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Helplessness, Hopelessness, and Despair: Identifying the Precursors to Indian Youth Suicide

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Suicide among American Indian youth is a matter of serious concern to members of all Indian tribal organizations across the nation and is an important issue confronting the human services professions today. Suicide is the second leading cause of death among American Indian youths fifteen to nineteen years of age, with a rate 2.7 times (37.1 per 100,000) that of youth of all races in the United States, and the fourth leading cause of death among American Indian youth ages five through fourteen, with a rate 2.8 times (2.5 per 100,000)higher than that of all races in the United States.[1] Within the Indian youth suicide group, American Indian children placed in non-Indian homes for adoptive or foster care suffer a rate of seventy suicides per 100,000, six times higher than that of other youth in the United States.[2] While suicide rates for youths fourteen through nineteen years old have decreased somewhat, rates for ten and fourteen year olds are approximately four times higher than that for the general U.S. population and have continued to increase steadily. In 1987 Irving N. Berlin reported, "there are considerable data to indicate that the more than 50,000 American Indian children adoptees in Anglo homes are at considerable risk."[3] A host of issues are germane to suicide trends. These include data vital to the planning of intervention programs for age groups most at risk, pattern variations among tribes,[4] and common associate factors that include alcoholism, arrest careers, and interpersonal distress such as anomie, helplessness, hopelessness, and despair.[5]

American Indian suicide first came to public attention in 1968 when Senator Robert F. Kennedy visited an intermountain Indian reservation. On the day of his visit, the community had suffered the loss of an Indian youth by

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suicide, and thus Indian suicide was a major topic of conversation. This intermountain reservation became the focus of government attention and research which revealed a suicide rate that was approximately 100 per 100,000, nearly ten times the national average. This number became widely publicized as the "Indian suicide rate," even though it only represented the rate of one small reservation at one particular time, since large tribes with low suicide rates received little public attention.[6] From this emerged the stereotype of the "suicidal Indian."[7] It should be noted that this same intermountain tribe was able to lower the suicide rate and improve tribal self-image.[8]

It is dangerous to generalize, oversimplify, or overemphasize American Indian suicide. Studies show that the stereotype of the suicidal Indian can lead to low self-esteem and low self-image, which may actually perpetuate American Indian suicides. According to James Shore, the major misconceptions that result from the suicidal Indian stereotype are: (1) an assumption that all American Indians have the same health problems and subsequently the same suicide pattern and rates; (2) a failure to recognize the importance of tribal differences; and (3) a danger that public health personnel will not individualize their approach in developing tribal programs for suicide prevention and intervention.[9]

Although the American Indian youth suicide rate is on average double that of the non-Indian population, it must be recognized that this rate is distorted. First, some tribes' suicide rates are much lower than the average U.S. rate, some are similar to the U.S. rate, and some are significantly higher than the U.S. rate. In some tribes, suicide is a relatively recent phenomenon, while in others suicide was present, whether positively or negatively sanctioned, before European contact. Since written records of suicide were not kept before European contact or during the early reservation period, a true history of America Indian suicide is not possible.[10] Second, since American Indian populations are so small in comparison to the non-Indian population, small localized suicide occurrences can significantly affect the national comparison rate.[11] Third, the American Indian suicide rate most likely does not include urban American Indian people, for whom statistics are not kept and who now represent the majority of the American Indian population: they are often not identified as American Indian, nor do they use Indian Health Service facilities. Several studies of American Indian adolescent suicides have been conducted with subgroups of American Indian youth, such as those in boarding schools or jails, who may have had preexisting mental health issues, and thus such populations do not reflect an accurate cross-section of a given community. In addition, although not unique to American Indians, many suicides are disguised or unintentionally certified as accidents on official records.[12]

Though he acknowledges tribal diversity in American Indian suicide patterns, Philip May identifies several general characteristics of American Indian suicides that have emerged from more than forty studies on suicide among various Indian groups:[13]

(1) Suicide among American Indians occurs primarily among the young. This is the opposite of the general U.S. trend in which suicidal behavior increases

with age. It should be noted, however, that the American Indian population is significantly younger on the whole than the U.S. population.

