, behavioral health, education, child welfare, justice services, environmental, and other Federal programming; (2) improve ac-

tions to recognize and address the impacts of adverse childhood experiences among AI/AN populations; and (3) to the extent possible, better align programs to address trauma, prevent additional trauma, and support trauma-informed services that are continuous across systems.

Examples of specific HHS activities to improve coordination and collaboration include: ACF, in collaboration with the Centers for Disease Control and Prevention, Health Resources and Services Administration, IHS, and SAMHSA, is leading work to support improved social-emotional and behavioral health for children and families in tribal communities. The agencies hosted a one-day Tribal Experts Workgroup Meeting on February 25. The meeting included tribal leaders, community members, researchers, and advocates, as well as representatives from Federal agencies including HHS, the Department of Justice, and the Office of Management and Budget. The goal of the meeting was to learn from experts and discuss how we can better work together to: (1) raise awareness of challenges that pre-school children face in tribal populations with high rates of adult mental health and substance abuse issues; (2) provide tools and effective strategies for caregivers to support improved social-emotional and behavioral health outcomes for children and their families in tribal communities; and (3) develop policy recommendations to address funding and service delivery challenges. Development of a comprehensive ACF Native American Child and Youth Policy Agenda to highlight the ongoing work of ACF program and staff offices to support thriving, resilient, safe, healthy, and economically secure children, families, and communities. The focus areas for this Policy Agenda are: (1) quality early childhood development and learning; (2) the role of self-determination and nation-building in strengthening families; (3) fostering child and youth well-being and resiliency in the face of trauma and adversity; (4) financial and economic security; and (5) building a new narrative with data. The ACF Policy Agenda is intended to both function as a structure for innovative policymaking to guide stronger and more effective programming and to lift up successful tribal models across the identified five focus areas. The Policy Agenda is very much an action-oriented roadmap we hope will provide AI/AN parents, caregivers, leadership, and children and youth, and federal staff with the tools they need to ensure improved child and youth outcomes.

IHS, in collaboration with SAMHSA, developed the FY 2016 funding opportunity for the Methamphetamine and Suicide Prevention Initiative Generation Indigenous. The funding opportunity is framed around addressing trauma by focusing on the following objectives: increasing positive youth development, building resiliency, and promoting family engagement. Newly awarded projects will have the opportunity to hire behavioral health providers to implement trauma informed services and programs, including the option to increase the number of paraprofessionals serving children, adolescents, and families.

SAMHSA established the Federal Partners Committee on Women and Trauma that is co-chaired by the Department of Labor. The Committee's work has been guided by the recognition that the impact of violence and trauma on women is a public health prob-

lem with profound consequences for many different Federal departments and agencies. Initial efforts focused on identifying the impact of trauma on the mission and activities of each agency, raising awareness about trauma across government, and promoting evidence-based public health practices. The Committee includes more than 100 members from 40 divisions of 13 Federal departments and agencies. An objective is to build a trauma-informed Nation through effective practices and cross-agency, systemic efforts at governmental levels. The Committee hosted a trauma event that reached an estimated 2,000 individuals each day, over the course of two days. Given the impact of the Committee's work and significance of trauma-informed approaches for AI/AN women.

Discussions are underway on opportunities for leveraging these efforts as Federal partners work to support trauma-informed efforts for tribal youth, families, and communities build Federal and Tribal Capacity through On-Going and Coordinated Technical Assistance. HHS will continue to provide dynamic and collaborative technical assistance solutions that are evidence- and practice-informed, culturally relevant, and designed to help agencies and organizations build their capacity to improve and expand quality services to tribal communities. Examples of HHS work in this area include: ACF, in partnership with other HHS agencies and offices, is currently developing toolkits to assist human services programs bring a trauma-informed lens to programs serving children, youth, and families, including focused resources tailored to the needs of programs serving AI/AN individuals and communities. To assist managers and administrators of HHS-supported human services programs, the HHS Behavioral Health Coordinating Committee's Subcommittee on Trauma and Early Intervention, which is co-led by ACF and the Office of the Assistant Secretary for Planning and Evaluation, will produce a Primer on Trauma-Informed Human Services. The Primer is designed to introduce human services program leaders and their staff at the state, tribal, territorial, and local level to recent advances in trauma, toxic stress, and executive functioning, and inform program leaders and their staff about the implications of this research for program design, policy, evaluation, and service delivery. The Primer stresses historical trauma, a form of complex trauma that manifests throughout the life span and is passed down through generations. This psychological suffering endured by a group is particularly relevant to AI/AN communities, and the Primer provides a road-map to resources from ACF, SAMHSA, IHS, and others on addressing trauma through human services programs in AI/AN communities.

Discussions with tribal leaders on SAMHSA's Tribal Technical Advisory Committee (TTAC) led to the conceptualization of the National Tribal Behavioral Health Agenda. The voices of TTAC were joined by tribal leaders on the HHS STAC and other engaged leaders who sought a comprehensive behavioral health effort grounded in tribal and federal collaboration. Their intent was to address the root causes of behavioral health problems in tribal communities and not just the contributing factors. Some of these problems result from adverse childhood experiences and traumatic events that have been experienced historically and intergenerationally. The root causes and resulting behavioral health issues impact other areas

that contribute to well-being such as overall health, education, employment, child welfare, and engagement with the justice system in response to these concerns, SAMHSA and IHS worked with other Federal agencies and the National Indian Health Board to identify foundational elements, priorities, and strategies for the TBHA. The TBHA was drafted based on the voices and recommendations of tribal leaders and representatives acknowledges the importance of tribal wisdom and cultural practices in meeting the needs of tribal communities; provides a clear, national statement about prioritizing behavioral health as an essential component to improving overall health and wellness; facilitates tribal/Federal collaboration on common behavioral health priorities; and supports opportunities for improving behavioral health-related policies and programs geared to the specific needs of tribal communities.

I would be happy to share with your staff a more complete listing of the programs and activities HHS is engaged in which focus on addressing trauma and behavioral health and wellness.

Thank you for your work on this important issue and the opportunity to speak with you today. I am happy to answer any questions you may have.

[The prepared statement of Ms. Robinson follows:]

PREPARED STATEMENT OF HON. LILLIAN SPARKS ROBINSON, COMMISSIONER, ADMINISTRATION OF NATIVE AMERICANS—ADMINISTRATION FOR CHILDREN AND FAMILIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Senator Heitkamp and members of the Senate Committee on Indian Affairs, it is my honor to testify before this Committee on behalf of the Department of Health and Human Services (HHS) on the important topic of "Addressing Trauma and Mental Health Challenges in Indian Country". I am a member of the Rosebud Sioux Tribe, which is located in South Dakota. I serve as the Commissioner for the Administration for Native Americans, which is part of the Administration for Children and Families (ACF), as well as the Chair of the Intradepartmental Council on Native American Affairs (ICNAA).

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Ongoing Work to Address Trauma

Since receipt of the Committee's letter, my colleagues and I have worked hard to reach across agencies to identify trauma-informed work already being done in the Department and ways we, as champions for AI/AN children, youth, families, and communities, can coordinate this work better. We are focused on ways we can more effectively take advantage of the Department's health and human services assets.

I would like to share with the Committee and participants in this field hearing the three-pronged framework HHS is pursuing.

Prong 1—Increase Awareness and Understanding. The initial step is to improve information available to key staff across HHS about the extent and impact of trauma in tribal communities and opportunities to more effectively improve well-being. This prong will be supported by increasing Federal staff access to webinars and informational materials and encouraging greater engagement with tribal leaders and representatives. Resources and discussions are intended to build staff knowledge

about cultural, practice, and evidence-based opportunities for creating and/or supporting systems that are trauma-informed.

Among some examples of specific HHS activities to increase Federal staff awareness and understanding of trauma and its effects are:

- The development of the ACF *Principles for Working with Federally Recognized Indian Tribes;* a set of principles designed and intended to foster AI/AN well-being by providing a framework for Federal leadership, partnership, and compassionate and effective human services delivery. These principles are intended to guide the internal management of ACF in its partnership with people in Federally-recognized tribes.
- The launching of the ACF Trauma Network, which is a community of practice for ACF staff designed to share lessons learned and promising practices and to strengthen the agency's ability to support trauma-informed programmatic work. The ACF Trauma Network will host an internal training on issues of trauma and resilience in AI/AN communities, currently scheduled for October 2016. This program will address research on protective factors and positive youth development strategies that may have a larger impact on prevention of negative health outcomes than risk reduction strategies. Representatives from the Center for American Indian Health of the Johns Hopkins School of Public Health will share with ACF leadership and staff strength-based interventions developed and evaluated with the White Mountain Apache and Navajo communities; interventions that have now been scaled to 75 tribal communities across 15 states, and two non-Native communities.
- Each year, SAMHSA, through its Tribal Training and Technical Assistance Center, hosts a training program focused on improving the Agency's work with AI/AN people. The training includes experiential exercises to assist SAMHSA staff gain greater awareness and understanding of intergenerational and historical trauma and their effects on tribal communities. The training is delivered in a format that allows SAMHSA staff at all levels to participate during the three-day program. Webinars are also offered throughout the year to improve knowledge about trauma-related issues in tribal communities and opportunities for addressing them.
- Home visiting helps expectant families and those with young children provide stimulating learning environments and nurturing relationships. Beginning in 2013, the IHS Community Health Representatives Program also partnered with the Center for American Indian Health of the Johns Hopkins School of Public Health to implement Family Spirit, an evidence-based, culturally tailored home-visiting program as a core strategy to support young families. Six pilot sites received intensive on-site training and technical assistance. Using lessons learned from the pilot project, IHS and Johns Hopkins will expand Family Spirit for implementation in other tribal communities beginning in 2016. Since 2010, ACF has been operating the Tribal Home Visiting Program, part of the Maternal, Infant, and Early Childhood Home Visiting Program. The Tribal Home Visiting Program is an unprecedented expansion of culturally responsive services for vulnerable AI/AN families and children. The program serves some of the most vulnerable families who experience multiple challenges often attributed to historical trauma. The program has served a total of 1,523 families and provided nearly 20,000 home visits through 25 funded grantees in 14 states. There are currently 15 rural grantees, three urban grantees, and seven grantees in a mix of rural and urban settings.
- IHS provides comprehensive training options to build a workforce that is trauma-informed and responsive. Topics cover historical trauma, adverse childhood experiences, early screening and assessment of trauma, treating complex trauma, trauma informed care services and programming, and many others. Training is available online through the IHS TeleBehavioral Health Center of Excellence.
- This year's IHS AI/AN National Behavioral Health Conference was planned around the theme, "Creating Trauma Informed Systems in AI/AN Communities." The conference was held in Portland, Oregon, from August 9–11, 2016, with 550 registrants over 35 breakout sessions, 90 presenters, and more than 45 continuing education hours offered at no cost to participants.

Prong 2—Improve Coordination and Collaboration. HHS is developing a comprehensive, integrated policy on actions that support healing from trauma and advance trauma-informed practices through programs that contribute to improving the health and well-being of tribal communities. As part of our work with the other agencies on these issues, we are developing a template for creating complementary

policies across Federal agencies that support trauma-informed practices. The intent is to: (1) strengthen support systems across health, behavioral health, education, child welfare, justice services, environmental, and other Federal programming; (2) improve actions to recognize and address the impacts of adverse childhood experiences among AI/AN populations; and (3) to the extent possible, better align programs to address trauma, prevent additional trauma, and support trauma-informed services that are continuous across systems.

Examples of specific HHS activities to improve coordination and collaboration include:

- ACF, in collaboration with the Centers for Disease Control and Prevention, Health Resources and Services Administration, IHS, and SAMHSA, is leading work to support improved social-emotional and behavioral health for children and families in tribal communities. The agencies hosted a one-day Tribal Experts Workgroup Meeting on February 25. The meeting included tribal leaders, community members, researchers, and advocates, as well as representatives from Federal agencies including HHS, the Department of Justice, and the Office of Management and Budget. The goal of the meeting was to learn from experts and discuss how we can better work together to: (1) raise awareness of challenges that pre-school children face in tribal populations with high rates of adult mental health and substance abuse issues; (2) provide tools and effective strategies for caregivers to support improved social-emotional and behavioral health outcomes for children and their families in tribal communities; and (3) develop policy recommendations to address funding and service delivery challenges.
- Development of a comprehensive ACF Native American Child and Youth Policy Agenda to highlight the ongoing work of ACF program and staff offices to support thriving, resilient, safe, healthy, and economically secure children, families, and communities. The focus areas for this Policy Agenda are: (1) quality early childhood development and learning; (2) the role of self-determination and nation-building in strengthening families; (3) fostering child and youth well-being and resiliency in the face of trauma and adversity; (4) financial and economic security; and (5) building a new narrative with data. The ACF Policy Agenda is intended to both function as a structure for innovative policymaking to guide stronger and more effective programming and to lift up successful tribal models across the identified five focus areas. The Policy Agenda is very much an action-oriented roadmap we hope will provide AI/AN parents, caregivers, leadership, and children and youth, and federal staff with the tools they need to ensure improved child and youth outcomes.
- IHS, in collaboration with SAMHSA, developed the FY 2016 funding opportunity for the Methamphetamine and Suicide Prevention Initiative Generation Indigenous. The funding opportunity is framed around addressing trauma by focusing on the following objectives: increasing positive youth development, building resiliency, and promoting family engagement. Newly awarded projects will have the opportunity to hire behavioral health providers to implement trauma informed services and programs, including the option to increase the number of paraprofessionals serving children, adolescents, and families.
- SAMHSA established the Federal Partners Committee on Women and Trauma that is co-chaired by the Department of Labor. The Committee's work has been guided by the recognition that the impact of violence and trauma on women is a public health problem with profound consequences for many different Federal departments and agencies. Initial efforts focused on identifying the impact of trauma on the mission and activities of each agency, raising awareness about trauma across government, and promoting evidence-based public health practices. The Committee includes more than 100 members from 40 divisions of 13 Federal departments and agencies. An objective is to build a trauma-informed Nation through effective practices and cross-agency, systemic efforts at governmental levels. The Committee hosted a trauma event that reached an estimated 2,000 individuals each day, over the course of two days. Given the impact of the Committee's work and significance of trauma-informed approaches for AI/AN women, discussions are underway on opportunities for leveraging these efforts as Federal partners work to support trauma-informed efforts for tribal youth, families, and communities.

