Joanne Shenandoah: Thank you very much, Anita. Okay, the Advisory Committee will now turn our attention to Panel #4 who will be providing the Advisory Committee with a broad national overview of bullying, truancy, and suicide issues related to American-Indian children exposed to violence; identify training available to teachers and other professionals working with the children in tribal communities on identification, assessment, and healing of American-Indian children exposed to violence. Also, they will identify gaps in related services and systems, provide concrete recommendations for improvements. Each panelist provides a 10-minute presentation for a total of 30 minutes followed by 30 minutes of questioning by the Advisory Committee. Kathy from TLPI will be reminding you of your time and she's seated in the front row.

The witnesses for Panel #4 are the following: Tribal Schools Facing Violence, Iris PrettyPaint, Blackfeet/Crow, Training and Technical Assistance Director and Native Aspirations Project Director, Kauffman & Associates, Inc.; Marlene Wong, Assistant Dean and Clinical Professor, University of Southern California School of Social Work; and Matthew Taylor, Associate Director, National Native Children's Trauma Center, Director, Montana Safe Schools Center, and Associate Director, Institution of Education Research and Service, University of Montana. Welcome and we look forward to your testimony. Ms. PrettyPaint, you may begin.

Iris PrettyPaint: Good morning. (NATIVE LANGUAGE @ 6:55_APR160827PM). Our people are at a crossroads today and we've been there many times with each federal department that we do business with. This is a civil rights issue today. How many more children, how many more mothers, fathers, uncles, our relatives, have to wake up one day and be in fear of their grandchildren loading a gun and taking their life? How many more of our people that are born into this world have to be in fear of their own siblings? Probably many more from this day forward but, today, I believe that we have a sleeping giant in the room. I believe that we have a committee of people that have a heart and a soul for our children.

And the information that you're gathering here today, yesterday I listened to the testimony and, in my written testimony, I could go back over the same statistics that you heard yesterday and they would be a part of our story that would make you cry. If you have a heart for children then you probably got a lump in your throat yesterday as you heard about Baby Veronica. I did, and yet I've heard it many times over.

We can second guess what we've done over the years. We can wonder if the evidence that comes forward tells the true story about healing. But we know in our hearts (NATIVE LANGUAGE @ 8:59_APR160827PM); we are powerful people. And if we weren't meant to be here, we wouldn't be here, but we're still here today. Why—where could you find in Indian country the strength of people to overcome the years of oppression among our people? Where do they find that strength? They find it because in our culture and way of life, we understand systems. We live by them. The way we learn them is what nourishes our very existence.

We know that without our language we are nothing. It is our language that holds our values, our ethics, our guidance, everything that we stand for is in our language. And I request today that those of you that can write in the English language, that you find a translator, that you translate the research and the findings into a practical way for people in communities to use.

I have several recommendations that I would like to leave today when I leave this room I want you to have in your heart. And many people have already mentioned these, but I thought long and hard about the schools. And what I'd like to see is I'd like to see prevention programs that are developed in schools that are based on our strengths rather than our deficits. And in order to do that, you have to know what makes us strong. You have to know that we come from a people that have a history that is real, that our stories that are passed down from generation to generation, they teach us respect.

These programs and the schools, this issue is not just a school problem, it's a community problem. And when you engage communities, you have to realize that whatever you bring forward to a community, you have to first of all be able to assess the readiness of that community to change. Because you may be coming in at a much higher level of education and prevention, then you don't realize you're dealing with people that have very little awareness of human trafficking. They have very little awareness of even what we refer to as slavery, harboring people in our communities that are continuing every day to hurt our children. They could be a school teacher.

Bullying is not just for children. It's for adults as well. It even goes as far as our tribal councils. Our elected officials bully their own people. Where is the recourse in our communities? Where can we turn if we can't turn to the tribal courts? We have no recourse and for the older people that live in our communities, some of them have said, "I have never even stepped in that school. I don't feel welcome. I don't have a place there." Every school should have an elder in residence. And I admire these hearings today because you do have our elders here.

And yesterday I left here with a heavy heart and I thought I know what to do; we cleanse ourselves after we listen to this kind of information. [LAUGHS] So thank you for that song this morning. We know that every one of us are unique and different and that is our strength. If we were not unique, they would have done away with us a long time ago. But just when they think they figure us out, then we make a turn and we go a different direction. That is our strength as people. And so there is no one way, there is no recipe. What you have to do is you have to trust the community that those answers have to come from within, not from outside.