(2) Indian suicide in most tribes is predominantly male. American Indian females tend to have lower suicide rates than the dominant population. However, Indian females attempt suicide more often than Indian males. It is important not to neglect American Indian female suicidal behavior, despite the lower completed suicide rates. Teresa D. LaFramboise and Beth Howard-Pitney's article, "Suicidal Behavior in American Indian Female Adolescents" points out that young American Indian women are much more prone to depression than young American Indian men.[14] This depression is often the result of victimization associated with racism and sexual abuse.

(3) Indian males tend to use highly violent or lethal methods to commit suicide, such as guns and hanging, more so than other groups in the U.S. Indian females, on the other hand, tend to attempt suicide by drug overdose, which more often than not does not result in the completion of the suicide.

(4) Tribes with loose social integration which emphasize a high degree of individuality generally have higher suicide rates than those with tight integration that emphasize conformity. In May's study of New Mexico Indian tribes, he found that the acculturated tribes had the highest rates, the traditional had the lowest, and the transitional had intermediate rates.[15]

(5) Tribes that are undergoing rapid change in their social and economic conditions have higher rates than those who are not.

The suicide rate among American Indian youth for the age group fifteen through nineteen is approximately 2.1 times that of their cohorts in the dominant population. One area that has not been adequately addressed in the empirical literature and thus is not reflected in these statistics is that of equivocal death by means of unexplained single car accidents, particularly within the boundaries of Indian reservations. In "Suicide Among American Indian Youth: A Look at the Issues," May states that "accidental death from motor vehicle crashes is higher among most tribes than the general population"—3.4 times the overall U.S. rate.[16] He questions how many accidents are self-inflicted, suggesting that suicide attempts and single-vehicle crashes overlap and that the single-vehicle crash among Indian youth may hide forms of self-destruction and/or suicide.[17] In attempting to develop a "pattern of suicide behavior," researchers in suicidology have investigated medical records, suicide notes, personal diaries, police records, and clinical records of persons at risk for suicide or of clients who have attempted suicide without success.[18] May's research shows that among most tribes accidental deaths from motor vehicle crashes occur at a rate of "136 per 100,000 which is 3.4 times the U.S. rate of 39.8." More than half of these accidental deaths are from motor vehicle crashes.[19]

BEHAVIORAL CHARACTERISTICS

Scholars point to important aspects of human behavior, common to all suicidal individuals, that can be applied to Indian youth. This set of relationships is composed of underlying causes—circumstances in the individual's environment, precipitating stress events, and personal feelings such as alienation, anomie, helplessness, hopelessness, and despair. Such personal feelings are placed into motion by stressful events that manifest themselves in the development of suicidal thoughts and gestures, the culmination being the successful suicide act. American Indians in general suffer from high depression rates. According to Shroe and Manson, one-third to one-half of all patients visiting Indian Health Service mental health outpatient clinics have been treated for symptoms of depression. Overwhelming stress from rapid acculturation and loss of traditional identify often leads to a state of chronic depression.[20] The unemployment rate for Indian people continues to be higher than national averages; on some reservations unemployment is higher than 60 percent. According to census bureau data for 1990, the median income of Indian families in the United States was $21,750—considerably lower than the national average of $35,225, and more than twice as many Indian people (51 percent) were living below the poverty level.[21] The educational attainment of Indian people is also below national averages. While 20 percent of those twenty-five years and older in the general population have completed four years of college, only 9 percent of American Indian people have done so.[22] Finally, alcoholism is a major threat to the survival of Indian culture as fewer traditional values and lifeways are passed on to the youth in the society.

Environmental circumstances, coupled with stress events, place Indian youth on a dangerous path toward suicidal behavior. Stress events may include a death among the immediate or extended family members, failure in school or work, or conflicts between white social values and deep-seated cultural beliefs. While most American youth are faced with the problems of making the transition into adulthood, Indian youth face even greater conflicts, namely, their minority status, fewer economic and educational opportunities, and cultural differences. Indian adolescents must choose from at least two uncertain paths: that of their own culture and that of the mainstream culture. Faced with this pressure, some—particularly those who have suffered the consequences of prejudice, discrimination, and unclear and seemingly hostile values—turn to various forms of self-destructive behavior, including suicide.