Prong 3—Build Federal and Tribal Capacity through On-Going and Coordinated Technical Assistance. HHS will continue to provide dynamic and collaborative technical assistance solutions that are evidence- and practice-informed, culturally relevant, and designed to help agencies and organizations build their capacity to im-

prove and expand quality services to tribal communities. Examples of HHS work in this area include:

- ACF, in partnership with other HHS agencies and offices, is currently developing toolkits to assist human services programs bring a trauma-informed lens to programs serving children, youth, and families, including focused resources tailored to the needs of programs serving AI/AN individuals and communities. To assist managers and administrators of HHS-supported human services programs, the HHS Behavioral Health Coordinating Committee's Subcommittee on Trauma and Early Intervention, which is co-led by ACF and the Office of the Assistant Secretary for Planning and Evaluation, will produce a *Primer on Trauma-Informed Human Services.* The *Primer* is designed to introduce human services program leaders and their staff at the state, tribal, territorial, and local level to recent advances in trauma, toxic stress, and executive functioning, and inform program leaders and their staff about the implications of this research for program design, policy, evaluation, and service delivery. The *Primer* stresses historical trauma, a form of complex trauma that manifests throughout the life span and is passed down through generations. This psychological suffering endured by a group is particularly relevant to AI/AN communities, and the Primer provides a road-map to resources from ACF, SAMHSA, IHS, and others on addressing trauma through human services programs in AI/AN communities.
- Discussions with tribal leaders on SAMHSA's Tribal Technical Advisory Committee (TTAC) led to the conceptualization of the National Tribal Behavioral Health Agenda. The voices of TTAC were joined by tribal leaders on the HHS STAC and other engaged leaders who sought a comprehensive behavioral health effort grounded in tribal and federal collaboration. Their intent was to address the root causes of behavioral health problems in tribal communities and not just the contributing factors. Some of these problems result from adverse childhood experiences and traumatic events that have been experienced historically and intergenerationally. The root causes and resulting behavioral health issues impact other areas that contribute to well-being such as overall health, education, employment, child welfare, and engagement with the justice system.
- In response to these concerns, SAMHSA and IHS worked with other Federal agencies and the National Indian Health Board to identify foundational elements, priorities, and strategies for the TBHA. The TBHA was drafted based on the voices and recommendations of tribal leaders and representatives—it acknowledges the importance of tribal wisdom and cultural practices in meeting the needs of tribal communities; provides a clear, national statement about prioritizing behavioral health as an essential component to improving overall health and wellness; facilitates tribal/Federal collaboration on common behavioral health priorities; and supports opportunities for improving behavioral health-related policies and programs geared to the specific needs of tribal communities.

I would be happy to share with your staff a more complete listing of the programs and activities HHS is engaged in which focus on addressing trauma and behavioral health and wellness.

Thank you for your work on this important issue and the opportunity to speak with you today. I am happy to answer any questions you may have.

Senator HEITKAMP. Thank you. Next we will hear from Officer Darren Cruzan. He is the Director of the Office of Justice Services at the Bureau of Indian Affairs in the Department of the Interior.

STATEMENT OF DARREN CRUZAN, DIRECTOR, OFFICE OF JUSTICE SERVICES, BUREAU OF INDIAN AFFAIRS, U.S. DEPARTMENT OF THE INTERIOR

Mr. CRUZAN. My name is Darren Cruzan and I am the Director for the Office of Justice Services at the Bureau of Indian Affairs in the Department of the Interior. I am pleased to submit this statement for the Department on the topic of "Addressing Trauma and Mental Health Challenges in Indian Country."

As a result of repudiated past federal policies intended to disrupt American Indian and Alaska Native (AI/AN) families, today many

tribal citizens suffer from the effects of generational trauma. Trauma may be from emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, witnessing substance abuse or domestic violence in the home, or experiencing a parent's divorce or incarceration. Symptoms can range from anxiety, impulsivity, to depression, and can manifest themselves as criminal behavior, poor school performance, chronic illness, and mental health issues. In November 2014, the Attorney General's Taskforce on American Indian/Alaska Native Children Exposed to Violence documented a high rate of trauma in Indian Country and made policy recommendations to reduce it.

As the Department responsible for providing law enforcement, child protection services and social workers, support for tribal courts, and education services, we know we are a key partner in addressing trauma in Indian Country. While we do not diagnose or treat individuals, we or tribes that administer our programs and services are the often the first responders to crisis in the home or at school and serve as a bridge for connecting families and individuals to the services they need. Officers, teachers, social worker and other professionals also witness firsthand the lack of resources available to treat the underlying conditions responsible for many of the troubling statistics. We appreciate the Committee's efforts to raise awareness of this important issue and the opportunity to provide testimony today.

BIA Trauma Informed Care Training Progress in addressing trauma in Indian Country cannot be made until more education on trauma and its effects occurs. To better equip our staff, earlier this year, the BIA provided training to all BIA regional social workers on trauma informed care. This training was presented by subject matter experts from the National Institute of Health and Johns Hopkins University. The regional social workers received information on historical trauma and additional training opportunities regarding this issue.

In addition to this nationwide training, many of the regions are providing training directly to, or in partnership with, tribes in their service areas. Some examples are: Alaska Region—In partnership with the Southcentral Foundation Family Wellness Program, the Alaska Region provided trauma informed care training at the BIA Providers Conference this past year. The presentation was attended by approximately 400 tribal representatives, including ICWA workers, tribal administrators and tribal council members. Southern Plains Region, The Anadarko Agency, located in the Southern Plains Region, operates the Positive Indian Parenting Program, an effort to address the parenting challenges the Agency has identified in their clients. This program was developed by the Agency after years of seeing how historical trauma impacting parenting skills as a result of the parents, experience during the boarding school era. These problems have been passed down generation to generation, and impacts many child protective services referrals the Agency receives. The Positive Indian Parenting Program instructor is certified through the Active Parenting Program and has attended and uses the curriculum from the National Indian Child Welfare Association's (NICWA) Positive Indian Parenting training. Through the combination of these parenting pro-

grams, the Agency has provided positive Indian parenting courses to Native parents. ,h Rocky Mountain Region—The Rocky Mountain Regional Office has forged a partnership with the Native Children's Trauma Center—University of Montana for the last five years to develop Trauma Informed Child Protection Services. The Native Children's Trauma Center has done training for social service staff and tribal court staff over that period, and has provided onsite technical assistance at case staffing and child protection meetings. The region provided several region-wide trainings, a webinar series and more recently in 2016, developed a two-week trauma informed training curriculum for Social Service staff. ,h Midwest Region—The BIA, Midwest Regional Office in partnership with the Native Wellness Institute (NWI) offered a series of trauma-informed training to the Tribes at the Midwest Region's 2016 Partners in Action Conference. The NWI recognizes the great impacts of historical trauma on Native people, and its impact on current day trauma in our families and communities. The NWI's mission is to promote the well-being of individuals, families and communities; to create an awareness of where our negative behavior comes from and provide opportunities for community/family growth and healing.

We are also empowering tribal communities to address trauma in their communities. As recommended by the Attorney General in 3.1 of its report, Ending Violence so Children Can Thrive, we created a new initiative to allow tribes to braid federal funds together to address the distinct needs of their communities.

Tiwahe, which means family in Lakota, is an initiative designed to demonstrate the effectiveness of wraparound services in tribal communities. It looks at funding streams from social services, child welfare, employment and training, recidivism and/or tribal courts and asks tribes to develop a plan to combine these funding streams to improve outcomes. The goal is to reduce the rate AI/NA children enter foster care, increase family reunification rates, reduce recidivism rates, and build capacity within tribal courts.

In FY 2016, six tribes are participating in the demonstration project. These are: the Association of Village Council Presidents (AVCP); the Spirit Lake Tribe; Red Lake Band of Chippewa Indians; Ute Mountain Ute Tribe; Fort Belknap Indian Community; and the Pascua Yaqui Tribe. In addition, all tribes received an across-the-board increase to their base funding, referred to as Tribal Priority Allocation, for Indian Child Welfare Act and Social Services. We recently hired a National Tiwahe Coordinator who will start later this month to work with participating tribes.

As we continue to build this program, our hope is to also improve how we collect data in partnership with tribes to fully understand how trauma and its effects impact Indian County.

Current, relevant, and robust data is necessary to make informed policy decisions to craft effective trauma interventions.

There is no more important issue than addressing the high suicide rate in Indian Country, particularly among youth, which is often the result of an individual's exposure to trauma. Indian Affairs is directly involved in youth suicide prevention through the BIE, which provides technical assistance and monitoring to ensure schools are compliant with intervention strategies and reporting

protocols to further ensure student safety. In addition, under the BIE reorganization the School Health Policy Advisor position was created. This individual will support the BIE Associate Deputy Directors, staff in the Education Resource Centers and BIE schools with the development of additional mental health programs, initiatives and policies as well as suicide and substance abuse prevention. They will also coordinate with the BIA and support interagency work of the White House Council on Native American Affairs.

BIE's partnering with other federal agencies, including the Departments of Health and Human Services (Substance Abuse and Mental Health Services Administration and the Indian Health Service (IHS)) and Education, has enabled BIE to address the unique needs of students within these schools in the areas of mental and substance use disorders, including suicide.

The BIE has developed a Suicide Prevention, Early Intervention and Postvention Policy to promote suicide prevention in BIE schools. The policy mandates specific actions in all schools, dormitories and the two post-secondary institutions; and encourages tribally-operated schools to develop similar policies. These actions create a safety net for students who are at risk of suicide and promotes proactive involvement of school personnel and communities in intervention, prevention and postvention activities.

The BIA Office of Justice Services (OJS) partners with numerous health and social service programs to assist in educating and presenting at schools, seminars, workshops and community events to the youth and the community on suicide prevention. OJS gathers statistical data and identifies youth suicide trends within Indian Country, and will look for ways to expand suicide prevention training with other stakeholders in the future.

The BIA's Law Enforcement and Tribal Services programs, along with the BIE, continually seek ways to collaborate and to support activities directed at suicide prevention and services coordination. The BIE utilizes the Youth Risk Behavior Survey, Native American Student Information System (NASIS), local BIA Law Enforcement, and IHS data to develop interventions and track trends for program implementation and is committed to seeking out and enacting prevention strategies while ensuring a safe and secure environment for our students.

Additionally, BIE schools and dormitories use NASIS to track and identify specific behavior trends to develop interventions to address school specific behavior issues. Training is provided on site by the School Safety Specialist at a number of locations throughout the school year during staff training sessions and all residential staff are required to receive suicide prevention training.

It is important to note that Indian Country continues to suffer from a lack of comprehensive mental health treatment options. For example, OJS officers responding to a call for service involving a suicide threat are often left with no option but to arrest the individual. Without mental health facilities, jail is oftentimes the only place where the safety of the individual can be guaranteed.

Indian Affairs has the advantage of working alongside tribes and understands firsthand the severity of the lack of resources in Indian Country and the impact it has on tribal communities. We look

forward to our continued partnership with Tribal governments, on a government-to-government basis, and with our federal partners to continue to address trauma related issues.

Thank you. I will give the rest of my time to the others.

[The prepared statement of Mr. Cruzan follows:]

PREPARED STATEMENT OF DARREN CRUZAN, DIRECTOR, OFFICE OF JUSTICE SERVICES, BUREAU OF INDIAN AFFAIRS, U.S. DEPARTMENT OF THE INTERIOR

My name is Darren Cruzan and I am the Director for the Office of Justice Services at the Bureau of Indian Affairs in the Department of the Interior. I am pleased to submit this statement for the Department on the topic of "Addressing Trauma and Mental Health Challenges in Indian Country."

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BIA Trauma Informed Care Training

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Tiwahe Initiative

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As we continue to build this program, our hope is to also improve how we collect data in partnership with tribes to fully understand how trauma and its effects impact Indian County. Current, relevant, and robust data is necessary to make informed policy decisions to craft effective trauma interventions.

Suicide Prevention

There is no more important issue than addressing the high suicide rate in Indian Country, particularly among youth, which is often the result of an individual's exposure to trauma. Indian Affairs is directly involved in youth suicide prevention through the BIE, which provides technical assistance and monitoring to ensure schools are compliant with intervention strategies and reporting protocols to further ensure student safety. In addition, under the BIE reorganization the School Health Policy Advisor position was created. This individual will support the BIE Associate Deputy Directors, staff in the Education Resource Centers and BIE schools with the development of additional mental health programs, initiatives and policies as well as suicide and substance abuse prevention. They will also coordinate with the BIA and support interagency work of the White House Council on Native American Affairs.

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Conclusion

Indian Affairs has the advantage of working alongside tribes and understands firsthand the severity of the lack of resources in Indian Country and the impact it has on tribal communities. We look forward to our continued partnership with Tribal governments, on a government-to-government basis, and with our federal partners to continue to address trauma related issues.

Senator HEITKAMP. I have been preaching to the rest of the world about the great success that you had addressing trauma. So I want to congratulate you and the tribal leadership on taking this on. Your work has been recognized. You have a long history of working on behalf of your tribe and importantly on behalf of the children of your tribe. So I'm interested in hearing, and I know my colleagues and Senator Hoeven are interested in hearing about your success and what ideas we can share with the rest of the world. Thank you.

STATEMENT OF HON. MYRNA WARRINGTON, CHAIRWOMAN, HEALTH AND FAMILY COMMITTEE, MENOMINEE INDIAN TRIBE OF WISCONSIN

Ms. WARRINGTON. Thank you for inviting us here. It's good to know that tribes have been recognized nationally for their effort to address the problems of our children and families. Senator Heitkamp, Senator Hoeven, and members of the Committee, my name is Myrna Warrington. This is my 8th year serving as on the Menominee Tribal Legislature and at this time I serve on the Menominee Indian Tribe's Executive Team as the Secretary. Thank you for the opportunity to provide the Committee with the Menominee statement that addresses the trauma and mental health challenges experienced in Indian Country.

The Menominee Indian Tribe is located in northeast Wisconsin, within our ancestral territory. Our Reservation is comprised of 234,000 acres of land; bountiful in rivers, lakes, streams, wildlife, and forest land. Roughly 90 percent of the land held in trust for the Tribe is held in sustained yield for the Tribe's long-standing practice in Sustainable Forest Management. The Tribal membership includes over 9,000 enrolled members.

The Tribes history is mired in trauma due to the loss of Tribal status, identity, language and culture that was forced on our people by the Federal Government through overarching assimilation objectives, enactments of federal Indian policy, treaties, and judicial rul-

ings. The negative remnants of trauma experienced from the treaty era, Boarding School Era, Menominee Termination Act of 1954, Federal Relocation Act of 1956, and finally the Restoration of the Menominee Indian Tribe to Federal Recognition in 1973, remain visible in the lives of our Tribal members. Throughout the last two centuries, the Menominee endured the large loss of ancestral territory, near extinction of Menominee language, and the loss of many critical cultural and religious beliefs, practices and communal values that guided the traditional Menominee society. Our oral history and the historical record remain to help guide the Tribe in the right direction to address the impacts from these experiences.

In 2006, the Menominee Tribal Government, Menominee Indian School District, and Menominee Tribal Clinic, who, because of limited resources with narrow guidelines, broke down the silos to form the community collaboration. The Menominee Community Collaboration committed to creating data-driven solutions. The purpose was aimed at addressing the cumulative impacts that historical and intergenerational trauma were presenting upon the families of the Menominee Community. The initial identification process began with defining the negative behavioral, health, and educational problems that were manifesting in the lives of the Menominee youth. The community collaboration research led to the premise that the symptoms of poverty, low academic achievement, and poor health outcomes and factors were interconnected. Through this process, the Tribe was forced to confront the reality that the negative changes occurring within the youth population were a direct result of the changing family dynamic and community structure that were symptoms of a larger problem. These issues had not manifested overnight and were not isolated to just one event, but rather were symptoms resulting from trauma experienced throughout the course of the Tribes history.