The funding has to come from the outside because, as you heard President Scott say yesterday, economic development. We can talk about poverty. We have a culture of poverty in our communities. But we know that we have many opportunities, many more opportunities to come together, to work together. And yet if we're looking at the

issues of gangs, if we're looking at the issue of prostitution, if we're looking at the issues of suicide, all I can tell you is when I walk into communities and I have a school principal tell me, "Iris, I don't know if I can go any further. This is the twentieth suicide. I don't know what to do. It feels like we don't get to heal. What do you think we should do? Where should we go? Where should we turn?" And all we do is we come back to, well, what is it that we know about ourselves? And what we know is things have to be culturally relevant. They have to be based in our way of life.

And that community that we live in, they were explained yesterday as being isolated. They're very rural. When you go out into Indian country, you have to know you're going out in a blizzard or you have to know you're going out to subsistence. And that all the fancy planning that you did for the community event, everybody went fishing and you're the only one in the village. So when you're trying to take from the Lower 48 promising practices and you want to take them north to Alaska, you have a lot to learn because the context is totally different. So that when you read research about American Indians and Alaska Natives, you right away should open up the study and look at the fidelity of that work and ask yourself, did they interview our people? Or when they refer to us as a whole group in the country, are they just referring to us as being able to come up with those five federal strategies that will change the world?

Everything is up today for review, everything. Everybody that is a part of this issue, every piece of technical assistance that you provide to our people, has to be evaluated in a different way. Is it effective? Is it working? And, if so, you bring it forward and the interpretations that we have for each other, we can only do so much. And my ten minutes is up. Thank you.

[APPLAUSE]

Joanne Shenandoah: Thank you very much for your testimony and your words are very well accepted by this Advisory Committee. And Mrs. Wong?

Marlene Wong: Thank you. Well, good morning everyone. I'm Marlene Wong and I am so honored to be here today and to share the information that I have about the original studies that were done about children exposed to violence in the last 17 years. The information that I'm bringing today is from the work that I've done with my colleagues at RAND and at UCLA while I was the Director of Mental Health, the Director of Suicide Prevention Programs, and the Director of Crisis Interventions Programs, the crisis teams at the Los Angeles Unified School District. When we would go out on crisis calls—and Los Angeles Unified School District is the second-largest school district in the United States and when I worked there some years ago there were 750,000 children K-12 in 1,000 schools. Many acts of violence in the community came onto the school grounds and we had about 2,500 to 3,000 crisis incidents per year which our crisis teams addressed.

So I guess what I want to talk about is why we started these studies of exposure to violence and that is that the crisis teams would go out—especially in communities of poverty. So you have to understand that Los Angeles Unified School District is the City of Los Angeles and 26 other municipalities, so it's spread over 750 square miles. What happens in one area doesn't necessarily happen in another. And what we found is, in South Los Angeles and East Los Angeles, we would ask the children there, "Has this kind of violence ever happened to you," some kind of gang shooting, some other kind of violence in the community. And they would say yes, almost every one of them: I saw my brother being beaten up by a gang member. I was robbed at the store down the street."

And when I went to my colleagues at RAND—because I wasn't a researcher, I was an administrator—I said, "Look, I think there's something happening here and isn't exposure to violence the first risk factor for post-traumatic stress disorder?" And they said, "Absolutely, but what you're telling me is a story. You have absolutely no data." So that was the beginning of my work with them back in 1997. And, in fact, what we did was we surveyed cohorts of about 1,000 children in those areas and we discovered that we were

looking at 88% of children saying, on average, that they had been exposed to some sort of community violence. And what we mean by that is, in the past year, have you been fit, kicked, punched, beaten, or threatened with a gun or a knife?

We decided to do a larger study and we surveyed 33,000 children, every single sixth grader in Los Angeles Unified School District, and we got 28,800 returns on that survey. And sure enough, in those areas and those zip codes with the highest rates of poverty and crime and gang activity and drug use, those children had over 90% exposure to violence. And in that same study, we provided an opportunity for children to respond to a clinical survey and found that 27% of those kids had full-on PTSD and an additional 16% of those children had full-on depression at very high rates. These are hidden disorders. Not one child, despite teachers, parents, others who cared about the, these are hidden disorders just in the way that the invisible wounds of warriors who return home from Afghanistan are experiencing.

