Outline of a Restoration to Health Strategy for Indian Country

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BACKGROUND:

I am a Princeton University and University of Michigan trained attorney who left law practice 12 years ago in a career change to focus on behavioral modification and healing within Indian Country (Alaska). I served as the chief executive for 2 rural Alaska tribal non-profits over the course of about 10 years. Both organizations improved dramatically under my leadership, and at the same time I learned about Alaska Native health issues in a very deep way. In 2008 I wrote a paper titled "A Proposed Path to Wellness for Alaska Natives." (I will refer to it as Restoration to Health Strategy –RTHS) I distributed it widely, but found little interest in the concepts I laid out. I currently serve as a Research Fellow for the Sealaska Heritage Institute, President of the Native American Children's Alliance and as a member of the American Indian/Alaska Native Task Force on Suicide Prevention.

The first recommendation I made in my paper was for adoption of the principles of Lean Healthcare management within the Indian Health Service and its compactors. As a management insider, I found that the IHS and its compactors are not generally well managed. As a result, the services provided are not timely, nor comprehensive. While not requested in the "Request for Information" (RFI) by NIMH, I do recommend review of the principles of Lean Healthcare and would be pleased to expand on the topic. It is not, however, a main focus for this paper.

In order to address the issues of suicide, I also wrote a paper titled "Suicide Among Alaska Natives" and made three presentations at Indian Health Service sponsored conferences and an Alaska Public Health Conference. In 2010, I broadly introduced the theory behind Adverse Childhood Experiences (ACE's) to Alaska through my invitation to have Dr. Vincent Felitti speak to our organizational leaders and a group of other state and non-profit leaders. I am widely accepted nationally as an advocate of trauma informed response to health and behavioral issues.

The approach I am encouraging NIMH to examine is based on evaluation of humans as a "system" of environmental adaptation, family and cultural experiences, nutritional development and as responding to a wide range developmental trauma experience. Using this approach as a model, what I have observed during my 35 years of engagement in community social and behavioral issues is an identifiable progression for an individual that results in adoption of behaviors from a range of possibilities. Suicide is but one choice, and I believe it is considered by a small subset of the population, not by all. If we consider suicide as one of many symptoms of developmental trauma, it forces us to take a deeper look at individuals fitting within a pattern for which symptom recognition provides clues for the relative strength of deficits.

If we look at a lifetime pattern of trauma, behavior adoption and nutritional deficits, our learning curve will continue to give us clues that allow identification of potential suicide victims earlier.

In this RFI, I treat suicide as one in a wide range of responses to developmental trauma. In Alaska, 4 precipitating factors have been identified as generally occurring within a short period of time prior to a suicide attempt: Alcohol abuse, domestic violence, depression and breaking up or stress in a relationship. In the context of determining etiology of suicide in Alaska, recognition of each precipitator is taught as necessary in order to identify and help suicide ideators. Instead, I believe that there are a limited number of Root Causes for identifying suicide precipitators. I further believe that we can assess individual development based on these Root Causes and intervene much earlier than we can currently, and stop or prevent the development of suicide precipitating behaviors, and suicide ideation or attempts as a byproduct of a systemic approach.

RESPONSE TO RFI:

My experience, and that of almost everyone else, is that health care is in crisis in Alaska. Chronic disease like diabetes, heart disease and cancer, among others, is rampant and increasing. Behavioral issues including alcoholism, drug abuse, violence and suicide, among others, have overwhelmed the capacity of tribes to respond. Such behaviors also contribute to health issues. Indian children are dropping out of school, becoming pregnant as teens, smoking, drinking and sinking into poverty at substantial rates. Programs to assist in reducing negative behavioral and health problems are either non-existent or contained in silos where they lack sufficient funding or efficiencies to make much of a difference.

RTHS is a systemic proposal to address behavioral and health issues as a process of progressive development. The genesis of this process is birth. Developmental trauma and nutrition deficits lead to development of trauma and a system of response and relief. Developmental trauma, through frequent activation of the fear response, prepares a child for living in a dangerous environment. However, unlike an evolutionary fear response, this child is not able to escape from a physical threat. There is no fighting or fleeing from the threats presented by ACE's. A child is left with the only other possible response, that is, to freeze. And they are also left with the aftermath of the chemicals produced in response to fear. These chemicals are generally used up and dissipated in a traditional fear response of fighting or fleeing. When a freeze response is common and frequent, chemical use and dissipation does not occur. In nature, an animal for freezes dissipates the chemical production throw a process called "Tremoring." The tremoring response starts with finding a safe place, entering into deep rhythmic breathing followed by the body starting to shake. The chemicals are dissipated and cause no further damage to the body.