Alienation appears as an early symptom of fear and confusion resulting from stress, and is frequently accompanied by dramatic changes in behavior patterns such as a decline in school performance or in self-destructive acts such as alcohol or drug abuse. Indian youth begin to feel powerless over their environment: events seem insurmountable, and the individual feels isolated and alone. Deepening feelings of alienation lead to a sense of helplessness, defined as a desire to escape from what one considers to be an insoluble problem and a lack of hope that relief is possible. The sense of hopelessness is associated with alcohol use among American Indian adolescents. In addition to alcoholism, socioeconomic factors severely impact family discord and dysfunction, further contributing to the sense of hopelessness and the self-

destructive behavior. It is at this point that the individual is most vulnerable. Usually, there are few human resource services available and a limited number of people with whom to consult.

Many schools that serve American Indian students do not support the academic, social, cultural, and spiritual needs of Native students. Indian youth may face racism from fellow students as well as inaccurate portrayals of Native Americans in American history, further lowering their self esteem. According to the Group for the Advancement of Psychiatry, pathways to assimilation to dominant society norms are often blocked due to racism, and, as a result, Indian youth slip into cultural marginalization, at which point they have lost many essential values of their traditional culture and have not been able to replace them by active participation in American society in ways conducive to enhanced cultural and psychological self esteem.[23] Without the help of friends and relatives, finality is near. Anomie is the next step, when the Indian youth loses his or her sense of personal identity and purpose in life. Anomie is followed rapidly by despair.

When the youth enters the final stage of despair, he or she falters between thoughts of life and death, which is usually accompanied by severe withdrawal symptoms. Often subtle clues to suicide are given, while behavior usually changes dramatically. Talking about wanting to join dead relatives or having an experience of being visited by the dead may provide a clue to an impending suicide attempt.[24] The individual will seem to break the depression cycle, which may appear promising. However, it may simply mean that all options have been exhausted and that a plan for suicide has been developed. Intervention and planning are critical at this point: counseling may generate thinking about activities of life to detract from thoughts of death. Planned intervention must reconnect the at-risk person with a human resource that fits his or her particular need. This reconnection is often with members of the extended family, peers, or teachers. Another critical point of reconnection is with the Indian culture from which Native American people often draw their strength.

INTERVENTION

Intervention plans must prompt this network to reach out and reenter the life of the potential suicide victim. Thus, suicide intervention must take an active, critical approach. The intervention designs addressed in the remainder of this article are intended to provide action guidelines for human service professionals, family members, and other members of the support network which will enable them to intervene and break the suicide pattern for Indian youth at risk and to provide ongoing interventions which will prevent other Indian youth from starting down this self-destructive path.

Action guidelines must mitigate impacts among factors associated with suicide rather than simply reacting to a suicide event itself. This approach anticipates a likelihood that suicide, suicide attempts, and suicidal manifestations will occur within a given population impacted by selected circumstances. The empirical literature concerning suicide among American Indian

youth illuminates several specific life circumstances or events that provide clues for planning in primary prevention. Specific predictors have been identified:

(1) Seventy percent of American Indian adolescent suicides had more than one significant caretaker or parental figure before age fifteen as compared to 15 percent of the adolescents in a cohort control group.

(2) Forty percent of the primary caretakers or parent figures of the suicide group had five or more arrests compared to 7.5 percent of the comparison group's caretakers.

(3) Fifty percent of the suicide group had experienced two or more parental losses by divorce or desertion compared to 10 percent of the comparison group.

(4) Eighty percent of the suicides had one or more arrests in the twelve months before their suicide compared to 25.5 percent of the comparison adolescents.

(5) By age fifteen, 70 percent of suicides had been arrested compared to 20 percent of the control group.

(6) Sixty percent of the suicides attended boarding school before ninth grade compared to 27.5 percent of the control group.[25]

In identifying characteristics of this group and areas where an intervention might be most effective, using the psychological autopsy may prove beneficial. The psychological autopsy retraces life events immediately prior to the suicide event, aiming to reveal a deceased person's state of mind prior to his or her death. The procedure consists of interviews with survivors, including both the immediate and extended family members, and an examination of public and private documents that reveal the personality of the deceased party. Such documents include those related to medical, hospital, adoptive, and foster home placement histories, as well as those revealing violations of tribal, state, and federal laws. Considerable evidence shows that as many as 80 percent of Indian youth suicide victims had been arrested one or more times in the twelve months prior to their suicide. Data on Indian youth suggest that these early arrest careers may in fact be symptomatic behaviors akin to "cries for help."[26]

Since psychological autopsies have never been utilized for the purposes considered here, a procedure has not yet been established for use specifically with American Indian youth. Recommendations can, however, be taken from the works of Selkin, Weisman, and Shneidman, who recommend establishing a team consisting of psychiatrists, psychologists, social workers, and nurse-clinicians.[27] Such a team should be headed by a person from the same Indian tribe as the suicide victim, and all other members of the team must be extremely sensitive to the tribal, cultural, and religious beliefs of the survivors.