Well, what we needed to know then was what can we do about it? And over a period of a couple of years, we developed an evidence-based intervention called the Cognitive Behavioral Intervention for Trauma in Schools, CBITS for short. And what we wanted to do is address what we considered a public health crisis. If 27% of the people in any given population had diabetes, we'd certainly hear about it. But we didn't hear about it in Los Angeles. So when we created this, we did effectiveness studies—as only RAND can do—with randomizing children and checking the fidelity of the intervention. And that study, which established the effectiveness of CBITS was published in the *Journal of the American Medical Association* in the year 2003. After that study, the very next day when it was released, the *L.A. Times* announced that children in South L.A. had rates of PTSD that in some ways exceeded the rates of those who were returning from war from the Middle East.

So what can we do about this information? Well, first of all, we have to stop listening to people who just observe. We

actually have to ask the children, "Have you been sleeping? Are you able to eat?" There are a whole array of three clusters of PTS symptomatology that children must meet in order to be diagnosed with PTSD. And are they re-experiencing this? Are they having flashbacks? Not the kind of flashbacks of war, but perhaps the war that they confront in their neighborhoods where they think about the threat that they received from a gang member. And they're thinking about in class, but how they're going to get home for the day. Or maybe they don't want to go to school.

So when we looked at our big study, we found that exposure to violence—whether or not children had PTSD or depression—if we remove those aspects of it, that children who were exposed to violence—hit, kicked, punched, threatened with a gun or knife—they had higher rates of absenteeism. They had higher rates of dropout. They had extremely high rates of expulsion and suspension. And when we looked at the way that our school district was dealing with them, there was no study of what the background was of that child, what was the experience of that child, what was the trauma of that child, and what was going on in the family? We simply expelled them. That has now completely changed. There's a restorative justice approach now that's being taken and CBITS is widely used throughout Los Angeles Unified School District.

But I think the real reason that I'm here today is that I had the opportunity to meet my colleagues at the University of Montana. They were very, very concerned about the rates of exposure to violence and had read our study. And here today is Dr. Matt Taylor, one of the original team members who brought CBITS and other interventions. And CBITS is but one that has been taken to Rocky Boy, specifically into other Native American reservations. And I flew to Montana and one of the things I have to say is it made me understand who I was and *why* I was so interested, why I was so passionate about this topic. And I was involved in a talking circle. My name was Marlene. I wasn't Dr. Wong. They probably knew where I came from, but we didn't talk about that. And we each had to talk about why we were there. And the reason I had been brought there was because two

young boys had killed a 30 year old who had promised them some alcohol and other drugs. And he had taken their money and failed to give it to them. And the FBI was on the site. So I was there to talk about how CBITS might be helpful to them.

And what I discovered in my own talk about grief and loss was the secret that my family had had for a very long time; that my grandmother, when I was twelve years old, had told me the secret that she had been sold as a child when she was five. That she faced her mother on the island of Macau in their home and her mother turned to her when two strangers entered the house—a man and a woman—and said, "This will be your mother now." And she never saw her mother again. I think I always look for those children. I think I look for the ones that never tell the secret but are suffering silently and who greatly need all of our help. So I thank you for being here today. And you'll hear more about the great work that was done in Montana by my colleague, Matt Taylor.

Joanne Shenandoah: Thank you so very much for your testimony.

[APPLAUSE]

And, Dr. Taylor, you may begin.

Matthew Taylor: So I'll do my best here to keep in the timeframe. So Co-Chairs Fineday, Shenandoah, distinguished members of the committee, it is an honor to be with you today. My name is Matthew Taylor and I serve as Director of the Montana Safe Schools Center and Associate Director of the National Native Children's Trauma Center at the University of Montana. And so I appreciate the opportunity to share reflections from the work myself and colleagues have been able to do in partnerships with tribes.

But, first off, let me say that our organizations recognize that American Indians and Alaska Natives share a collective history of military subjugation, attempts towards cultural genocide, forced removal from ancestral homelands, prohibition of tribal, religious and cultural practices, and

forcible placement of children into boarding schools. This is deeply tragic and represents some of the darkest chapters of this nation's history. As a consequence, many tribal communities suffer from historical effects of trauma. Mental health, behavioral health, school and child welfare systems serving Indian country face the challenges of serving clients and students with high levels of recent, direct, and historical trauma and they do this with resources that are fundamentally inadequate to address the problem. Yet, in my experience, most workers in these agencies are resourceful and hopeful. They are committed to the well-being of children and adults alike. At some level, most share a belief that the inherent resilience and deep, culturally-rooted strengths that these children and their families possess.

