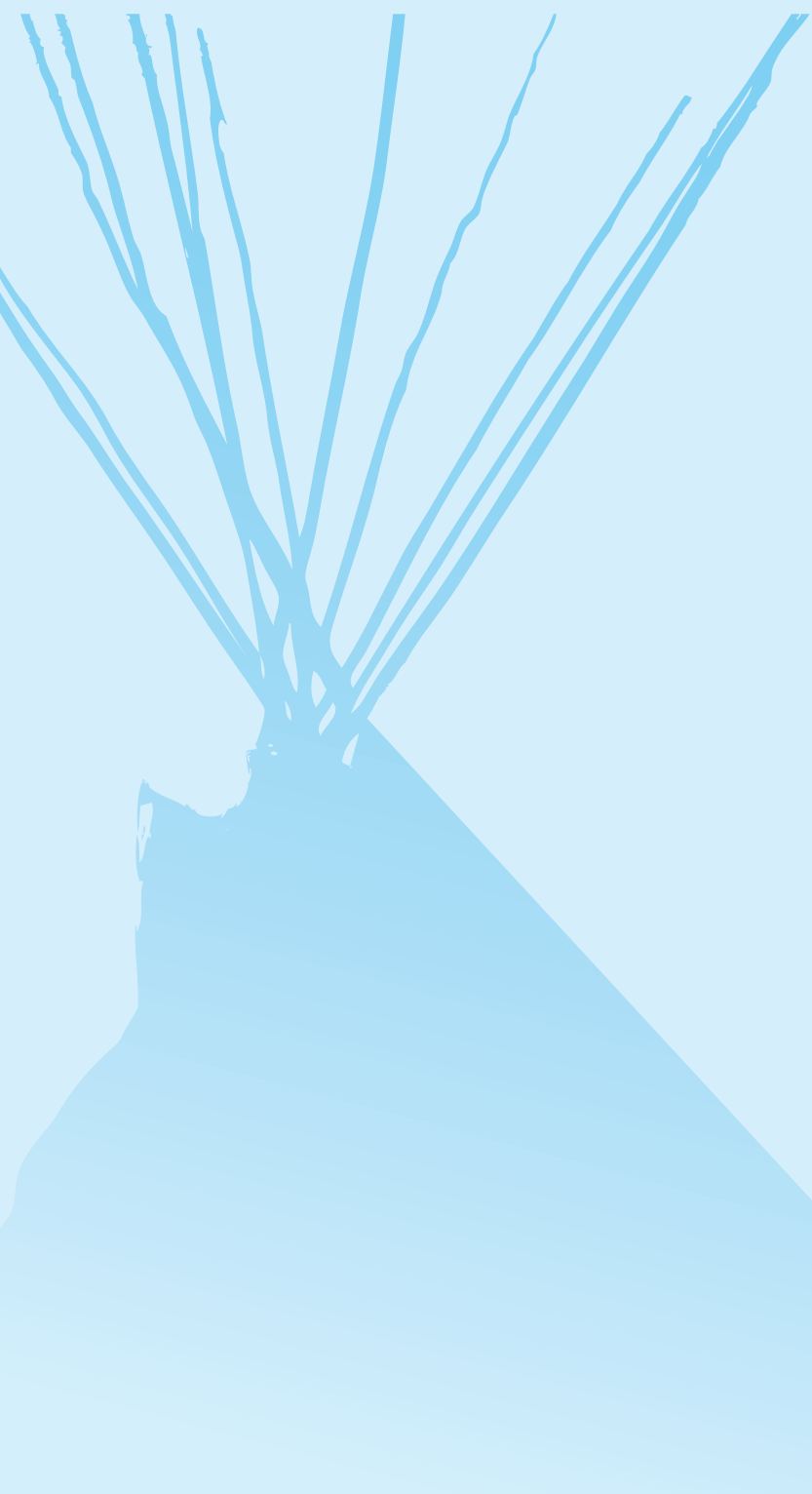# *To Live To See the Great Day That Dawns:*

Preventing Suicide by American Indian and Alaska Native Youth and Young Adults

To Live To See the Great Day That Dawns:

Preventing Suicide by American Indian and
Alaska Native Youth and Young Adults

ACKNOWLEDGMENTS

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ORIGINATING OFFICE

Contents

Chapter 1: Introduction to the Guide

Introduction

Suicide and suicidal behavior are preventable. This fact has led communities across the Nation, including many American Indian and Alaska Native (AI/AN) communities, to implement programs that successfully reduce factors known to contribute to suicide by young people and strengthen factors known to help protect them against suicide. The approaches taken by these communities are based on the public health model, which means that they are proactive and holistic. Such approaches do more than help young people choose life. They also help young people choose to live their life well—full of hope in themselves and their ability to accept the challenges and gifts that life has to offer.

All of America's young people deserve a life well-lived, which will have sound mental health as its foundation. To help achieve this goal, the Substance Abuse and Mental Health Services Administration (SAMHSA) has created this guide as a resource for community-based efforts to prevent suicide by AI/AN youth and young adults. The need is urgent, and the reasons are clear. More than 38 percent of AI/ANs are under age 19. Another 23 percent are between the ages of 20 and 34. In total, AI/AN youth and young adults make up 61 percent of all Native populations. They are the center of hope for the survival of their people and their culture. They also are the living spirit of our country's past and a vital part of its future. And yet AI/AN youth and young adults have the highest suicide rate of any cultural or ethnic group in the United States.[1]

The purpose of this guide is to support AI/AN communities and those who serve them in developing effective, culturally appropriate suicide prevention plans. Its intended users include Tribal and Village leaders, Elders, healers, and youth activists; State and county injury and suicide prevention program leaders; community organizers and program directors; school administrators; and other community members. In short, this guide is for everyone who has a stake in the health and well-being of AI/AN youth and young adults.

This guide lays the groundwork for comprehensive prevention planning, with prevention broadly defined. Prevention is not limited to programs that just address the needs of individuals who may be at risk of suicide. Prevention also includes programs that a community can use to promote the mental health of its young. It also is the actions that
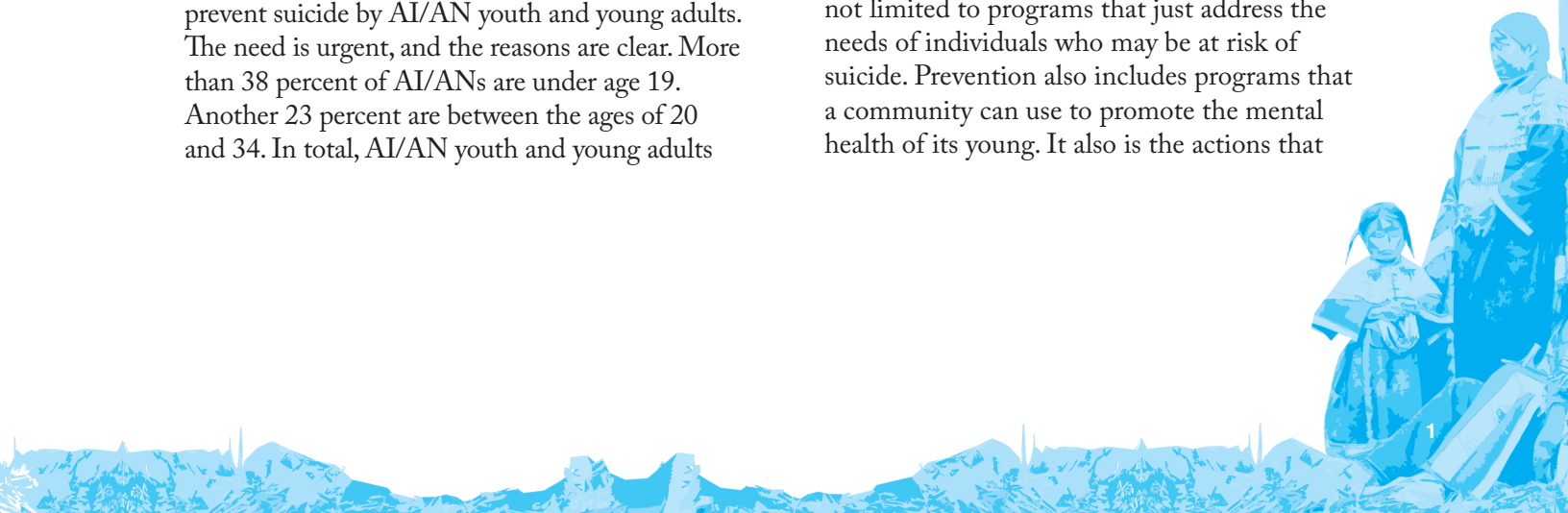
a community can take in response to a suicide that has occurred—or postvention—to help the community heal and thereby prevent related suicidal behaviors.

A comprehensive suicide prevention plan will involve community-based assessments of risk and protective factors, one or more programs or strategies that respond to those factors, and the building of coalitions to help fund, carry out, and sustain the plan. Therefore, this guide:

- Explores some of the cultural issues around prevention;

- Describes approaches that respectfully address these issues as part of prevention planning; and

- Provides practical tools and resources that a community can use for assessment, program selection, coalition-building, and implementation of the strategies it incorporates as part of a comprehensive plan.

This guide also reflects SAMHSA's support of a public health approach to suicide prevention. The Institute of Medicine (IOM) defines public health as "what society does collectively to assure the conditions for people to be healthy."[2] The premise of a public health approach is that caring for the health of a community protects the individual, while caring for the health of an individual protects the community—with an overall benefit to society at large. The public health approach also assumes that it is inherently better to promote health and to prevent illness before an illness begins. By being proactive, the public health approach offers both a humane and cost-effective way for individuals, families, and communities to be spared the needless pain, suffering, and costly consequences of suicide.

Content and Structure

The content of this guide represents a gathering of wisdom from many sources. Many Native

individuals as well as many other caring individuals and organizations graciously shared their knowledge and experiences. A preliminary guide to suicide prevention prepared by the One Sky Center was the foundation on which this guide was built.

While much of the content may seem to apply most directly to AI/ANs living on reservations and villages, a great deal of it also is applicable to preventing suicide by urban Natives. Many urban areas have Indian health and community centers that can be the focal point for prevention efforts. Efforts undertaken by these centers also must be based on an understanding of how culture can profoundly affect health and healing. Respect for cultural appropriateness in health care has no boundaries. As Shankar Vedantam noted in *Culture and Mind: Psychiatry's Missing Diagnosis,* "no matter how much science learns about the brain, culture and the environment will continue to play a huge role in why people develop emotional problems, what treatments they respond to, and whether they recover."[3]

We have organized the guide in a way that is intended to help readers understand the complex, but necessary, process of developing suicide prevention plans within a cultural context.

The focus of each of the remaining chapters is summarized below.

- **Chapter 2: Culture, Community, and Prevention** explores risk and protective factors and the ways in which AI/AN cultures can help promote the mental health of a community's young people.

- **Chapter 3: Breaking the Silence Around the Suicide Conversation** is intended to help break down the silence and the myths that too often surround suicide and are barriers to a community's open discussion of potential solutions.

- **Chapter 4: Responding to Suicide** deals specifically with actions that a community might take after a suicide occurs. Young people appear to be particularly susceptible to suicidal behavior when exposed to the suicide death of another person. As a result, a community's effective response to one suicide may help to prevent others.

- **Chapter 5: Community Readiness** discusses the stages of change that any community must go through before it can confront the possible causes and solutions to suicide. This chapter emphasizes that an AI/AN community may need to first heal from historical trauma as its foundation for change.

- **Chapter 6: Community Action** describes the public health approach to prevention, with SAMHSA's Strategic Prevention Framework as a model for action.

- **Chapter 7: Promising Suicide Prevention Programs** examines some of the issues around "evidence" of effectiveness and also describes programs that hold promise for preventing suicide among AI/AN youth and young adults.

- **Chapter 8: Federal Suicide Prevention Resources** summarizes suicide prevention programs and resources offered by SAMHSA as well as resources, including possible funding opportunities, available from other Federal agencies.

- **Chapter 9: Conclusion to the Guide** briefly states SAMHSA's hopes for the conversations about culturally appropriate suicide prevention that this guide may inspire.

Many of these chapters include text boxes entitled "Questions for Seeking the Wisdom of Elders." The questions in each box are designed to explore a community's traditional ways of maintaining "balance" or "harmony" among its members. This exploration will be beneficial to both AI/AN

community members and those involved with them in laying the groundwork for a prevention plan. Not all cultures use the same language, concepts, or values in discussing or understanding the causes and prevention of suicide. "Mental illness," for example, is not a universally accepted concept. Many cultures, including some AI/AN populations, understand health in holistic terms. Wellness, therefore, is a state of balance between a person's mind, body, and spirit. Someone experiencing an emotional crisis would be considered as being out of balance or out of harmony with nature, including with possible spiritual forces.

In this guide, we use the terms, mental health and balance or harmony, interchangeably. Developing a common language for understanding and discussing mental health will be essential to any effort to create culturally appropriate prevention plans and evaluate their effectiveness.

This guide also includes four appendixes that contain a wealth of information.[a]

- **Appendix B: Glossary of Terms** contains definitions of mental health terminology used in the guide. These terms have been taken primarily from the *National Strategy for Suicide Prevention: Goals and Objectives for Action.*

- **Appendix C: Statistics Related to Suicide by American Indian and Alaska Native Youth and Young Adults** is a compilation of statistics that a community may find useful in completing a needs assessment for grant applications. A community also might use these statistics to direct media attention to the issue of suicide—without a precipitating tragedy.

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[a]Appendix A, which was referenced in the front matter, contains a list of contributors and reviewers.

- **Appendix D: Decisionmaking Tools and Resources** contains a copy of the American Indian Community Suicide Prevention Assessment Tool. It also includes contact information for State suicide prevention planning team leaders, a list of other tools that may be helpful to prevention planning, and an order form for resources available from SAMHSA's National Suicide Prevention Lifeline.

- **Appendix E: Web Site Resources and Bibliography** categorizes numerous sources of online information about suicide prevention and Native American health as well as a bibliography for each chapter.

Themes

If there are any primary "themes" within this guide, they are the overlapping themes of resilience, empowerment, and—ultimately—hope.

First, this guide recognizes and pays honor to the resilience of AI/AN communities in resisting cultural suppression and overcoming a legacy of historical trauma. In many cases, it is by revitalizing their culture—and drawing upon their traditional values, beliefs, and practices—that AI/AN communities are successful in addressing the variety of social and economic challenges that confront them.

This guide acknowledges historical trauma as an underlying and continuing threat to the balance and harmony of AI/AN communities. While some communities already have begun the courageous process of healing from historical trauma, other communities have yet to open up about this painful subject. Where healing circles have been held within small groups, the hope is that healing will move into the entire community, where all can benefit from the natural strengths and resources of its members. For many

"It is time to speak your truth, create your community, and do not look outside yourself for the leader. We are the ones we've been waiting for."

— Hopi Elders
Community Works Web site
http://www.communityworksinfo/hopi.htm

communities, healing from historical trauma is the first step in dealing with the causes of suicide.

Second, this guide recognizes the power of each community in developing the most appropriate responses to suicide and its related risk factors. This theme also demonstrates respect for the incredible diversity among AI/AN communities and the unique strengths of each individual culture. AI/AN communities have a wealth of traditions and stories to guide them in developing solutions that best meet the needs of their members. This guide provides guidelines on prevention planning. It is based, however, on the recognition that those most familiar with a community and its culture will know best which programs to choose, how they need to be implemented, and how such efforts can be sustained.

The third theme is hope. This theme is based on an awareness of the power of hope in a future that is grounded in faith and derived from the AI/AN intimate understanding of the cycles of nature. It is the natural continuity of spring following winter and of a world that inevitably turns toward the dawn that becomes the foundation for a young person's hope in the future.

Conclusion

This guide is a work in progress rather than a definitive guide to preventing suicide by AI/AN youth and young adults. There is a diversity of AI/AN cultures and limited—although growing—research into what strategies may work best within different cultures. Any current discussion of what works in AI/AN communities or what should be considered in prevention planning will be based largely on suicide prevention research within the American population in general, supplemented by the more extensive research that has been conducted among First Nations in Canada. Consequently, it is not possible or even wise for this guide to attempt to offer universal solutions to a problem as complex as suicide. In fact, we believe it is more important for this guide to raise questions about what we still need to learn from AI/AN communities about prevention than to offer any pat solutions. We trust that this guide—which is offered in the spirit of honoring and preserving the uniqueness of individual Tribes and Villages—will be an acceptable starting point for discovery.

Chapter 2: Culture, Community, and Prevention

> "Clearly, a society's perception of suicide and its cultural traditions can influence the suicide rate."
>
> *Reducing Suicide: A National Imperative*
> Institute of Medicine (2002)

Introduction

Just as suicide rates vary greatly by country, State, and region, they also vary between and within racial and ethnic groups. While some American Indian and Alaska Native (AI/AN) communities have experienced suicide rates as much as 10 times the national rate, others have rates that are much lower than the national rate. The more extensive research that exists for suicide among Canadian Tribes indicates that some First Nations Tribes have not experienced a single suicide in 15 years.[4] What explains these variations?

The answer, in large part, is culture. Culture, as described in this chapter, plays a significant role in suicide prevention. Also, as discussed in the next chapter, culture can present some barriers to developing a comprehensive prevention plan.

This chapter explores the relationship between a community, its culture, and prevention. As part of this discussion, it presents factors known to increase a person's risk of suicide or to protect against it, with special attention given to those factors that place AI/AN youth and young adults at particular risk. The value of cultural connectedness as a protective factor also is examined. However, any attempt to describe suicide and suicidal behavior throughout AI/AN communities cannot fully take into account the vast cultural differences that exist within and between these communities. Caution should be used in any attempt to generalize cultural influences on suicidal behavior across Tribes.[5]

The Concept of Culture

Culture is difficult to define simply. This difficulty may result from the complexity of the many cultures that exist or because each person's own unique culture defines his or her life and identity in many apparent and unseen ways. David Hoopes and Margaret Pusch, in their writing on multicultural education, made the following attempt to define culture comprehensively:

> *Culture is the sum total of ways of living*, including values, beliefs, aesthetic standards, linguistic expression, patterns of thinking, behavioral norms, and styles of communication which a group of people has developed to assure its survival in a particular physical and human environment. Culture, and the people who are part of it, interact, so that culture is not static. Culture is the response of a group of human beings to the valid and particular needs of its members. It, therefore, has an inherent logic and essential balance between positive and negative dimensions. [Emphasis added.][6]

In practice, this definition implies that suicide prevention efforts need to acknowledge the cultural context of *each individual community*. This would include each community's unique risk and protective factors and how the community understands, discusses, and experiences suicide and suicidal behavior.

The Institute of Medicine (IOM) similarly underscored the importance of culture in *Reducing Suicide: A National Imperative.*

According to the IOM:

> Society and culture play an enormous role in guiding how people respond to and view mental health and suicide. Culture influences the way in which mental health and mental illness is understood and defined, the ability of community members to access care, the nature of the care they seek, the quality of the interaction between provider and patient in the health care system, and the response to intervention and treatment.[7]

As these references to culture make clear, suicide does not happen within a vacuum. Rather, suicide reflects the many cultural forces that shape the lives of young people. Because culture, as defined by Hoopes and Pusch, has an "essential balance between positive and negative dimensions," these forces are both good and bad—in other words, factors that protect against suicide and that increase a young person's risk.