Selken points out that the psychological autopsy is a multidisciplinary case-work conference designed to draw together and correlate medical, social, and psychiatric information about a patient during the final period of his or her life. This multidisciplinary approach would be used to identify areas where intervention could have been introduced, concentrating on cries for help such as the frequency rate of arrests. For example, since May suggests that single-car accidents may in fact be suicides, arrest records could be monitored and used to identify and target this potential suicide group.

While the best intervention technique is a multidisciplinary team approach as suggested by Selkin, the requisites for a team, particularly from a financial and personnel standpoint, may seem overwhelming. Operational funds are obviously necessary. The Indian Health Service and Indian tribes are two logical and available sources for limited funding that could perhaps be persuaded to shift a modest one or two percent of funds into mental health. Tribal councils could also be approached to set aside an amount of tribal funds for alcohol, juvenile justice, and child welfare programs. The dollar amounts would not be enormous, but would provide seed funds to launch a primary intervention program.

Hiring additional personnel could be offset by recasting existing work assignments. By utilizing flex-time schedules, the services of selected professionals and paraprofessionals presently employed in programs associated with high-risk factors in suicide could be arranged. This central staff could be drawn from child welfare and alcoholism programs. The team could also include teachers, community health nurses, tribal elders, and other volunteers interested in tutorial and health education services. The work schedules of this staff should coincide with critical periods during which youth are most likely to be in crisis. The primary point of contact of this central staff would be through tribal and off-reservation courts, police, and juvenile justice systems. Through this effort alone, large numbers of potential suicide victims could be identified, reached, and counseled.

This central team should be augmented with a volunteer network of teachers, parents, and health and social service personnel who would serve three key roles. First, they could provide personal and telephone counseling as a follow-up to the efforts of the central team. Second, they could canvass the community and observe other youth in distress or at risk. Third, they could assist with efforts in community education and awareness, including educating members of both the nuclear and extended family about risk behavior. One member of this support team could serve as coordinator for training volunteers and for assigning work schedules. While reliance on the use of volunteers is questionable from the standpoint of availability and commitment, a number of parents and community residents are genuinely concerned about preventing youth suicide and could be counted on to provide emergency shelter and youth supervision on an emergency basis. Housing prevention services, of course, requires available space in the community. Possible sites include schools, tribal offices, churches, head-start programs, or dining centers. Key to securing space involves surveying the community and communicating the seriousness of the situation to concerned citizens.

During the past two decades a number of investigators have examined important cultural issues associated with youth suicide among American Indians. Findings showed that the more traditional the tribe and the more stable the Native religious traditions, clan, and extended family, the fewer the mental health problems and the smaller the number of suicides. As might be expected, in less traditional tribes where pressures to acculturate have been great and tribal conflict exists concerning traditional religion, governmental structure, clans, societies, and the importance of the extended families, the suicide rate in the adolescent and young adult population is high. Examples of disruptive pressures are chaotic families with a great number of divorces or separations, single-parent families, alcoholism, and child neglect or abuse. The Indian adolescent feels pressured to "make it" in the non-Indian world because few are "making it" in the reservation setting. Further exacerbating the cultural dilemma, the Indian youth feels the pressure to abandon the old ways, resulting in serious conflict between contradictory values.

RECOVERING CULTURE

As a result of U.S. westward expansion, many Indian tribes have been displaced from their traditional lands, and their ways of maintaining economic stability have altered. People who were once agriculturists or hunters are now involved in a variety of economic pursuits. Previous religious leaders often have no role in modern society, as many American Indian religions were banned by the federal government. Extended families have become fragmented, and alcoholism is prevalent on some reservations. It should be noted that the extended family has always been of critical importance to the maintenance of culture in most Indian communities. Traditionally, grandparents, aunts, or uncles raised children, and parents provided the economic sustenance. When extended families were intact the family unit usually admired and respected elders who provided role models for male and female adult behavior. Hunters, tribal chiefs, and medicine people now have decreased or limited functions within the Indian community, and the extended family has dispersed. Often few, if any, traditional role models exist on many Indian reservations. What remains for the Indian youth is a cultural vacuum which, when combined with a stress event, many times results in suicide.