If the chemicals are not dissipated, they remain in the body as a protective response to a threat that is not apparent. One byproduct is the body's preparation for healing in case of injury. Chemicals introduced through the fear response increase inflammation in the body. Inflammation helps healing if physical injury is experienced. Unused inflammation can lead to damage to the body because of the high chemical load.

The fear response also increases stress, tension and anxiety. Without any ability to dissipate the chemical response, the child seeks relief through activities that are soothing and calming from a neurological perspective. Ingesting sugar produces a release of soothing and calming chemicals, fueling an addiction to sugar. Later in life, alcohol (because of its high sugar content and numbing qualities) is supplements sugar. Bullying behaviors may also develop in a child and carryover into teen and adult behaviors. If you see that fighting is a natural response to fear, it makes sense that bullying assists the child in dissipating the chemicals activated by fear. Attention and praise are also soothing and calming behaviors sought out by children.

After puberty, negative behaviors accumulate in children with significant ACE's exposure. Smoking, drinking, drug use, promiscuity, suicide ideation, depression, obesity, ADD/ADHD and other behavioral responses escalate. Health issues start to intervene in many teens. Research demonstrates that poor nutrition is a significant contributor to these negative behaviors.

Positive behaviors (from a perspective that they don't contribute to societal harm) can also contribute to our understanding and assessment of the level of stress in an individual. A child who experiences success in academics, sports, music, arts or other endeavor is typically recognized for their success. Recognition and praise leads to a good feeling that helps counter stress, tension and anxiety. As with any addictive behavior, that child pursues more recognition through increasing success. The same feelings come from buying things that the child likes. Women call this "retail therapy." Achievement and acquisition become goals because of the brains response by producing soothing and calming chemicals. Gambling is an excellent example. Many bingo and pull tab players in Indian Country are poor, and spend a disproportionate amount of their income on gambling. Each win or near win in gambling excites a reward response of soothing and calming chemicals, reinforcing the behavior even in the absence of positive economic gain. Observing positive development behavior in response to ACE's can help us identify potential long term health problem development.

Using this information in an assessment process can start from a single entry portal within a primary care system. It starts with development of an "Assessment Instrument" (AI) that is designed to identify Patients/Clients (Client) affected by deep seated trauma (Toxic Stress) and nutritional deficiencies, each of which I identify as Root Causes for both behavioral and health problems. A Root Cause is the deepest and earliest discoverable explanation we can find for a behavioral or health problem. For example, smoking often leads to development of lung cancer. Many declare that smoking is the cause of lung cancer. A Root Cause analysis will ask, what caused the smoking behavior? Asking why until you have no more answers should be used as the Root Cause. Solving the problem of smoking then becomes the problem of solving the Root Cause. ACE research shows that smoking behaviors are related to Developmental Trauma (ACE's) and are likely caused by ACE's in a majority of cases. Eliminating ACE's, or treating the stress, tension and anxiety caused by ACE's, should eliminate the behavior.

If both Negative and Positive Behavior adoption are symptoms of Developmental Trauma and Nutritional Deficits, then treating the source should eliminate the behaviors as a cause. With this in mind, the Assessment Instrument is used to find the Root Cause for behaviors through a four level evaluation. Level 1 is a typical Patient/Client (PC) Interview (PCI) asking whether the PC has had ACE's while growing up. Because many PC's have no memories until age 5 or later, Level 2 involves gathering hearsay information about ACE's. Level 3 uses available documentary evidence for clues to developmental trauma, including family services involvement, juvenile justice contacts, school records, medical records and police/justice system contacts. Level 4 is a series of Nutritional Testing. Level 5 is an analysis of behavioral adoption (both negative and positive) linked to developmental trauma and nutritional deficits.

The goal of this Strategy is to identify traumatized children and adults at as early a stage as possible and provide intervention services appropriate to the stage of Trauma they are located. Those services are discussed later in this paper.

Medical, Behavioral and Nutrition specialists (Team) staff the family health care entry portal. They should be trained about the impact of childhood developed Toxic Stress, adult onset traumatic experience and nutritional deficiencies on negative behavior development, chronic disease, learning and cognition deficit development and on violent behavior. Even more important, they should understand and have confidence in the systemic approach for the Assessment and treatment protocol. The team will assess a Client, who has elected to voluntarily participate, and can be assisted by a web-based questionnaire, Client History, existing documentary history, a chronological history of both Negative and Positive behavioral practices, and appropriate testing for nutritional deficiencies.