Each of you, of course, are well aware that American-Indian/Alaska-Native children are disproportionately affected by trauma and have limited access to mental health services. The research is clear; unidentified and untreated childhood trauma has deleterious effects on health, school performance, contact with the juvenile justice system, and across the lifespan. However, similar to others who have testified before you today and yesterday, my colleagues and I firmly believe that trauma is treatable and trauma is preventable. We also believe that youth, family, tribal, and community resilience is *the* key asset in our collective efforts to improve services across Indian country.

We argue that some of the most promising approaches involve evidence-based, trauma-informed interventions joined *with* practices that promote tribal language, culture, and traditional healing. In fact, we agree that many traditional healing modalities and ceremonies have long, rich histories of being effective for the spiritual community and behavioral health needs of Native people. And as such, many of these can equally be viewed as evidence-based practices in their own right. If we are to adequately support children and families in a lifelong journey of wellness, then we must look at approaches that engage the communities they live in. However, relevant to the status of clinical treatment in Indian country is the reality that many Native

people are justifiably skeptical of Eurocentric medicine and mental health care, even when those services are readily available.

I respect that many families in Indian country are mistrustful of schools, given the role many educational institutions had in perpetrating the kinds of trauma that I just mentioned. If schools engage with families and communities respectfully, and an acknowledgement of this potential for mistrust, then the public school system, as a venue for some community behavioral health services, can significantly reduce stigma. The reality is that regardless of the setting, schools are still the de facto mental health provider in the United States.

After 14 years of work with reservation schools, my colleagues and I conclude that, with culturally-appropriate training and support, then school-based providers can effectively implement evidence-based practices such as: American Indian Life Skills Development, Honoring Children, Mending the Circle, adaptations of Parent-Child Interaction Therapy—such as what your colleague, Dr. Dee Bigfoot, has done—Cognitive Behavioral Intervention for Trauma in Schools that Dr. Wong just spoke about, suicide prevention training such as the ASIST model—the Applied Suicide Intervention Skills Training—Sources of Strength, youth mentorship, Suicide Alertness for Everyone—also known as safeTALK—and experientially-based programs such Project Venture.

I also believe the promising practices such as the Child and Family Traumatic Stress Intervention and the Attachment, Self-Regulation and Competency framework for child-serving agencies are two additional approaches that merit broad implementation in Indian country. Our experience teaches us that with such interventions, Native youth show significantly improved behavioral functioning, reduced symptoms of trauma, less PTSD, healing, and post-traumatic growth. Like you, we deeply believe in the healing power of talking circles, of sweat, of ceremony to heal through grief. But for trauma-informed interventions to be more broadly accepted, outreach needs to better explain how such practices can in fact be complementary to traditional spiritual

practices. Such outreach also needs to engage the opinions of all stakeholders including youth.

In a 2012 publication entitled "Promoting Youth Voice in Indian Country," my colleagues, Dr. James Caringi, Rick van den Pol, and your fellow committee member, Marilyn Zimmerman, argued that far too often in the spirit of "helping youth," many initiatives unintentionally silence youth voice. When the perspectives of youth are sincerely engaged, I believe that the nature of clinical services and community initiatives changes for the better. Instead of focusing on reducing the negative impacts of trauma and loss—such as Iris was talking about—such initiatives begin to shift a focus towards promoting resilience, supporting protective factors, and strengthening social support networks.

But I'd also like to say that we must not lose sight of the provider's own wellness. Tribal health staff, educators, IHS employees, BIA, and Tribal Welfare workers give so much of their lives to children, but there is a cost for caring. And secondary traumatic stress, sometimes referred to as compassion fatigue, is very real yet it is often underrecognized and unaddressed. And this impacts absenteeism, turnover, and significantly reduces these individuals' ability to help affected children and their families. Strategies that promote collaboration, self-care, professional and personal balance can significantly offset the impacts of secondary traumatic stress. And these, I would argue, are critically needed in Indian country. For trauma-informed training and services to be relevant in Indian country, they need to remain flexible and respect local wisdom and practice. No single intervention or program is the solution.

So from my perspective, here are 12 strategies that support youth resilience and prevent or reverse the impacts of trauma—in no particular order here, by the way. First of all, school systems can implement ongoing versus reactive suicide prevention programs and embed trauma-informed, evidence-based practices in to school mental health. Second, schools should develop safety plans which reflect the latest guidance from the U.S. Department of Education in keeping with President Obama's Now is the Time initiative.

Third, programs that celebrate resiliency, cultural identification, youth leadership, and peer support should be incorporated and sustained in schools. They should be seen as directly linked to academic and social achievement.

Number 4: Schools, law enforcement, tribal courts, child welfare, and behavioral health agencies can actively promote wellness plans where staff and administration are able to seek support from peers, counselors, or elders. Number 5—I feel like I'm doing a top-ten list here.