Research suggests that one of the strongest factors that protect Native youth and young adults against suicidal behavior is their sense of belonging to their culture and community.[8] Similarly, the idea that a loss of culture or community can cause a loss of well-being is well understood by the many AI/ANs whose cultural identity gives purpose and meaning to their life.

Risk and Protective Factors

Before we discuss the protective influences of culture and community, a general discussion of suicide risk and protective factors is in order. Briefly, risk factors are associated with a greater potential for suicide and suicidal behaviors. Protective factors are associated with reducing that potential. It may be helpful to think of these factors in terms of how they may hinder or help a person as he or she travels along life's path. Protective factors, such as close family bonds, are like roadmaps that help a person stay safely on the correct path. Risk factors, such as substance abuse, are like detours and potholes that can cause a person to stumble off or along the path. Suicide occurs when a person becomes so lost and hopeless that he or she gives up hope of ever finding the way back or reaching a destination and ends his or her journey forever. It is often the role of Elders and adults, and sometimes the role of older peers, to guide the young along their life's path and help them avoid, or at least cope with, some of the roadblocks that are bound to appear.

Recognizing the extent to which risk and protective factors exist in a community is the beginning of an effective suicide prevention plan. Ideally, a community will not view the prevention of suicide alone as the sole reason for identifying these factors. As stated at the very beginning of this guide, sound mental health helps young people develop the resilience and skills they need to accept the challenges and gifts that life has to offer. Communities can and should identify factors that will promote the balance of its young people while also reducing or eliminating factors that increase their risk of suicide. Many programs, such as those described in Chapter 7: Promising Suicide Prevention Programs, enable a community to do both effectively.

Risk Factors

Suicide is complex, and there is no single reason, cause, or emotional state that directly leads to suicide. Substantial research has been conducted on suicidal behavior, risk factors, and trigger events in the general population, but research within AI/AN communities is comparatively limited. Exhibit 1 illustrates what current research into AI/AN suicide suggests are risk factors that place any individual at risk (e.g., mental illness and substance abuse) together with factors that are unique to AI/ANs (e.g., historical trauma).

Exhibit 1. Interrelated Risk Factors for Suicide Among American Indians and Alaska Natives*

Historical trauma

Family history of mental illness/ substance abuse

Substance use and abuse

Cultural distress

Feelings of hopelessness or isolation

Negative boarding school experience

Suicide

Impulsive behavior

Psychological and physical vulnerability (e.g., chronic illness)

Family disruption/ abuse

Poverty, unemployment, geographic isolation, and other environmental factors

Mental illness and its stigma

Suicidal behavior of self or others

*Adapted from Walker, D., Walker, P. S., & Bigelow, D. (2006). *Native Adolescent Suicide Cofactors: Prevention and Treatment Best Practices*. PowerPoint presentation available from One Sky Center, at http://www.oneskycenter.org/education/presentations.cfm.

Risk factors can be divided into those that a community can change and those that it cannot change to reduce a person's risk of suicide. Some changeable risk factors, such as substance abuse, are like a bear that crosses our path along life's journey. If we are trained in the ways of bears, we know how to avoid them and the dangers they present. A community working together also can drive the bear away. Other changeable risk factors, such as exposure to bullying and violence, are like a tree that falls across the path. If we have the skills to cope with this challenge and remove it from the path, we can proceed with our journey. A community, for example, could help its children develop the resilience and problem-

solving skills that enable them to cope with bullying, violence, or other challenges that may occur during their journey.

Factors that cannot be changed, such as age, gender, and genetics, are different in that neither communities nor individuals can alter the risk of suicide they represent. For example, within AI/AN communities, the group at the highest risk for suicide attempts is females between the ages of 15 and 24. Those at highest risk of completed suicides are males in the same age group. The age and gender of the individuals cannot be changed, even though these characteristics place them in groups at higher

risk. This is similar to these youth having to travel down an unavoidable path known to be more dangerous. Unchangeable risk factors for suicide, however, do not predict anything, especially suicidal behavior. No matter how high the rates of suicide within any particular group, most of the individuals within the group do not plan, attempt, or complete suicide. In addition, while a community cannot change any of these factors, its members can be aware of the increased risk for suicide that these factors present. Mental health promotion and suicide prevention programs focused on youth and young adults in higher-risk groups can help them navigate their paths safely.

Just as one example, consider how a community might offer programs to help its young males—the group at greatest risk of completed suicides—cope with life's demands. The reasons why more males than females complete suicide are complex, but one possibility may be the social pressures and family demands placed on males at an early age. Males may feel burdened by the expectations that they will be strong protectors and providers, particularly during a time of high unemployment. In addition, the traditional role of males of any ethnic group is associated with greater risk-taking behaviors.[9] Currently, these behaviors include substance abuse, aggression, violence, and others that might be considered antisocial.[10]

Young males also appear more reluctant than young females to seek help for a variety of health-related issues, including depression and stressful life events.[11] Whether this lack of help-seeking behavior is the result of stigma, shame, conditioning, attitudes, or not wishing to appear weak, the outcome is the same—young males do not receive needed assistance. However, while males might not *seek* help, they may be willing to *accept* help when offered.[12] If so, then programs that offer support and guidance, such as mentoring, can guide young males safely to adulthood and beyond.

Risk factors have a cumulative effect. That is, the larger the number of risk factors a person is exposed to, the greater the risk of suicide. Risk factors also are interrelated. This relationship appears to be very strong between mental illnesses and substance abuse and between these two factors and suicide. According to the IOM, an estimated 90 percent of individuals who die by suicide have a mental illness, a substance abuse disorder, or both.[13] The next few paragraphs explore this relationship in more detail.

Depression among youth in the general population is significant. *Major Depressive Episodes Among Youths Aged 12 to 17 in the United States of America: 2006*—a Substance Abuse and Mental Health Services Administration (SAMHSA) study released in 2008—concluded that 8.5 percent of adolescents, or the equivalent of 1 in every 12, had experienced a major depressive episode during the past year.[14] This same report also revealed the often devastating effect these major depressive episodes can have on adolescents. Nearly half of adolescents experiencing major depression reported that it severely impaired their ability to function in at least one of four major areas of their everyday lives. These areas are home life, school/work, family relationships, and social life.

In the general population, substance abuse disorders also are common among those who experience serious mental illnesses, which include chronic depression. Among individuals being treated in a mental health setting, 20 to 50 percent also have a substance abuse disorder. The converse also is true: substance abuse is linked to risk factors for mental health problems. Underage drinking, for example, contributes to academic failure, violence, and risky sexual behavior.[15] Among individuals receiving clinical treatment for substance abuse, 50 to 75 percent have a mental illness.

On the positive side, the interrelationship of risk factors means that efforts to reduce one

also can help to reduce others. Prevention of suicide thus becomes prevention of mental and substance abuse disorders and vice versa. The results of the U.S. Air Force suicide prevention program illustrate this connection. In 1996, in addition to specific training in suicide prevention, the U.S. Air Force introduced a broad-based program within its community to increase its general understanding of mental health and decrease the stigma of seeking help for a mental or behavioral problem. The outcome of the program was that while suicides were reduced by 33 percent, homicides *also* were reduced by 52 percent. Serious domestic violence rates dropped by 54 percent.[16] Clearly, actions taken to reduce self-harm also help to reduce other forms of personal violence that threaten a community's mental health.

Factors Placing AI/AN Youth at Increased Risk

Certain risk factors are more common among AI/AN youth and may contribute significantly to their higher suicide rate. These factors are *not* part of the AI/AN culture but, instead, may be symptoms of other factors such as poverty and depression that affect AI/AN communities disproportionately.

AI/AN youth aged 12 to 17 have the highest rate of alcohol use of all racial/ethnic groups. In 2006, more than 20 percent, or one out of every five AI/AN youth, engaged in underage drinking.[17] During the same time period, 15 percent of AI/AN youth aged 12 to 17 had used marijuana within the past month. This rate is more than double that of any other racial group. AI/AN youth also were more likely than other groups to "perceive minimal risk of harm from substance use." Research indicates that the lower the perceived risk, the less likely a person is to seek help for substance abuse. Other risk factors specific to AI/AN youth are the perceived discrimination felt by AI/AN adolescents,[18] the

racism they experience,[19] and the related stress associated with these issues.

Historical Trauma as a Risk Factor

In the definition of culture given earlier, Hoopes and Pusch state that culture is what a group of people have developed "to assure its survival in a particular physical and human environment." This statement raises serious questions about the way in which historical trauma may contribute to the suicide rates of AI/ANs. What happens to a group of people when they are torn away from their culture? What happens to their ability to survive? How do they adapt to trauma and what effect does this adaptation have on them personally and as part of a community? Because "culture, and the people who are part of it, interact," these reactions to trauma become part of the culture.

Historical trauma is a risk factor for suicide that affects multiple generations of AI/ANs. Historical trauma includes forced relocation, the removal of children who were sent to boarding schools, the prohibition of the practice of language and cultural traditions, and the outlawing of traditional religious practices. These past attempts to eliminate the AI/AN culture are well-documented, and the lasting influence of this legacy of victimization cannot be underestimated.

Many parents and grandparents of young adults who currently are at risk of suicide may have experienced these traumas directly. They may have been removed from their parents and forced into boarding schools or been raised by parents who grew up in boarding schools. As described in *The History of Victimization in Native Communities*, "It is important to realize the historical content of victimization is not limited to individuals since all Native families have a collective history of trauma and abuse."[20]

Elders who lived though the boarding school experience are "[N]ative children [who] suffered

deprivations beyond description and those who did survive became the wounded guardians of the culture and tentative parents to the next generation of children."[21] As a result, many parents struggle every day to pass on to the next generation what they themselves may never have received in terms of nurturing or a sense of belonging.

Historical trauma also may have an effect on the help-seeking behavior of AI/ANs, as does AI/AN culture in general. When seeking mental health care, some AI/ANs avoid professional services. They may believe these services represent the "white man's" system and culture or that the professionals will not understand Native ways. They may have a lack of faith in mental health care in general.[22] Some AI/ANs go to both specialized professional health services and to traditional healing rituals and services. However, not only do a majority of AI/ANs use traditional healing,[23] they rate their healer's advice 61.4 percent higher than their physician's advice.[24] In addition, they may not tell the physician everything. Only 14.8 percent of AI/AN patients who see healers tell their physician about their substance use.[25]

Dolores Subia BigFoot, Ph.D., with the Indian Country Child Trauma Center at the University of Oklahoma Health Sciences Center, divides trauma into four interrelated categories:

- **Cultural trauma** is an attack on the fabric of a society, affecting the essence of the community and its members.

- **Historical trauma** is the cumulative exposure of traumatic events that affects an individual and continues to affect subsequent generations.

- **Intergenerational trauma** occurs when trauma is not resolved, subsequently internalized, and passed from one generation to the next.

- **Present trauma** is what vulnerable youth are experiencing on a daily basis.[26]

The lesson to be learned about trauma of *any form* is that it never affects just one person, one family, one generation, or even one community. Like the rock thrown into the pond, the effects of trauma ripple out until its waves touch all shores.

Given the widespread and continuing impact of trauma, a community should ensure that its suicide prevention plan is "trauma-informed."[27] A trauma-informed plan will be one in which all of its components have been considered and evaluated "in the light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services."[28] While these words were written to describe direct service system planning, the same approach should apply to suicide prevention planning.

Other Cultural Considerations in Assessing Risk Factors

Many risk factors for suicidal behavior are best understood and addressed within the context of culture and community. These risk factors explore the core questions that challenge youth and young adults, such as "Who am I?," "What is the meaning of my life?," and "Where am I going in life?" These factors also explore the broader question faced by all AI/ANs of "Who are we as a people?"

Each of the factors listed below are followed by questions intended to stimulate discussion as to how they apply to youth and young adults within an individual community.

- **Feeling disconnected from family and community.** The need to belong to a valued group is powerful and deeply ingrained in all cultures. When this need is blocked or the individual feels disconnected, his or her physical and emotional health can be undermined.[29]

  Given that suicide rates are highest among AI/AN adolescent males, how might community leaders and Elders help this vulnerable group feel connected? How might a community involve adolescents, especially males, in important decisions about their place within the community and their future? How can they have a meaningful role in community prevention efforts?

  This factor may have particular significance for young AI/AN men and women returning from military service, some of whom feel isolated by their combat experiences.[30] The New Mexico Veterans Affairs (VA) Health Care System in Albuquerque, NM, has created a Talking Circle Group for local American Indian veterans. The traditional Talking Circle brings people together in a quiet, respectful manner for the purposes of teaching, listening, learning, and sharing. The way in which this group is organized and the beliefs behind its slogan—Trauma for American Indian Veterans: The Warrior and the Soul Wound—is intended to help group members feel a part of a larger community and to bring some degree of healing to the mind, heart, body, and spirit. AI/AN communities should engage their military veterans, who may be at higher risk of suicide, in any suicide prevention planning so that their needs can be considered.

- **Feeling that one is a burden.** A feeling that one is of little use to his or her community or a burden to others contributes strongly to the desire for suicide.[31] What are some ways to help youth and young adults feel that they are an important part of the community, that they matter, and that they have a great deal to offer to everyone? How can their contributions be honored? These questions seem to be grounded in strong traditional beliefs, such as the need to honor one's Elders and to consider how individual actions can affect generations to come. Perhaps the young person who feels the least valuable to a community is the same one that needs to be invited into exploring the solution.

- **Unwillingness to seek help because of stigma attached to mental and substance abuse disorders and/or suicidal thoughts.** Stigma is not unique to AI/AN communities, but the cultural values and traditions of a community affect the way in which its young people perceive the risk of harm associated with certain behaviors and the likelihood that they will seek help for them. How does a community talk about mental illness, substance abuse, and suicide? What messages are the youth receiving? How is asking for help viewed within the community? How can a community let them know that asking for help is the brave thing to do?

- **Suicide contagion or cluster suicide.** One or more suicides within a community can trigger additional suicides and suicide attempts, particularly among the family members and close friends of those who first took their lives. In what ways is a community prepared to respond to suicide? What grief-sharing or counseling opportunities are available? Chapter 4: Responding to Suicide discusses suicide response plans in greater detail.

Protective Factors

The reduction of risk factors is essential to any suicide prevention plan. However, a 1999 study of risk and strengthening protective factors among AI/AN youth showed that "adding protective factors was equally or more effective than decreasing risk factors in terms of reducing suicidal risk."[32] Thus, it may be more valuable for a community to expend limited resources on strengthening protective factors. Protective factors, similar to risk factors, are cumulative and interrelated. Enhancing the way in which young people feel connected to community and family and strengthening their ability to cope with life's challenges will help them achieve their full potential as individuals as well as avoid suicidal behavior.

> "It is much more difficult to handle depression and suicidal ideation after the fact. If we can create a positive outlook for our youth, and programs that have daily contact with our young people, we will be much better prepared to stop this cycle of loss [to suicide]."
>
> — Julie Garreau
> Executive Director,
> Cheyenne River Youth Project
> Testimony Before the U.S. Senate
> Committee on Indian Affairs
> June 15, 2005

Common protective factors that have been found to prevent suicide include:

- Effective and appropriate clinical care for mental, physical, and substance abuse disorders;

- Easy access to a variety of clinical interventions and support for seeking help;

- Restricted access to highly lethal methods of suicide;

- Family and community support;

- Support from ongoing medical and mental health care relationships;

- Learned skills in problem-solving, conflict resolution, and nonviolent handling of disputes; and

- Cultural and religious beliefs that discourage suicide and support self-preservation instincts.[33]

Culture as a Protective Factor

Nurturing of children is one of the most basic aspects of AI/AN cultures. Protection of children against harm is embedded in centuries-old spiritual beliefs, child-rearing methods, extended family roles, and systems of clans, bands, or societies. Although this cultural aspect has been threatened and undermined over time as a result of historical trauma, boarding schools, externally imposed social services, alcoholism, and poverty, traditional family values have survived. It is these very traditional family values that will lend strength to Native-led efforts to prevent suicide among their youth and young adults.

> "As Native Americans, we honor our families, cultures, and clan system and traditional values, but our greatest resource is our children."
>
> — Carl Venne
> Crow Tribal Chairman, Testimony Before
> the U.S. Senate Finance Committee
> September 12, 2006
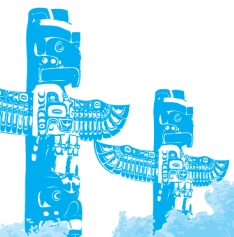
According to a document jointly published by the Suicide Prevention Action Network USA and the Substance Abuse and Mental Health Services Administration (SAMHSA) Suicide Prevention Resource Center, the most significant protective factors against suicide attempts among AI/AN youth are the opportunity to discuss problems with family or friends, feeling connected to their family, and positive emotional health.[34] When these factors are translated into action, culturally sensitive programs that strengthen family ties can help protect Native American adolescents against suicide.[35]

Various studies of the Native cultures suggest additional culturally based protective factors. One study of AIs living on reservations found that individuals with a strong Tribal spiritual orientation were half as likely to report a suicide attempt in their lifetimes.[36] This is consistent with the role of religion as a protective factor in the general population. When a suicide has occurred, the possibility of suicide contagion (i.e., one suicide seeming to cause others) seems to be decreased by a healing process that involves the role of Elders and youth in decisionmaking, the presence of adult role models, and the use of traditional healing practices.[37]

Cultural Continuity as a Protective Factor

Michael Chandler and Christopher Lalonde, researchers at the University of British Columbia, have found a distinct, positive relationship between some particular aspects of what they refer to as "cultural continuity" and reduced suicide and suicidal behavior among Native youth. Based on their studies, "First Nations communities that succeed in taking steps to preserve their heritage culture and work to control their own destinies are dramatically more successful in insulating their youth against the risks of suicide."[38] Their theory is that, when youth have a secure sense of the past, present, and future of their culture, it is easier for them to develop and maintain a sense of connectedness to their own future (i.e., self-continuity).[b]

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[b] Chandler and Lalonde have written extensively about self-continuity and the need for a personal narrative in understanding one's place in life, which they contend is closely tied to cultural continuity and suicide prevention among Native communities. According to the researchers, culture is the foundation of personal identity. If that culture is thrown into disarray, "the ground upon which a coherent sense of self is ordinarily made to rest is cut away, life is made cheap, and the prospect of one's own death becomes a matter of indifference." A detailed discussion of this theory and supporting evidence goes beyond the scope of this guide, but can be found in a series of articles by the researchers and available online at http://web.uvic.ca/~lalonde/manuscripts.

Questions for Seeking the Wisdom of Elders

- What strengths do community members have that will help them cope with and overcome their problems?

- How did the Elders help community members overcome past traumas and maintain their cultural identity?

- In what traditional ways were the community's children taught coping and problem-solving skills?

- How were community members helped to feel good about themselves?

- What are some of the old stories that help the youth deal with change?

- What can be said to young people to give them greater hope in themselves and their future?

Although this research is based on First Nations Tribes and Inuit peoples in Canada and the Northern Territory, it has relevance for AI/AN communities. Furthermore, given common U.S. and Canadian concerns about the rising suicide rates within Native communities, cross-border research-sharing can help create solid culturally based prevention models.