The lack of Indian role models has compelled American Indian groups to try innovative approaches to reach Indian youth. The Association of American Indian Affairs in New York City and the Black Hawk Dancers from the Chitimacha tribe of Louisiana are two groups involved in providing cultural approaches to youth who have exhibited self-destructive behavior, primarily through drug or alcohol abuse. The Association of American Indian Affairs supports a traditional Indian musical group known as "Project Dream." The Indian youth who started the project were former substance abusers attempting to reach out to other teenagers in trouble. In one year, Project Dream performed before 336 Indian youth who identified themselves as substance abusers or as demonstrating self-destructive behavior. To reach a larger audience the group made a video for other Indian teenagers that showed com-

mon experiences shared by many Indian youth and, most important, that informed them of other choices. Project Dream representatives stated that "the response has been overwhelming; tribes from all across the United States have requested copies of the video for use in youth counseling." The initial Project Dream musical group has inspired numerous traditional Indian musical groups to form on and off reservations across the United States.

With a home base on their reservation in Charenton, Louisiana, the Chitimacha Black Hawk Dancers, dressed in their traditional clothing, performed American Indian dancing for Indian schools and tribal organizations in the Southeastern part of the United States. Each member of the group was a former substance abuser and gave testimony about his or her experience during each performance. All members were required to have been "dry" or "clean" since joining the dance group and all served as role models for the youth. While the Black Hawk Dancers organization no longer exists, Remy Ordoyne, the group organizer, singer, and drummer, stated that "this group [did] more for reversing the direction of our youth than all of the elders on our reservation.[28]

Forming American Indian youth musical and dance groups such as Project Dream and the Black Hawk Dancers can provide the physical and cultural reconnection necessary to reduce substance abuse and suicide on reservations. The elders can once again be used as role models for youth at risk. It is in the memories of these elders that the traditional music and dances reside—the music and dances performed by the Black Hawk Dancers were learned from their elders.

The cost of implementing the programs mentioned above would be minimal. Musical instruments utilized in American Indian music and dance ceremonies vary, but for the most part are handmade by the user. Drums, rattles, flutes, bells—all are generally made from materials found in nature or are available at minimal costs. Native dress, or regalia, is also individually made by the performer, with great pride and care. While this can become expensive, the regalia generally begins very simply and becomes more elaborate and sophisticated over time as resources become available. Native musical and dance groups would, in most instances, consist of members of the local tribe and would perform on the reservation. When travel to another reservation might take place, honor dances (traditional dances in which donations are solicited to reimburse performers) are commonly conducted to reimburse dancers for travel expenses.

American Indian youth music and dance groups can also function as effective intervention/prevention approaches in urban areas. The Southern California Indian Center Education Component runs an intertribal dance workshop for urban Indian youth in Los Angeles and Orange counties. Those involved with the dance workshop have seen youth diverted from gangs and other self-destructive behaviors as a result of the cultural reconnection and improved self-image that resulted from participation in these programs. Urban programs, however, face additional issues of tribal diversity, transportation, and communication problems inherent in an urban environment. Whether on the reservation or in an urban environment, Native American

song and dance groups will help this extremely vulnerable group to regain touch with important cultural traditions. If the at-risk group of Indian youth can be reached through these interventions, reconnected with their tribal culture through traditional song and dance, and view tribal elders as role models, the substance abuse and suicide rate among American Indian youth can be significantly reduced.