What is trauma informed care? Trauma Informed Care is defined as an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma informed care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment for the Menominee, the definitional scope of trauma was lacking any recognition of self-worth and cultural competency and had to be expanded to include the loss of Menominee language, values, and beliefs in order to accurately examine the collective impacts that historical and intergenerational trauma had on the community as a whole. By doing so, the Tribe was able to identify the symptoms of trauma which included suicide, poverty, substance abuse/addiction, identity loss, loss of societal/cultural norms, and many others and identify the impacts that these had on the individual, family unit, and community.

To accurately assess the magnitude of traumatic experiences and the impact these had on Menominee youth and within the family dynamic, the Community Collaboration examined the statistics identifying child victimization rates in Menominee County which included neglect, abuse, suicide attempts, and alcohol and drug use/abuse. In 2013, 1,423 children resided on the Menominee Indian Reservation. According to the 2013 Wisconsin Department of

Children & Families Annual Report to the Governor and Legislature, approximately 10 children in 1,000 were victimized by either neglect, physical, sexual or emotional abuse. Equally alarming was the high incidence of youth hospitalizations for AODA and self-harm. For example, in 2015, there were 10 youth hospitalizations for emergency detention alone. From January through June 2016, there have already been a total of 14 emergency detention hospitalizations, 11 youth hospitalized, and 8 out of 11 youth hospitalized reported substance abuse and/or tested positive for alcohol or drugs at the time of admission. Statistics such as these are what initiated what is now known as the Menominee Fostering Futures Pilot Project that began in 2013.

Based on the statistics identifying the high incidence of traumatic experiences for tribal children, the Community Collaboration identified that existing policies, procedures, and mandates were not working. Menominee children and families were continuing to suffer. The County/Tribe was continually ranked 72 out of 72 for health outcomes and factors by the University of Wisconsin Population Health Institute. Educational Attainment was at an all-time low among high school students. The Menominee Indian School District was in fact, coined a drop-out factor due to the extremely low percentage of students graduating. Finally, crime, victimization, and death rates remained high.

The Community Collaborative Workgroup started by building a Menominee Model using the Bridges Out of Poverty framework which was a model for economic and social change, sustainability and stability. The simple premise of the Community Collaboration Workgroup identified that the causes of poverty, low academic achievement and poor health are inter-connected and formulated that the resources and responses the Community Collaboration would develop to combat them must also be inter-connected. This Community Collaborative workgroup vision of the Menominee Model evolved over time, which included the introduction and development of the Menominee Fostering Futures Initiative.

The goal of Fostering Futures was designed to improve the lives of children and families by translating the knowledge gained from the Adverse Childhood Experience Study, neuroscientific information, and mental health literature on the long-term effects of chronic adversity and trauma in childhood. As a part of our Fostering Futures work, we had to pick 2 areas of concentration for our community. We chose the following: (1) Providing Adverse Childhood Experience Study and Trauma Informed Care education; and (2) Evaluating and modifying policies and procedures to be congruent with the Adverse Childhood Experience study and Trauma Informed Care.

From the first goal, our Introduction to Trauma Informed Care training was developed. Initiatives of the Community Collaboration have included: Education Summits focused on Historical Trauma due to boarding schools and termination; the implementation of the Fostering Futures Program reservation wide promoting community awareness of Adverse Childhood Experiences (ACEs) and Trauma Informed Care (TIC).

Trauma Informed Service Delivery is a key component and focus of the Community Engagement Workgroup. The Community En-

gagement meetings focus on the development, execution and completion of 90-day plans developed and reported quarterly on issues established by the workgroup that now involve all community service providers. The Tribe's programs are implementing Trauma Informed Services by: reviewing internal policies and practices with an awareness of Trauma Informed Care; Continuing the Fostering Future Initiatives aimed at awareness of Trauma Informed Care, Adverse Childhood Experiences and sustainability; development of an AODA specific strategic plan to focus community efforts in areas of most critical need; using the Community Engagement Initiative to re-design the service delivery systems of government to ensure they are client focused and Trauma Informed; working to develop functions that: document processes being employed so that they can be cataloged and replicated; establishing a sustainable community-wide data collection and analysis function to measure results and guide decisionmaking; and requiring continuous collaboration among service providers when new grants or other initiatives are begun to eliminate duplication and stretch limited resources.

Through diligence, outreach, community education and involvement of elected leaders from the various governmental entities, the workgroup now includes all 41 departments of the Menominee Tribal Government, Menominee County Human Services; the Menominee Indian School District and the College of Menominee Nation.

The expansion of Trauma Informed Service Delivery across Menominee Community had led to extensive organizational and institutional changes that are showing growing success for our people. Some of these changes are evidenced by the following:

1. Menominee Indian School District—The Menominee Indian School District has made many organizational changes aimed at increasing the student's ability to self-identify and obtain assistance to regulate emotions in order to increase function and learning ability. Staff at all learning facilitates have been trained in Adverse Childhood Experiences, Trauma and Regulation. Beginning with the youngest learners, the District has removed the stigma of disciplinary action and created the morning mood check, the "Sakom Room" and Calm down boxes that allow the student who is disregulated the opportunity to restore balance in a safe setting before returning to the learning environment. The District also provides for student physical and mental health at each facility and instituted the Screening, Brief Intervention, Referral Treatment (SBIRT) program for students with substance concerns. Finally, the District provides graduation coaches for all High School seniors. These interventions have led to a dramatic increase in high school graduation rates from 60 percent person in 2007 to nearly 99 percent percent in 2014.

2. Menominee Tribal Head Start Program—At the Menominee Tribal Head Start all staff has completed the Head Start Trauma Smart Training and each facility has trained trauma coaches and family coaches. This aids in early recognition and intervention strategies benefiting our youngest learners and their families. In the coming academic year, families will have the opportunity to participate in the 10 module training.

3. Menominee Tribal Clinic—The integration of Trauma Informed Care and Adverse Childhood Experiences (ACES) survey has redesigned and changed operations in order to better assist patients, family and service providers by completely integrating services available. Noticing a problem of the high absenteeism, the Tribal Clinic redesigned the system by deviating from traditional appointment scheduling and offered same-day appointments, which was shown a dramatic decrease in absenteeism rates. By changing policies and procedures, the clinic has increased access to medical, dental, and mental health care to many individuals. The clinic has trained all staff on Trauma Informed Care; each patient is regularly screened for trauma in both the behavioral health and medical departments. The Tribal Clinic also has 4 full-time counselors trained in trauma interventions. These counselors rotate through the student health center at the Menominee Indian High School. The Tribal Clinic has also been accepted to start a Learning Collaborative in September 2016, to begin the accreditation process for pre and post PhD Psychology Interns.

4. Menominee County Health and Human Services—The Menominee County Health & Human Services has trained all staff on Trauma Informed Care approaches. They have also started the Alternative Response, which focuses on providing less intimidating approaches to working with families.

5. Community Education Initiative—The Community Education Initiative serves to provide the foundation for the Fostering Futures Initiative by providing awareness, information, and outreach to the Community and Service Providers on the principles of Trauma Informed Care and the relationship to historical trauma, brain development, Adverse Childhood Experiences, Secondary Trauma, and Resiliency. We have 2 Master Trainers working in the Community who have completed the Wisconsin Adverse Childhood Experience Training. Educational opportunities are offered to the community on a quarterly basis and to agencies upon request. This education is also offered to our families participating in the Temporary Assistance for Needy Families Program.

What is Resilience? Resilience is the ability to adapt well over time to life-changing situations and stressful conditions. While many things contribute to resilience, studies show that caring and supportive relationships can help enhance resilience. Factors associated with resilience include, but are not limited to: (1) the ability to make and implement realistic plans; (2) A positive and confident outlook; (3) the ability to communicate and solve problems.

We have recognized that while it is important to understand how and why traumatic experiences influence the person over their lifetime, we also know that it is equally important to understand and provide a foundation to overcome those traumatic experiences through education, awareness and support. The Community Collaboration has provided all agencies that work with children and families with consistent resiliency materials from the Children's Resiliency Initiative or also known as Resilience Trumps ACES.

In October 2015, the Menominee Indian Tribe, Menominee County, and Menominee Indian School District were recognized as 1 of 8 communities to receive the Robert Wood Johnson Culture of Health Award for our innovative efforts to help our community

lead healthier lives. The Tribe has been featured in the SAMSHA Spotlight and we continue to receive requests from other Communities for our presentation delivery of Trauma Informed Care.

Trauma Informed Care requires removal of silos created by limited resources with narrow guidelines and dated beliefs in service delivery to achieve outcomes based on mutual collaboration of resources for all community partners, providers, and individuals. To achieve that end, I am here today on behalf of the Menominee Community Collaboration to not only demonstrate the growing success of this concept, but to also ask the United States Senate Committee on Indian Affairs to assist and support Indian Country in this endeavor. We are asking that you recommend to Congress to appropriate funding for Native American need-specific interventions that include the ability for Tribes and organizations to pool goal-specific funding across federal agencies to progress our intervention goals. We are also asking that Tribes and partnering organizations have the ability to pool federal funds from any agency that were for the purpose of addressing some aspect of the problems facing that community.

Fortunately, such provisions have already been created within the 2014 Consolidated Appropriations Act, titled the Performance Partnership for Disconnected Youth. This piece of legislation addresses siloing of Federal Programs by authorizing ten pilot projects under which states, cities, and tribes would be permitted to pool grant funds from any agency that were for the purpose of addressing some aspect of the problems facing disconnected youth. It directs OMB to designate a lead agency to manage the pooled grants. It also empowers each Secretary to waive any statute or regulations that will increase the efficiency of the program or increase access by the target population, so long as the waiver is consistent with the overall purposes of the program.

[The prepared statement of Ms. Warrington follows:]

PREPARED STATEMENT OF HON. MYRNA WARRINGTON, CHAIRWOMAN, HEALTH AND FAMILY COMMITTEE, MENOMINEE INDIAN TRIBE OF WISCONSIN

I. Introduction

Posoh (Hello in my Menominee Language) Senator Heitkamp, Senator Hoeven, and members of the Committee, my name is Myrna Warrington. This is my 8th year serving as on the Menominee Tribal Legislature and at this time I serve on the Menominee Indian Tribe's Executive Team as the Secretary. Thank you for the opportunity to provide the Committee with the Menominee statement that addresses the trauma and mental health challenges experienced in Indian Country.

The Menominee Indian Tribe is located in northeast Wisconsin, within our ancestral territory. Our Reservation is comprised of 234,000 acres of land; bountiful in rivers, lakes, streams, wildlife, and forest land. Roughly 90 percent of the land held in trust for the Tribe is held in sustained yield for the Tribe's longstanding practice in Sustainable Forest Management. The Tribal membership includes over 9,000 enrolled members.

The Tribes history is mired in trauma due to the loss of Tribal status, identity, language and culture that was forced on our people by the Federal Government through overarching assimilation objectives, enactments of federal Indian policy, treaties, and judicial rulings. The negative remnants of trauma experienced from the treaty era, Boarding School Era, Menominee Termination Act of 1954, Federal Relocation Act of 1956, and finally the Restoration of the Menominee Indian Tribe to Federal Recognition in 1973, remain visible in the lives of our Tribal members. Throughout the last two centuries, the Menominee endured the large loss of ancestral territory, near extinction of Menominee language, and the loss of many critical cultural and religious beliefs, practices and communal values that guided the tradi-

tional Menominee society. Our oral history and the historical record remain to help guide the Tribe in the right direction to address the impacts from these experiences.

In 2006, the Menominee Tribal Government, Menominee Indian School District, and Menominee Tribal Clinic, who, because of limited resources with narrow guidelines, broke down the silos to form the community collaboration. The Menominee Community Collaboration committed to creating data-driven solutions. The purpose was aimed at addressing the cumulative impacts that historical and intergenerational trauma were presenting upon the families of the Menominee Community. The initial identification process began with defining the negative behavioral, health, and educational problems that were manifesting in the lives of the Menominee youth. The community collaboration research led to the premise that the symptoms of poverty, low academic achievement, and poor health outcomes and factors were interconnected. Through this process, the Tribe was forced to confront the reality that the negative changes occurring within the youth population were a direct result of the changing family dynamic and community structure that were symptoms of a larger problem. These issues had not manifested overnight and were not isolated to just one event, but rather were symptoms resulting from trauma experienced throughout the course of the Tribes history.

What is trauma informed care? Trauma Informed Care is defined as "an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma informed care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment" (Trauma Informed Care Project, 2016). For the Menominee, the definitional scope of trauma was lacking any recognition of self-worth and cultural competency and had to be expanded to include the loss of Menominee language, values, and beliefs in order to accurately examine the collective impacts that historical and intergenerational trauma had on the community as a whole. By doing so, the Tribe was able to identify the symptoms of trauma which included suicide, poverty, substance abuse/addiction, identity loss, loss of societal/cultural norms, and many others and identify the impacts that these had on the individual, family unit, and community.

II. Statistics

To accurately assess the magnitude of traumatic experiences and the impact these had on Menominee youth and within the family dynamic, the Community Collaboration examined the statistics identifying child victimization rates in Menominee County which included neglect, abuse, suicide attempts, and alcohol and drug use/abuse. In 2013, 1,423 children resided on the Menominee Indian Reservation. According to the 2013 Wisconsin Department of Children & Families Annual Report to the Governor and Legislature, approximately 10 children in 1,000 were victimized by either neglect, physical, sexual or emotional abuse (p. 71). Equally alarming was the high incidence of youth hospitalizations for AODA and self-harm. For example, in 2015, there were 10 youth hospitalizations for emergency detention alone. From January through June 2016, there have already been a total of 14 emergency detention hospitalizations, 11 youth hospitalized, and 8 out of 11 youth hospitalized reported substance abuse and/or tested positive for alcohol or drugs at the time of admission. Statistics such as these are what initiated what is now known as the Menominee Fostering Futures Pilot Project that began in 2013.

III. Menominee Problem Identification & Solutions

Based on the statistics identifying the high incidence of traumatic experiences for tribal children, the Community Collaboration identified that existing policies, procedures, and mandates were not working. Menominee children and families were continuing to suffer. The County/Tribe was continually ranked 72 out of 72 for health outcomes and factors by the University of Wisconsin Population Health Institute. Educational Attainment was at an all-time low among high school students. The Menominee Indian School District was in fact, coined a "drop-out factory" due to the extremely low percentage of students graduating. Finally, crime, victimization, and death rates remained high.