[LAUGHTER]

Number 5: Self-care should be modeled and celebrated, particularly by tribal leaders and by agency administrators. 6: Schools can partner with tribal agencies to offer support groups for parents. They should provide take-home information regarding traumatic stress, recovery, resilience, hopeful messaging, and parenting tips. Number 7: All school personnel, tribal court officials, and juvenile justice staff who are in positions to support students should receive adequate training on how to identify, support, and refer youth who may be at risk for traumatic stress and suicide. 8: Parents, students, and elders can powerfully advocate for safe places where students experiencing violence or risk for self-harm can go to during the evening and the summer. Such resources are sorely lacking in many rural tribal communities. And to add a personal note, it frustrates me to no end about that. Public awareness campaigns and support for non-stigmatizing transportation to such locations is also important. 9: Communities can implement drug and alcohol prevention programs at the earliest possible grade range so they're not seen as add-on programs. 10: Federal and tribal support can help schools provide cognitive and social skill-building curriculum into the daily learning activities of all students at every grade range. 11: Support for school-wide bullying-prevention programs simply must be expanded in Indian country. And 12: Schools can embrace opportunities for tribal elders to interact with students as mentors both during school hours and in afterschool cultural activities and to adopt strength-based programming that promotes Native languages, cultural identification, and

community engagement.

So, in conclusion, schools and communities must affirm their commitment to understanding the mental and social needs of their students. Similarly, I believe programming and funding decisions at the state, school, federal, and tribal level must be prioritized to first expand school-based mental health and to do so in a way that further encompasses the incorporation of traditional local healing practices. Second, we must deepen suicide prevention and substance abuse programs. Third, they should further support youth leadership initiatives and, fourth, expand training and technical assistance for trauma-informed care across Indian country.

So in creating a community of caring, we must work harder to increase our students' feelings of belonging in the school and their connectedness to cultural identity. And in keeping with the missions of the Montana Safe Schools Center, the National Native Children's Trauma Center, and the National Child Traumatic Stress Network from which our center is funded, I joined with you and local partners in the belief that through collaboration, through honoring tradition, and fostering every individual's resilience, then we all create a rich ground where hope and healing grows strong. I thank and respect the entire committee for your kind attention, and particularly for your dedication to children. Thank you.

[APPLAUSE]

Joanne Shenandoah: We'd like to thank all three of you for your incredible testimony and the work on behalf of our children. Now we're going to turn to the Advisory Committee and ask if they have any questions. Ron?

Ron Whitener: I was wondering if you could talk a little bit about the role of screening in schools and what you see as best practices for being able to identify as early as possible those children that may be exposed to violence but haven't as yet hit juvenile justice system or a truancy system, similar to that. What do you think of the screening tools that are out there right now?

Marlene Wong: Well, I only have experience with the ones that we used. It was an instrument that had been used with adults about screening. But through focus groups with parents of the children—who are primarily Latino, African America and Asian-Pacific Islanders—we found that it was acceptable because the language was understood by children. So the other thing was that clearly we all know where the communities at risk are. They're where the children are not doing well. I mean exposure to violence and poor grades, dropout rates, all of those are—and I think that screening is important particularly for those area and it can start there.

One of the things that I think is difficult is that, in most schools, mental health is not necessarily integrated into the schools and so it's seen as an outside kind of force. And I've heard principals and superintendents call it mission creep. And what they mean by that is that they're mission is education. Their mission is not the mental behavioral health of children. I mean it's important, but they don't see it that as being their mission. So I think there are very fine instruments that are there both for suicide prevention as well as for trauma, exposure to violence, depression, et cetera. But the bigger challenge may be convincing, from a systemic level, educators and educational leaders to use those instruments.

Matthew Taylor: And I would like to add to Marlene's comments here that, first of all, I support broad screening for depression and things like that in schools. But we have a resource issue in that—especially in tribal rural communities—there is simply a shortage of clinical services available. And so the problem in many schools is you can do all these screenings, but then you end up with this long list of kids that need clinical services and then either their parents or caregivers don't consent to it, the school is not a trusted setting or, more commonly, there just simply aren't enough providers.