Cultural continuity is the extent to which the language, traditions, values, and practices of a culture have continued over time and are likely to continue into the future. In their study, the Canadian researchers found that cultural continuity could be promoted by a Tribe or Village's control over such things as its educational services, police and fire protection services, and health delivery services by local institutions.[39] Other results of their research demonstrate that indigenous language use, as a marker of cultural persistence, is a strong predictor of health and well-being in Canada's Aboriginal communities.[40] Furthermore, Tribes and Villages that had "established within their communities certain officially recognized 'cultural facilities' to help preserve and enrich their cultural lives" had lower youth suicide rates.[41]

These results should not be surprising. Just as with individuals, a community's sense of having some control over its daily life can be empowering and contribute to the community's general well-being. Youth who feel included in this community also share in this well-being, with positive results. Feelings of empowerment and hopelessness do not travel down the same path together.

Another key aspect of cultural continuity is spiritual continuity. Western medicine recently has discovered what many AI/AN Elders always have known: Strong spiritual beliefs and practices are protective and promote survival. Furthermore, issues connected to illness and healing are best understood within the wider domain of a religious or spiritual worldview.[42]

This relationship is too seldom addressed in Western-based suicide prevention planning, even though "cultural and religious beliefs that discourage suicide and support self-preservation instincts" are described as a protective factor in the *National Strategy for Suicide Prevention*.[43] To bridge the spirituality gap, any discussion of cultural considerations in suicide prevention also must include the spiritual.

Acculturation, Assimilation, and Alternation

As Chandler and LaLonde demonstrate in their studies of First Nations youth, cultural continuity appears to be a strong protective factor against suicide. This finding also implies that cultural disruption would be a risk factor. Several studies support this implication with research that concludes that social disruption caused by dramatic and rapid cultural changes may account for the increased suicide rates among indigenous groups in Alaska and Canada.[44,45] This conclusion, however, does not fully address the sometimes conflicting outcomes of the long multigenerational acculturation and assimilation processes of many Tribal communities or the urban Indian experience.

Acculturation is the process whereby the attitudes and behaviors of people from one culture are modified as a result of contact with a different culture. Acculturation implies a mutual influence in which elements of two cultures mingle and merge. For AIs and ANs, acculturation has affected their Tribal structure, religious practices, and community identity, among other cultural aspects.

People undergoing acculturation essentially live in the juncture of two cultures. An AI who lives and works in the city, for example, might receive health care from the city-based Indian Health Service (IHS) services but go home to

the reservation for a traditional healing ceremony when needed. An AN might practice a Christian religion while his or her parents or grandparents are grounded in traditional spiritualism.

Depending on the degree to which a person is able to balance elements of the two cultures, an individual undergoing acculturation can feel part of two worlds, one world, or none. Furthermore, when a "clash of cultures" results, traditional values may be lost and not replaced by acceptable values from the new culture. Cultural voids created by acculturation can result in alienation, identity confusion, depression, alcohol abuse, and suicide.[46]

Assimilation occurs when a member of one culture gives up his or her original cultural identity as he or she acquires a new identity in a second culture. Assimilation may be voluntary or it may be involuntary, as occurred in the AI/AN experience with boarding schools. Some studies suggest that less assimilation into the dominant culture increases an individual's risk of suicide.[47] The speculation is that these less assimilated individuals are less prepared to handle the stress that may be imposed by their new lifestyle.[48] Conversely, other studies suggest that too much assimilation may strip the individual of the protection that culture provides.[49,50] This situation, for example, especially appears to be the case for immigrant families who bring their cultural protective factors to their new country, only to see those protective factors disappear in subsequent, assimilating generations.

How, then, can these contradictory views of acculturation and assimilation be resolved? It may be that an important protective factor for many AI/AN youth and young adults is to have a solid foot in both worlds and to feel that this dual identity is acceptable to their peers and community. Without this grounding, they may develop feelings of isolation and alienation that cut them off from the protective factors of either world.[51]

Urban Natives, Cultural Connectedness, and Suicide

As mentioned previously, approximately 2.8 million AI/ANs make up the "invisible Tribe" that does not live on reservations and may lack a strong connection to their culture and community. Currently, more than 65 percent of AI/AN youth live in urban areas.

Because there is no formal public health surveillance system for urban Natives, little is known about suicide rates within this population. Some of what is known comes from a 2004 study published in the *American Journal of Public Health*, which found that when urban Natives were compared to the general population:

- Their death rate due to unintentional injuries was 38 percent higher;
- Their death rate due to chronic liver disease and cirrhosis was 126 percent higher; and
- Their rate of alcohol-related deaths was 178 percent higher.[52]

Unintentional injuries, substance abuse, and suicide are closely related. Consequently, these figures suggest that the suicide rate of urban Natives also may exceed the national rate.

Researchers are beginning to study protective and risk factors associated with suicide among AI/AN youth living in urban areas as well as those living on reservations and in villages. One such study revealed that while a Native who was raised in an urban setting had a lower rate of suicide ideation than a reservation-reared youth, the suicide attempt rate was generally the same.[53] This study goes on to state that there are some distinctive differences in psychological risk factors between these two groups. A history of physical abuse, a friend attempting or completing suicide, and family history of suicidality were positively associated with a history of attempted suicide by AI/AN

youth raised in an urban setting. By comparison, depression, conduct disorder, cigarette smoking, a family history of substance abuse, and perceived discrimination were correlated with a history of attempted suicide only within the reservation-reared sample.[54]

The hope is that separate studies of these groups will lead to better prevention and intervention programs that account for each group's strengths and challenges. Mounting evidence suggests that efforts to reestablish or strengthen the connection between urban Natives and their culture and community may have a significant effect on their mental well-being and their overall quality of life and health.

Conclusion

In developing suicide prevention plans, communities will need to assess the presence of risk and protective factors that affect the balance, or overall well-being, of their members. While attention should be given to reducing risk factors, equal and perhaps greater attention should be given to increasing protective factors that promote overall mental health and well-being. This does not imply that communities should ignore risk factors. Examination of these factors can raise community awareness of the problems that people, especially youth, are facing and draw attention to their need for help and supporting programs and services.

As part of this process, AI/AN communities may wish to identify and incorporate aspects of their culture that promote balance among their young people and also reduce their risk of suicide. These aspects include such things as spiritual beliefs, traditional values and healing methods, spiritual and cultural continuity, and ensuring that their young people have a valued role in preserving their heritage. In addition, communities might wish to encourage and support life skills and coping skills that help prepare youth to live successfully in a bicultural world.

Chapter 3: Breaking the Silence Around the Suicide Conversation

Introduction

The words of a First Nations Elder quoted above speak a powerful truth, particularly when applied to the silence surrounding the subject of suicide. Suicide, shrouded as it is in guilt, grief, anger, and the wrongful stigma of mental and substance abuse disorders, is one of the last great taboo conversations. The silence that may surround suicide, however, is not only dangerous but deadly. It affects the conversation that a community can have to address this issue, the conversation with an individual that can save a life, and the conversation with suicide survivors that can soothe their pain and prevent additional suicides. Only by having this conversation can a community begin to understand why some of its youth and young adults have chosen death. Only by having this conversation can a community then determine how it can help its children develop and maintain their hopes in themselves and their lives.

Many of the barriers to having an open conversation about suicide are not unique to American Indian and Alaska Native (AI/AN) communities. Various cultures around the world share in the difficulty of having this conversation and for many of the same reasons. Many people believe that initiating a conversation about suicide is too painful or is too intrusive and inappropriate. Some might consider this to be disrespectful of the dead. Even general grieving and mourning processes incorporate various culturally based practices and formalities. How does someone who has lost a loved one to suicide speak of it with others? How do the members of a community that have lost numerous young people to suicide speak of it openly in public meetings and with people outside of their own community? What do you say to a parent who has lost a child to suicide?

Although extremely difficult, such conversations are necessary in any community. Having said this, it is also important to acknowledge that some members of AI/AN communities may feel that there are religious or spiritual beliefs governing the appropriateness of the suicide conversation. Many belief systems contain rules that guide how and with whom this conversation can take place. These are traditions to respect as part of creating a culturally appropriate suicide prevention plan.

This chapter focuses on breaking the silence surrounding suicide. It describes some of the barriers and myths surrounding a suicide conversation, including those that may be specific to AI/AN communities. This chapter also discusses why it is important for a community to overcome these barriers in its own way and within its own specific cultural context.

Some of these barriers and myths apply to conversations with individuals who may be considering suicide, with family and friends of someone who has completed suicide, and with communities that hope to prevent or are responding to suicides. How does a father ask his son if he is thinking about suicide? How might someone who is contemplating suicide express those feelings to a friend, parent, grandparent, or other adult? These, too, are difficult conversations, but ones that can save lives.

Barriers to the Suicide Conversation

In the following discussion, honor, historical trauma, and respect are labeled as barriers to a suicide conversation. This labeling is not intended to minimize their importance within AI/AN communities but rather to explain and help us understand why having a suicide conversation is so complex.

Underlying all of the barriers to the suicide conversation is language. As stated earlier, not all cultures use the same language, concepts, or values in discussing or understanding suicide. Consequently, the act of suicide, as well as its causes and prevention, may be spoken of in words and with a meaning not well understood within Native cultures. As a participant at the 2006 joint U.S.–Canada conference on indigenous suicide stated, "We find ourselves forced to speak about our health with language and concepts that are not our own." Finding ways in which everyone can understand and discuss suicide is critical to holding the suicide discussion and developing a prevention plan.

"One of the problems is that the definitions we are using here are too narrow. We need to remember the balance of the fire and the water, the male and female, the light and the dark, to be able to see this in a holistic way."

— Speaker, conference on "Indigenous Suicide Prevention Research and Programs in Canada and the United States," Albuquerque, NM (2006)

From Honorable to Forbidden Behavior

Suicide is viewed differently by various cultures, depending on the circumstances and the period of time. For some individuals, suicide is "forbidden in their traditional culture" and "to take one's own life will cause the soul to remain in a state of distress."[55] Other cultures have accepted—and some may still accept—suicide as honorable behavior when a person's death is:

- An atonement for shame they have brought onto themselves and their family;

- A protest against injustice;

- A form of martyrdom or a show of devotion for a great cause or religion;

- An exercise of a person's right to choose how and when he or she will die;

- A show of bravery when one charges an enemy who has superior weapons; and

- A demonstration of selflessness, as when a person has gone far out into the snow to die so that others may share what little food is available and live.

Among AI/ANs, many of the stories, perspectives, and understanding of what has been labeled as suicidal behavior are deeply

rooted in cultural history. Some deaths may be associated as easily with honor, sacrifice, and selflessness as with shame, grief, and depression. These contradictory and conflicting beliefs and emotions complicate the suicide conversation.

The concept of suicide as "honorable" needs to be acknowledged within its historical context and then reassessed and confronted as it applies to the lives of today's youth and young adults.

Historical Trauma

As noted in the previous chapter, historical trauma is a risk factor for suicide that affects multiple generations. Many older members in the community may be reluctant to talk about this part of their past for a variety of reasons such as shame or not wanting to burden the young with their pain. Their silence might result from a reason as simple and basic as their not wanting to reexperience that terrible pain.

As a result, it may be necessary for a community to address the impact of historical trauma prior to initiating or discussing any suicide prevention efforts. This conversation should only be undertaken with a full understanding of how an open and direct conversation about current suicides may force some older AI/ANs to reexperience and reveal painful events of years past. One personal experience shared at the 2008 Tree of Healing Conference, presented by Camas Path of the Kalispel Tribe of Indians in Washington State, can provide some insight. An Elder who grew up in boarding schools told how young Native males frequently were found hanged to death in the school basement. These suicides always were reported by the school's administrators as "accidents" and never were discussed with the students. In this way, a whole generation may have been taught to respond to suicide with silence. Individual AI/AN communities will know best how to address the

suicide conversation within the context of their own collective experience.

Guilt and Shame

Native Americans view children as gifts from the Creator. Their parents, grandparents, aunts, uncles, Elders, and other members of the whole extended family and others are responsible for caring for and protecting that gift within the Sacred Circle of the community. What does it mean to all of these people to lose that gift to suicide?

As much as we try to understand the continuing negative impact of historical trauma on AI/AN communities and families, this single factor seems like an inadequate explanation as to why a young person dies by suicide. Despite the best efforts of their community and family, youth and young adults sometimes take their own lives. Those most closely related to the person may find it hardest to explore the reasons why.

For parents, this tragedy is often compounded by guilt, shame, and the haunting questions of "What did I do wrong?," "Why didn't I see this coming?," and "Why didn't my child come to me?" Any direct discussion about their child's death may cause them to experience these painful feelings again. Many will feel additional reluctance to engage in a suicide conversation if their child's suicide is linked to alcohol and substance abuse, particularly if they or their parents also struggle with the same disorder.

It also is common for parents who have lost a child to suicide to wonder what others in the community must be thinking. If they are asking themselves the "why" questions, then surely everyone else in the community must be doing the same. Again, parents may not want to talk with others within the community because of their feelings of guilt and shame. Some may not

want to bring up the topic of suicide for fear of causing others to feel these emotions. Either way, the end result for the suffering family member is the same: isolation.

Having a suicide conversation can help a family member—or even a community—begin to heal from the tragedy of suicide. Even if someone does not know the proper words to say, he or she can take part in a conversation by listening. As one suicide survivor observed about her healing process, "Sometimes, I just needed someone to listen."

Personal Pain

The pain experienced by those who have lost loved ones to suicide is another barrier to having an open and public conversation about suicide. Some communities have many people who have lost a loved one to suicide, making a conversation about suicide even more difficult to start. Talking about suicide can be distressing both for the person who is talking and the person who is listening. Not talking about suicide is one way to try and avoid this pain.

With this barrier in mind, it is appropriate that the person wishing to hold a suicide conversation within an AI/AN community should first ask permission to bring up the topic. Permission can come in many forms, such as from the Elders within the community or the leadership of the community as well as from all those who attend the gathering and have lost a loved one. It also may be appropriate for the person who started the conversation to ask for forgiveness for causing painful feelings when the conversation is over. Time also must be available for those who wish to speak about loved ones who died by suicide, as it may be the first time anyone has asked them to share their stories.

One example of sharing occurred as a result of a Talking Circle conversation about suicide, which was facilitated by a community coordinator

with Native Aspirations, a Substance Abuse and Mental Health Services Administration (SAMHSA) program to reduce violence, bullying, and suicide among AI/AN youth. An Alaska Native woman spoke of her isolation, saying that "after my son killed himself, no one talked with me about it, no one came to my house to comfort me. I am still hurt and angry about that." Her son had been dead for 20 years. As painful as the memory must have been for her, she came to the gathering and spoke publicly of her pain. Her ability to finally share her story with the community let the healing within herself begin.

During the same Talking Circle mentioned above, an elderly man spoke of his good friend who had completed suicide when they were just out of high school. With tears in his eyes, he spoke as if he were sharing the pain and experience for the first time. Having been invited to speak of this experience, he felt he had received permission to share his pain.

Not every culture, however, relies on words to deal with grief and loss. For some, grieving involves participation in a specific traditional ceremony. Sharing a family's loss may be expressed in an act as simple as offering condolences through a gift such as a pound of coffee. In attempting to open up a suicide conversation with a family who has lost someone to suicide, it is polite to inquire first as to what would be helpful or if they would like to talk about their loved one or about their grief. In any event, ask permission before beginning.

Collective Grief

Given what has been discussed about barriers thus far, it is not unusual to find a great deal of unspoken grief surrounding the topic of suicide within the community as a whole. Perhaps the specific ceremony was not performed, or the time period for talking about the loved one has passed.

Initial suicide prevention efforts either may be blocked by this silent grief or may provide community members with permission to release their grief in a flood of emotions. Either way, AI/AN community prevention plans may need to include community-based ceremonies and traditions to begin the healing of this collective grief. This may be accomplished through ceremonies such as the Wiping of the Tears or a Gathering of Native Americans (GONA).[c]

The release of pent-up emotions is more likely to happen over time rather than at once. Questions arise as to how the community can have the suicide conversation in a way that respects and

[c] A GONA is a 4-day gathering for Native Americans who want to become change agents, community developers, and leaders. The GONA is based on several ideas: community healing is necessary for substance abuse prevention; healthy traditions in the Native American community are key to effective prevention; the holistic approach to wellness is a traditional part of Native American belief systems; every community member is of value in empowering the community; and the GONA is a safe place for communities to share, heal, and plan for action. A GONA manual can be downloaded from SAMHSA at http://preventiontraining.samhsa.gov/CTI05/Cti05ttl.htm.

protects people experiencing grief. A primary question is: How can suicide prevention planning meetings and training sessions be conducted in a way that provides enough time so that once the wounds have been opened they are not left open when everyone goes home? To ensure that everyone who attends these gatherings are given support during the conversation, counselors or traditional healers may need to be present and willing to stay after the meeting to help the community begin to heal its collective grief.

Politeness and Respect

Politeness and respect may seem like strange barriers to a conversation about protecting the youth of a community. In any community, these qualities are valued as a necessity for community living. As Erving Goffman described in his early study of what has become known as "politeness theory:"

Politeness Theory and Suicidal Warning Signs

Someone who is contemplating suicide often will send warning signs to those around him or her, but these signs may be unclear and difficult to recognize as a call for help. This raises the question of why people considering suicide are not more direct in making their personal pain known. Politeness theory offers some answer. This theory helps to explain why many of us use a unique conversational logic and language that:

- Is designed to very carefully avoid what could be interpreted as rude or disrespectful speech;

- Is intended to avoid an unpleasant confrontation that might lead to the receiver losing face or being embarrassed; and

- Is meant to avoid placing a burden on the person hearing the call for help that they may not desire or feel able to fulfill.

As for individuals experiencing a suicidal crisis, vague or indirect calls for help helps protect them from their own embarrassment if others fail to respond. Potentially suicidal individuals also can deny the intent of their warning signs if it leads to a conversation that makes them feel uncomfortable. Vagueness of warning signs allows everyone concerned a way out of a potentially difficult and embarrassing situation.

No matter how strong the politeness convention of a culture is, the value of life should be stronger. Politeness should not prevent a caring person from asking someone directly if he or she is thinking about suicide when having this conversation may save a life.

In any society, whenever the physical possibility of spoken interactions arises, it seems that a system of practices, conventions, and procedural rules comes into play which functions as a means of guiding and organizing the flow of messages. An understanding will prevail as to when and where it will be permissible to initiate talk among whom, and by means of what topics of conversations.[56]

In many ways, these conventions help define "culture" and establish the rules for how community members will interact. These conventions evolve over time and, while rarely written down, are passed from generation to generation. Although many members of a community and culture may not be able to list all of these conventions, they know it when they violate one.

Holding a suicide conversation challenges these conventions. It is a difficult conversation to have on both the personal level and on the community level. For example, we might be able to ask a sister or brother if they are having thoughts of suicide but not a parent or Elder. We might be able to talk with a close friend about thoughts of suicide or of a suicide in the family but not at a public meeting or with strangers. In addition, it may be considered rude and disrespectful to make others uncomfortable or embarrassed in a public setting or to speak publicly about suicide within the community without first having permission from an Elder. As important as these conventions are to social interaction, they can prevent the community from coming together and talking about the causes and prevention of suicide.

It falls on the community to resolve the issues presented by politeness and respect. Just as cultural differences occur between each Tribal community, different values are placed on politeness and respect. For prevention efforts to be successful, wever, each community must

find its way to have a respectful conversation about suicide.