IV. Menominee Model Making the Difference

The Community Collaborative Workgroup started by building a Menominee Model using the "Bridges Out of Poverty" framework—which was a model for economic and social change, sustainability and stability. The simple premise of the Community Collaboration Workgroup identified that the causes of poverty, low academic achievement and poor health are inter-connected and formulated that the resources and responses the Community Collaboration would develop to combat them must also be inter-connected. This Community Collaborative workgroup vision of the Me-

nominee Model evolved over time, which included the introduction and development of the Menominee Fostering Futures Initiative.

The goal of Fostering Futures was designed to improve the lives of children and families by translating the knowledge gained from the Adverse Childhood Experience Study, neuroscientific information, and mental health literature on the long-term effects of chronic adversity and trauma in childhood. As a part of our Fostering Futures work, we had to pick 2 areas of concentration for our community. We chose the following:

1. Providing Adverse Childhood Experience Study and Trauma Informed Care education; and
2. Evaluating and modifying policies and procedures to be congruent with the Adverse Childhood Experience study and Trauma Informed Care.

From the first goal, our Introduction to Trauma Informed Care training was developed. Initiatives of the Community Collaboration have included:

- Education Summits focused on Historical Trauma due to boarding schools and termination;
- The implementation of the Fostering Futures Program reservation wide promoting community awareness of Adverse Childhood Experiences (ACEs) and Trauma Informed Care (TIC).

Trauma Informed Service Delivery is a key component and focus of the Community Engagement Workgroup. The Community Engagement meetings focus on the development, execution and completion of 90-day plans developed and reported quarterly on issues established by the workgroup that now involve all community service providers. The Tribe's programs are implementing Trauma Informed Services by:

- Reviewing internal policies and practices with an awareness of Trauma Informed Care; Continuing the Fostering Future Initiatives aimed at awareness of Trauma Informed Care, Adverse Childhood Experiences and sustainability;
- Development of an AODA specific strategic plan to focus community efforts in areas of most critical need;
- Using the Community Engagement Initiative to re-design the service delivery systems of government to ensure they are client focused and Trauma Informed;
- Working to develop functions that: document processes being employed so that they can be cataloged and replicated; establishing a sustainable community-wide data collection and analysis function to measure results and guide decision-making; and
- Requiring continuous collaboration among service providers when new grants or other initiatives are begun to eliminate duplication and stretch limited resources.

Through diligence, outreach, community education and involvement of elected leaders from the various governmental entities, the workgroup now includes all 41 departments of the Menominee Tribal Government, Menominee County Human Services; the Menominee Indian School District and the College of Menominee Nation.

The expansion of Trauma Informed Service Delivery across Menominee Community had led to extensive organizational and institutional changes that are showing growing success for our people. Some of these changes are evidenced by the following:

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The Menominee Indian School District has made many organizational changes aimed at increasing the student's ability to self-identify and obtain assistance to regulate emotions in order to increase function and learning ability. Staff at all learning facilitates have been trained in Adverse Childhood Experiences, Trauma and Regulation. Beginning with the youngest learners, the District has removed the stigma of disciplinary action and created the morning mood check, the "Sakom Room" and Calm down boxes that allow the student who is dysregulated the opportunity to restore balance in a safe setting before returning to the learning environment. The District also provides for student physical and mental health at each facility and instituted the Screening, Brief Intervention, Referral Treatment (SBIRT) program for students with substance concerns. Finally, the District provides graduation coaches for all High School seniors. These interventions have led to a dramatic increase in high school graduation rates from 60 percent person in 2007 to nearly 99 percent percent in 2014.

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V. Resilience

What is Resilience? Resilience is the ability to adapt well over time to life-changing situations and stressful conditions. While many things contribute to resilience, studies show that caring and supportive relationships can help enhance resilience. Factors associated with resilience include, but are not limited to: (1) the ability to make and implement realistic plans; (2) A positive and confident outlook; (3) the ability to communicate and solve problems. (DS Bigfoot, 2015).

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VI. Tribal Ask

Trauma Informed Care requires removal of silos created by limited resources with narrow guidelines and dated beliefs in service delivery to achieve outcomes based on mutual collaboration of resources for all community partners, providers, and individuals. To achieve that end, I am here today on behalf of the Menominee Community Collaboration to not only demonstrate the growing success of this concept, but to also ask the United States Senate Committee on Indian Affairs to assist and support Indian Country in this endeavor. We are asking that you recommend to Congress to appropriate funding for Native American need-specific interventions that

include the ability for Tribes and organizations to pool goal-specific funding across federal agencies to progress our intervention goals. We are also asking that Tribes and partnering organizations have the ability to pool federal funds from any agency that were for the purpose of addressing some aspect of the problems facing that community.

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Senator HEITKAMP. Thank you. And I know we'll have an opportunity to expand on our testimony during our questions. Next we're going to hear from Dr. Kathryn Eagle-Williams. Dr. Eagle-Williams, it's good to see you again. Thank you for your committed effort holistically on what you do as a health care provider.

STATEMENT OF KATHRYN R. EAGLE-WILLIAMS, M.D., CEO/ QUALITY CARE DIRECTOR, ELBOWOODS MEMORIAL HEALTH CENTER, MANDAN, HIDATSA AND ARIKARA NATION

Dr. EAGLE-WILLIAMS. My name is Dr. Kathryn Eagle-Williams (Red Cedar Women) I am the Chief Executive Officer of Elbowoods Memorial Center of the Three Affiliated Tribes and an enrolled member of the Arikara. First of all, I would like to thank for your interest in addressing trauma and mental health challenges in Indian Country and in particular in North Dakota. I am going to start by informing the committee that I am a survivor of suicide. On September 7, 2011 I lost my daughter to depression. She died by way of hanging. As a result of her death we have an entire immediate family of approximately 50 plus individuals affected by her death, and an even large number of extended family and community members. She died in Tucson, Arizona where we made our home. Within 7 months of her death I moved home to North Dakota and this is where my healing process began. Although, we were in Arizona at the time the picture is still the same. In general, access to basic health services is limited as is funding and expertise in working with Native American populations in regard to mental health and trauma. Access to mental health services is more limited due to lack of mental health providers, programs, and funding.

As health care providers in behavioral health we are aware of the fact that adverse child experiences contribute significantly to the health outcomes of any individual within a population, but must be mindful of the disparities within our Native American populations.

Based on the latest statistics from 2009–2013 the suicide rate among AIAN was the highest in the United States, 34.3 deaths per 100,000 for men and 9.9 deaths per 100,000 for women. AIAN males are twice as likely to complete suicide compared to other gender, racial and ethnic subgroups. Suicide is the 2nd leading cause of death for AIAN persons age 15–24 and 4x the national average.

Losing a child to depression is my story, but we all know there are many more stories of our men, women, and children who are suffering and have died from mental illness. We as Native people have heard the stories of our historical trauma and are still suffering from not only those traumas that affected our ancestors, but also the traumas that are a daily occurrence on our reservations and among our family and community members. We are still trying to overcome the Garrison Dam experience, we have a few elders still living who actually recall life before the dam and who remember a life that was much happier with few social and health issues and who recall the devastation of having to move from the bottom lands to higher ground.

Through my personal journey with the help of friends, colleagues, and my tribe have been able to work on healing and for that I am grateful. Much my healing experience did not come from sitting in a counselors office, but from the support of my community and spiritual leaders. Our work in the area of health and wellness is has only begun, we need mental health first responders or behavioral health technicians to help with sudden unexpected deaths and trauma such as domestic violence and sexual assaults; we need grief counselors, and must destigmatize mental illness.

In order to begin to heal a community we must first identify and recognized the trauma before we deal with it. Our people are living in crisis situations as I once was and are simply just trying to survive. At Elbowoods Memorial Health Center we are fully aware of the need for and protective factors associated with traditional medicine, but it seems as though the federal and state governments have not recognized the importance of spirituality and identity, which limits our ability to create programs that are meaningful and successful. We would like to see more of an investment into these modalities of therapy and health practices. We would like to offer these practices here with the possible consideration of medical reimbursement.

Today I would like to share with some of what we experience on the Fort Berthold Reservation otherwise known as the Three Affiliated Tribes.

The core of our challenges are as follows: (1) Limited access to services as a result of underfunding, criteria requirements, and licensure required for clinicians (locally), and lack of availability regionally. (2) Lack of access to hospital beds required for acute care and life threatening mental health conditions. (3) Lack of a plan to transport emergency life threatening mental health conditions requiring ambulance verse civil transports to the accepting hospitals. (4) Limited human resources and expertise: inability to staff our already under funded behavioral health programs. (5) Lack of funding, funding is often competitive and requires data that is often not available or scattered. (6) Lack of culturally sensitive trauma informed care models and training. (7) Limited resources in regard to prevention and intervention programs associated with suicide and mental and brain health. (8) Stigma associated with mental illness. (9) Social determinates of mental health. (10) Need of mental health first responders program to be established reservation wide.

So, the question is how do we address these core challenges? First of all, it is through support of our leadership, tribal, state,

and federal that we can begin to impact the disparities. Secondly, we must educate and inform our policy maker and funding agencies the importance of working with Tribes and understanding the true demand may not always be established through data as we may not have access to meaningful data. Finally, the continuation of tribal consultation is a necessity initially and throughout the process of planning and development of programs.

With that being said we are appreciative of the state's respect and consideration to ask for tribal consultation and would like to be an integral part of a state wide plan to the development of realistic services and training that are not only on paper, but are being implemented throughout the great plains. Dr. Monica Taylor-Desir, Chief Medical Officer for Elbwoods Memorial Health Center, who we are very fortune to have, has reviewed the ND suicide prevention plan. Dr. Taylor Desir has identified the plan includes working with Native Americans but there is no evidence in the last 6 months of the enactment of that plan in particular with our tribes. We need action not just words. We need support to educate and train our own people to help address the lack of human resources and access.

We need help in addressing the social determinants of mental health which include the following: discrimination and social exclusion; adverse childhood experiences; poor education, unemployment, underemployment, job insecurity; income inequality, poverty and neighborhood deprivation; food insecurity; poor housing quality and housing instability; poor access to mental health care.

It is our recommendation that when working with Native American people we must work from a strength based approach. It must be recognized that our cultural traditional ways of life and living are important protective factors in regard with mental, spiritual wellbeing of our people. We must destigmatize mental illness and focus on brain health and wellness. We must incorporating cultural practices into approved grants and other funding opportunities. We must promote commitment to cultural spirituality as well as promote strengthening of family ties and relationships. Incorporating, traditional spirituality and wellness must be recognized as a best practice. And in order to get at the heart of mental health we must incorporate trauma informed care while addressing addictions. We must not criminalize the addict or the broken spirit.

As I conclude I would once again like to say thank you for your interest and consideration as we attempt to meet the health needs of our people. In writing this testimony I am honored and humbled to share my story which is an experience I unfortunately share with far too many of my people.

[The prepared statement of Dr. Eagle-Williams follows:]

PREPARED STATEMENT OF KATHRYN R. EAGLE-WILLIAMS, M.D., CEO/QUALITY CARE DIRECTOR, ELBOWOODS MEMORIAL HEALTH CENTER, MANDAN, HIDATSA AND ARIKARA NATION

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In order to begin to heal a community we must first identify and recognized the trauma before we deal with it. Our people are living in crisis situations as I once was and are simply just trying to survive. At Elbowoods Memorial Health Center we are fully aware of the need for and protective factors associated with traditional medicine, but it seems as though the federal and state governments have not recognized the importance of spirituality and identity, which limits are ability to create programs that are meaningful and successful. We would like to see more of an investment into these modalities of therapy and health practices. We would like to offer these practices here with the possible consideration of medical reimbursement.

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The core of our challenges are as follows:

1. Limited access to services as a result of underfunding, criteria requirements, and licensure required for clinicians (locally), and lack of availability regionally.
2. Lack of access to hospital beds required for acute care and life threatening mental health conditions.
3. Lack of a plan to transport emergency life threating mental health conditions requiring ambulance verse civil transports to the accepting hospitals.
4. Limited human resources and expertise: inability to staff our already under funded behavioral health programs.
5. Lack of funding, funding is often competitive and requires data that is often not available or scattered.
6. Lack of culturally sensitive trauma informed care models and training.
7. Limited resources in regard to prevention and intervention programs associated with suicide and mental “brain” health.

8. Stigma associated with mental illness
9. Social determinates of mental health
10. Need of mental health first responders program to be established reservation wide

So, the question is how do we address these core challenges? First of all, it is through support of our leadership, tribal, state, and federal that we can begin to impact the disparities. Secondly, we must educate and inform our policy maker and funding agencies the importance of working with tribes and understanding the true demand may not always be established through data as we may not have access to meaningful data. Finally, the continuation of tribal consultation is a necessity initially and throughout the process of planning and development of programs.

With that being said we are appreciative of the state's respect and consideration to ask for tribal consultation and would like to be an integral part of a state wide plan to the development of realistic services and training that are not only on paper, but are being implemented throughout the great plains. Dr. Monica Taylor-Desir, Chief Medical Officer for Elbwoods Memorial Health Center, who we are very fortune to have, has reviewed the ND suicide prevention plan. Dr. Taylor-Desir has identified the plan includes working with Native Americans but there is no evidence in the last 6 months of the enactment of that plan in particular with our tribes. We need action not just words. We need support to educate and train our own people to help address the lack of human resources and access.

We need help in addressing the social determinants of mental health which include the following:

- Discrimination and social exclusion
- Adverse childhood experiences
- Poor education
- Unemployment, underemployment, job insecurity
- Income inequality, poverty and neighborhood deprivation
- Food insecurity
- Poor housing quality and housing instability
- Poor access to mental health care

It is our recommendation that when working with Native American people we must work from a strength based approach. It must be recognized that our cultural traditional ways of life and living are important protective factors in regard with mental, spiritual wellbeing of our people. We must destigmatize mental illness and focus on brain health and wellness. We must incorporating cultural practices into approved grants and other funding opportunities. We must promote commitment to cultural spirituality as well as promote strengthening of family ties and relationships. Incorporating, traditional spirituality and wellness must be recognized as a best practice. And in order to get at the heart of mental health we must incorporate trauma informed care while addressing addictions. We must not criminalize the addict or the broken spirit.

As I conclude I would once again like to say thank you for your interest and consideration as we attempt to meet the health needs of our people. In writing this testimony I am honored and humbled to share my story which is an experience I unfortunately share with far too many of my people.

Below you will find more information that has been gathered by our Behavioral Health Director, Dr. Lisa Keller-Schafer, a trained psychologist.