And so I think it's incumbent on all of us to further develop intervention tools such as even adaptations of the CBITS model that Marlene was talking about. There's one called SSET, Support for Students Exposed to Trauma. I also mentioned another one, the Child-Family Traumatic Stress

Intervention. These are sort of brief therapies and sometimes they don't have to be done—not all of them have to be done by clinical mental health professionals, but certainly can be done with supervision assistance. And that's one way to sort of scale up the ability to provide services when likely the screening instruments will generate high numbers of students who need services. And, finally, I would just also have to add that screening instruments to be relevant in Indian country need to also be built within Indian country or from the input of folks in Indian country because many screening instruments are still obviously built from a very sort of "Western Eurocentric" medical model.

Joanne Shenandoah: I think, Dee, you had a question?

Dee Bigfoot: Thank you. For one, I've always promoted evidence-based practices so I'm always happy to hear people that are in support of that. My question to Dr. Taylor and Dr. (inaudible @ 42:26_APR160827PM), as you have brought these programs, can you both speak a little about what it took to implement these programs into the schools? What kind of personnel did you have? What kind of supervision did you provide for the implementation? What kind of feedback did you receive?

I know that Native Aspirations has been there for a while and you've been able to do a lot with that. I know that CBITS has been implemented in the schools on reservations. So can you speak a little bit about the implementation effort? Because we have interventions that we know that work in other settings; we want to know something that works in Indian country. We know that there's been a lot of effort over the last eight years or ten years. And so if you could speak to that implementation effort and what it took to get to the point where things were making a difference and what kind of assessments did you make so that you knew that things were making a difference?

Matthew Taylor: Iris, do you want to comment first?

Iris PrettyPaint: Sure. Well, Native Aspirations was an eight-year project that came out of the shooting at Red Lake, Minnesota. And the

implementation lessons learned from that project, we worked with 65 tribes across 15 Alaska-Native villages and across the Lower 48. And we had many issues that we're familiar with that we've talked about, but being able to engage the tribal council with these issues is critical and being able to get that level of buy-in for whatever you're bringing forward into the community is absolutely essential. And so that is a very unique approach when you go to the top of the community and start there with explaining what it is that you want to do and encouraging tribal councils to place these prevention efforts in stable agencies. And when we were able to get schools selected, we had the most improved relationships. The school was sometimes the heart of the community. It didn't just go from 8 to 5, Monday through Friday. They did evenings and weekend events. And so we had that advantage in our implementation. So when you have an agency that is structured in the tribal infrastructure and it's an 8 to 5, Monday through Friday, you know that everything that you're going to deal with is going to be after 5:00 and it's going to be on weekends. And so when you don't have that kind of flexibility, it's difficult.

The other issues that we encountered were capacity. The very simple issues of how to conduct a meeting, how to write an agenda, how to speak in a PSA [LAUGHS], I mean the very ground up. And what we realized was that when you deal with communities that have had years of oppression, the first scale that you lose is planning. And so when you come in, you come in with the basics of planning for a community and you teach them what is a plan. And the other lesson that we learned is around the tool called Community Readiness Assessment, is that you can assess a school, you can assess the students, but if you don't assess the community and where they are in terms of these issues, you will place all your resources and you will get very little results at the end. And some of them went for eight years with us and the ones that were at the far end of very successful implementations were those that had the support of not just elected officials, but community opinion leaders. They were successful because they actually built a collaboration that was grounded in their culture and wasn't sort of something they were adapting from the outside. But

they acknowledged they had feasts for people and they fed people and they did it in the traditional ways. So those collaborations are still continuing today.

We also know that there's a lot of our staff that are in positions and have been there a long time. It's very difficult to get them to change their mind in how they do things. [LAUGHS] And so what kind of cuts two ways is that you want the experience, but they can't really hear the new information and the new strategies. And so some of the most successful comments that I take away from my work with Native Aspirations was we had a community that averaged six suicides a year for the last fifteen years. And they were struggling and suffering and once Native Aspirations came into their community, they had six years with not a single suicide. And they attribute it to a safe house. That they just went and found a home and they all had to work on it to fix it up and they had to just go from every source and get money to come together.

And what they discovered was that their children were being taken to jail—and that's where they were killing themselves—or they were being picked up and then taken home and that's where they were hanging themselves. So when that little window of safety was created, you see the suicides drop. And safety is not just at that far end of deciding to take your life. It can be at any place of a young person's. Is it the school? And we have a long ways to go in education to be able to get those kinds of services to come together, and yet we have an opportunity today to create just that, is to bring behavioral health, mental health, all the services, and connect them with those leaders and schools.