Stigma

The act of suicide is surrounded by stigma. Many religious denominations consider suicide a sin, and some previously did not allow a consecrated funeral for the "sinner." Historically, suicide was reported as a crime—a practice that did not end in all States until the 1990s. We see this stigma in the language used to describe suicide: someone who takes his or her own life "commits suicide." This wording carries the same social disapproval as when a person "commits" a sin or "commits" a crime. Consequently, those who have attempted suicide or survived the death of a loved one prefer the wording "completed suicide" or "died by suicide," as is used in this document.

The stigma of suicide also affects the suicidal person and his or her family.[57] This stigma can cause many families to suffer in silence and isolation[58] and prevent them from receiving the support they need, particularly when another family member responds to the first suicide with his or her own suicide.

Some of the stigma that surrounds suicide can be positive. The idea that suicide is a sin or a crime against life prevents some people from attempting suicide. At the same time, this stigma can prevent a person experiencing a suicidal crisis from seeking the help he or she desperately needs. One 2007 survey of AI/AN adolescents who had thought about or attempted suicide identified "stigma" and "embarrassment" as common reasons for not seeking help.[59] After a suicide completion or attempt, the stigma of suicide becomes a barrier to discussing why someone ended or tried to end his or her own life.

The stigma of suicide is compounded by the stigma associated with mental illness

and substance abuse—the risk factors most commonly associated with suicide. It may be difficult for a community to have an open, comprehensive discussion about the causes and prevention of suicide before it first deals openly with the need to prevent and treat these two disorders.

Paul Quinnett, author of *Suicide: The Forever Decision,*[d] often proposes that clinics, schools, hospitals, and other public places post signs that say "Suicide Spoken Here." While such an action may seem extreme, it may be the kind of action needed to remove some of the stigma that surrounds a suicide conversation. Individuals should be able to speak without fear or shame about their suicidal thoughts and what may be causing these thoughts. When this is possible, they will find the care and support they need to honor themselves and their lives.

Fear

A major barrier is fear—fear that talking to someone who appears at risk of suicide might push that person over the edge, fear that such a conversation might actually plant the seed for suicidal actions. If this fear of raising the topic of suicide with an individual exists, then how great

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[d] This book is available free online from the QPR (Question, Persuade, Refer) Institute at http://www.qprinstitute.com.

"Some people think curbing alcohol and substance abuse and the related problems is too sensitive an issue. It isn't. I believe Villagers are ready to begin the healing process. We are a tough, strong people."

— Anonymous Alaska Native
Alaska Natives Combating Substance Abuse and Related Violence Through Self-Healing: A Report for the People Center for Alcohol and Addiction Studies (1999)

is the fear of engaging an entire community in a discussion of suicide? This particular barrier will be addressed in greater detail later in this section, under Myths About Suicide.

Social Disapproval

The stigma attached to suicide sometimes extends to those in the community who have broken the code of silence around suicide and are in the forefront of prevention efforts. Although these individuals have overcome their own reluctance, grief, and fear to speak openly about this sensitive topic, others in the same community may not have reached this level of openness or healing. As a result, they may feel

Questions for Seeking the Wisdom of Elders

- What traditional values does the community associate with death and conversations about the dead?
- Does the community's language have a word or phrase to describe suicide?
- How has suicide been understood, discussed, or dealt with?
- Are there any taboos around talking about suicide?
- If so, how might the community address these taboos so they may consider a suicide prevention plan?
- Are there specific healing ceremonies for the family and community after a tragedy?

anger towards the person who is making them feel uncomfortable. They may resent the attention that a suicide conversation draws to risk factors within their community. In addition—out of fear or discomfort—they may avoid someone who seems unafraid of speaking to others about suicide and death.

Elders, healers, and others in the community can reach out to those who are engaged in suicide prevention by supporting and blessing their work. Suicide prevention is difficult but vital work, and those who engage in it need to be assured that they and their work are valued by their community. With leadership, engagement in suicide prevention can be a community-wide priority. For example, in January 2001, the White Mountain Apache Tribe became the first group in the United States to mandate community-wide reporting of suicide completions, attempts, and ideation.[60]

Responding to Conversation Barriers

Many of the barriers to holding a suicide conversation overlap and compound each other. There is no easy or single solution to breaking the silence around suicide. Many Tribes and Villages, however, have faced this challenge successfully and are helping their children experience the joys of life. Some of the prevention activities being used by these communities are described later in Chapter 7: Promising Suicide Prevention Programs.

As difficult as it is to have the suicide conversation, it seems that not having it is no longer an option. The question is not *if* a community should have conversation about suicide but *how* and *when*. It is the responsibility of each community to find the ways to overcome the barriers to the suicide conversation. Communities may want to invite a gathering of Elders to explore how suicide can be spoken of within the community. The

"I am firmly convinced that the 'secret' to suicide prevention is family and community involvement and commitment in trying as many strategies as is necessary to save the lives of our youth. It can happen, and we will be the ones to do it."

— Dr. Rod McCormick
Mohawk Nation
Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies
Canadian Mental Health Association (2004)

results of this conversation may need to be shared with community members before any major prevention program is developed. The more people feel they have permission to talk, and the invitation, opportunity, and support to talk—with people who will listen—the more an open and productive conversation will flow.

Myths About Suicide

Several widely held myths about suicide interfere with a suicide conversation. Many people worry about what might happen if they talk about suicide. This concern is different from the worry about causing someone to feel guilt, shame, or pain, or being rude and disrespectful. Instead, this concern is grounded in the power of the spoken word. Within different AI/AN cultures, words have the power to call forth or create and to name or define. The person through which the words flow is the teller of history. Words are also about honor and the importance of giving one's word to another.

The power of the spoken word raises many questions about a suicide conversation. Will speaking about suicide cause it to happen? Will

it plant the idea in the mind of a young person who may have not otherwise thought about it? If suicide were never spoken of again, would suicides stop? These questions can create genuine concern about how, when, and under what circumstances a person can speak about suicide.

As important as it is to honor the belief in the power of words, it is equally important to be able to discuss suicide openly in order to develop a viable suicide prevention program. As noted in the *National Strategy for Suicide Prevention*, confronting the myths about suicide and suicide prevention is essential to creating an informed public and the kinds of social and policy changes that lead to greater investments in prevention efforts. Furthermore, "if the general public understands that suicide and suicidal behaviors can be prevented, and people are made aware of the roles individuals and groups can play in prevention, many lives can be saved."[61]

Everyone needs to become involved in dispelling the following myths so that a conversation around suicide can take place. This may include recognizing the importance of involving Tribal Elders, leaders, and healers in any suicide prevention effort. This may mean an opening and closing ceremony around the suicide conversation, gaining permission from Elders to speak of suicide, or both. Each community may find specific ways of addressing the belief in the power of words in order to begin the conversation.

Finally, while the following myths refer more to having a direct conversation with a potentially suicidal person than they have with community-wide prevention efforts, it is still important to address them in this section. If not addressed, these myths might interfere with the involvement of many AI/AN community members in the prevention effort. These stakeholders might even be afraid that any suicide prevention effort might cause more harm than good.

Myth 1: Talking about suicide, especially with adolescents, will "plant" the idea.

Many adults find it difficult to believe that a young person, with a full life ahead, could be thinking about suicide. They fear that asking the person about suicide will only introduce it as a possibility. They wonder, "What does a question about suicide say to young people about our trust and belief in them and their future?," "Isn't it important to stay positive?," and "What can or should I do if an adolescent admits to thinking about suicide?" It might be even more frightening to have our concerns and suspicions about their thoughts of suicide confirmed.

Truth: Talking with youth and young adults about suicide will not plant the idea in their heads.

This truth bears repeating because the "seed-planting" myth is so powerful and pervasive that even some mental health professionals seem to accept it. First, AI/AN youth and young adults already are well aware of suicide from their experience and conversations with suicidal peers and from the media.[62] In fact, they are more likely to feel relief that someone cares enough to ask. Starting the conversation about suicide may help them to feel less alone and isolated.[63]

Second, the research rejecting this myth is overwhelming. According to the U.S. Centers for Disease Control and Prevention (CDC), there is no evidence that youth who participated in general suicide education programs had any increase in suicidal thoughts or behavior.[64] Instead, some studies indicate that these youth have decreased feelings of hopelessness and were less likely to believe that social withdrawal was an effective way to solve problems.[65]

Third, numerous research and intervention efforts have been completed without any reports of harm.[66] Finally, several evaluations of school-based suicide prevention programs show that

adolescents are more likely to tell an adult about a friend who is suicidal or have reduced suicidal thoughts after being given information about suicide.[67, 68, 69, 70, 71, 72]

The most important reason for shattering this myth is that when suicide prevention programs are established in schools, they reduce the rates of suicide. Two long-term follow-up studies have demonstrated this fact. In various counties where suicide prevention programs were provided in nearly all of its schools over a period of years, youth suicide rates declined, while State rates remained unchanged or increased for the same period of time.[73, 74]

It is important to note that school-based suicide prevention programs are not designed nor intended to focus exclusively on suicidal feeling, but instead are focused on help-seeking behaviors, knowing the warning signs, addressing the myths about suicide, becoming aware of school resources, and resolving to take action. Of equal importance is the need to ensure that all of the adults in the school have received training prior to introducing such training to the students. In this way, the adults can develop the necessary policies, procedures, and resources to respond to any increase in requests for help from the students.

Myth 2: No one can prevent suicide— it is inevitable.

This fatalistic view of suicide is reflected in a belief that suicide has become so commonplace that it is to be expected. No one can do anything to prevent it. This false belief may be one of many responses to the high rates of suicide in a particular community. High suicide rates can numb the community and cause many people to want to shut down in grief. Community members can be so overwhelmed by loss that they feel helpless in finding opportunities to prevent more deaths. Accepting suicide as preventable also may create profound guilt. The question becomes, "Why couldn't I prevent my loved one from killing himself/herself?"

Others see suicide as too complicated and mysterious to understand. Why would anyone reject life? This view becomes a barrier to prevention because it may seem futile to try to prevent what cannot be understood. Still others may see suicide as one individual's response to his or her own unique personal problems. What can a community as a whole do to prevent suicide among diverse individuals?

Truth: Suicide is preventable.

According to former U.S. Surgeon General David Satcher, suicide is our most preventable form of death.[75] And, as devastating as even one death by suicide in a community can be, most people, including AI/AN adolescents and young adults, do not die by suicide.

To help dispel the idea that suicide is inevitable, suicide prevention actions frequently focus on the positive aspects of living: strengthening families, developing in youth the skills that help them cope with life's challenges, and building up a youth's sense of self-worth. A focus solely on risk factors could simply perpetuate a feeling of helplessness in a community. In suicide prevention, the message must be one of hope for everyone in a community. Prevention is as much about strengthening what is good and working within a community as it is about correcting what may be threatening the health and well-being of its members.

The power of hope in preventing suicide cannot be over-estimated. An example of its power can be seen in clinical trials to test new medications. In some study designs, half of the group is given sugar pills while the other half is given the new drug. Up to 20 percent of the people taking the sugar pills may show improvement— because they *believe* that they will. This result is called the placebo effect. Suicide prevention

is as much about instilling hope in life as it is about knowing what programs are effective and implementing them.

Myth 3: Only the experts can prevent suicide.

This myth is based on the belief that suicide prevention is the work of therapists, physicians, psychologists, or other trained specialists rather than that of a community at large.

Truth: Prevention is the task of the whole community.

It seems logical that people who are considering suicide be seen by a professional. It is important, however, to distinguish between the treatment of a suicidal person and preventing suicide by engaging a person at risk in a suicide conversation. Everyone in the community needs to be involved in suicide prevention, from Tribal and Village leadership, to Elders, to the extended family, to teachers, and to youth and young adults themselves. Everyone can help to promote the mental health of youth as well as decrease factors that place them at risk of suicide. Everyone can be alert for signs that a young person may feel troubled. The idea that an entire community must come together to prevent suicide and how they can do so is discussed in more detail in Chapter 6: Community Action. According to Native American culture, children are the gift of the Creator and it is the responsibility of the entire community to care for and protect that gift.

Myth 4: Individuals who are considering suicide keep their plans to themselves, and this secrecy makes prevention impossible.

This myth assumes that most people considering suicide do not want to be stopped.

Truth: Individuals considering suicide frequently give verbal, behavioral, and situational "clues" or "warning signs" before they engage in suicidal behavior.[76, 77, 78, 79]

Commonly accepted warning signs are shown in Exhibit 2. However, further research is needed to identify any signs that may be unique to AI/AN youth and young adults.

Exhibit 2. Suicide Warning Signs

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1–800–273–TALK (8255) if you or someone you know exhibits any of the following signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself;
- Looking for ways to kill oneself by seeking access to firearms, pills, or other means;
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person;
- Feeling hopeless;
- Feeling rage or uncontrolled anger or seeking revenge;
- Acting reckless or engaging in risky activities—seemingly without thinking;
- Feeling trapped—like there's no way out;
- Increasing alcohol or drug use;
- Withdrawing from friends, family, and society;
- Feeling anxious, agitated, or unable to sleep or sleeping all the time;
- Experiencing dramatic mood changes; and
- Seeing no reason for living or having no sense of purpose in life.

As was discussed earlier in this chapter, many reasons exist as to why a suicidal person might "code" or disguise a warning that he or she intends to die. The reality is that most suicidal people tell someone about their intent during the week prior to their suicide attempt. This fact is the foundation for community awareness campaigns and general gatekeeper or peer training activities, which focus on identifying and referring at-risk individuals for treatment and supporting services. Gatekeeper training will be covered in greater detail in Chapter 7: Promising Suicide Prevention Programs.

Myth 5: Those who talk about suicide don't actually go on to attempt it.

This myth is related to Myth 4, with many people believing that those who intend to complete suicide don't tell anyone about it, while those who talk about it don't intend to take their own life.

Truth: The opposite of this myth is actually true.

As described under Myth 4, verbal, behavioral, and situational clues and warning signs frequently precede suicidal behavior.

Myth 6: Once a person decides to die by suicide, there is nothing anyone can do to prevent it.

This myth is a variation of Myth 2, which is that no one can stop suicide or a person intent on suicide. The mistaken belief appears to be that, even if we could watch over a suicidal person every day, all day, he or she eventually would find a way to end his or her life.

Truth: Much can be done to prevent suicide.

It starts with asking someone who is showing suicidal clues and warning signs a simple question: "Are you thinking about suicide?" This question opens a conversation that can reduce a person's feelings of isolation, anxiety, and distress and may lead them to seek help. Just asking the suicide question can reduce a person's risk of suicide.

Also, as discussed under Myth 2, there are various reasons why someone would want to believe this myth. If a family has lost a loved one to suicide, and they are later told that suicide is preventable, what does that say about them? What could or should they have done to stop their loved one from dying? The idea that suicide is preventable can be very difficult to accept without experiencing guilt, shame, and anger if a suicide has occured. In any prevention program, it is important to stress that people should not feel guilty about the past because of what they are learning just now in the present.

Conclusion

Talking about suicide is a difficult conversation that is complicated by barriers, myths, taboos, fears, and legitimate cultural considerations. As individuals, we might feel that suicide is beyond our abilities to prevent, yet we each have the power to speak and to act. Collectively, a community has incredible power when everyone comes together to talk, listen, plan, and act to help its children thrive.

It seems fitting to end this chapter as it began, with the words of the Canadian First Nations Elder:

> Silence is dangerous when we pretend the problem is not there . . . communication is a healer to break the silence.

Chapter 4: Responding to Suicide

"We can stop others from committing suicide if we talk openly in our communities and if we provide safe and supportive places for people to go when they need help for themselves or their family members. We need to share the message [of my sister's suicide]— 'tell the ones trying to end their lives this way that it is not the way to go.'"

— Dana (age 16), Spirit Lake Lakotah Nation
Testimony Before the U.S. Senate Committee on Indian Affairs,
February 26, 2009

Introduction

The loss of a loved one by suicide is shocking, painful, and unexpected. Survivors, including whole communities, may experience a broad range of emotions including denial, anger, blame, guilt, helplessness, and confusion. One of the dangers of a suicide is that others in the community may be so overwhelmed by these emotions that they too try to take their own life. This situation is referred to as suicide contagion and, when it occurs, can be just as deadly to a community's well-being as the spread of other deadly viruses.

This chapter focuses on how a community might respond when tragedy does occur—when one of its youth or young adults takes his or her own life. It also describes actions that an American Indian and Alaska Native (AI/AN) community might take to reduce the risk of additional suicides or suicide attempts. Directions on how to request an emergency response team through the Indian Health Service (IHS) are given.

Because a community is the sum of its individual members, this chapter begins with a discussion of how a community might comfort suicide survivors, who are those most affected by another person's suicide or suicide attempt.

Next, the chapter describes how a community might develop a planned response to suicide contagion, to which youth and young adults appear most susceptible. The roles of the media, emergency health care providers, and suicide survivors and suicide attempt survivors in reducing the possibility of suicide contagion also are presented.[e] The final section of the chapter describes Federal emergency response resources available to Tribes and Villages affected by suicide.

Responding to Suicide Survivors

For every suicide there are at least six survivors, which may be a conservative estimate.[80] This most probably is the case for AI/AN communities because the number of suicide survivors usually refers just to blood relatives, significant others (e.g., spouse), or close friends. It does not take into account the interconnectedness of relationships within Tribes and Villages or the complex and extensive relational network of a culture that sees others as *all my relations*. When considered within the

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[e]"Suicide survivor" is the term used to describe a family member or close friend of someone who dies by suicide, while "suicide attempt survivor" is the term used to describe someone who has made a suicide attempt and lived.

AI/AN worldview, the number of survivors to a suicide might be closer to a range of 25 to everyone in the community and beyond. In a small Alaska Village of 500 to 800, all members conceivably could be considered survivors. Another way to understand the full impact of suicide on AI/AN communities is to expand the concept of survivors to include those affected by a loved one's suicide *attempt*. Although estimates for Native Americans, in general, are not available, one survey of Bureau of Indian Affairs schools suggests that 16 percent of AI/AN youth had attempted suicide in the preceding year.[81]

While experiencing relief that their loved one is still alive, these individuals may experience many of the same feelings of pain, guilt, shame, and fear as those whose loved one did not survive. They also may be troubled by many of the same questions, such as "How could this happen?," "Why didn't he or she come to me?," or "Why didn't I see this coming?" When you include suicide attempt survivors with the numbers of suicide survivors, it is not difficult to imagine that the majority of AI/ANs have been directly and personally affected by suicide and suicidal behavior within their communities.

The emotional turmoil felt by those affected by a suicide or suicide attempt can be intense, complex, and long-term. These feelings may be compounded by the preexistence of historical trauma. Feelings of isolation also may complicate the grieving process and impede healing. Survivors of suicide often feel abandoned at a time when they desperately need unconditional support and understanding.