Behavioral Health (BH) Obstacles for NA residing on and off Fort Berthold reservation

1. Access to mental health services is severely limited for those living on and off the reservation due to:

a. Lack of insurance

i. 33 percent reported not having insurance compared to 11 percent of Whites; with 46 percent reported they could not afford the cost of healthcare

ii. 57 percent rely on IHS for care

b. Lack of tribal funding

i. Due to changes in budgeting and outside payee sources many programs' funding has been cut—some—including behavioral health, up to 50%

c. Lack of transportation

i. Of those who own a car, most cannot afford to fix minor repairs, pay for gas, or general upkeep.

ii. Others rely on relatives/friends to transport them, which often is money paid out of their pocket. An elderly lady reported having to pay $100 to her relative for each trip she took to a store

d. Lack of providers

i. currently Fort Berthold has one provider to cover the entire reservation

ii. of those who apply for counseling positions, most are underqualified or not licensed

iii. the only recruiting incentive is student loan repayment programs for those who are licensed

iv. In regards to reasons tribal members do not seek BH services: 39 percent of tribal members reported a lack of providers and 48 percent reported limited clinic hours kept them from seeking mental health services; another 40 percent did not trust their information would not be kept confidential

e. High poverty rates

i. The percentage of the reservation population with income below the poverty level is at 23.1 percent. In comparison, this is more than double the average North Dakota poverty rate of 11.2 percent and is higher than the U.S. rate of 15.9 percent. In respect to children, the situation is worse, with 31.6 percent of the reservation population under the age of 18 living below the poverty line compared to 13.2 percent in North Dakota and 22.6 percent in the U.S. overall

f. Emergency Service Barriers

i. 78 percent of tribal members report there are no emergency services available in their area

ii. ambulance drivers can refuse to transport individuals presenting with psychosis or a danger to others claiming they are at greater risk of harm because those individuals are violent—WHICH is a myth

iii. there are no police transports for individuals presenting with severe mental illness—even those with homicidal and suicidal ideations due to boundary issues—basically TAT police are required to place criminal charges on individuals who they transport. This means for clients presenting with mental illness, they would have to be criminally charged before police can transport. AND even if police could transport they could only bring a client to the reservation line and then another police officer from the next county would need to take the client from there. AND the client would not be escorted to a hospital ED, but instead because criminal charges were placed on that client—the client would go to jail until his/her hearing.

iv. There is no clean-cut civil commitment on the reservation. Family and friends who are attempting to get their loved ones help and the loved one is over 18 years must complete affidavits indicating why the loved one is a danger to the self or others. This goes to the judge who decides if the individual should be detained—but that is if the loved one can be easily found—given the PD are also understaffed.

g. Lack of awareness about mental health issues and services AND Stigma

i. Many elderly believe talking about mental health issues such as suicide will make things worse

ii. Approximately 78 percent of all individuals presenting for mental health services have reported a dislike of psychotropic medications, but have used licit and illicit substances to relieve their symptoms

iii. Many do not believe their information will remain confidential

iv. misguided views that people with mental health problems may be more violent or unpredictable than people without such problems, or somehow just "different", but none of these beliefs has any basis in fact; Psych ward—insane asylums—bloodthirsty killers in straightjackets -

v. early beliefs about the causes of mental health problems, such as demonic or spirit possession, were 'explanations' that would almost certainly give rise to reactions of caution, fear and discrimination.

vi. Even the medical model of mental health problems is itself an unwitting source of stigmatizing beliefs. First, the medical model implies that mental health problems are on a par with physical illnesses and may result from medical or physical dysfunction in some way (when many may not be simply reducible to biological or medical causes). This itself implies that people with mental health problems are in some way 'different' from 'normally' func-

tioning individuals. Secondly, the medical model implies diagnosis, and diagnosis implies a label that is applied to a 'patient'. That label may well be associated with undesirable attributes (e.g. 'mad' people cannot function properly in society, or can sometimes be violent), and this again will perpetuate the view that people with mental health problems are different and should be treated with caution.

vii. stigma directed at adolescents with mental health problems came from family members, peers, and teachers.

viii. stigma perpetrated by teachers and school staff, who expressed fear, dislike, avoidance, and under-estimation of abilities

ix. Mental health stigma is even widespread in the medical profession, at least in part because it is given a low priority during the training of physicians and GPs

h. Limited services available on the reservation

i. There is no speech or occupational services—46 percent have requested these services

ii. There are no pain clinics—41 percent have requested these services—these services are essential for those using opiates to mask mental illness

iii. No alternative care such as massage, acupuncture—35 percent have requested these services

iv. There is no CT, MRI, Pet Scans

v. There is no sleep study program, respiratory care, EEG

Consequences

1. *Suicide:* There are currently no statistics for the Fort Berthold Reservation in regards to the number of suicides. However, the Aberdeen IHS office has presented the following example from other reservations in its' area. "It could be argued that the senseless stabbing death of a young teenage girl in January 2007 by two other young teenage girls being egged on by a circle of peers really set the tone for the 2014 year: one of dread and despair that led to a continuous cycle of death. . . *of 16 other adolescents who took their own lives.* In spite of efforts over the past 12 months to reach-out to youth and families, to train all community members on prevention and intervention strategies, to partner with state and federal agencies for an increase in services, these lives lost are the best indicator that there are gaps, inadequacies, and barriers to current service structures. As shown above, in the number of agencies and organizations devoting resources to youth, there is dedication of purpose. These purposes and efforts, however, have not yet led to a transformed community where the choice for life far outreaches the choice for death."

2. *Serious Emotional Behavioral Disorder* (SEBD) reflects an individual (ages 8 to 89 years) who:

a. Is angry, bitter, hostile, and aggressive, prone to fighting and bulling, uses excessive profanity, who is constantly getting into trouble, prone to steal, arson and gang activity and who may act out sexually;

b. Appears withdrawn, upset, frustrated, pouting and sulking, lazy and lethargic, confused, lacking attention, and who has poor hygiene, inadequate nutritional intake, sleep disturbance, and prone to lying, running away from home, self-mutilation;

c. Shows a lack of respect, failure to thrive, has health problems and depression, is defiant, has low self-esteem, has attachment issues and prone to gang participation, has poor academic performance; and,

d. Is prone to suicidal thoughts and ideations, social phobias and fear of certain people, has a false pride and demonstrates grandiosity or 'big head'.

3. *Methamphetamine* use is increasing. The Aberdeen Area Indian Health Service (IHS) reported that on average Behavioral Health Units (Alcohol Programs as well as IHS Mental Health Programs) are seeing an average of 48.5 cases of confirmed methamphetamine use per month per site.

4. *Liver diseases* are "broken spirit" diseases for Indian people. HIV and Hepatitis (HBV and HCV) affects AI/AN in ways that are not always apparent because of small population sizes. Of all races/ethnicities, AI/AN had the highest percentages of diagnosed HIV and Hepatitis infections due to injection drug use. AI/AN face HIV and Hepatitis prevention challenges, including poverty, high rates of STIs, stigma, and lack of psychiatric care to treat predisposing mental illnesses.

5. A national study on *Violence Against Women* reported that American Indian women and experience the highest rate of Domestic Violence in the United States, and that three-fourths of Native American women and children have or will experience some type of sexual assault in their life time; with approximately 76 percent of women being raped by their significant other at least one time. Although recent reports of violence vary and specific numbers are not known, it is estimated that over the past 3 years Fort Berthold shows an increase in the number of violence-induced injuries including 664 assaults, 60 stabbings, and 31 possible rapes. This report is a rough estimation of persons seeking medical or legal intervention on and off the reservation.

6. *The poverty of the area* has a major impact on the health and wellness of the people. The Aberdeen Area Indian Health Service IHS which provides health care to Fort Berthold, and the tribes in South Dakota and Iowa, has some of the most startling health statistics of the twelve national IHS service areas (Indian Health Service, 2007):

- The age-adjusted death rate (all causes) is more than double the U.S. All Races rate, and is the second highest Area rate in the Indian Health Service.
- Other Data on Mortality rates: the 2nd highest Suicide Death Rate; the highest Alcoholism Death Rate; the second highest Diseases of the Heart Death Rate
- The Diabetes Mellitus Death Rate is five times the U.S. All Races Rate. Diabetes is the fifth leading cause of death for Tribes in the Aberdeen Area (following heart disease, cancer, accidents, liver disease and cirrhosis).
- The lowest Life Expectancy at Birth: 64.8 years compared to 75.8 years for the U.S. All Races and 71.1 years for the All IHS service populations.
- The highest Years of Potential Life Lost Rate: 119.5 years/per 1,000 persons under the age of 65, which is 2.5 times the U.S. all races total.

Senator HEITKAMP. Thank you very much, Dr. Eagle. Next we have Dr. DeCoteau shares some responsibility of talking about what more we could do to carry forward the idea and the knowledge about trauma. She is a leading expert throughout the country.

STATEMENT OF TAMI DECOTEAU, PH.D., CLINICAL PSYCHOLOGIST, DECOTEAU TRAUMA—INFORMED CARE AND PRACTICE, PLLC

Dr. DECOTEAU. Thank you, Senator Heitkamp. I am honored to be here. My name is Dr. Tami DeCoteau. I am an enrolled tribal member of the Mandan Hidatsa Arikara Nation and a proud descendant of the Turtle Mountain Chippewa. I have worked as a licensed clinical psychologist with an emphasis on the treatment of trauma disorders for more than a decade. In addition to maintaining a busy patient caseload, I own a Bismarck-based private practice that employs 6 mental health workers who are uniquely trained in the application of trauma-specific interventions for adults, children and families. Thank you for holding this hearing on trauma and mental health challenges in Indian country and inviting me to testify.

Senator Heitkamp, I would like to thank you for your key role in advancing Native American priorities, your efforts to improve the lives of Native American people and for illuminating the important but tragically overlooked issue of historical trauma. I would also like to thank you for drafting and advocating for S. 246, "The Alyce Spotted Bear and Walter Soboleff Commission on Native Children." S. 246 is essential to enhancing the lives of Native children.

I have been asked by members of the Committee to focus my testimony on my professional experience and my clinical perspective on trauma.

I obtained a doctorate degree in Clinical Psychology in 2003 from the University of Nebraska-Lincoln with specialization in the cognitive-behavioral treatment of anxiety disorders, which at the time encompassed trauma disorders. My professional practice work has focused on providing services to trauma-survivors. I am certified in trauma-focused cognitive behavioral therapy. I have received training in the Neurosequential Model of Therapuetics (NMT), a developmentally sensitive, neurobiology-informed approach to working with at-risk children; Trust-Based Relational Intervention (TBRI), a therapeutic model that trains caregivers to provide effective support for at-risk children; and Eye Movement Desensitization and Reprocessing (EMDR), an intervention approach that helps reduce the long-lasting effects of traumatic memories.

During my undergraduate and graduate training I received the honor of becoming a McNair Scholar and then an American Psychological Association (APA) Fellow. I also received the Indian Health Service 2009 Health Professional of the Year Award for outstanding service and the American Psychological Foundation 2010 Early Career Award for providing culturally competent practice techniques for Native Americans and for developing training programs in rural, underserved areas.

My career began with the Veteran's Administration where I provided psychological services to traumatized Veterans. During my interim at the VA, Dr. Arthur McDonald (Ogala Lakota) and I joined forces to create psychology internship training and services for Native Americans. Our initial effort was funded by HRSA/BHP. During the 3-year grant phase we designed and implemented a model for training psychologists to provide culturally competent and relevant services in rural Native American communities. From this experience, evolved the stimulus for a much greater vision to develop reservation-based internship programs with unique missions to restore the individual and the collective sense of worth of Native American people by supporting the belief that the healing of Native Nations lies within the Nations themselves.

The Standing Rock Psychology Internship and Post-doctoral Program became the flagship model of our vision. The Program evidenced success in recruiting and retaining psychology providers for rural Native American populations and substantially increased accessible mental health services. Doctorate-level trainees worked collaboratively with tribal health, schools, and judicial departments. In addition to the well over 3,000 hours of direct patient care, trainees provided community education, suicide prevention, and even equine assisted psychotherapy. One of the highlights of the Program was the mobile crisis response team that worked to prevent and reduce suicides on the reservation. The Program was a tribally-driven initiative that provided an excellent example of Indian self-determination.

Unfortunately, it is difficult to sustain mental health services on the reservation. Mental health providers in Indian Country are at a particularly high risk for burnout. We work in an intense and crisis-oriented environment on a day-to-day basis. We face an unusual array of highly-stressful conditions including inadequate compensation, safety issues, lack of basic resources such as supplies and testing materials, professional isolation, lack of appropriate referral

and consultation resources, excessive time demands, and inadequate funding. In addition, we serve a patient population that has an unimaginable amount of emotional trauma and social problems. These conditions cause us to experience a constant state of physical and mental exhaustion and lead to feelings of depersonalization and dissatisfaction. It is no surprise that decreased worker effectiveness and burnout are common among mental health professional in rural Indian Country.

While my heart still resides in working on Indian reservations, I have been drawn towards education and advocacy for trauma-survivors including training local teachers, educating congressional leaders, and serving as the president of Council for Native American Trauma-Informed Initiatives which is hosting this afternoon's Roundtable on the Causes and Effects of Trauma In Native American Communities.

Thus, in 2011, I step away from my clinical work on the reservation and began work as a private practice and consulting psychologist in Bismarck, ND. In a very short amount of time my clinic schedule was full of patients, primarily children in foster care with complex developmental trauma. Whether it be on, or off the reservation the need for trauma-based psychological services in North Dakota is immense. Over the course of my career I have become acutely aware of the "culture of trauma" that is overwhelming Indian communities and inhibiting the traditional "healing culture" practices. I will discuss the culture of trauma first.

Historical trauma is the cumulative impact of historical losses caused by European settlers' efforts to exterminate Native Americans and our culture and transmitted across generations. The assimilation policies of the federal government, particularly the one that involved sending young Indian children to boarding schools, continue to have a tremendous detrimental effect on Indian people. This history has led to a generational pattern of trauma that perpetuates itself in the form of abuse, neglect, substance addiction, violence, mental unwellness, physical illness, and unresolved grief.

Trauma by definition is an unbearable and out of control sensation in the body. It leaves an imprint on the mind, body and brain and results in reorganization of the way the mind and brain manage perceptions. Trauma changes what we think, how we think, and our very capacity to think. Traumatized people have trouble deciphering what is going on around them. They superimpose their trauma on everything. Individuals who become conditioned to adversity come to believe they have no control over their lives so they give up trying—a response referred to as learned helplessness. Trauma affects those who are directly exposed to it as well as those around them. The current challenges in Indian country, including difficulties with social-environmental, physiological and psychological functioning, are evidence that the trauma that occurred long ago continues to impact Native Americans today.

The therapists in my practice serve hundreds of traumatized individuals, many of whom are Native American children. The gut-wrenching impact of trauma on these precious souls is evident in their persistent hyperarousal and hyperactivity. These children struggle to regulate their own emotions, attend to stimuli, and their capacity for learning is often greatly impaired. While they are

desperate for love and affection, their persisting fear-response causes them to perceive everything as threatening, and they are likely to lash out at even the most loving caregivers. Children who have such complex trauma cannot become functioning members of society without skillful trauma-focused intervention.