The other lessons learned is, yes, the evidence-based, it has to be a combination. You have to have the evidence-based intervention, but it has to be adapted because some of them have limitations. They're too expensive. You buy all their equipment and you train people how to use them and then all of that equipment was sitting in a shed and nobody knew how to use it. Thirty thousand dollars' worth of equipment and no one knew how to do the ropes program. So the

combination with culture-based interventions, practice-based interventions, and evidence-based intervention is how we're going to be able to screen, identify, and get the help that's needed for young people.

Matthew Taylor: Dee, I'll just answer your question really briefly and say we joke in our center of what it takes is a rigid state of flexibility.

[LAUGHTER]

Iris PrettyPaint: Is that packaged in any particular way?

Matthew Taylor: Yeah, with a lot of patience and an understanding. First of all, in our center we go where we're invited. That's first and foremost. And we recognize that there are political structures in tribal communities that we do need to go through, very appropriate in terms of getting like tribal resolutions for support. But we also recognize and have had bits of us chewed off at times in the whole political process that many tribal councils are very much embroiled in and the change that happens every few years. So it's important to build a broad base of support in a community with elders, with youth advocates, with tribal leaders, with the heads of behavioral health agencies, and also the bottom line—or sort of front-line staff workers that are champions for change. So it takes that flexibility to constantly try and work around roadblocks. It takes a humility—that's, I think, very important—and an intentionality, carrying yourself with an intentionality in Indian country that this is about helping children and looking towards the future. But a rigid state of flexibility is one of the basis we operate on. [LAUGHS]

Joanne Shenandoah: Thank you.

Ron Whitener: First of all, I'd like to thank each of you for your contributions to the body of knowledge in this area and you, Matt, for your persistence over the course of time with the tribes that you work with. I guess my question has to do with the intersection between resource availability—or lack thereof—and ability to generalize this knowledge, if you will. A lot of the programming that you've done have been associated with a grant from here or there and has helped the

communities a lot, the communities that you've worked with. What about those communities that haven't got the grant? And you talked about the need for programs that didn't require formally trained people to implement. What have you learned or what are your thoughts about sort of moving these programs into those communities that have a desire but don't have the resources that a discretionary grant would bring to a community to allow them to have that $30,000 worth of equipment in the shed. I mean at last it's in the shed. And so what are your thoughts about generalizability of what you've learned in the communities that don't have the resources that a discretionary grant might bring?

Matthew Taylor: I think that's an excellent question. I think that there are key elements of a number of the interventions that I was just mentioning in my comments which do have general applicability across Indian country. I think that our experience in working with many tribes—and I respect this perspective, I honestly do respect this perspective—but there's always a very deep-seeded belief that, well, that worked there but it won't work here because you don't know our history, this tribe's perspective. And I think—if I can humbly say this—there is a certain level of sort of a two-way, cross-cultural sensibility that goes on here in recognizing that it is really important to understand the local history and the tribal values and histories of this particular tribe, but it is also incumbent on tribes to recognize that many of these interventions do have core elements that make them applicable more broadly than sometimes they are thought of. I think that there are key avenues for dissemination by providing trainings, for example, at National Indian behavioral health conferences and things like that.

And there needs to be more training of front-line workers with these kind of interventions. I mean I would love to see more federal, state, tribal initiatives that help further push out the evidence-based practices and adaptations that have occurred so that they can be seen as a little bit more generalizable. But I would say this; from a personal perspective, it requires people on both sides to say, "Look, this is part of this intervention that you could customize, that you don't need a clinical background to customize." And it

takes some faith on the people at the other end of the spectrum to say, "Okay, we're willing to be able to accept something that maybe was developed in Los Angeles but has been adapted in Rocky Boy and see if it may also work with Arapaho or something like that. Sometimes there is I think too much of a basis of, well, it wasn't built here so it won't work here. And I think there is more flexibility and applicability than sometimes we like to think.

Iris PrettyPaint: I think that's a good question and the only thing that I think will cross every tribal community and urban community—because not all of our children reside on a reservation—but the one thing that, if I could leave you with today, and that is leadership. You have to have a certain kind of person that has a gift. We say a gift from the Creator, but a leader is someone they have to be knowledgeable of their culture. They have to be grounded in their culture. They have to be able to speak to many different audiences. They have to be able to facilitate that tension that can emerge when you don't have trust. You have to have the kind of leaders that can write and that can stand up and articulate the pain and the hurt, the suffering, but also the difference. You have to have a leader that knows the difference between hope and faith. You have to know that when you're hoping for something and you're wishing for something, it is far out there on the horizon and that's how you're speaking.