There is no timeline for grieving. Those around the survivor may help most when they:

- Accept the intensity of the survivor's grief;
- Listen with their hearts;
- Avoid simplistic explanations and clichés;
- Show compassion;
- Respect the survivor's need to grieve;
- Understand the uniqueness of suicide grief;
- Are aware of holidays and anniversaries;
- Are aware of support groups;
- Respect the person's faith and spirituality; and
- Work together as a helper for the survivor.[82]

Grief work is a culturally specific process that each person experiences in his or her own way and at his or her own pace.[83] The way in which each community and its members respond to suicide survivors will depend on a variety of individual, family, and community cultural values and beliefs. In order for a community to develop the most appropriate and effective way of address survivor grief, community members

Questions for Seeking the Wisdom of Elders

- What are traditional ways in which the community responded to a suicide, sudden death, or other great loss?
- How did community members help the families most affected, what words were spoken, or what actions were taken to help them heal?
- Were there rituals or ceremonies that helped the family and community deal with its loss?
- If someone became trapped in their grief, how did the community help them?
- What are some stories that could help families and communities deal with grief?

are encouraged to discuss how they might respond as part of their suicide prevention plan development. Possible sources of support for survivors include talking with Tribal leaders, Elders, church and traditional healers, other survivors, and other community members. The extended effect of suicides among AI/AN communities adds urgency to the need for communities to determine culturally appropriate ways to reach out and support those who have lost someone to suicide.

Survivor Groups

The Arctic Sounder, a newspaper serving Northwest Arctic and the North Slope, featured an article about a Tlingit woman originally from Hoonah who survived the death of her son to suicide. It was not long after her son died that people started telling her that she needed to "get over it." The woman would respond by saying, "You don't get over it. . . . You need help to get through it." In a closing comment, she added that, "I want to let suicide survivors know that they're not alone and they have someone to talk to."[84]

Many Tribal and Village communities have established survivor support groups and Talking Circles to help survivors deal with their grief. A support group facilitator's guide written by survivor Linda Flatt is available from the Suicide Prevention Action Network (SPAN) USA. The guide is titled *The Basics: Facilitating a Suicide Survivors Support Group.* While a community prevention specialist and leaders, Elders, and healers may need to first review the guide to ensure that it addresses culturally relevant beliefs and ceremonies, it does make a contribution to efforts to help survivors know that they are not alone.

Preventing Suicide Contagion

Suicide contagion is a process by which exposure to the suicide or suicidal behavior of one or more individuals influences other individuals to complete or attempt suicide. This term sometimes is used interchangeably with the term "suicide clusters," which is more specifically defined as when a group of suicides or suicide attempts occur closer together in time and space than would normally be expected in a given community.

Suicide contagion is real, and research suggests that even a single suicide within a community can increase the risk of additional suicides.[85, 86, 87] Suicide contagion is not a new phenomenon, nor is it confined to AI/AN communities. Contagion has been reported within high schools, colleges, Marine troops, prisons, and religious sects, to name a few. However, teenagers and young adults appear most at risk.[88, 89] This is not surprising given the characteristics of impulsiveness, difficulty with delayed gratification, and susceptibility to peer and media pressure that are typically assigned to younger people. The addition of early experimentation with drugs and alcohol can further increase their susceptibility.

Deaths that trigger suicidal behavior, however, do not have to be as a result of a suicide. According to the Centers for Disease Control and Prevention (CDC), several clusters of suicides or suicide attempts were preceded by one or more traumatic deaths—intentional or unintentional—among the youth of the community.[90] In one case study, two close friends of a young person who died as a result of an unintentional fall went on to complete suicide.[91]

This research suggests a heightened potential for suicide contagion among AI/AN adolescents and young adults, given the rate of sudden deaths due to unintentional injuries. Unintentional injuries are the leading cause of death for AI/ANs ages 1 to 44. Most of these deaths are caused by traffic crashes and poisoning.[92]

While there are no easy answers to the threat of suicide contagion, there are proactive steps that communities can take. "Postvention" is a term used to describe prevention measures that are taken after a crisis or traumatic event to reduce the risk to those who have witnessed or been affected by the tragedy. Postvention can involve both actions to help survivors through their grief process and to identify and respond to individuals who may be at risk of suicide contagion.

Identifying Individuals at Risk for Contagion

Exhibit 3 is a list of questions that community or school leaders can use to help identify individuals who may be at risk of suicide following the death of another. If someone appears to be vulnerable, a suicide conversation should follow and those at risk should be encouraged to seek help.

Developing a Postvention Plan

A community's efforts to develop a postvention plan will be similar to its efforts to develop a broader suicide prevention plan. The community will need to understand the risk and protective factors associated with suicide contagion and develop strategies to reduce risks and enhance protective factors. Some of the risk factors, such as preexisting trauma and assuming blame for the person's death, are suggested in Exhibit 3.

A community should consider postvention as part of their overall suicide prevention planning rather than try to develop a response immediately after a suicide. At this time, a community may be in shock and mourning, which can prevent its members from coming together to deal effectively with the issue.

The CDC has put together a number of recommendations for postvention planning (see Exhibit 4). Each community will need to consider

> ### Exhibit 3. Sample Questions for Identifying Individuals at Risk of Suicide Contagion*
>
> - Which other adolescents or community members might identify with the person who died by suicide?
> - Was the deceased person part of a formal/informal group, organization, team, etc.?
> - What risk factors associated with the deceased may be shared by peers or others in the community?
> - Are any peers/family members currently demonstrating suicide–related warning signs?
> - Which peers/family members who may have previously been identified as a suicide risk need to be contacted for follow up?
> - What, if any, school/community memorial services and/or gravesite vigils occurred or have been planned?
> - Are there any peers/family members being blamed for or seen as a reason for the suicide?
> - Does a survivor blame himself/herself for the suicide?
> - Has the survivor experienced previous trauma that was never addressed?
>
> *Adapted from *Community response: Effective action after a suicide*, a presentation by Frank J. Zenere, Ed.S, National Association of School Psychologists, National Emergency Assistance Team. Available online at http://www.sprc.org/featured_resources. trainingandevents/conferences/no/pdf/commresponse.pdf.

its particular needs and cultural strengths as it incorporates various recommendations into its own plan.

The CDC also offers general guidelines for preventing suicide contagion, which are to:

- Avoid glorifying suicides;
- Offer support to families and friends of victims;
- Identify vulnerable relatives and friends and offer counseling; and
- Enlist the support of the media.

Some of these guidelines warrant further discussion as they apply to AI/AN communities.

The first guideline is to avoid glorifying suicides. The concern is that too much "positive attention given to someone who has died (or attempted to die) by suicide can lead vulnerable individuals who desire such attention to take their own lives."[93] This is obviously a delicate balance without clear guidelines or rules. Many survivors become upset if told how they should grieve or what is an appropriate response. The need to avoid traumatizing suicide survivors any further is another reason to incorporate

Exhibit 4. CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters*

1. A community should review these recommendations and develop its own response before the onset of a suicide cluster.

2. The response to the crisis should involve all concerned sectors of the community and should be coordinated by:

   a. A coordinating committee, which manages the day-to-day response to the crisis; and

   b. A host agency, whose responsibilities would include "housing" the plan, monitoring the incidence of suicide, and calling meetings of the coordinating committee when necessary.

3. The relevant community resources should be identified.

4. The response plan should be implemented under either of the following two conditions:

   a. When a suicide cluster occurs in the community; or

   b. When one or more deaths from trauma occur in the community, especially among adolescents or young adults, which may potentially influence others to attempt or complete suicide.

5. If the response plan is to be implemented, the first step should be to contact and prepare those groups who will play key roles in the first days of the response.

6. The response should be conducted in a manner that avoids glorification of the suicide victims and minimizes sensationalism.

7. Persons who may be at high risk of suicide should be identified and have at least one screening interview with a trained counselor; these persons should be referred for further counseling or other services as needed.

8. A timely flow of accurate, appropriate information should be provided to the media.

9. Elements in the environment that might increase the likelihood of further suicides or suicide attempts should be identified and changed.

10. Long-term issues suggested by the nature of the suicide cluster should be addressed.

*From *MMWR Supplements*, August 19, 1988, 37(5-6), 1-12. Available online at http://www.cdc.gov/mmwr/preview/mmwrhtml/00001755.htm.

postvention planning into overall suicide prevention planning rather than as a reaction to suicide. As always, it is important to include a strong cultural foundation and to include the voices of survivors. In addition, this guideline should not be interpreted as a prohibition against the performance of Pipe or Wiping of the Tears ceremony.

Role of the Media

Another of the CDC guidelines for preventing suicide contagion is to enlist the support of the media. On the surface, this seems to contradict the recommendation to avoid glorifying suicides. Media stories can dramatize or romanticize suicides, with tragic results. For example, between 1984 and 1987, journalists in Vienna, Austria, covered the deaths of individuals who jumped in front of subway trains. The media coverage was extensive and dramatic. In 1987, an educational campaign was launched that alerted reporters to the possible negative effects of such reporting and suggested alternative strategies for coverage. Within 6 months after the campaign began, subway suicides and nonfatal attempts dropped by more than 80 percent. The total number of suicides in Vienna declined as well.[94, 95]

While it is the media's job to report on newsworthy events—whether local, Tribal, State, national, or international—it also is their responsibility to satisfy the "public's right to know" in a way that does not exploit a community's grief or cause further harm. The media, however, can have a powerful role in suicide prevention through responsible reporting. Stories about suicide can inform readers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. The media also can highlight opportunities for individuals and organizations to help prevent suicide and inform community members about local resources.

The media also can be asked to participate in suicide prevention efforts before a suicide occurs. Local media can play an important and positive role in any community's prevention plans and initiatives, especially when it comes to getting the message out about prevention events and activities. Individuals within the media make valuable partners in prevention planning efforts, and they should be recruited early in the process.

Exhibit 5 summarizes guidelines for responsible reporting that were developed in collaboration by the CDC, National Institute of Mental Health, Office of the Surgeon General, Substance Abuse and Mental Health Services Administration (SAMHSA), American Foundation for Suicide Prevention, American Association of Suicidology, and the Annenberg Public Policy Center. At the very least, State and local media outlets should be provided with these guidelines before a community shares any detailed information about a suicide with reporters. Appendix E: Web Site Resources and Bibliography lists additional publications that provide guidance for enlisting the media in prevention efforts and for reporting on suicide.

Role of Emergency Health Care Providers

Whether in urban cities or in small towns in and around a reservation or village, the emergency department (ED) and after-hours health clinic play a unique role in health care delivery for AI/AN people in need of services. This need sometimes extends to those who have attempted suicide. The ED is their typical entry point into services and the place where many will have their first opportunity to have their suicidal behavior assessed. Such services can place a burden on a health care system already stretched. They also may be highly demanding of staff who may not be trained in suicide risk assessment and management. These statistics

> ## Exhibit 5. Media Guidelines for Safe Reporting on Suicide*
>
> **What To Avoid**
>
> - Avoid detailed descriptions of the suicide, including specifics.
> - Avoid romanticizing someone who has died by suicide.
> - Avoid featuring tributes by friends or relatives.
> - Avoid first-person accounts from adolescents about their suicide attempts.
> - Avoid glamorizing the suicide of a celebrity.
> - Avoid oversimplifying the causes of suicides, murder-suicides, or suicide pacts, and avoid presenting them as inexplicable or unavoidable.
> - Avoid overstating the frequency of suicide.
> - Avoid using the words "committed suicide," or a "failed" or "successful" suicide attempt.
>
> **What To Do**
>
> - Always include a referral phone number and information about local crisis intervention services.
> - Emphasize recent treatment advances for depression and other mental illnesses.
> - Include stories of people whose treatment was life-saving or who overcame despair without attempting suicide.
> - Interview a mental health professional who is knowledgeable about suicide and the role of treatment or screening for mental disorders as a preventive strategy.
> - Emphasize decreasing trends in national suicide rates over the past decade.
> - Emphasize actions that communities can take to prevent suicides.
> - Report on activities coordinated by a local or State suicide prevention coalition.
>
> *From *At-a-Glance: Safe Reporting on Suicide*, available from the Suicide Prevention Resource Center at http://www.sprc.org/library/at_a_glance.pdf.

give some idea of the possible impact: There were 33,300 completed suicides in the United States in 2006, the lastest data available at the time of this printing.[96] In 2008, 1.1 million adults—0.5 percent of all adult Americans—reported having attempted suicide in the past year, according to the first national scientific survey of its size on this public health problem. About 6 in 10 of those adults received medical attention for their suicide attempt.[97]

Attempt survivors are an extremely high-risk group for suicide. Consequently, ED and after-hours clinic personnel have a critical and necessary role in suicide prevention by encouraging attempt survivors to seek help. The training of emergency health care providers should be considered in developing any community-wide prevention initiative. General guidelines for ED care is available in the SAMHSA document, *After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt*

Survivors. This document can be downloaded or ordered at http://www.samhsa.gov/shin. Or, please call SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español). (An order form is included in Appendix D: Decisionmaking Tools and Resources and on the last page of this document.)

Role of Suicide Survivors and Suicide Attempt Survivors

Those who are most affected by suicide—including those who have attempted suicide—also have a role in preventing additional suicides. No one knows better the darkness that surrounds suicide than those who have walked in its shadow—or the light that comes from knowing that they might be able to help others avoid similar grief. The following are just a few examples of how suicide survivors are helping others to avoid the pain of a similar loss of a loved one.

Former Senator Gordon Smith of Oregon led the enactment of the Garrett Lee Smith Memorial Act in memory of his college-aged son who died by suicide. This Act provides significant funding for SAMHSA's suicide prevention programs, and is a powerful example of how survivors have used their experiences to motivate others to action.

SPAN USA, a division of the American Foundation for Suicide Prevention (AFSP), is dedicated to preventing suicide through public education and awareness, community action, and Federal, State, and local grassroots advocacy. SPAN USA was born out of a family's grief over the suicide of their daughter and the need to "transform their grief into positive action to prevent future tragedies."[98] SPAN USA/AFSP also demonstrates the resiliency, power, and strength of families affected by suicide.

In some communities, survivors have banded together to take turns going with the police when they inform a family of the death of a loved one by suicide so that they are available immediately to provide support.

Suicide attempt survivors increasingly are asking that they be involved in suicide prevention efforts. No one can speak with greater understanding about outreach to and services most needed by vulnerable individuals than attempt survivors. Suicide attempt survivors also can be invaluable as mentors for those at risk. According to one participant at a SAMHSA-sponsored meeting of suicide attempt survivors:

> There is a lot of fear and stigma associated with attempters, and people are uncomfortable dealing with us….That is the main reason for attempters to get involved and to get our stories out there to destigmatize the whole issue of people who have survived attempts, and to make the point that attempters are human beings who can be productive and can help others.[99]

IHS Emergency Response Model

The IHS has designed an emergency response model for helping AI/AN communities when tragedy strikes. Under this model, communities work through the IHS to access support from the U.S. Public Health Service (USPHS). This support consists of teams of two or more USPHS mental health providers who offer emergency mental health and community outreach services. The teams work in 2-week rotations for up to 90 days of emergency response. The goal is to help the community lessen the impact of the immediate crisis and to stabilize its members so that they can begin to develop long-term solutions (i.e., planning, prevention, and implementation plans). The process for requesting and accessing such help follows.

1. The AI/AN community makes a request for help to the IHS area office through the IHS service unit, Tribal health program, or urban Indian clinic.

2. The IHS Area Director submits the request to IHS Headquarters (HQ) Division of Behavioral Health (DBH) director, who notifies the appropriate IHS HQ staff.

3. The IHS DBH and Emergency Services (ES) staff members respond to the affected community and conduct a rapid needs assessment. While on site, HQ staff members meet with the IHS area office, Tribal health program, urban Indian clinic, IHS Chief Executive Officer, the Tribal Council, and other Tribal programs as requested.

4. Depending on the rapid needs assessment and the expressed needs of the community, the IHS ES Director can forward the request for emergency assistance to the USPHS Office of Force Readiness and Deployment for action.

Conclusion

A suicide within a community—whether that community is a school, a reservation or village, or a group of individuals in an urban area who share common bonds—can have a profound impact on the lives of those who are touched by the death. These individuals need the support, comfort, and understanding of others as they work through their grief.

One danger of suicide is suicide contagion, for which suicide survivors and particularly adolescents and young adults appear at risk. Consequently, each community should strive to develop its postvention, or suicide response, plan before tragedy strikes. Such a plan is an essential part of any community's efforts to prevent suicide by its youth and young adults. As with any suicide prevention effort, the broader the involvement of community members in helping to prevent suicide contagion, the more effective prevention will be. If suicides do occur, communities may want to request emergency support through IHS.
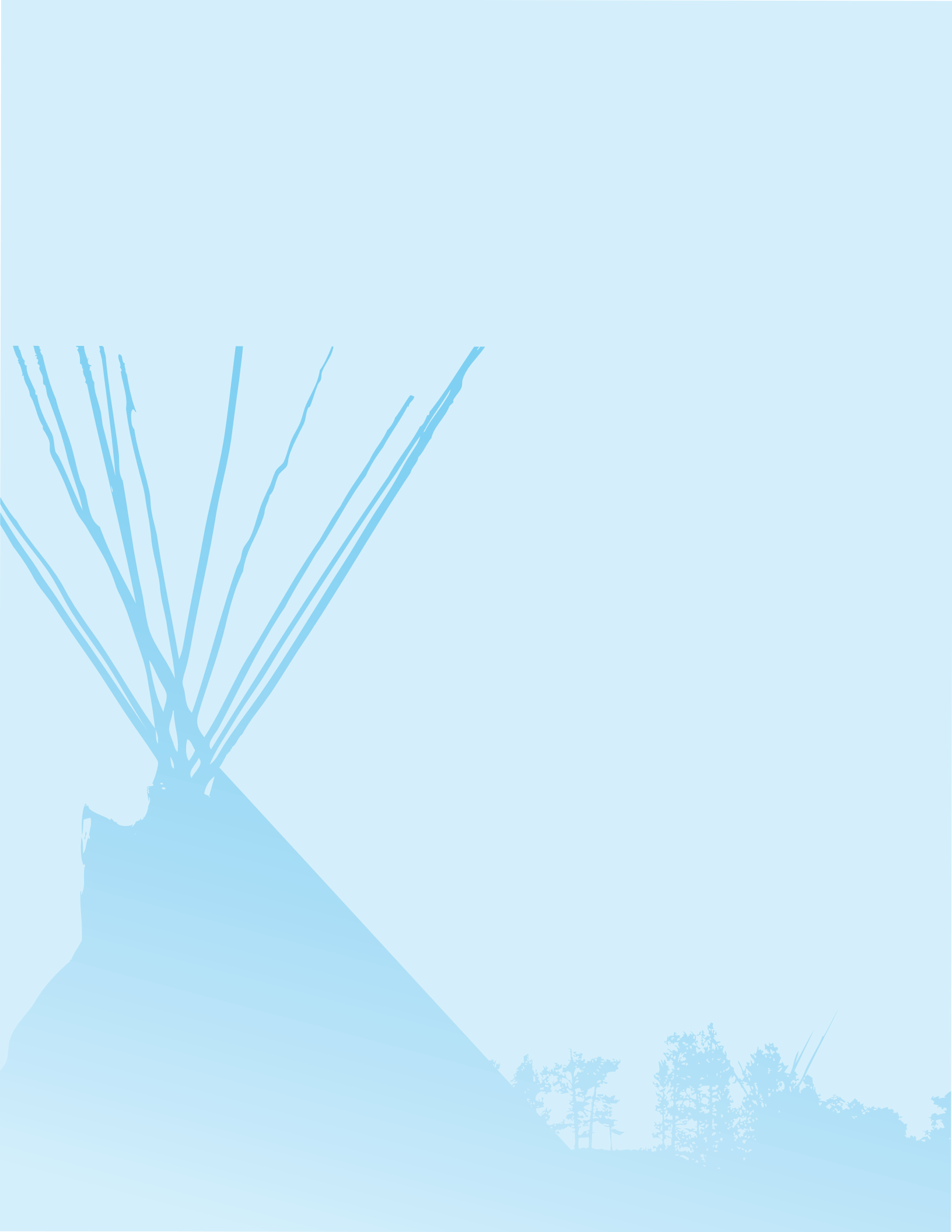
Chapter 5: Community Readiness

> "To build something worthwhile that is lasting, whether as an individual or a community, one must have a working philosophy that allows one to dream and envision a better future."
>
> *The Renaissance of American Indian Education: Capturing the Dream*
> Maenette Ah Nee-Benham and Wayne Stein (Eds.) (2003)

Introduction

Suicide prevention efforts often get their start as a response to a tragedy and from survivors of one or more suicides within their own family. The desire in their hearts is strong, their passions run deep, and their drive for action and results is understandable. However, as clear as the need for action may be to some, it doesn't mean that everyone within a community agrees. Suicide prevention, by its very nature, implies changes in the status quo. And change, no matter how necessary, can be as uncomfortable and threatening to some as it is welcomed by others. Some community members may even oppose the degree of change involved, bringing community action to a halt.