Research shows that helping trauma survivors to describe their trauma is helpful, but is often not enough. Since trauma is encoded in the mind and body, for healing to occur, mind-body communication is needed. Scientists have discovered that individuals can restore their arousal system through practices such as mindfulness, movement, and rhythm—principles that have been used by Native American cultures for centuries. Although Native principles in healing have long been regarded as nonsense by modern day medicine, we now have scientific proof that the ability to heal ourselves and our communities lies within our traditional cultural practices.

Recent scientific studies have developed some practical and effective interventions for trauma, and we now have a pretty good idea of what tribes can do to address the causes and effects of historical and childhood trauma. A comprehensive trauma-informed initiative that involves every institution on the reservation must be implemented. My recommendations are provided below.

1. Implement Comprehensive Trauma Informed Initiatives. There is no one single intervention that every tribe must adopt. Rather, there are a number of different ones that have been shown to be effective for a specific area—the schools, the mental health program, the law enforcement system, and so on. Each tribe needs to select the approaches that are most appropriate for its values and culture. The keys are that the initiative must be comprehensive and the community must be fully educated about trauma and involved in the initiative. The problem is that right now there is no place a tribe can turn to in order to obtain technical assistance in setting up a comprehensive trauma-informed program. I urge Congress to appropriate funds to create an institute that would provide on-going assistance to tribes that are seeking to implement a comprehensive trauma-informed initiative.

2. Provide funding for the use of interns. There is a desperate and immediate need for increased human service resources in order to address childhood and historical trauma. Although the Standing Rock Program is no longer in operation its model is universally applicable and has the ability to be reproduced in other underserved areas. By providing funding to enable tribes to implement psychology intern programs that bring pre- and post-doctoral psychologists to reservations we can expand the mental health workforce in our region.

Senator Heitkamp and honorable members of the Committee, childhood and historical trauma are long-standing issues that have detrimental effects on our Federal and State budgets, health, and overall well-being. Indian Country needs maximum mental health power to deal with the trauma. Money must be allocated for tribal comprehensive trauma initiatives. I thank you for the time and opportunity to share my perspective on trauma and mental health challenges in Indian Country.

[The prepared statement of Dr. DeCoteau follows:]

PREPARED STATEMENT OF TAMI DECOTEAU, PH.D., CLINICAL PSYCHOLOGIST, DECOTEAU TRAUMA—INFORMED CARE AND PRACTICE, PLLC

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The Culture of Trauma

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The Healing Culture

Research shows that helping trauma survivors to describe their trauma is helpful, but is often not enough. Since trauma is encoded in the mind and body, for healing to occur, mind-body communication is needed. Scientists have discovered that individuals can restore their arousal system through practices such as mindfulness, movement, and rhythm—principles that have been used by Native American cultures for centuries. Although Native principles in healing have long been regarded as nonsense by modern day medicine, we now have scientific proof that the ability to heal ourselves and our communities lies within our traditional cultural practices.

Recommendations

Recent scientific studies have developed some practical and effective interventions for trauma, and we now have a pretty good idea of what tribes can do to address the causes and effects of historical and childhood trauma. A comprehensive trauma-informed initiative that involves every institution on the reservation must be implemented. My recommendations are provided below.

1. Implement Comprehensive Trauma Informed Initiatives. There is no one single intervention that every tribe must adopt. Rather, there are a number of different ones that have been shown to be effective for a specific area—the schools, the mental health program, the law enforcement system, and so on.

Each tribe needs to select the approaches that are most appropriate for its values and culture. The keys are that the initiative must be comprehensive and the community must be fully educated about trauma and involved in the initiative. The problem is that right now there is no place a tribe can turn to in order to obtain technical assistance in setting up a comprehensive trauma-informed program. I urge Congress to appropriate funds to create an institute that would provide on-going assistance to tribes that are seeking to implement a comprehensive trauma-informed initiative.

2. Provide funding for the use of interns. There is a desperate and immediate need for increased human service resources in order to address childhood and historical trauma. Although the Standing Rock Program is no longer in operation its model is universally applicable and has the ability to be reproduced in other underserved areas. By providing funding to enable tribes to implement psychology intern programs that bring pre- and post-doctoral psychologists to reservations we can expand the mental health workforce in our region.

Conclusion

Mr. Chairman and honorable members of the Committee, childhood and historical trauma are long-standing issues that have detrimental effects on our Federal and State budgets, health, and overall well-being. Indian Country needs maximum mental health power to deal with the trauma. Money must be allocated for tribal comprehensive trauma initiatives. I thank you for the time and opportunity to share my perspective on trauma and mental health challenges in Indian Country.

Senator HEITKAMP. Thank you so much, Dr. DeCoteau. Thank you so much for your leadership and educating me on these issues. I don't think that I would be nearly as informed without your assistance, without your persistence. And thank you to Don Schmitt for helping making this hearing a reality. I have known Don for many, many years. More years than probably either one of us want to recognize. There has been no greater advocate for children in foster care looking for advanced solutions, and we know so many heroes like this, and it's important where we do have people who dedicate their life, that we recognize that.

So I'm going to turn first turn to Senator Hoeven for a round of questions. I think we're around five minutes, or as long as you want to go.

Senator HOEVEN. Thank you to all of our witnesses. What I would start out with is the need for a comprehensive approach. I ask each witness to describe what that comprehensive approach looks like? Recently the State Department of Human Services had a workshop in Fargo on the opiods epidemic. We really talked about—and we had the people work on the prevention, people who work on treatment, and law enforcement. So the idea was we got people from the front lines and experts. We had them from all areas. So we can try to come at the problem in a comprehensive way. We talked about everything from drug court to making sure there's education in schools and prevention, so people understand these drugs are not only addictive but they're dangerous and they're killing us. And then how law enforcement has to be able to not just incarcerate but to have treatment options. So same thing here, how each of you—What's it take to get that comprehensive approach? And I would start with Miss Sparks.

Ms. ROBINSON. Thank you. Thank you for that question. It's a difficult question to answer, because it's such a difficult issue for us to tackle and for us to wrap our minds around. As I mentioned, there are many pathways to be able to treat parts of the trauma and behavioral health. But what we first have to understand is

what actually are the causes. And I think that really varies impacting from community to community. We heard from Dr. Eagle Williams that the Garrison Dam is still something that's impacting the elders and it's transmitting down to the youth as well. And I think that each tribal community will have a similar story as to what is the root cause. But prevention, intervention, providing services, it's complicated. Unfortunately I don't have an answer for exactly what is the comprehensive approach, but I can tell you from Children and Families' perspective would be that we want to start early childhood programs. We want to be able to provide trauma and foster care to the service providers in our head start and our childcare and our native language programs. We want to be able to reach the parents that might not only be suffering from some of the symptoms of trauma but are suffering from some of the more complex historicals or PTSD or other adverse childhood experiences and help them get the services they need. We want to be able to prevent the adverse childhood experiences before they happen. And if they have happened, how do we get to the kids where they are to prevent them from being further traumatized. But, you know, that's just one way of approaching this particular topic.

Mr. CRUZAN. Very interesting. And I realize now that it's not just a drug and alcohol thing, which is what we see primarily. We have these activating events. There's law enforcement and you're dealing with really the symptoms and not the cause. One of the things we're trying to do within the Office of Justice Services, you could sort of, which I'm not sure we'll talk about, it's a thing more than a thing. It's a series of things, right? But one of the parts of that is a break in the system of services that are out there. I mean, I'm sure these people struggling with these issues can be referred separately, but for us there's an activating event. We're developing a graded system of services. It's basically a poster that we're trying to teach our law enforcement folks that you are a part of this healing process, for lack of better words, from the very beginning. So we're trying to develop a system where a police officer gets called to an event where you have these individuals who are displaying the symptoms of a greater problem, where you can divert them, maybe have a court option, but you don't immediately go to that judicial branch. You sort of have a diversion process where the officers who are dealing with these folks over and over again—I was just at Standing Rock yesterday and you look at the board of who is in the facility, and you can almost go back two years ago and it's almost the same people. It's the same names over and over again. So these officers who are dealing with these folks, if we have an option to divert them out of that judicial process into some sort of treatment, that would be our first option. Maybe that works. Maybe it doesn't. If it doesn't, you continue on this, continue here where now you go to work and Courts now have more options. Maybe it's adjudication. Maybe it's court ordered treatment. Maybe it's through drug court. Maybe it's a number of things. We've got a new system in place, and I think it's fairly generic. It's post-adjudication pre-sentencing that—So I'm arrested, I get brought in, I sit down, and I go through this with a court personnel. It's an assessment that really begins to ask questions about my likelihood of reoffending and if it's into where I should probably be. So maybe

court ordered treatment. It maybe jail as opposed to treatment. So you continue this through these services, hopefully these off ramps back in the community where they can live healthy lives. Again, I think we're a part of the solution. I think it's becoming more and more clear to me that we could be more active participants in this. But the issues that these folks that we're dealing with are much deeper, and I'm not trying to tie this into these issues that—but foster homes, I can't control. It's in my head and and acting differently because of it. You know, you go and say, well, going down that path—You know, these folks that are struggling with these adverse childhood experiences are dealing with things that they can't comprehend, they can't control, and you can't really reason yourself out of it. I'm not saying I completely can relate, but I can understand, and it makes a little bit more sense. They are acting out in these ways. It's more than just alcohol and drug abuse. And we are working with that and I think for us it's going to diving into the professionals with our analytical data and our statistics and our numbers. So I don't know if I have a solution.

Senator HEITKAMP. Thank you. Miss Warrington?

Ms. WARRINGTON. Thank you. One of the things that we have been doing is getting from volume from all our governmental bodies. So they know what we are doing. We have quarterly meetings with them and we report to them on what we're doing for trauma care. We have a casino and we involve all the players. The police department supports all the businesses. We involve them all so that they know that this is not going to wayside. It's not a little thing we're going to play right now. It's continuing on, and they know this because we also ask them for money. We have to prove to them what we are doing, because they do contribute to the foster futures in the trauma group of people that we continue to work. We have regular meetings, but we have quarterly meetings as well. So I think it's important to let them know who is being trained, what kind of training is going on, but also because—and I've been doing this for three years, and we are starting the evaluation process now, because it isn't just, okay, here's what trauma informed care is. It's going back and saying, are you practicing it? How are you practicing it? Is it including your agencies? Is it improving your relationships? So that to us is very important to not to just be preaching to the choir, but also what are you doing? Are you actually feeling better about this, and do you have any ideas? What can we do to make it better? And I think that's the number one thing, but also reporting out to those agencies so they can, if they are asked, they can say what it is that they're doing. It's a core group. We started with eight people, but we brought in several others involved in these regular meetings. We also said engagement meetings where we involve anybody from the community. So that is so important. We're addressing the youth, bring them in. What are these kids saying? What do they need? What do they think is going to help us? So to talk about this we have to have the youth involved as well.

Dr. EAGLE-WILLIAMS. Thank you so much. Some of what we're seeing and what we're doing is very similar. We're very happy that we are working with our justice center as well as as our police force in educating them on basically what's happening also in the homes

and the actual psychological effects of the parent and having the children witness these things, and also to help the police officers identify that. So we've been educating them on what we are seeing. And so that I think has been really helpful in working with the police force. And also coming from the aspect of, you know, not criminalizing our addicts. We have to change that mindset. Working in Indian country, I've worked primarily with women, I evaluated and did interviews, and when I did that there were 80 to 90 percent of the women that we treated on an outpatient treatment program, were molested, raped, had domestic violence in their homes. I realized that I had all of those risk factors as well, and I didn't even know, and I'm a professional. So we are working on educating our communities. We've gone through the Ace study with some of our staff, and when we did that there wasn't a dry eye in there of our women and our community members that hadn't experienced those childhood experiences. So we are working on educating, and the powers in the community. The thing is, we don't have enough staff. We have one counselor. You know, it's just so difficult to find individuals that are able to address these situations. I have to say, that the other, finding ways to bringing that culture or peace that's sometimes missing in these families is very important. And as we're working with these individuals that are either getting incarcerated or children who are taken from their home, we have to develop a reentry program that are allowed to bring those families back together. Because you could be an alcoholic and still be extremely supportive of your family and or an addict could still have that love, but because of that addiction, we cannot criminalize those individuals because of any experiences that led them to where they are. The other things we have, or I've include in my testimony, includes addressing the mental health. Definitely we need prevention and intervention, the alternatives to abuses. I actually took my daughter to the ER two weeks before she died, and she said, "Mom, I am having chest pains." You know, my heart was pounding. I was like, "Is she having an anxiety attack? What's going on?" So I'm trying to do all these things and ask the right questions, and we're working on collecting data from the State. It's amazing how—I can't remember the exact numbers, but we were identifying people at that point that were having anxiety or were suffering from depression but were released. That's kind of where we're at. So, again, thank you. Thank you for listening.

Dr. DECOTEAU. So we know that trauma has horrible impact on a human being. There's no one single approach that will work. We need comprehensive initiative from the community and it must include education of childhood trauma and historical trauma for all tribal systems and tribal leaders. There needs to be education on what the science says about intervention, and I think what tribal communities will find is that these interventions are very, they are very consistent with their tribal ways. What research is saying now is that safe, consistent relationships are a priority in restoring a traumatized individual, and things like rhythm and movement and mindfulness. And we've had these in our culture for generations. So we now understand that what use to be thought of as nonsense is scientifically proven as a successful intervention for traumatized individuals. A comprehensive initiative needs to have technical as-

sistance that the tribes can reach out to for support, and identify consultants who are experts in their areas and who can assist the tribe in developing their own comprehensive initiatives in their communities. Tribal communities need a workforce, a workforce of mental health providers who are willing to leave the comfort of their office and do outreach to the furthest corners of the reservation. We've got to get to those folks because in my experience, those are the folks that are the highest risk for suicide. When I was working on the reservation, the one thing that was crystal clear to me was when there was a suicide, this was not somebody I knew. They were not a mental health patient. We're not reaching the services that they need, and we need to do a better job in doing that. We need to develop internship programs. It's hard to get folks to North Dakota. It's hard to get folks to rural areas to work, but the Veteran's Administration, other universities have established for decades that the best way to recruit professionals to our region is to develop internship training programs. We had that success and experience in the program at Standing Rock. We know that works. Thank you.

Senator HOEVEN. Follow up questions for the next round. Thanks to each of you.

Senator HEITKAMP. I think the great thing that's here is we have the person who has been tasked with the challenge of taking a look, kind of breaking down those silos, and thinking about emanating programs. So many times we hear we started a project, we received great results and then the funding was up and it went away. So one of the concerns that I had about this issue involved consistency and longevity. So Dr. Robinson is here. She is tasked with that goal, and I want to just ask the three health care professionals here to offer some advice to her on what would be helpful in addressing trauma and making sure the trauma programs continue on and we continue to see the success that you're seeing, but what more do you need from HHS to tackle this process.