The Medical specialist will assess PC for true medical care needs. Research reveals that as many as 50% to 70% of patients who seek primary health care receive a diagnosis of "Medically Unexplained Symptoms (MUS)." Most of this cohort suffers from either Toxic Stress (childhood derived or adult onset) stress and/or anxiety. Clients with clearly identifiable medical symptoms will be treated medically. Clients with identifiable stress or anxiety will be assessed for degree of stress and offered a Stress/Anxiety treatment healing protocol (Protocol). All Clients will be assessed for nutritional deficiencies that include Omega 3/6 imbalance and Vitamin D3 deficiency, among others

Clients needing Emergent Assistance will be treated immediately by all available means. If the emergency is caused by behavioral means (such as a suicide attempt, Alcohol Based Accident or Domestic Violence), the Client will receive a follow up offer to participate in an Assessment. The Assessment will also be offered to Clients who seek help with Siloed services, Criminal Justice referrals and Child Welfare/Juvenile Justice contacts.

The Protocol is designed for a group setting of from 6 to 10 individuals, with a leader trained to take the group through successive stages in a set order. The group setting has a specific purpose as well. By working on common goals through learning and collaboration, the group will become a team assisting each other learning and internalizing the healing lessons. With a common interest in healing, they support each other. When they have

experienced a measure of healing, they become an example to the community of what is possible. And they transform the culture of the community progressively from one heavily influenced by trauma to one fully knowledgeable of the reasons for existence of many of their problems, and capable of serving as a resource for new PC's going through RTHS.

Stage 1 is referred to as "Knowledge," and is designed to increase insight by a client and overcome denial and noncompliance with healing advice through education and discussion. Utilizing a non-blaming, non-shaming environment, Clients will be shown what impact Trauma, Stress, Anxiety and Nutritional Deficiencies have on the development of negative behaviors and health issues. The Team Leader will guide the initial discussion. At this stage, if consented to, Clients will start learning about "Body Awareness." Body Awareness is frequently deficient in a Client with Child Derived Toxic Stress and can facilitate healing from the Trauma.

Stage 2 starts with Nutritional therapy. Recent studies have demonstrated that nutritional deficiencies contribute to numerous behavioral and psychological problems. For many who suffer, blood/urine testing can help reverse nutritional deficiencies and assist with full or partial healing from a variety of problems, including, among others, depression, violent behaviors, learning disorders, sleeping disorders, and others.

Stage 3 continues with body awareness training and introduces the concept of somatic experiencing through Trauma Release Exercise (TRE) and release through other forms of exercise that facilitates the release of endorphins. Because Childhood derived Toxic Stress is often inflicted pre language development and at the Limbic System Level, there is generally no "Talking Hook" upon which to focus with talk therapy. Building body awareness, together with learning proper breathing techniques and how to identify when your body is activating due to stress can allow Client to soothe and calm without resort to negative (or positively viewed) behaviors.

Stage 4 utilized therapeutic techniques to help the patient cope with the impact of Toxic Stress and Anxiety. Emotional Freedom Technique, both self practiced or with a therapist, has proven beneficial in clinical and private settings. Eye Movement Desensitization and Reprocessing (EMRD) has been successful in "erasing" Toxic Stress without a known cause. Mindfulness (meditation) has helped Clients soothe and calm, as well as assist with breathing and body awareness. An added benefit of Mindfulness has been with healing through reduction of the inflammatory effect of fear system activation.

Stage 5 utilizes assisted Therapy to address the more severe cases of behavioral issues. Cognitive Behavioral Therapy, Pesso Boyden System Psychomotor Therapy, the Internal Family Systems Model or other successful therapies will be used as indicated.

Lets a look at a fictional example of how RTHS works. A PC seeks medical attention. During intake, a profile is observed of a patient complaining of a particular symptom. A provider trained in RTHS observes a patient history that includes previous MUS diagnoses, a history that includes obesity, teen pregnancy and STD, dropping out of school, injuries symptomatic of domestic violence and depression. An emergency room visit was alcohol related. The

provider has seen evidence consistent with predictors so suicide and recommends referral to the intake team and completion of the AI, with or without assistance. The AI reveals a total of 7 ACE's, a DUI conviction and problems with an office of children and family services. A nutrition assessment reveals an imbalance between Omega6/Omega 3 essential fatty acids and a Vitamin D3 deficiency, among others.