Communities, just like their members, will differ in their ability to deal with all of the issues surrounding suicide and its prevention. The challenge in successful prevention planning is to understand a community's readiness to take action and design prevention strategies accordingly. Strategies that are too ambitious are likely to fail because community members may not be ready or able to respond. Alternatively, efforts that are not ambitious enough will fail to take advantage of community commitment, resources, and momentum.

This chapter focuses on a community's readiness for change as it relates to suicide prevention. It describes readiness as a concept, the stages of readiness, and the potential impact of historical trauma on readiness. Implications of change for American Indian and Alaska Native (AI/AN) communities also are presented.

The "Readiness" Concept

Readiness is the degree to which a community is prepared to take action against an issue.[100] The concept of "community readiness" evolved from research about individual readiness and the stages of change.[101] According to this research, community readiness for change is related to the degree that its members become dissatisfied with the difference between the status quo and the desired goal or between what is happening in the present and what they value for the future.[102] It is this discrepancy between *what is* and *what is desired* that becomes a community's necessary motivational source for change.

Beliefs and values play a large role in a community's awareness of such discrepancies and their dissatisfaction with them. Many of the stories told by the Elders hold the values of what once was and the vision of what ought to be and can be for a Tribe or Village. Thus, when an AI/AN community views the behavior of its young and finds it at odds with the values of these stories, the seeds of change are germinated. When the discrepancy becomes large enough and

change seems important enough, the community will begin to search for possible methods for change.[103] The kind and degree of change possible depends on the community's stage of readiness.

Stages of Community Readiness[f]

The Tri-Ethnic Center for Prevention Research conducts research into community dynamics and the social, psychological, and cultural factors that contribute to substance use, violence, suicide, and other social problems. As part of its work, the center has helped a variety of rural AI communities develop prevention plans that address these problems within their communities. Center professionals soon realized that "initiating or improving prevention programs required learning first how to change a community's readiness for prevention."[104]

The Tri-Ethnic Center has identified nine developmental stages of community readiness (see Exhibit 6). The emphasis is on following a step-by-step process to move communities through the developmental stages of change and toward the implementation of comprehensive and effective prevention programs. Each stage

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[f] Much of what is reviewed in this section comes from the work of Pamela Jumper Thurman, Ph.D., Barbara Plested, Ph.D., and the staff of the Tri-Ethnic Center for Prevention and Research at Colorado State University. For additional information, readers are encouraged to visit http://www.triethniccenter.colostate.edu/about.shtml, where they can review numerous articles, download the center's *Handbook for Successful Change*, or contact the center for additional information or assistance.

of readiness is accompanied by an appropriate prevention goal and one or two examples of possible strategies.

"We now know that truly successful prevention efforts must be conceived from models that are community specific, culturally relevant, and consistent with the level of readiness of the community to implement an intervention."

Community Readiness: A Promising Model for Community Healing
Pamela Jumper Thurman (2002)

Community vs. Community Member Readiness

Just as communities need to grow in readiness, so do their members. Not all members of a community will reach the same stage of readiness at the same time. Different community members may have different levels of motivation or be motivated by different issues. They also may demonstrate different levels of readiness to become involved at different points in time in the process.

Some members have already started and have been waiting for the rest of the community to catch up. They may see themselves as the rightful

Exhibit 6. Tri-Ethnic Center for Prevention Research's Stages of Community Readiness*

1. **No awareness.** Community members or leaders do not generally recognize the issue as a problem—"It's just the way things are." Community climate may unknowingly encourage the behavior although the behavior may be expected of one group and not of another (e.g., by gender, race, or age).

   Prevention goal: Raise awareness of suicide as an issue.

   Possible strategy: Make one-on-one visits with community leaders/members or community groups to discuss suicide.

2. **Denial or resistance.** Some members of the community recognize the issue as a problem, but don't see it as their community's problem or see any need for community action—"It's not our problem," "It's just those people who do that," or "We can't do anything about it." Community climate tends to be passive or guarded.

   Prevention goal: Raise awareness that suicide or the potential for suicide exist in the community.

   Possible strategies: Continue discussions with community leaders/members; write letters to the editor in local/Tribal newspapers, develop informational flyers to bring to community groups or to hand out at places people gather.

3. **Vague awareness.** There is a general feeling among some in the community that there is a local problem and that something ought to be done about it, but there is no immediate motivation to do anything. There may be stories or anecdotes about the problem, but ideas about why the problem occurs and who has the problem tend to be stereotyped, vague, or both. No identifiable leadership exists or leadership lacks energy or motivation for dealing with this problem.

Community climate does not serve to motivate leaders.

   Prevention goal: Raise awareness that the community can do something about suicide prevention.

   Possible strategies: Hold a suicide Talking Circle to discuss who is most vulnerable and why, conduct informal surveys, post/hand out flyers at local events or Pow Wows.

4. **Preplanning.** There is clear recognition on the part of at least some that there is a local problem and that something should be done about it. There are identifiable leaders, and there may even be a committee, but efforts are not focused or detailed. There is discussion but no real planning of actions to address the problem. Community climate is beginning to acknowledge the necessity of dealing with the problem.

   Prevention goal: Continue to raise awareness by presenting concrete ideas about prevention opportunities.

   Possible strategy: Hold a community meeting to explore possible solutions or have a GONA (Gathering of Native Americans) to bring the community together and lay the foundation for establishing an action plan.

   (A GONA manual can be downloaded from the Substance Abuse and Mental Health Services Administration (SAMHSA) at http://preventiontraining.samhsa.gov/Cti05/Cti05ttl.htm.)

5. **Preparation.** Prevention planning is underway and is focused on practical details. There is general information about local problems and about the pros and cons of prevention activities, actions, or policies, but it may not be based on formally collected data. Leadership is active and

(Continued)

(Continued)

energetic. Decisions are being made about what will be done and who will do it. Resources (e.g., people, money, time, and space) are being actively sought or have been committed. Community climate offers at least modest support of efforts.

Prevention goal: Gather existing information with which to plan strategies.

Possible strategies: Conduct community- or school-based surveys or interviews about risk and protective factors; ask community leaders or Elders to become involved and speak on behalf of these efforts.

6. **Initiation.** Enough information is available to justify efforts (i.e., activities, actions, or policies). There may be great enthusiasm among the leaders because limitations and problems have not been experienced yet. Community climate can vary, but there usually is no active resistance, (except, possibly, from a small group of extremists), and there is often a modest involvement of community members in the efforts.

Prevention goal: Provide information that is specific to the target audience.

Possible strategy: Begin basic evaluation of prevention strategies.

7. **Stabilization.** One or two programs or activities are running, supported by community leaders or administrators. Programs, activities, or policies are viewed as stable. Staff are usually trained and experienced. There is little perceived need for change or expansion. Limitations may be known, but there is no in-depth evaluation of effectiveness, nor is there a sense that any recognized limitations suggest an immediate need for change. There may or may not be some form of routine tracking of prevalence. Community climate generally supports what is occurring.

Prevention goal: Stabilize efforts and programs.

Possible strategies: Conduct training for community members; hold events to recognize local supporters and maintain community support for prevention.

8. **Confirmation/expansion.** There are standard efforts in place and community members feel comfortable in using the services provided. Community leaders and other decisionmakers support expanding or improving prevention efforts to reach more people at risk or different demographic groups. Resources for new efforts are being sought or committed. Data are regularly obtained on the extent of local problems and efforts are made to assess risk factors and causes of the problems. Due to increased knowledge and desire for improved programs, community climate may challenge specific efforts, but is fundamentally supportive.

Prevention goal: Expand and enhance services.

Possible strategy: Use evaluation data to support renewed and reinvigorated efforts.

9. **High level of community ownership.** Community members have a detailed and sophisticated knowledge of prevalence, risk factors, and causes of the problem. Some efforts may be aimed at general populations, while others are targeted at specific risk factors and/or high-risk groups. Highly trained staff are running programs or activities, leaders are supportive, and community involvement is high. Effective evaluation is used to test and modify programs, policies, or activities. Although community climate is fundamentally supportive, community members ideally should continue to hold programs accountable.

Prevention goal: Maintain momentum and continue growth.

Possible strategies: Continue progress reports for the benefit of community leaders and program funders; diversify funding sources to ensure sustainability.

*From Edwards, R. W., Jumper-Thurman, P., Plested, B. A., Oetting, E. R., & Swanson, L. (2000). Community readiness: Research to practice. *Journal of Community Psychology, 28*(3), 291–307.

leaders of any new program. They may believe that they should receive any grant funding coming into the community in recognition of their past efforts and involvement or so they can continue their good work. Some may still be in pain from a recent suicide and find it too difficult to talk about it, while others who have lost a loved one may feel driven to take immediate action. Others may never fully embrace community efforts.

Why someone might want to become involved in suicide prevention efforts and to what level and in what capacity will vary greatly. Regardless of their readiness stage as individuals, each person within a community may need to be honored and validated for the degree to which they feel ready to participate. The goal of prevention efforts should be to engage as many people as possible and as early as possible so that all who wish to speak can do so and all potential solutions can be considered.

Historical Trauma and Community Readiness

Eduardo Duran, director of health and wellness for the United Auburn Indian Community of Northern California, provides community interventions and consultations around the issue of historical trauma. He contends that an AI/AN community's seeming inability to address current issues of violence, including suicide, sometimes can be traced to the internalization of the violence perpetrated on Native people for generations.

In his book, *Healing the Soul Wound: Counseling with American Indians and Other Native Peoples*, Duran describes how important it is for a community to engage in a healing process that reflects its own history of trauma rather than generic Native American trauma. He writes,

> Preparation for community healing is critical. It is important that the community's specific traumas be delineated first in order for the

intervention to be relevant. It is useful to speak in general of the historical trauma and no one would fault the attempt at healing with this approach. However, I have found that communities, like individuals, have their own set of traumas that result in particular symptoms that need to be dealt with very specifically.[105]

It is through this process of healing that Duran feels community members begin to release the burden of shame and guilt and to recognize the historical path that has led them to the present day. The emphasis is on the process of healing and restoring balance. Identification of historical trauma is viewed as the beginning rather than the end of a journey.

> "We have already paid the price. It's time to accept the many blessings that the Creator has in store for us. We must honor our people who sacrificed everything through honoring ourselves and healing ourselves. By healing ourselves, we will also heal the wounds of our ancestors and the unborn generations."
>
> — *Healing the American Indian Soul Wound: International Handbook of Multigenerational Legacies of Trauma.* Eduardo Duran, et al. (1998)

The Aboriginal Healing Foundation (AHF) has identified four phases to community healing that provide some insight into this journey. AHF is a Canadian initiative developed to address the impact of residential schools on First Nations communities. Its principle focus is on achieving community well-being by addressing personal and intergenerational trauma, which it believes will help end cycles of abuse and violence and

build strength and resiliency within the survivors and the community. As shown in Exhibit 7, the healing process moves a community from personal healing to systems transformation and from problems to solutions.

Implications of Prevention for AI/AN Communities

The preceding sections of this chapter have dealt with a community's readiness to change and how it may prepare itself for the changes that prevention implies. This section briefly addresses some additional implications as to how change relates to suicide prevention by AI/AN communities.

Native peoples have a long history of being told that they should change. Such direction often has been unwelcome because the assumption has been that others outside of the Tribe or Village know what is best for its members.

As a consequence, a call for "change" stirs up differing emotions and reactions. Although some community members may welcome programs to reduce suicide or its risks, others may resent the implication that their current efforts are not good enough or even wrong. Even those who may be advocating for change may not agree on what changes need to happen, how soon, and who needs to be involved in the change. Talking about change and the change process early in any prevention effort, and ensuring that all voices are heard, can be essential in moving the planning process along. People are far less resistant to change when they help initiate the change.

Another potential implication of suicide prevention is that the Tribe or Village may feel under attack. Historically, AI/ANs have tended to be described in terms of weakness, pathology, and mortality rather than as being adaptive, innovative, resilient, and strong. Native people also have been romanticized, creating an equally unrealistic picture of them and their culture.

To some extent, these characterizations persist today and extend to the issue of suicide. If the suicide rate is so high in AI/AN communities, then what does that say about being a Native? Does this rate imply that just being AI/AN is an independent risk factor for suicidal behavior? Elders involved in their community's healing process have described this negative way of thinking as a "spiritual injury, soul sickness, soul wounding, and ancestral hurt."[106]

Finally, there is the issue of change itself. Some Tribal and Village members might believe that the biggest challenge facing their community is the rapid changes taking place in the larger society that make it increasingly difficult for AI/AN youth to maintain their Native cultural identity. Some researchers argue that this rapid change is a primary reason for the high suicide rates in some Native communities.[107, 108]

Successful prevention within a community may mean a return to traditional ways or the integration of traditional ways into science-based prevention programs. As an example, mental health promotion programs work to strengthen a child's resilience, which is the child's ability to cope with the challenges that life can present.

The concept of resilience is not new to AI/AN people. Native youth have long been taught to stand tall and strong, to try their best, and to never give up. Combining science and tradition in one prevention program may draw upon the best of both approaches.

Conclusion

Some communities may be ready for prevention planning, while others may be ready to expand successful efforts that are underway. Still other communities may need to go through a healing process that first restores their sense of balance, worth, and empowerment before they can confront an issue as traumatic as suicide. Which prevention strategies a community is willing or able to implement will be based on its stage of readiness for change. Furthermore, the process used to develop a community's readiness will be important in developing its long-term capacity to carry out a comprehensive and sustainable suicide prevention plan. Consensus building among all members of a community may take longer up front, but the result can be stronger, more effective prevention efforts.
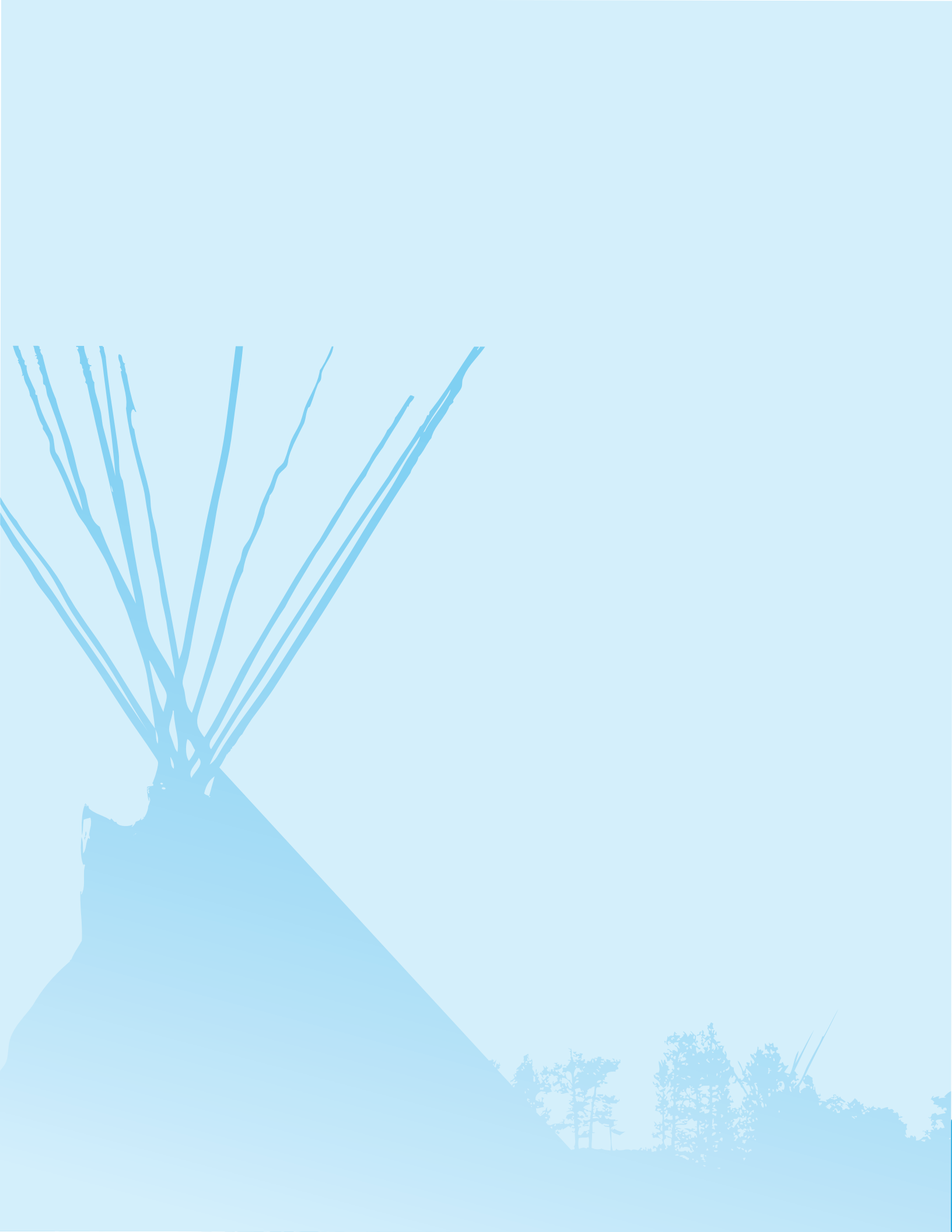
Chapter 6: Community Action

> ". . . [W]hile we recognize the debilitating impacts of historical trauma and other environmental causes that represent limitations and promote dependency among our people, we must go well beyond this discussion and critically think about ways to demonstrate leadership as well as our individual and collective responsibility to create safe, life-enhancing Tribal communities."
>
> — Hayes A. Lewis, Zuni
> Testimony Before the U.S. Senate Committee on Indian Affairs,
> February 26, 2009

Introduction

Although suicide is an individual act, we cannot understand or prevent such acts simply by considering the behavior of the individual. Just as with another living, interdependent community, there can be no true understanding of the behavior of a bee without considering its relationship to the hive. Similarly, there can be no true understanding of suicide and its prevention without considering how individuals fit within their communities.

This chapter looks at the role of a community in prevention, both in theory and in practice. It first describes two general ways that a community can think about prevention: the public health model and the ecological model. Although presented separately, these models are related. The ecological model is simply an interpretation of the public health model that best fits the way Native communities historically have thought about their relationship to their members and their environment.