Ms. WARRINGTON. We've said it before, and that is like someone else said, the professional assistance. You know, having people there that can help, can counsel, and different programs, pediatric care, whether working with children. What better way to do that is to start with trauma affecting the lives and starting from when they are very young, but those experiences where they need care and they are few and far between. So having professionals that will go to where you want them to is very important to our treatment program for counseling services up there. I think that really that is one of the biggest things to me is having a professional availability and resources.

Senator HEITKAMP. And you mean not in Washington DC, but actually on and in the trenches?

Ms. WARRINGTON. Make that a point.

Senator HEITKAMP. Next.

Dr. EAGLE-WILLIAMS. We would like to see training programs that are accessible and efficient to train our local people as well as internships and funding that supports traditional health and wellness. Like Dr. DeCoteau said, why would a 17 year old girl who is extremely healthy, a leader in her school, and basketball player have to go to the hospital. We're not seeing those individuals. We're

not even seeing the individuals that are making attempts until we go through 911 calls, and at that time it's three months later. So we're developing the referral process, stuff like that, but we'd like to see more traditional health and wellness. We would also like to see incorporating the entire family, because obviously this is not just affecting that individual. It's affecting the entire family and addressing the domestic violence within our homes. Just people in general are carrying, you know, historical trauma. We are carrying the trauma of our parents, our grandparents, and our children are doing the same.

Dr. DECOTEAU. So the first thing that comes to mind is to provide the infrastructure for the mental health workers. I agree that we need a workforce, but coming from my own experience in reservation work, and many of you probably understand, when you're doing mental health work on the reservation, you are the receptionist and the director and the clinician, and a number of other things. So the burnout is intense, and it's very difficult to sustain that work even if that's where your heart is. It's exhausting. So we need to develop an infrastructure that supports the mental health workers and makes it possible for these individuals to function and stay in these jobs. Most of the people who do this, that's where their hearts are, and if they leave, they leave for other reasons. So we need infrastructure. We need flexible use of funding. Sometimes when financing a grant for something I have to shave off the most innovative parts of my project to fit into what the grant is looking for. We need the ability to use the funding in flexible ways that make sense for the community and don't just make sense for the granting agency. We also need a mandate for collaboration from emergency rooms both on and off the reservation. I cannot tell you how many times I have referred a high risk suicidal youth to the emergency room with burn marks on their neck because of an attempt, and they were turned away because they told the doctor they weren't suicidal. It happens over and over and over, and we must collaborate better with our emergency rooms and doctors need to be educated, so we can help these individuals and save lives. We need to develop an ability to bill for services at the Federal rate, so that we can have sustainable funding sources for this type of project. We need to develop the ability for providers to private practice outside of the IHS system to have access to the same Federal rates when we're doing reservation based work.

Senator HEITKAMP. Miss Sparks-Robinson, if you could just kind of comment on what you've heard. And I'm particularly concerned, obviously we are at the end of the administration that has progressed greatly over the last eight years and their awareness and their willingness to commit, how do we perpetuate that?

Ms. ROBINSON. So what I've heard from the listening session is that definitely the approaches have to be flexible, they have to be developed from tribal perspectives, they have to support the local solutions, and there's a critical role of native language of education, and looking at the health. So that gives us some parameters on how we should collaborate. What I will tell you is that the staff is really helpful and is really dedicated to making sure trauma informed care is part of our normal practice. Especially for ACF and also at HHS. There is an HHS coordinating committee that will ad-

dress trauma, not just in Indian communities, but across all of our programming. So this is an education piece that's happening. There's grants that we are providing specific to Indian Country that hopefully will provide some flexibility and it also is requiring that it's done from the tribe perspective. We also have the methamphetamine/suicide initiative. We have tribal behavior health grants that we're providing as well. So these are some of the activities and program funding that will continue to be available, you know, regardless of who is sitting here next year in this position. Last, we have to come up with proposals in the President's budget that will allow for tribal training assistance center specific to native youth. That will look at small resources that are needed specific to trauma informed care.

Senator HEITKAMP. Thank you. Just to make a comment, which is, we have seen with Indian health, and we've had some direct challenges with the Great Plains district; shutting down emergency rooms, failure to provid care, and we need to really examine Indian health in a way that I don't think it's been examined for awhile. But when we look at outcomes, and we know that Native Americans, their longevity is not what it is in the rest of the country. That tells us something. That tells us even though we're working on beating chronic disease, whether it's diabetes, whether it's hypertension, we're really only treating a symptom of something that we need to. Actually we're finding this out all across the country that we no longer can afford to ignore mental health. We no longer can afford to ignore trauma and the things that lead to trauma. You know, one of the challenges that we have, and I hope you take back, is CMS needs to be responsive. We need to figure out how we pay to treat people in ways that actually achieve an outcome, not just, oh, you know, came and made sure that he had blood pressure checked, as opposed to why is this person experiencing hypertension? Why is this person experiencing high blood pressure? You know, we know that adverse childhood experiences have a very traumatic effect. Some reports would say 20 years off your life, we repeat treating the symptoms, and that's expensive. If we don't start looking at this differently, we not only will dig our hole deeper, but we're going to continue to have the same outcomes. So we're just really interested in how—and especially with Indian health. We need to have greater access to behavior and mental health services. We've got tribal chairmen in this room who would tell you that someone who is suffering from addiction, who is the first responder, the first responder the family calls is tribal court, BIA police. They didn't commit a crime, but the emergency room isn't a place where you're going to go to get help. So the person looks for help in a church or a precinct. That is not an outcome that should happen. We've got to figure this out, and the challenge for me is to provide, you know, some sense that we can change outcomes. I think so many people have given up. So many people have given up and said, "It's never going to change. We just have to continue to do what we've always done." We can change it. We can change it if we take this great science that's being done, great talents that are being developed in trauma informed and trauma based programs, and we start involving communities and we start involving what makes those communities unique. That's the critical piece of

this, because we cannot fund our way out of this chronic disease without dealing with this issue as a potential to make change overall. So I'm committed to making sure that these programs continue to get attention. I'm going to turn it over to Senator Hoeven for some last questions. Thank you so much.

Senator HOEVEN. And I just want to follow up. I appreciate that each of you had very good concepts and ideas to offer. I just want to follow up on a number of those with you. So I'm going to start with Miss Sparks-Robinson. You were talking about early childhood trauma, what is the key component to impacting outcomes?

Ms. ROBINSON. Well there is a group who is incredibly dedicated to improving outcomes for Indian country. I spent some time with folks, including those that were practitioners in the community, to come up with what is the action that we need? What can we do to impact outcomes? And what we found is, so far, because the book is not done, is that there has to be screening tools. There has to be culturally specific screening that's done in our health care center, in our childcare centers. They have to be developed in partnership with Indian Health Service to be able to identify what the needs are in that particular family. It has to be family based. We need that. When I have these conversations out in Indian country, both the kids and parents and leaders have all said, "I wish someone taught me how to be a better parent. I wish there was somewhere I could go to to be a better parent." The youth are saying, "I wish my mom would talk to me. I wish I knew how to talk to my dad. I wish my parents knew what I needed." And tribal leaders are saying, "I wish there was a way to provide this service to our community members."

Senator HOEVEN. Does HHS or IHS have people come in and do some of the assessments?

Ms. ROBINSON. So ACF through the tribal program, so ACH funds that program that's funded through Versa. So we do have the ability, but you have to come in and apply but then there is somebody that actually comes out and does prenatal and early childhood activities. We have someone that teaches them, okay, this is what you need to be able to deliver a healthy baby. We need you to destress. We need you to make sure that you're not being overwhelmed. This is what you need to be able to expect. Then comes in and does some screenings in the home, which we can't always expect the patient or the person that's in need to go to the place where the service is being provided.

Senator HOEVEN. Thank you. Mr. Cruzan, you mentioned too, could you describe a little bit what you think is particularly effective in North Dakota about the program?

Mr. CRUZAN. Absolutely. I think this one initiative in itself is really an effort, to the government watching in DC, we're certainly not going to solve anybody's problem by saying, "This is the way we're going to do it." So it is a break in services, if you will, and it's an effort to give those services. The people closest to the issue, know the solution. People that have resources will ask. So I think that's the effort that's happening right now. Currently they are developing local plans driven by tribal leadership and the community and those service providers to tell, basically to say, "Here's the direction we want to go." There are—One size doesn't fit all certainly

when it comes to that. So I think that's what we're doing is being very sensitive to the tribe's developing a plan. And then being flexible with the funding and saying, "Well this isn't normal but that sounds reasonable. So let's do it."

Senator HOEVEN. Thank you. I agree and describing what they think would help. So I appreciate that. Dr. DeCoteau, you talked about a comprehensive approach, you talk about education of childhood trauma. So I wanted you to just describe what that is? You talked about safe and consistent relationships. You talked about technical assistance. I just don't understand what you mean when you say "technical assistance." Then you talk about outreach and internship programs as a way to resource, and I'm just wondering how you might structure or how you would come up with those outreach initiatives?

Dr. DECOTEAU. So when I work with parents who are raising children with complex developmental trauma, one of the first things I do is I teach the parents how trauma impacts the brain and what that does to the child's neurochemistry, so the parents can see that it isn't a behavioral issue. It's a brain development issue, and that's what education about childhood trauma needs involve. Whether it be in the school systems or the parents or other agencies, people need to understand that the behaviors we see are the behaviors of traumatized children because they lack brain capacity to put forth the behaviors that are expected. Until parents and our systems learn to nurture the brains in the individuals, and have strategies that are directly targeted to rebuild the brain so we can rebuild the brain. And I always tell parents, it's a brain development issue. I think if we had samples of the neurotransmitter panels of these children, we would see and understand that they are so disregulated. They cannot function. That helps us respond to these children in an empathetic way instead of an angry way. Safe relationships, that's a simple term, but it really means a lot in terms of how do we help reduce the stress response in children that are always in a state of fear. We cannot rebuild a brain that has a constant fear signal, and they will always react to their environment in ways where they perceive fear. We don't have a learning brain when there's a fear response in the brain. So we need to interact with the child in a way that reduces that fear response, and we have a learning brain and now we can rebuild the brain. That comes first and foremost most with safe relationships. And what I've learned is that in our society loving, nurturing parents need help to know how to do this especially in traumatized children. So there needs to be strategies to teach parents how to be mindful with your child, how to provide healthy touches, how to provide nurturing, how to correct behaviors in ways that are not punitive, and build their self esteem, sense of self, which will, again, trigger their response. When I talk about technical assistance, I talked about, and I mean that rather broadly, I mean that in terms of having the kind of infrastructure support in a system where one person is not wearing all hats. Also, in terms of an ability to develop some research to provide timelines and to provide the data that we need to get the funding. When I was on the reservation a number of years ago, we had a project that was working to reduce the suicide rates, and we had a very unfortunate response

from the government. We were able to provide information about how this program is working and the government officials looked at myself and the tribal officials as we made our presentation and said, "I need to see timelines. This is just antidotal information, and it's useless to us without data." And I understand that data is required for funding, but the problem with that in reservation communities is you don't have the infrastructure to develop a research base. Not that we couldn't, but we need the assistance to be able to do that. We need the infrastructure to be able to do that. Outreach and internship, so there's a difficulty in getting mental health workers and qualified mental health workers who want to do this work in Indian country. In my experience what I find is it's harder to bring in providers who have been working. It's harder to train those people because what's required is an attitudal change in how you're going to do your work. But interns and trainees are fresh, and they're energetic and they want to make change and they're idealistic and they want to follow your direction. They are usually younger, and they have a ton of energy. They come in with the mindset of changing the world. Of course we can't change the world, but we can do what we can do. So using those internship models is a way to recruit people from outside the state, from inside the state, and keep them here. In fact, the internships that we had at Standing Rock, more than 30 percent of them came in from outside this state and stayed in this region.

Senator HOEVEN. To me that makes a lot of sense.

Dr. DECOTEAU. One important point I would like to make about that, Senator, is a handful of years ago I worked with this Committee on the Indian Health Care Reform Bill, and we made sure there was a specific provision written into that bill to allow for interns and trainees, not just in the field of mental health, but in all fields of health, to be billable providers at the Federal rate. So if we we could bill for those service and create stainable funding for our service. And these aren't just, these are doctorate level trained folks. So they are quality individuals. I don't know anybody that has used that yet, but it would have provide a system of funding.

Senator HOEVEN. Thank you. Chairman Warrington, you mentioned having the counties more involved. Could you elaborate on that?

Ms. WARRINGTON. Well a lot of times the counties are the only ones that are eligible for funding, so they can put—

Senator HOEVEN. So you're talking now about State dollars?

Ms. WARRINGTON. Yes. And I know that a lot of tribes can't get the county to the table to help share those resources to serve the people. We are a county, so most of them are part of the tribe. So we have a good relationship, but I know a lot of them don't. And if we got in there, there's ways that the government can make them do it. But I think that having that mandate, I think because they have to pay for some of these services to tribal members, because the tribe does not have the funds.

Senator HOEVEN. How about some kind of cooperative agreement? Have you tried anything like that?

Ms. WARRINGTON. I would think that would work, if the county was willing to do that.

Senator HOEVEN. When I was governor we had cooperative agreements, not necessarily in this area, just in general. Just asking if you think that might be possible?

Ms. WARRINGTON. I don't know if you would be able to do that with the county.

Senator HOEVEN. And the idea of working together makes sense.

Ms. WARRINGTON. It does to me, because pulling all those resources together makes it better.

Senator HOEVEN. Right. Combine Federal and State resources?

Ms. WARRINGTON. Yes. So we could apply for resources.

Senator HOEVEN. Dr. Eagle-Williams, I am incredibly sorry for your loss. It takes incredible courage and strength to be here and talk about his. So I just want to commend you as far as making a difference for others. I want to bring up the Indians in the medicine programs and the Indians in the psychology programs. The reason is because of your testimony that you know there is obviously a lack with cultural and experienced trauma. So I think those are programs very good. Through our university system we're trying to combine the training, you know, very sophisticated and comprehensive medical training, and some of these cultural understandings that we talked about. So I'm just going to ask what we think of those programs? Are they working? Should they be adjusted? Is there something more we should do, and how do we build off those kinds of programs?

Dr. EAGLE-WILLIAMS. Actually those programs are very helpful, but we're not necessarily seeing those individuals come back and return to our home. So it's very difficult. The other thing is —

Senator HOEVEN. Do you mean they don't come back to the reservation?

Dr. EAGLE-WILLIAMS. To Fort Berthold. Yes. But the other thing that we had experienced, we actually had a representative working very closely with the University of North Dakota and is actually an employee. Within the years that I had been there, we only had one graduate of that program. And actually, the success, it took six years to become a licensed clinical counselor, and that's a challenge because the policy requirements in the State of North Dakota. And that's what I'm saying, there's a need for behavioral health specialists, you know, policy modifications to allow for sort of the layperson to receive adequate training to provide services that are universal. Because we're not seeing a whole lot of people who are going into the field of medicine. I think we recently only had one graduate from the college of medicine who is a tribal member this last past year. I cannot say, we didn't know, but I believe I was the last one to graduate from medical school in 2002 from the University of Arizona with little to no support as, I mean, I don't practice medicine because of that. Getting through the boards and then dealing with all my own trauma, you know, just trauma being one in five in college of medicine, you know, that's traumatizing, so.