Upon completion of the AI, the PC fits a profile of a number of target populations. They include a potential for suicide. With 7 ACE's, depression history, alcohol abuse history and relationship issues, the PC joins a grouping where at least 35% will attempt suicide at some time in their life. Other target populations include acquiring health issues later in life, imprisonment for violence, un/under employment and relationship issues involving perpetration or victimization. If we look at PC fitting within numerous target populations, we will see that they have already been progressively moving on a path towards more negative behavioral issues and health problems. Cumulative memberships point towards more possible negative impacts in their lives. Regardless of their level of need, the Protocol can help and is modified to meet specific needs by the intervention Team.

I have some observations about the role of culture and historical trauma in the development of healing strategies. My observations are heavily influenced by what is referred to as a Restorative Integral Support Model (RISM). RISM focuses on 4 quadrants: brain development and influencing factors; behavioral development; family and cultural constructs influencing the PC; and the Societal Surround. Family and cultural constructs can have either a positive or negative influence. Growing up in a culturally grounded family that inflicts substantial ACE's upon the child generation will not produce healthy children or adults by itself. While culture in an American Indian/Alaska Native community is important, it is not a solution. In cultural implementations, we have seen improvements in the outcome experienced by children, but we have not analyzed the other variables involved. The other variables include regular social contact by the student with responsible adults; activity and reinforcement of learning; teaching positive social practices; and providing social supports. Whether cultural implementations can overcome developmental trauma is dependent on the other cultural structures the child belongs to.

Historical trauma is important for 2 reasons. First, this is likely the generational source where negative behaviors are developed and nurtured. The process of intergenerational transfer of trauma starts here. I believe it is the intergenerational transfer that is of paramount importance. Second, research demonstrates that an epigenetic transfer of some of the antecedents of trauma and nutritional deficits can be passed on by a traumatized generation. I hear this theory posited regularly, but without a recommendation for healing accompanying it. My belief is that historical trauma will continue perpetuating through succeeding generations unless we intervene. If a deficit is genetic, we need to explore how to mediate the effects, and I believe the Protocol can accomplish that.

Both concepts, culture and historical trauma, are responses advocated for by Tribal Leadership. IT supports non-healing goals including requests for greater funding support for cultural restoration. Historical trauma supports non-healing goals like greater tribal sovereignty, funding increases and apology. My approach is intended to bring healing down

to an individual level, and allow the PC to make their own choices about the impact of culture and historical trauma to their healing.

Because so many behavioral issues are accompanied by a breakdown in learning and skill development, there is a need for additional services in addition to healing: Education, job skills, parenting, social skills and others will need to be learned. Tribal resources should be utilized to provide a support system for Clients engaged in healing from Toxic Stress and Anxiety. When families have economic and social supports appropriate to their circumstances, they have an ability to move up the economic support ladder.

My recommendations for future work by NIMH are:

1. Measure the depth of intergenerational trauma within Indian Country through replication of the Adverse Childhood Experience Study, updated for advances made in the past 20 years. For example, Current ACE theory elevates 4 of the original 10 ACE's as a more toxic subset: Parental Mental Health Problems; Sexual Abuse; Physical Abuse; and Emotional Abuse. My experience and review of existing research puts AI/AN populations at a level 2 to 4 times the level of ACE's in the general population.

2. Develop an Assessment Instrument that identifies a variety of Target Populations based on ACE Impact; Social Disadvantage; Nutritional Deficits; Maladaptive Behaviors and Health Disparity. The goal for identifying target populations is to support a cumulating theory of trauma. A graded scale of potential behavioral responses experience by each target population may allow identification of PC's at an entry level Target Population and give opportunity for early intervention.

3. Support trials for use of the healing Protocol.

4 Support the development of training materials for the Team to utilize the AI and trials for implementing the Protocol. Assist with funding the collaboration requirements within a primary care system.

I realize this comment leaves a lot of questions open, and I would be pleased to respond to any that occur. The question asked by NIMH focused on Suicide Prevention and what should it could support in response to the increased level of Suicide in Indian Country. My response is that Suicide is a symptom of developmental trauma and nutritional deficiencies. Addressing both should lead to a reduction in suicide. It should also lead to a reduction in other negative behaviors and future poor health outcomes.

Respectfully Submitted:

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