As described, both the public health and the ecological models reflect the same key principles of prevention. First, prevention goes beyond a focus on the individual to include all members of a community. Second, prevention is proactive, with health promotion as an essential element

of prevention. Third, prevention is collaborative. The broader the base of community involvement, the greater the chances that prevention efforts will succeed. And, finally, everyone within a community has a stake in and responsibility for the health of its individual members.

The second half of this chapter describes tools that a community might use to develop a comprehensive suicide prevention plan. The Substance Abuse and Mental Health Services Administration (SAMHSA) Strategic Prevention Framework (SPF), which is based on the public health model, provides a set of steps that communities can use to assess their need for action, develop strategies and resources for responding to identified needs, and evaluate the effectiveness of their response. The American Indian Community Suicide Prevention Assessment Tool (see Appendix D) also may help communities assess suicide risks and possible responses. This chapter ends with a few suggestions about how communities can increase the effectiveness of their efforts by engaging all stakeholders in prevention.

The Public Health Model

The *U.S. Surgeon General's Call To Action To Prevent Suicide* calls for a public health approach

to suicide. As suicide is considered a public health problem, with many complex contributing factors, this approach is very appropriate. In addition, the model's emphasis on promoting mental health as a way to prevent mental illness holds great promise for American Indian and Alaska Native (AI/AN) communities and lends itself to cultural adaptation.

The easiest way to understand the public health approach is to compare the public health model with the traditional medical model. The medical model focuses primarily on reducing illnesses by treating individuals who already have been diagnosed with a specific disorder. The public health model, on the other hand, is concerned with the health of an entire population. It goes beyond the diagnosis and treatment of individuals to include health promotion and disease prevention. It also includes evaluations of the health of the population at large, the effectiveness of available services, access to services, and how well these services reduce illnesses. Thus, while the medical model is concerned with restoring the health of an individual, the public health model is concerned with establishing and maintaining the health of a community. The most basic premise of the public health model is that caring for the health of the community protects the individual while caring for the health of an individual protects the community, with an overall benefit to society at large. Mandatory childhood immunizations, which have all but wiped out several once-common and deadly diseases, are examples of a successful public health approach.

The medical model also emphasizes the physical or biological causes of an illness, such as a virus or a person's genetic vulnerability to disease. The public health model views health within a larger context. Health also is affected by the physical, psychological, cultural, and social environments in which people live, work, and go to school. This is a very holistic approach to health that considers many of the factors within a community that contribute to or

reduce its health risks. When applied to suicide, the medical model considers the history and health conditions that could lead to suicidal behavior in a single individual. The public health model focuses, instead, on identifying and understanding patterns of suicide and suicidal behavior throughout a community.

Similar to the medical model, there is a protocol, or process, to follow in applying the public health model. The public health model is based on an organized set of steps for identifying threats to a community's overall health and in developing a comprehensive and effective response. Steps in the public health model are listed below:

1. Define the problem (i.e., identify a community's needs, resources, and readiness to address the problem);

2. Assess risk and protective factors;

3. Develop and test prevention strategies (i.e., which strategies works best for a community, given its culture and other specific circumstances);

4. Implement effective prevention strategies; and

5. Monitor and evaluate.

A later section on SAMHSA's SPF will provide more details on how a community can apply these steps to suicide prevention efforts.

According to the public health model, all members of a community should be involved in promoting the mental health of individual members and preventing mental illnesses. This model represents a dramatically different approach to suicide prevention than many communities first consider taking. A common misperception about suicide prevention is that it is the sole or primary responsibility of the formal mental health system, which focuses on treating individuals who are experiencing a mental or substance abuse crisis. The public health model moves the prevention focus from the clinic into the community. This model recognizes that

all members of a community share risk and protective factors and also accepts that an entire community can be affected by the problems experienced by any one individual. Consider, for example, a young man with untreated depression. If his condition causes him to drop out of school, miss work, or drink alcohol or use drugs, then his family, friends, school or workplace, and community also may suffer consequences. Perhaps most important, the public health model encourages a community to pursue the numerous opportunities it has to prevent mental health problems in young people before they begin.

Under the public health model, all organizations within a community would collaborate in suicide prevention efforts that range from mental health promotion to risk reduction. For example, young people who are the victims or the perpetrators of violence are more prone than others to mental health problems. Families, schools, recreation centers, and the child welfare and juvenile justice systems all might work to teach and reinforce anger management skills in adolescents (promotion) and to identify and refer to counseling those young people who may have experienced violence (prevention).

Similarly, under the public health model, all organizations within a community would help provide services and supports to anyone who experienced a mental health problem, including substance abuse. It would not be enough for a young person simply to be referred to counseling for suicidal behavior. Under this model, a community also would ensure that the person had transportation to counseling services and would not be stigmatized at school or in the workplace for seeking help. Family members also might receive guidance in how to support their child through a difficult time.

A very powerful example of such a comprehensive and community-based public health approach to prevention can be found in the Western Athabaskan Tribal Nation (a pseudonym used to protect the identity of this Tribe) suicide prevention initiative. In the late 1980s, this Tribe's rate of suicide and suicidal attempts was 15 times the national average. This rate prompted the Tribal council, the community, and the Indian Health Service (IHS) to work together to establish and expand a comprehensive suicide prevention program. As part of this effort, the Tribe realized that it needed to address the community's underlying issues of alcoholism, domestic violence, child abuse, and unemployment. Prevention programs aimed at the entire community as well as individuals at various levels of risk were selected. All key constituents—Tribal leadership, health care providers, parents, Elders, and youth—were involved in planning and implementing the overall suicide prevention plan.

According to the evaluation of this program published in the *American Journal of Public Health*, the Tribe experienced a steady reduction in suicidal gestures and attempts throughout the course of the program.[109] Self-destructive acts, including suicide completions, among all age groups declined from 36 per year for 1988–1989 to 10 per year for 2000–2001. Among youth ages 11 to 18, the number of suicide attempts dropped from 14.5 per year for 1988–1989 to 1.5 per year for 2000–2001.

Public health lessons learned by the community in reducing suicidal behavior follow.

- Suicide prevention programs should not focus on a limited range of self-destructive behaviors; rather, programs must emphasize the root conditions and an array of social, psychological, and developmental issues. Community involvement from the beginning is critical in developing strategies with which to address issues identified in a culturally, environmentally, and clinically appropriate manner.

- Flexibility in program development and implementation is essential. Program development should be based on continuous evaluation and feedback from community and program staff.[110]
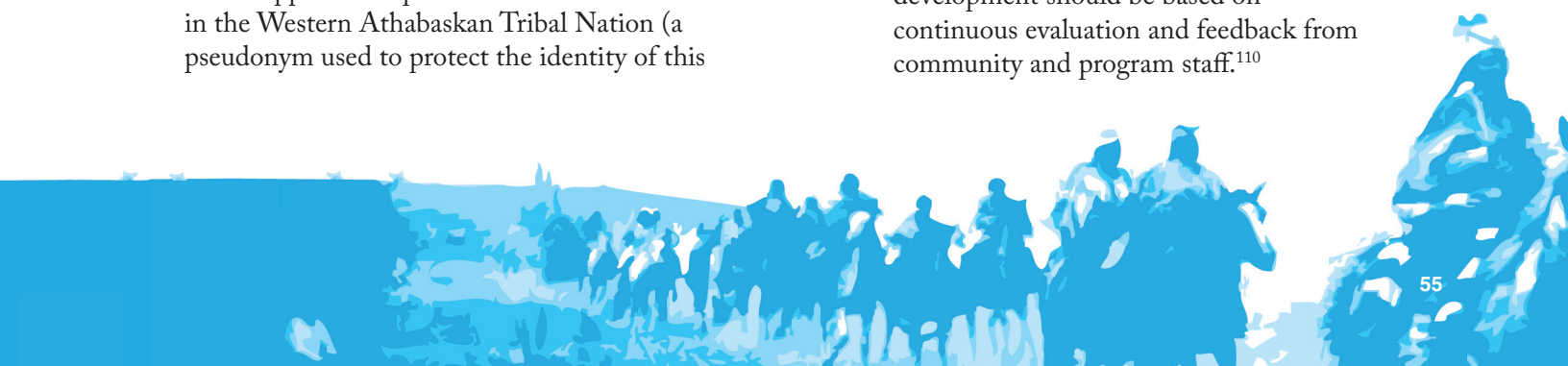
The White Mountain Apache Tribe, working together with the Johns Hopkins University Center for American Indian Health, has developed an important community-based suicide prevention effort. The White Mountain Apache Tribal Council enacted a resolution to mandate tribal members and community providers to report all suicidal behavior (ideation, attempts, and deaths) to a central data registry. For those who have made suicide attempts or were reported to be thinking about suicide, a community outreach visit by Apache para-professionals supervised by a clinical team from the Johns Hopkins Center for American Indian Health is attempted. SAMHSA is currently supporting an evaluation of the effectiveness of a specialized Emergency Department-linked intervention and in home coping skills curriculum for youth who have attempted suicide, as identified by the White Mountain Apache Tribe surveillance and community outreach system.

Clearly, a public health approach can prevent suicidal behaviors. But, as demonstrated by these examples, effective prevention requires the whole community coming together to address and overcome barriers and to follow through with a sustained effort.

The Ecological Model

As noted in the introduction to this chapter, the ecological model is one way to interpret the public health model. The ecological model has its origins in the observations of nature and the interrelationships among all living things and their environments. It acknowledges the cyclical nature of life and the necessity for interdependent relationships in creating a community. This relational worldview is a vital aspect to community-wide prevention efforts by AI/ANs. The ecological model is not new

Exhibit 8. The Ecological Model
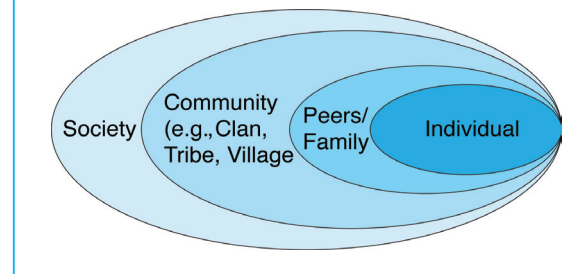
to AI/AN communities. It might even be said that AI/ANs and other aboriginal peoples were the first to truly live within and by this model, making it not so much an abstract theory as a way of life and of being in the universe.

In the ecological model, community members are seen not as separate individuals but as parts of a whole (see Exhibit 8). This model places the individual inside the family, which resides within the community and its culture, which, in turn, is part of society at large. Each level influences and is influenced by the other levels. Ideally, each level strengthens and nurtures the others. As in the public health model, the health of the individual is seen as a reflection of the physical, social, cultural, spiritual, and environmental status of the surrounding levels. All of these factors are interrelated in how they affect the health of the family, community, and society as well as the health of the individual.

The focus of the ecological model is on the interwoven relationships between individuals and their communities. While individuals are responsible for the choices they make that reduce their risk of illnesses and promote health, their choices largely are determined by their social environment, such as their community's existing norms, values, and practices. As an example, alcohol and substance use—both of which are risk factors for suicide—are lower among youth who believe that their parents (i.e.,

the family as "community") are more likely to disapprove of such behavior.[111] Thus, mentally healthy individuals are created through families, communities, and a society that encourages mentally healthy behaviors.

As this model implies, prevention involves a systemic, holistic approach to addressing risk and protective factors for mental and other illnesses at all of these levels. In addition, successful prevention efforts become part of each level and gain from everyone's energy and involvement. To illustrate, consider the experience of the Shuswap Tribe of Alkali Lake, in British Columbia, Canada, in reducing and preventing alcoholism. A very simplified case history and illustrations demonstrate how the ecological model applies both to the increasing and decreasing use of alcohol and its consequences.[g]

In the 1940s, the Shuswap Tribe was introduced to alcohol by non-Natives. At the same time, the

[g] For more information on the Tribal-led transformation of the Sushwap Indian Reserve at Alkali Lake and other real-life examples of community self-help and healing, visit the Squamish Nation, Four Worlds International, and the Chief Dan George Memorial Foundation Web site at http://www.4worlds.org/4w/ssr/Partiv.htm. We are grateful that we can share this story with others who may learn from it, and we thank the Shuswap Tribe for its courage in making this story known.

government was removing a whole generation of Tribal children from their families and sending them to boarding schools. While the schools provided a general education, school-based efforts to erase Tribal language and practices created a form of racial/cultural self-hatred in the children. The children also were exposed to widespread physical and sexual abuse. They returned to their communities damaged in mind and spirit.

These children had not been parented themselves; nor had they been able to internalize traditional values and practices of healthy family and community life. Because of these losses, this generation of Alkali Lake people was much more vulnerable to the culture of alcohol. Under the combined weight of growing alcoholism

Community Recovery

Society—Coalitions form to support Tribal wellness (e.g. Tribe and RCMP); society shares in the benefits of improved Tribal status.

Community—Alkali Lake Shuswap Tribe reinstates sobriety as a traditional social norm and adopts a holistic approach to improving overall health and well-being.

Family/Peers—Prevention advocates/ role models emerge. Excessive use of alcohol becomes less accepted while the stigma of seeking treatment is removed.

Individuals—Sobriety and hopefulness become motivation to lead community change.

Society—Government mandates practices that undermine traditional Tribal culture and values.

Community—Alkali Lake Shuswap Tribe becomes increasingly vulnerable to the culture of alcohol. Excessive use of alcohol becomes more accepted and widespread.

Family/Peers—Poverty, illness, violence, and abuse among Tribal members becomes common.

Individuals—Alcoholism, hopelessness, and suicide result.

Community Decline

and a legacy of historical trauma, a once hardworking Tribe found itself and its children being destroyed by the poverty, hunger, sickness, violence, sexual abuse, and suicide that had become common on the reservation. By the early 1970s, an estimated 100 percent of all adults and many young people drank excessively.

Change came in the form of community healing and community action, led by the first few Tribal members to refuse alcohol. In 1972, one of these individuals was elected chief. Together, he and a core group of supporters banned alcohol on the reservation. They joined with the Royal Canadian Mounted Police (RCMP) to identify bootleggers. Tribal members who committed alcohol-related crimes were given a choice: treatment or jail. Non-native community members, including clergy, who opposed these reforms were asked to leave. As the use of alcohol became less accepted within the Tribe, more Tribal members who experienced alcoholism began to seek treatment.

Tribal leaders recognized that their growing success in reducing alcoholism would be strengthened by linking the community's continuing healing process to social and economic progress. They achieved this critical linkage through these strategies:

- Making a deliberate effort to revive traditional Native forms of spirituality and healing;

- Creating a variety of economic enterprises to provide employment for the growing numbers of individuals who did not drink alcohol (By 1985, Alkali Lake had achieved full employment—everyone who wanted a job had a job.);

- Introducing a wide variety of training opportunities that were connected to personal and community wellness and the continued pursuit of social and economic improvements; and

- Building community unity. Whenever Tribal members left the community for treatment, their children were taken care of, their house was cleaned up and repaired, and there was a job waiting for them when they got back.

In short, the approach taken by the Shuswap Tribe to reduce and prevent alcoholism and its consequences demonstrates the ecological/public health model in action. Prevention efforts were both systemic and holistic. They went beyond a focus on the individual to include families, the Tribal community, and the larger surrounding society—which also had a stake in the outcome. The Tribal government, the justice system, businesses, and other local organizations all collaborated in both reducing risk factors for alcoholism and in promoting personal and community wellness. The success of this approach to prevention is apparent. By 1979—just a few years after prevention efforts began—only 2 percent of Alkali Lake Tribal members were still drinking alcohol.

The Transactional-Ecological Framework

The transactional-ecological framework is another way of looking at how a public health approach can be applied to suicide prevention. While similar to the ecological model, this framework places greater emphasis on two key elements within a community. Within this structure:

- Disorders (e.g., suicidal behavior and/or substance abuse) result from deviations from normal developmental pathways and processes; and

- The roots of an individual's disorder can be and often are outside of the individual.

From the perspective of this framework, the central objective of prevention programs is to create a community environment that helps young people avoid situations and behaviors that will start them along a pathway leading to negative outcomes. Prevention efforts will not focus on individuals or groups at risk or on a single behavioral disorder because such efforts can be seen as "victim blaming," in which the individual alone is responsible for his or her difficulties. Instead, a community would focus its efforts on the elimination of broad-based environmental conditions that can lead its members to engage in any number of undesirable, interrelated outcomes (e.g., school failure and substance abuse) and not just on one specific outcome (e.g., suicide).[112] The preceding example of the Western Athabaskan Tribal Nation demonstrates the success of this approach for Native communities.

The points of intervention—or the opportunities to return individuals to normal pathways—can involve the reduction of risk factors, the improvement of protective factors, or both. However, as noted earlier, increasing the number of protective factors has proved more effective in reducing suicide attempts than reducing the quantity of risk factors.[113]

Action-Planning Tools

The public health model is an evidence-based theory for picturing prevention. The following sections describe two tools that are available to communities in translating this theory into action.

SAMHSA's Strategic Prevention Framework

The SPF has been shown to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the lifespan. It is based on six key principles that are grounded in the public health approach. Because these principles are the foundation of the SPF process, they are described briefly first.

Guiding Principles of the SPF

1. Prevention is an ordered set of steps along a continuum to promote individual, family, and community health, prevent mental and behavioral disorders, support resilience and recovery, and prevent relapse.

Prevention activities range from deterring diseases and behaviors that contribute to them to delaying the onset of disease and reducing the severity of their symptoms and consequences. This principle acknowledges the importance of a spectrum of interventions that extend along the mental health continuum and involve all of the individuals and environments that affect a person's mental health and well-being.

2. Prevention is prevention is prevention.

It does not matter if the focus of prevention is on reducing the effects of cancer, cardiovascular disease, diabetes, substance abuse, or mental illness—the common components of effective prevention are the same. In addition, prevention of any one disorder frequently helps to reduce another. As noted in an earlier discussion of the U.S. Air Force suicide prevention program, prevention of suicide also helped to prevent homicide and domestic violence.

3. Common risks and protective factors exist for many substance abuse and mental health problems. Good prevention focuses on the common risk factors that can be altered.

Family conflict, low school readiness, and poor social skills all increase the risk for conduct disorders and depression in young people. These disorders, in turn, increase a young person's risk
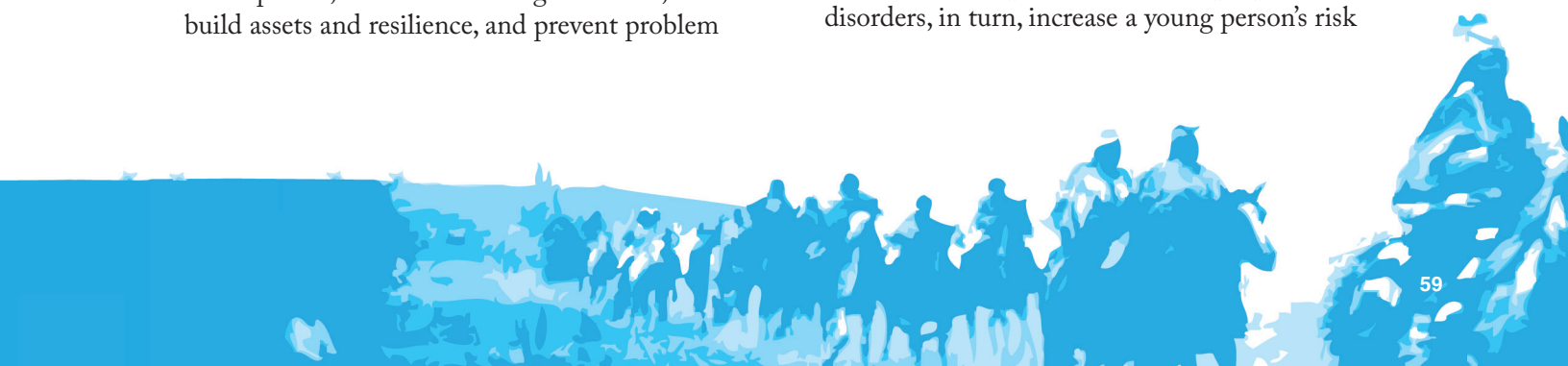
for substance abuse, delinquency, violence, and other factors that may contribute to suicide. Alternatively, protective factors such as strong family bonds, coping skills, opportunities for school success, and involvement in community activities can foster resilience and lessen the influence of these risk factors. Effective prevention works to reduce common risk factors and enhance common protective factors.