Senator HOEVEN. That's what I was just going to wrap up with. Dr. DeCoteau, any thoughts on how we get people into those programs?

Dr. DECOTEAU. Yes. So there's three Indian programs in the psychology programs in the nation. There's legislative law that will allow for up to five. They are great programs. Part of the difficulty

is that those individuals have an IHS pay back, and they have difficulty finding jobs in the IHS system. They are allowed to find jobs in other systems where they serve more than 50 percent native population, but there's not a lot of available jobs, and some of those students are in default in their loans. The other issue is that the pipeline was never, it was never finished. So graduate school is not less, but you have to go to internship and you have to go on to post-doctoral residency. That's where the recruitment is an issue. So if there's not internship in post-doctoral programs in these rural communities, they go off to other metro areas. And then they usually start there careers in other metro areas. So we need to finish the pipeline.

Senator HEITKAMP. I do want to comment that in our presence today is Dr. Don Warren, who runs the Ph.D. program for public health at NDSU and working very, very hard on building that capacity. Because a lot of what we're talking about is integrating those public health models into the medicine, you know, just bringing it all together so that we're not just focused on diabetes and hypertension and, you know, injuries, but that we're actually looking at bringing a model to the system in Indian health that treats the whole person and treats the whole person culturally. So I couldn't let it go by just talking about those two programs. I think Dr. Warren if you don't mind just telling us what percentage of your graduate students now are Native?

Dr. WARREN. In my program?

Senator HEITKAMP. Yes.

Dr. WARREN. Okay. We have the American Indian Public Health Program at NDSU is what you're referring to, and our students start, actually tomorrow we have new student orientation, and we've now got 107 students and of that number 27 are American Indian. So it's the most American Indians for any school in that timeframe. Sadly more than any school in our history. But we focus on health policy issues, cultural context issues, and recognizing the health disparities are really all the way back through historical trauma. But many of our students are planning to work in the tribal population and are wanting to work in public health, psychology. Essentially we need a public health focus which is dealing with prevention of a crisis.

Senator HEITKAMP. What percentage of your folks that you graduated are working directly in Indian country?

Dr. WARREN. We've had now of the 27 American Indian students, of that number there's been about seven who have graduated, and I think we have one who is working for Sanford. The rest are working in Indian country.

Senator HEITKAMP. That's a huge resource for North Dakota. I would like to make that point.

Senator HOEVEN. If I could ask, so kind of that follow up question that I'd asked for the panel members, how do you coordinate with the Deans of Medicine in those programs?

Dr. WARREN. Yes. So public health is a different field, of course, than psychology and medicine, but they are integrated once we get out into the field. So we do have what's called our coordinating counsel with UND. So we meet quarterly with the Medical School

Dean, their health care program direction, and other administrators to coordinate efforts.

Senator HEITKAMP. I think we have a couple more comments and then we need to close it out.

Dr. EAGLE-WILLIAMS. I would just like to say that the medicine program is actually a Federally funded program that may be a consideration of the State to implement into their budget for the next fiscal years.

Dr. DECOTEAU. President McDonald has just reminded me that our Alaska Native relatives are in fact implementing an internship training program in their community and apparently they are using the billing to sustain the funding for their students. So we have a model with our Alaska relatives that we could look closely into.

Senator HEITKAMP. We have a process that we need to follow. We've had a couple folks tell us that they would like to offer some comments. Comments, typically, because this is an official Senate hearing, we have to keep our usual schedule, what we planned on. So what I intend to do is offer an opportunity for anyone in this audience to submit written comments. Those written comments need to be sent to us in two weeks, and they will become part of the official record. So I'm going to close this hearing.

[Whereupon, the hearing was concluded.]

APPENDIX

PREPARED STATEMENT OF THE OCTETI SAKOWIN YOUTH

We, the youth of the seventh generation, request to have our testimony entered into the official record for the Senate Indian Affairs Committee Trauma Field Hearing to be held on August 17, 2016 in Bismarck North Dakota.

As youth of the seventh generation, we are still affected by the historical trauma inflicted upon our ancestors. Not only are we still trying to cope and grieve with the trauma that was endured by our ancestors, but we are facing a new trauma that you call Adverse Childhood Experiences. What we are experiencing today, is a continuation of the trauma of our people perpetrated by the U.S. government and large corporations.

Dr. Maria Yellow Horse-Braveheart identified six principle phases of historical trauma. We the youth, contend that currently there is another seventh phase happening that is affecting our generation. This phase is the continuation of the U.S. government failing in fulfilling its promises to our people by underfunding our tribal programs and Indian Health Services (IHS), and the approval and support of pipelines such as Keystone XL and the Dakota Access Pipeline that encroach on treaty territory and lands of cultural significance to us. Further these pipelines endanger the water we utilize on a daily basis to cook, bathe and sustain our bodies.

The U.S. government continues to tell us everything that is wrong with our people by sharing statistics about us but does not fulfill is treaty obligations to us. We have to compete with our fellow tribes for funding and resources that would support the culturally relevant services that would help us. We continue to have little to no access to mental health services in our communities. Although we have our own tribal community college, tribal consortiums, a Lakota language immersion nest and other culturally relevant services they are often the ones competing for money. These are much needed services that will help us regain our pride and cultural identity yet they are left often severely underfunded or unfunded.

We want to feel better and we want to perform better. We want to be able to learn our language and our ways. This is hard to do when we are constantly overlooked, underfunded, denied our treaty rights and constantly sent the message that our Native lives only matter during election season.

We are calling on President Obama, Senators Heitkamp and Hoeven, and our other elected officials who promised to help us, the indigenous youth of our state and nation, by hearing our voices.

We ask you what good does it do to talk and educate people and lawmakers about the causes and effects of historical trauma and Adverse Childhood Experience when, we the youth, often cannot access the much needed supports?

What good does it do to have meetings that discuss us and share our statistics when you yourselves send a message that our lives do not matter?

What good does it do to point out what is wrong when our own government blatantly continues its injustices against our own people?

We ask that our elected officials start looking at alternative sources of energy, stop approving of more pipelines that threaten our water source and our cultural sites that can help us get our identity back, and start funding our tribal programs and IHS facilities so that they can fully function.

Thank you for your time in hearing our testimony!

Signed by the youth of the Oceti Sakowin

NAME (PRINT)	SIGNATURE
1. Monty Richards	Monty Richards
2. Latrell Heart	Latrell Heart
3. Annalee Yellow Hammer	Annalee Yellow Hammer
4. Marilyn Fox	Marilyn Fox
5. Hailey Spotted Bull	Hailey Spotted bull
6. Maya Runnels	Maya Runnels
7. Ethan Black Fox	Ethan Black Fox
8. Devin Black Fox	Devin Black Fox
9. Monica Bailey	Monica Bailey
10. Trueth Crow Ghost	Trueth Crow Ghost
11. Luzahan Belt	Luzahan Belt
12. Keya Belt	Keya Belt
13. Kimi Belt	Kimi Belt
14. Kiza Belt	Kiza Belt
15. Jada Red Tomahawk	~~Trinity White Plume~~ Jada Red Tomahawk
16. Trinity White Plume	~~Wanahca Rowland~~ Trinity White Plume
17. Wanahca Rowland	Wanahca Rowland
18. Shawn Long Cloud	Shawn Long Cloud
19. Julius Waters	Julius Waters
20. Jerry Waters	Jerry Waters

NAME (PRINT)	SIGNATURE
1. KATAWNA GAYTON	Katawna Gayton
2. Betty Jo LaRoche	Betty Jo LaRoche
3. Kiersten Wilson	Kersten Wilson
4. Natasha LaRoche	Natasha LaRoche
5. Heaven Grass Rope	Heaven Grass Rope
6. Alyssa Box	Alyssa Box
7. Thomas Eagle Thunder	Thomas Eagle Thunder
8. Javon Grass Rope	Javon Grass Rope
9. Carlton Felicia	Carlton Felicia
10. [illegible] Francis	[illegible]
11. [illegible]	[illegible]
12. ~~Che~~ Jasmine Cheyenne Whitecrane	Jasmine Whitecrane
13. Jayvon Jean Whitecrane	Jayvon Whitecrane
14. Jordan James McGhee	Jordan McGhee
15. Jacob Paul McGhee	Jacob McGhee
16. Tristan White Twin	Tristan White Twin
17. Kyllian White Twin	Kyllian White Twin
18. Boyd White Twin Jr	Boyd White Twin Jr
19. Brittany White Twin	Brittany White Twin
20. Adam Eagleshield	Adam Eagleshield

NAME (PRINT)	SIGNATURE
1. Nepaumah Bates	Nepaumah Bates
2. Omar Gates	Omar Gates
3. Cierra Gates	Cierra Gates
4. Trent Gates	Trent Gates
5. Kayanni Gates	Kayanni Gates
6. Wadewatti Perkins	Wadewatti Perkins
7. Kynalyn Eagle Shield	Kynalyn Eagle Shield
8. Fatimi Win Three Legs	Fatimi Win Three Legs
9. Daniel Three Legs	Daniel Three Legs
10. Evan Three Legs	Evan Three Legs
11. Brayden Three Legs	Brayden Three Legs
12. Krista Laundreaux	Krista Laundreaux
13. BRAD LAMBREAUX	Brad Lambreaux
14. Toni Lessring	Toni Lessring
15. Veronica Lessring	Veronica Lessring
16. Tyrell Andrews	Tyrell Andrews
17. Kasey O'Rourke	Kasey O'Rourke
18. Sandi Phillips	Sandi Phillips
19. Sena Knifebird	Sena YB
20. Elliyce Bradley	Elliyce B.

NAME (PRINT)	SIGNATURE
1. Gracey Claymore	Gracey Claymore
2. Shaunte Clayton	Shaunte Clayton
3. St John Flute - Redfeast	St John Flute - Redfeast
4. Achuel Flute - Kirk	Achuel Flute - Kirk
5. Abel Flute	Abel Flute
6. Ashten Flute	Ashten Flute
7. Alexander Flute	Alexander Flute
8. Anthony Flute	Anthony Flute
9. Scottland laErumboise	Scottland laErumboise
10. Kendricks Blue	Kendricks Blue
11. Nation Blue	Nation Blue
12. Mia Flute	Mia Flute
13. Jeremiah Flute	Jeremiah Flute
14. Sylvanus Flute III	Sylvanus Flute III
15. Tristan Flute	Tristan Flute
16. Sabrina Flute	Sabrina Flute
17. Aurora Flute	Aurora Flute
18. John Flute - Cox	John Flute
19. Marissa Cook	Marissa Cook
20. Kiara Cook	Kiara Cook

NAME (PRINT)	SIGNATURE
1. Connie Brownotter	[illegible]
2. Chontyna [illegible]	[illegible]
3. Francis [illegible]	[illegible]
4. Santana Young Man	[illegible]
5. Karl Eagle Bull	[illegible]
6. Luke Young Man	[illegible]
7. Mercedese Young Man	[illegible]
8. Damien Young Man	[illegible]
9. Drey Wilier	[illegible]
10. Kimberly Felix	[illegible]
11. Kaylene Colhoff	[illegible]
12. Aurelia [illegible]	
13. Thomas Antochief	[illegible]
14. Annie Antonic	[illegible]
15. Matthew Hood	[illegible]
16. Javan Grasshope	Javan GrassRope
17. Carlton Felix	[illegible]
18. Thomas Eagle Thunder	[illegible]
19. Aleshanee Tom	[illegible]
20. Maureen Booker	[illegible]
21. Taityn Marrowbone	[illegible]
22 Kendron Bowker	[illegible]

NAME (PRINT)	SIGNATURE
1. Ernaye Moran	
2. Wilma Steele	[illegible]
3. Alice Brownotter	[illegible]
4. Jordin Sam	Jordin Sam
5. Chris Walton	[illegible]
6. Bobbi Jean Three Legs	[illegible]
7. Daniel Grassrope	[illegible]
8. Chelsea Summers	Chelsea Summers
9. Gabriella Garza	Gabby Garza
10. Treyzen Two Shields	Trezen TwoShields

PREPARED STATEMENT OF STEPHANIE YELLOW HAMMER, ENROLLED MEMBER, STANDING ROCK SIOUX TRIBE

I, Stephanie Yellow Hammer an enrolled member and lifelong resident of the Standing Rock Sioux Tribe and who has worked in the Early Childhood field here for 15 years, request to have my testimony entered into the official record for the Senate Indian Affairs Committee Trauma Field Hearing to be held on August 17, 2016 in Bismarck North Dakota.

Generation after generation our people have endured many historical traumatic events often one right after another. Each one of our generations has had to experience some type of traumatic event from the first contact of the European settlers to the present day event that is happening right now to the 7th generation with the placement of the Dakota Access Pipeline less than one mile north of our Standing Rock Reservation, which you people will refer to as an Adverse Childhood Experience (ACES) and once again breaking the treaties by placing this black snake that will carry crude oil from the northwestern part of North Dakota to Illinois. When this pipeline breaks it will contaminate not only our water source but all people who depend on the Missouri River for their water but we will be the first to feel this impact. In D/Lakota we say "Mni Wiconi" water is life; as without out water we cannot survive.

Our people have never been able to heal and grieve as many of these traumatic events have been inflicted one right after another and somewhere in this process

we have lost our resiliency as we have had so much taken from us; Our Land, Our Culture, Our Language, Our Kids Forced into Boarding Schools, Denied the Right to Practice Our Sacred Ceremonies, Forced Relocations, we can go on and on about what was taken from us and what we have lost, but you all know what has happened to us.

We need funding for housing as many of our families live in doubled or often tripled up homes, where some are exposed to alcohol, drug and sexual abuse.

We need funding for Indian Health Services as many of our youth and children are in dire need of mental health services from the "effects" of the historical trauma and ACEs that they experience at an alarming rate.

We need funding for cultural programs such as the Lakohol'iyapi Wahohpi and Wichakin Owayawa (Immersion) as we have lost our identity through all the trauma and grief. Our children need to be exposed to their culture and language so we can regain our identity that was stolen from us.

We need more funding for prevention and educational programs so we can better educate our children and youth so we do not have to function in a reactive mode.

We need a big push for the importance and need for Tribal Early Childhood Services so we can build strong children instead of repairing broken youth.

We need funding for an inpatient treatment facility and addiction services so we can provide the much needed treatment services that our youth and adults need.

You can educate people all you want on the Causes and Effects of Historical Trauma & Adverse Childhood Experiences in Native American Communities but until you can provide sufficient and adequate funding for our Tribal Nations you will continue to see the "Effects" of the trauma that the white man has inflicted on us. Hopefully this hearing will open the eyes of some of the elected officials and shed some much needed light on the issue.

Wophila Thanka (Thank You) for your time.