FOSTER CHILDREN IN NON-INDIAN HOMES

Another high risk group for suicide are Indian youth in non-Indian foster and adoptive homes. With a rate of 70 per 100,000, this group represents the highest suicide rate of any group in America, six times higher than youth in U.S. general society. Between 1969 and 1974, 25 to 35 percent of all Indian children were separated from their families and placed in non-Indian foster (or other) homes.[29] In 1978 one of the most sweeping statutes in the field of Indian law was enacted, the Indian Child Welfare Act (ICWA), which provided for the welfare of Indian children by establishing placement guidelines that prescribed separation from family or tribal settings only as a last resort.[30] ICWA authorized any recognized Indian tribe to establish group foster homes on the reservation, to be staffed by Indian people from the reservation, for the purpose of placing Indian children when Indian families were unavailable. While the duration (or time limit) of placement is not specified in the Act, the ideal situation would place a child for a short period while permanent foster care or adoption arrangements were made. This would not only protect the Indian child, but also employ tribal people who, on most reservations, suffer an extremely high unemployment rate.

In the twenty years since the enactment of ICWA, the number and percentage of Indian children placed in non-Indian foster homes have increased, rather than decreased as might be expected. A study completed in 1988 produced some dramatic new findings concerning the numbers, placement, and care of these children, revealing that twice as many Indian children were in substitute care than previously expected, with 51 percent in non-Indian homes. In 1969 this figure had been placed at between 25 and 35 percent. The number of children in tribal and off-reservation care has increased dramatically. In comparison to foster children of all ethnic groups, Indian children are greatly over-represented in the substitute care population. Clearly, a serious problem exists in the placement of this vulnerable group, the youngest American Indians and those most likely to take their own lives.

One intervention supported by the empirical literature recommends establishing additional Indian foster homes or tribal group homes rather than allowing American Indian children to be placed in at-risk situations in non-Indian homes. This may be more a matter of identifying available Indian homes than establishing additional foster homes. Indian people themselves are largely unaware of the high rate of placement in non-Indian homes and its concomitant link to the high rate of suicide among this group. An on-reservation and urban educational program is needed to inform Indian people about the seriousness of the suicide problem and the critical need for addi-

tional foster homes. This can be approached in two ways. First, most Indian reservations have a tribal council in which council members are elected and meetings are held. Council meetings are open to the tribal population and for the most part are well attended. This forum, while designed primarily to conduct tribal business, also offers an opportunity to promulgate general information to tribal members. Announcements, presentations, and printed literature could be distributed at these meetings soliciting families who would agree to operate a foster home for Indian children on a short- or long-term basis.

Approximately 65 percent of all Indian reservations publish their own tribal newspapers on the reservation, several with articles written in the native language. Information concerning youth suicide and the need for identifying and recruiting foster homes could reach a wide audience through this medium. Another avenue for recruiting Indian foster homes is through local radio stations. While only a limited number of reservations have radio stations of their own, many stations from nearby towns reach Indian people and feature weekly programs presented by tribal members. Taken together, most tribal members could be reached through tribal council meetings, tribal newspapers, and radio broadcasts and informed about this issue. Such communication can also be extended to Native people in urban areas. Local and national Indian media, such as newspapers, magazines, radio, and cable TV programs; public service announcements on radio and television; and announcements at urban Indian churches, service organizations, and political organization meetings can all be used to spread this information. The urban powwow has also become an important way to communicate with the diverse Indian population found in urban areas; tables can be set up to provide the necessary information. Effective communication in urban Indian communities is a problem that deserves greater attention.

The second approach—establishing tribal group foster homes—is authorized under the provisions of the ICWA; however, it is rarely utilized. Under provisions contained in ICWA, the federal government will provide funding for the construction and establishment of group foster homes on reservations for the placement of Indian children. The federal government will also pay for the training and salaries of Indian foster home workers. But a review of the empirical literature and consultation with American Indian people familiar with tribal compliance with the ICWA reveals only rare instances of this option being utilized. If additional Indian foster homes can be identified or recruited, or tribal group foster homes established, then an urgently needed suicide intervention has been identified, and this critical group of Indian youth can be protected. Identifying Indian foster homes in the urban area has also become a critical issue as more and more Indian children are in need of placement. A 1996 study funded by the Advocates for American Indian Children found that in 1990 Los Angeles had two hundred fifty Indian foster children and only twelve Indian foster homes available.[31]

Certainly these interventions are but a few that are available to and used by Native people. Norm Dorpat presents another such intervention in his article, "PRIDE: Substance Abuse Education/Intervention Program."[32] PRIDE is

an acronym for Positive Reinforcement in Drug Education, which is a prevention-based substance abuse education program that also incorporates strong intervention practices and policies as well as treatment referral and after-care provisions.[33] Candace Fleming addresses intervention for preventing substance abuse on the Flathead Indian Reservation in her article, "The Blue Bay Healing Center: Community Development and Healing as Prevention." Fleming explains the Blue Bay Healing Process, which involves the tribe, community, family, and individual in prevention, intervention, treatment, and aftercare.[34]