But in our community and among our people, we have some of the most beautiful leaders that live with faith. And the reason they live with that is because they know that faith stands right next to them. And there's no doubt. And there's no doubt in my heart today that you could strengthen that. You could help build and grow leaders that do this work and understand that if something is created in Los Angeles, let's adapt it. They call it Indianize. Let's Indianize it. And let's only take what helps our people, not everything. And that's what we've learned over the years is that there's a lot of theory that comes from Western culture, but it doesn't match us. And yet we are a people of theory. We are here today because we have indigenous, theoretical frameworks that are solid. They've served us. And that's the kind of leadership that you can generalize, that you can identify, that

you can allow these young people sitting in this room today the opportunity to get scholarships to come toward this work. And we have hundreds of young people that are ready to step forward. And many of us here today are going to be retiring and yet we don't have a transition plan. We're still at that place where we don't have support because we're too busy doing all of our work to be able to grow that next generation of young people. If you can contribute to that, we would make headway with these issues.

Joanne Shenandoah: Thank you for those words. And I would have a comment and also a question to Iris PrettyPaint. You mentioned about community, how important that is; language, how important that is; elders in residence, and also to have culturally-appropriate data. And I'm very curious about the research. I'd like to just comment that, in Akwesasne territory in Iroquois land, they have immersion school and that goes up to the eighth grade. And they're taught full immersion from math to science. When they leave that school they're two grades ahead of anyone locally and there, they learn through the language respect. There are no swear words. The words "I love you" actually simply is (NATIVE LANGUAGE @ 59:25_APR160827PM), which doesn't really mean I love you, it means how can I lift you up or how can I be of help to you? So that's just one example of how our traditional Iroquois people continue to build leaders and put some hope in our future.

I'm just curious, in your research across Indian Territory how many Native nations actually have immersion programs and/or have less suicide and gang and violence situations. I'm very curious about that.

Iris PrettyPaint: I'm sorry; could you just repeat the question?

Joanne Shenandoah: Yeah. I'm just curious, in your research, how you've noticed a huge difference with those Native nations who may have immersion programs and/or culturally-appropriate data as you mention in your written testimony.

Iris PrettyPaint: Well, we don't have a repository. And my dream has always been for someone at the federal level to develop a data

institute to have a place where all of our information can come to bear, including the cultural data. And so the methodologies that we promote in our universities and in other places that cerate research for our people, they have to adhere to an indigenous framework for our people to be able to communicate with them.

And so the Menominee Nation is one community that I think is moving in that direction. And one of the comments that started their process was they said that what they learned was to forgive each other. They didn't realize how the trauma that had come forward had taken away their ability to forgive. So they had generation-long disputes against relatives. [LAUGHS] And for some reason, they were all called to the table and they had to learn how to communicate with each other. And that was very empowering to them. And I wanted to encourage them to document the process. What did you do? Why was it different and who came to the table? And please tell that story of process.

So that in many of our cultures, not only do we live by—"evaluation" is kind of a charged word for us, but we come from a people that have always been evaluators. We put war bonnets on people to acknowledge their success. We stand them up in public and sing praise songs for them when we acknowledge their success. We will feed everybody to be able to tell people about their success. That's evaluation.

And so the translation of what we do and we know—I think that we're just on the cutting edge of being able to help our colleagues in evaluation step back and I would encourage them to develop a visiting methodology instead of a focus-group methodology. And the visiting methodology would have to be based on how deep you're going to go and how fast. Because the visiting that used to occur among our people would go on for weeks and months and that story could go on for a long time. It seems today we don't have time for the story and yet we have an opportunity in research to turn that corner so that we can help everyone understand why—the use of the words "talking circle," why is that becoming so popular? Why do we even say in public now, "sweat lodge" when before we were like, "Oh, no, we can't

say that in public? We can't talk about that." So we're still encouraging our own people to bring—I come from a community where there's been an immersion school there for 20 years by Darrell Kipp. And when they test my little relatives that go into public school after being there, the young children say, "Well, that advantage I have is I can talk to the elders." They're testing off the page on math and English, science, and it's because that language is there first and then they're coming toward learning another way of life, but they're able to express themselves and in a respectful way. That's what I hope research moves toward for our people.

Joanne Shenandoah: Thank you all very much for your testimony. We truly appreciate your time spent with us today.

[APPLAUSE]

Anita Fineday: Thank you for that panel. We're going to move into Panel #5, Promising Approaches, if those panelists would please come forward at this time. There's been a request for a ten-minute break, so I think we're going to—the panelists can come forward, but we'll take a break for ten minutes at this time and come back at 9:55. Thank you.

[BREAK]

[END PANEL #4]