To date, no formal studies have been conducted that specifically address the issue of American Indian suicides in urban areas. The link between child welfare, child placement, mental health, and suicide in urban areas needs to be studied; however, most suicide studies have been reservation-based. The importance of such a study cannot be overemphasized. The 1990 U.S. Census points out that more than 60 percent of Indian people now live off reservation, primarily in urban cities, and a recent Arizona coroner's study found that a major factor in American Indian suicides on reservations was the impact of the surrounding urban communities.[35]

Risk factors for American Indian suicide, including stress, rapid socioeconomic and cultural change, acculturation and loss of culture, isolation, and lack of strong identity are increased among American Indian youth in urban areas. Many of these youth are raised by parents who do not practice or instill traditional Native values, thus the youth do no not develop a cultural identity—which is strongly linked to high self-esteem. Often Indian youth may be raised by a grandparent or other member of the extended family who may practice traditional lifeways, resulting in not only a generational but a cultural gap within the family. American Indian youth in cities such as Los Angeles tend to be geographically dispersed, few in number, and from many diverse tribes which often leads to a further feeling of isolation. In the schools, American Indians are faced with racism, cultural insensitivity, and stereotypes, and because they are small in number they are ignored, misidentified, and/or lumped in with other ethnic groups, creating even further isolation.[36] As a result, Native children may feel that they do not fit in anywhere, and they can develop low self-image as well as low self-esteem. In Los Angeles as in other large urban cities, the pressures to assimilate and survive often contribute to higher rates of mental disorders, health problems, poverty, alcoholism, and youth suicide.[37] These feelings of alienation combined with feelings of isolation and low self-esteem can also lead to depression and high risk behavior, such as drug/alcohol abuse and gang-related activities.

Facilities such as the Indian Health Service do not adequately serve all urban areas. According to the Los Angeles City/County Native American Indian Commission, only about 5 percent of Indian Health Service (IHS) funds support the urban Indian population.[38] The IHS also funds approximately thirty-five urban Indian health programs, but these do not provide comprehensive care and are only funded at 1 percent of the total IHS budget.[39] As a result, many urban Indians do not, or cannot, use IHS facilities, and thus their health statistics are not tracked. Non-Indian service providers tend to believe that

Indians are "someone else's problem" and are not sensitive to the Indian community's needs.[40] As a result, accurate statistics regarding urban Indian health and issues such as Indian youth suicide are grossly underreported.

Identifying urban American Indian people is a major problem, especially in a multiethnic community such as Los Angeles where American Indian people become invisible within the system. The *American Journal of Public Health* reported that between 1979 and 1993 California death certificates identified less than one-third of the deaths among American Indian children and that racial misclassification is more likely to occur in urban areas.[41] There are numerous reasons why this may occur. When Indian people use non-Indian services, they may not self-identify as American Indian, or they may not be asked their ethnicity. Intake clerks and school teachers often assume ethnicity without asking, resulting in many American Indians being classified as belonging to other ethnic groups, usually Hispanic. In addition, Indian people in cities do not live in geographically defined areas and do not necessarily use common services or attend common events, which adds to the problem of proper identification. Many American Indians live in mixed-race homes, and children may be identified with the race of the non-Indian family parent. In 1997 a Los Angeles County Department of Mental Health employee attempted to research American Indian suicide rates for Los Angeles County. The worker found that the Los Angeles County Department of Health does not keep any specific data on American Indian people (including emergency room data) as it does for other ethnic groups. The worker also found that the coroner's office had only been keeping data on American Indian people since 1994. Further complicating the study, the coroner's office does not declare a death as a suicide unless there is a suicide note. As a result, the coroner's office reported only ten Indian suicides in a year, while a local Indian health agency was aware of a much larger number of American Indian suicides in the same period. Clearly, a comprehensive study of Indian youth suicide in the urban environment is needed to obtain an accurate picture of overall Indian youth health and suicide in this country and to design appropriate interventions. It is hoped that this article will in some way encourage such a study.

NOTES

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