4. Resilience is built by developing assets in individuals, families, and communities through evidence-based health promotion and prevention strategies.

Resilience is a person's ability to cope with the frequent challenges that life presents. Youth who have positive relationships with caring adults, good schools, and safe communities develop optimism, good problem-solving skills, and other assets that help them deal with adversity and go through life with a sense of mastery, competence, and hope.

5. Systems of prevention services work better than service silos.

Working together, researchers and communities have produced a number of highly effective prevention strategies and programs. Implementing these strategies within a broader system of services increases the likelihood of successful, sustained prevention activities. Collaborative partnerships enable communities to leverage scarce resources, build greater capacity, and make prevention everybody's business.

6. Baseline data, common assessment tools, and outcomes shared across service systems can promote accountability and effectiveness of prevention efforts.

A data-driven strategic approach that is adopted across service systems at the Federal, State, Tribal, community, and service delivery levels increases opportunities for collaboration and positive outcomes.

Exhibit 9. SAMHSA's SPF Process

Assessment

Evaluation

Sustainability and Cultural Competence

Capacity

Implementation

Planning

The SPF Process

The SPF, just like the public health model, uses a five-step process to organize prevention efforts. As shown in Exhibit 9, the SPF process is circular rather than linear. It is designed to be a process of discovery rather than simply a process. Communities will experience a certain amount of back-and-forth between steps as new ideas or new threats to health emerge, goals are met, and priorities change. At the heart of the entire process are cultural competence and sustainability of prevention activities.

Applying the SPF Process

The following section describes steps in the SPF process as they apply to suicide prevention by AI/AN communities. Additional information about the SPF is available at http://prevention. samhsa.gov/about/spf.aspx.

1. Assess the problem.

In this step, a Tribal community will develop a profile of the problem, its readiness to address the problem, and its resource needs. Common actions are to:

Questions for Seeking the Wisdom of Elders

- How can the community use traditional ways to become closer and work for the benefit of all?
- How can people who have not dealt well with each other for a while come together again?
- What are some ways that the community can strengthen its balance and harmony?

- Collect epidemiological data;
- Assess risk and protective factors, such as the magnitude of a substance abuse problem in or near the Native community;
- Assess Tribal/Village community assets and resources;
- Identify gaps in Federal and Tribal/Village services and capacity;
- Assess community readiness;
- Identify priorities; and
- Specify baseline data for the Tribe/Village against which process and outcomes can be measured.

2. Build the capacity to address these needs.

In this step, an AI/AN community will mobilize and build its capacity to address identified problems and gaps in service delivery. Capacity building activities may include:

- Convening Tribal/Village leaders and other community stakeholders;
- Building coalitions of Federal, State, local and Tribal/Village service providers; and
- Engaging Tribal/Village leaders and other community stakeholders to help sustain the activities.

3. Develop a strategic plan for addressing needs.

In this step, a community will develop a plan that will guide it in organizing and implementing the strategies that it believes will help it achieve its prevention goals. This plan also will help a community focus its resources on the group at greatest risk (e.g., adolescent males) and on issues of highest priority (e.g., mental health care services). The community can adjust its plan as new information becomes available or as it achieves its goals and objectives.

4. Implement evidence-based strategies with fidelity.

In this step, the community will select and implement programs that have proven effective in achieving the desired results. "Fidelity" in carrying out a strategy will be essential if a community is to achieve the same results. Fidelity refers to the degree to which a program or strategy is implemented as designed. For example, there is a loss of fidelity if a counseling program is supposed to have 10 sessions but funding only is provided for 7 sessions. Loss of fidelity can result in a loss of effectiveness. To maintain fidelity and outcomes, key elements of a strategy should remain intact even when minor adaptations are made to meet cultural needs.

Communities should consult with the program developer in adapting programs, if possible. Often, a program developer will help a community identify the key elements of the program that are necessary to achieve the desired outcomes and to adapt other elements to ensure cultural effectiveness.

5. Monitor and evaluate.

This step involves monitoring and evaluating the effectiveness of the prevention activities. In this way, a community can sustain those activities that are working or modify or replace those that are

not. Although evaluation is presented here as the last step, it actually is a continuous process that should begin with the first step. Evaluation lets a community and funding agencies (if any) know how effectively the community has defined, and is responding to, suicide.

The SPF and Cultural Competence

Cultural competence is at the heart of the SPF process. A culturally competent program demonstrates sensitivity to and understanding of cultural differences in program design, implementation, and evaluation. Such programs:

- Acknowledge culture as a predominant force in shaping behaviors, values, and institutions;

- Acknowledge and accept that cultural differences exist and have an impact on service delivery;

- Believe that diversity within cultures is as important as diversity between cultures;

- Respect the unique, culturally defined needs of various populations;

- Recognize that concepts such as family and community are different for various cultures and even for subgroups within cultures;

- Understand that people from different racial and ethnic groups and other cultural subgroups are usually best served by persons who are a part of or in tune with their culture; and

- Recognize that taking the best of both worlds enhances the capacity of all.

The SPF and Sustainability

Like cultural competence, sustainability is an essential element of each step of the SPF. Sustainability refers to the process through which a prevention system becomes a community norm. Sustainability is vital to ensuring that prevention values and processes are firmly established, that partnerships are strengthened, and that financial and other resources are secured over the long term. Sustainability also encourages the use of evaluation to determine which elements of a prevention program, policy, or service need to be continued and supported to maintain and improve outcomes. Because sustainability has a major effect on outcomes, communities need to make it an important part of each component in the whole planning process. If, for example, a community has a goal of reducing underage drinking by 20 percent, the community needs to plan how it will continue programs that produce the desired outcome. Such planning should begin as early in the assessment process as possible.

American Indian Community Suicide Prevention Assessment Tool

The American Indian Community Suicide Prevention Assessment Tool was developed by the One Sky Center, a national resource center for American Indians and Alaska Natives. It is dedicated to improving the prevention and treatment of substance abuse and mental health disorders across Indian Country.

This tool is designed as a template for assessing risk and protective factors within a Native community. It also is helpful in identifying available and needed prevention resources. Aspects of community health, such as the economic status of the Tribe, community readiness, and community self-help are integrated into a holistic evaluation of prevention opportunities. Some of the suggested uses of this tool include internal program assessment and planning. Information collected during the assessment also can be used to prepare grant applications, or the entire tool can be an appendix to an application. A

copy of the template is included in Appendix D: Decisionmaking Tools and Resources. Communities can download the tool free from the One Sky Center Web site at http://www.oneskycenter.org/education/publications.cfm.

Engaging Community Stakeholders in Prevention

Successful prevention means that an entire community is involved in planning, carrying out, and evaluating a comprehensive plan. Consequently, it is vital that all of a community's stakeholders be engaged in identifying both problems and solutions. Stakeholders usually are individuals within the community with the most "at stake" around a particular issue.

Stakeholders will vary from community to community. In suicide prevention, major stakeholders might include those who have been most affected by suicide, are in leadership positions, have direct access to youth and young adults, and have time and resources to invest in addressing the issue. Young people clearly should be involved in developing prevention efforts. Not only will they have an increased sense of their worth and belonging in the community, but they can also provide valuable insights into the challenges that their generation is facing.

Engagement takes leadership. Tribal or Village leaders can encourage participation by making suicide prevention a priority for the community. Another approach is for a concerned and committed group of stakeholders to appeal to their leaders for support.

Building a Community's Capacity for Prevention

Although community capacity building was covered briefly in the section about the SPF process, this aspect of prevention deserves further discussion. When people think about capacity building, they frequently think in terms of treatment programs, counseling, and other support services. Community capacity building, however, goes beyond formal services. It also means building people's commitment and skills to address problems and identify and respond to opportunities to promote mental health. It means recognizing the strengths that already exist within a community and making these strengths part of the solution. The emphasis of community capacity building should be on what is good and what already is working within the community. This approach has the added benefit of increasing a community's sense of empowerment in charting a more promising future for itself and its children.

"Long ago it was the cottonwood tree who taught us how to make our tipis, for the leaf is an exact pattern of the tipi, and this we learned when some of our old people were watching little children making play houses from these leaves. This, too, is a good example of how much grown men and women may learn from very little children, for the hearts of little children are pure, and, therefore, the Great Spirit may show to them many things which older people miss."

— Black Elk, Lakota Sioux
The Sacred Pipe: Black Elk's Account of the Seven Rites of the Oglala Sioux
Joseph E. Brown (Ed.) (1988)

On the other hand, community capacity building should not occur in isolation. As recognized in the *National Strategy for Suicide Prevention*, a comprehensive approach "requires a variety of organizations and individuals to become involved in suicide prevention and emphasizes coordination of resources and culturally appropriate services at all levels of government—Federal, State, Tribal, and community."[114] Prevention efforts need to be as broad and continuous as the threats to a community's mental health and the opportunities to combat them are. The best way to build, maintain, and sustain such efforts is to engage as many participants as possible in prevention.

Other ways in which community capacity building can increase the success of prevention plans are to:

- Use a variety of methods and a systematic approach;

- Emphasize collaboration and cooperation among community agencies;

- Recognize that any particular suicide prevention effort will be more successful if it is part of a broader community health and wellness vision;

- Understand that efforts by local people are likely to have the greatest and most sustainable impact in solving local problems and in setting local norms; and

- Remember that when community resources are tapped, efforts are more likely to be based on concepts and ideas that are ethnically and culturally appropriate for that unique community.[115]

Capacity Building and Gatekeeper Training

Many communities are adopting gatekeeper training as part of their youth suicide prevention plan. Through gatekeeper training, teachers, natural peer helpers, and others who come in regular contact with young people are taught the warning signs of suicide and how to encourage someone at risk to seek help. Several gatekeeper training programs are described in Chapter 7: Promising Suicide Prevention Programs.

As effective as gatekeeper training may be in identifying young people at risk,[116] it raises the issue of a community's capacity to handle the increase in referrals for services that can result. For Tribal communities with limited access to behavioral health services, the question becomes "refer where?" Without some thought to this question, gatekeeper training may result in increased pressure on an already overwhelmed medical and behavioral services system. Whenever possible, a community needs to coordinate prevention efforts with local behavioral health and primary care systems to ensure that they are aware of these efforts and can plan for increased service demands. It may be possible for these systems to apply for funding for additional staff to meet demand.

As community awareness increases, so do referrals. One answer to this increase in demand for services may be found in a particular type of community capacity building. As part of the community's overall prevention plan, first responders, nurses, outreach personnel, and various paraprofessionals could receive training that goes beyond the gatekeeper level. This could include triage, intervention, and supportive counseling. Again, triage training programs are described in Chapter 7: Promising Suicide Prevention Programs.

While there are costs associated with this additional level of training, it not only increases community capacity but also long-term sustainability. Where possible, Tribal and Village communities might seek partnerships and additional grants to address this need.

Appendix D: Decisionmaking Tools and Resources lists several guides for coalition building as well as tools for assessment, planning, and school-based program planning.

Conclusion

Decades ago, Lone Man (Isna-la-wica) of the Teton Sioux said, "I have seen that in any great undertaking it is not enough for a man to depend simply upon himself." As illustrated by the public health model, an entire community must come together in protecting its children from suicide. Prevention success cannot be achieved by leaving this greatest of undertakings to one family, one institution, one level of government, or even one Tribe or Village. Furthermore, what is learned about prevention must be shared among all of those who would benefit from this knowledge.

Communities can strengthen their suicide prevention efforts by making use of tools that

are based on the public health model. Such efforts provide a systematic way for communities to define the problem and develop an effective response. In carrying out prevention efforts, a community may find that it is more effective, as well as more cost-effective, to focus on promoting mental health as a way to reduce risk factors for suicide and prevent mental health problems from occurring in the first place.

The most important part of this process, however, is the involvement of all individuals and institutions with a stake in the mental health and well-being of the community. Just as the causes of the problem of suicide can be found within a community, so can the solutions. The broader the base of community involvement, the more opportunities for prevention. The more a community builds its capacity for action, the greater the potential for success. This is the true measure of community's action—people talking, sharing, and working together for the good of all.

Chapter 7: Promising Suicide Prevention Programs

"The goal of most prevention programs is to assist an individual in fulfilling their normative and developmentally appropriate potential, including a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen their ability to cope with adversity."

Preventing Mental, Emotional, and Behavioral Disorders
Among Young People: Progress and Possibilities
National Research Council and Institute of Medicine (2009)

Introduction

Suicide prevention programs that show promise for American Indian and Alaska Native (AI/AN) communities are those that have proven effective in reducing suicides and suicidal behaviors by enhancing protective factors, reducing risk factors, or both. While this definition seems simple enough, it raises questions about how the effectiveness of the program was measured and for whom it was effective. These questions have particular relevance in determining which prevention programs will work best within AI/AN communities, where research has been limited and the evidence supporting traditional or culturally based approaches may be anecdotal.

This chapter explores the issue of how evidence is defined and summarizes the difference between evidence-based and culturally based programs. The emphasis is on the need for all stakeholders to appreciate both of these approaches and to collaborate on building bridges between them. The issue is not which approach is best, but rather how we can learn from both in identifying, strengthening, and implementing AI/AN suicide prevention programs that work.

This chapter also identifies databases of evidence-based programs, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP) and its Suicide Prevention Resource Center's (SPRC's) Best Practices Registry. The chapter concludes with a discussion of two primary factors that a community should consider in selecting programs and descriptions of programs that hold promise for preventing suicides among AI/AN youth and young adults.

What Is Evidence?

Federal and State governments and other funding sources are placing increasing emphasis on the need for communities to implement evidence-based practices; that is, programs that have been shown through documented scientific evidence to achieve the desired outcome for the population of focus. As a result, it is becoming increasingly difficult for communities and organizations to receive funding for programs that have not met this standard. The rationale is easy to understand. Given limited prevention dollars and the urgency of preventing suicides by AI/AN youth and young adults, it makes the most sense to invest in programs that have proven effective.

But how do we determine what is evidence? The move toward more evidence-based practices in recent years has elevated the standards within the field of suicide prevention, but it also has raised concerns among AI/AN researchers and community members as to whether traditional AI/AN community values and practices are being adequately addressed. Some researchers have argued that the emphasis placed on the use of evidence-based practices in AI/AN communities might lead to an abandonment of more traditional holistic approaches.[117] These concerns are summarized in a report that was developed as a result of the National Alliance of Multi-Ethnic Behavioral Health Associations' Consensus Meeting on Evidence-Based Practices and Communities of Color, which states:

> The introduction of evidence-based practices (EBPs) would appear to be a solution to the misdiagnoses and poor outcomes that so many in diverse populations have encountered in the mental health system. However, it is equally as likely that EBPs could exacerbate and deepen existing inequities if they are implemented without sufficient attention to cultural competence and/or if policymakers fail to take into account the many practices within diverse communities that are respected and highly valued by these groups. Such practices may not be considered 'evidence-based' as they often lack access to research and evaluation funds that are critical for studying the efficacy and effectiveness of mental health interventions.[118]

At the heart of these concerns is the perceived divide between evidence-based and culturally based programs.

Evidence-Based vs. Culturally Based Programs

SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) defines evidence-based programs (EBPs) as:

> Approaches to prevention or treatment that are based in theory and have undergone scientific evaluation. 'Evidence-based' stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.

Culturally based programs, on the other hand, are those that are grounded in tradition and supported by "anecdotal evidence." For example, AI/AN prevention specialists or other Tribal members may contend that a traditional approach to suicide prevention will work, citing as evidence the rarity of suicide within their long cultural history before they came in contact with Western cultures. Such evidence, which is grounded in the stories passed down within the Native oral tradition, has value but is difficult to substantiate. It also may be that the culturally based program has yet to be evaluated in a meaningful way.

These two approaches, however, are not mutually exclusive. One example of successful integration of evidence-based and culturally based practices can be found in the work of Terry Cross, an enrolled member of the Seneca Nation of Indians and the Executive Director of the National Indian Child Welfare Association. He describes a system-of-care model for AI communities in which:

> Kinship networks and clan systems are being used as resources to provide respite care. Service providers and families are learning how traditional wellness concepts can facilitate a strengths-based approach to family harmony. Tools such as storytelling, the use of ritual and ceremony, rites of passage, and kinship support are being applied to a modern system of care.[119]

Although this example refers to a treatment delivery system, similar opportunities exist to integrate evidence-based and culturally based approaches to prevention efforts.

As stated earlier, the issue is not which approach is best. Instead, it is how we can use both approaches to develop and implement suicide prevention programs that work best in AI/AN communities. SAMHSA recognizes that EBPs have not been developed for all populations, service settings, or both. For example, certain programs for AI/AN populations, rural or isolated communities, or recent immigrant communities that appear effective may not have been formally evaluated. Thus, they will have a limited or nonexistent evidence base. In addition, other programs that have an established evidence base for certain populations or in certain settings may not have been formally evaluated with other subpopulations or within other settings.

SAMHSA has responded to this challenge by encouraging grant applicants who propose a program that has not been formally evaluated to provide other forms of evidence that the practice is appropriate for the population of focus. Evidence for these practices may include unpublished studies, preliminary evaluation results, clinical (or other professional association) guidelines, findings from focus groups held with community members, and other sources.

In learning from culturally based programs, the focus may need to shift from why an AI/AN community believes a traditional approach will work to what its members can do to demonstrate its effectiveness. With this shift, the discussion can move to essential considerations such as how AI/AN communities can have a voice in determining how their traditional ways will be measured, who will be doing the measuring, and how the knowledge gained will be shared with others and for what purpose.

Program Selection

A community needs to consider at least two factors in determining which strategy, or program, it will implement as part of its suicide prevention plan. The first is the population of focus. The second is the degree to which a program reflects or will need to be adapted to a community's unique culture.

Population of Focus

All of the programs described in this document are intended to prevent suicide by AI/AN youth and young adults. The decision to be made is which program is most appropriate for the subgroup that is the focus of a suicide prevention plan. This is a multilayered decision. If the plan is to focus on school-aged youth, should the program involve all students within a school, just those who have been identified as at risk, or just adolescent males who are at high risk? Should a program focus all of its resources on school-based activities or should it direct resources towards families and the general community where the youth live?

The Institute of Medicine (IOM) classification system is a useful tool in determining which program may best meet a community's prevention goals. The IOM model views mental health promotion as the foundation for preventing mental, emotional, and behavioral disorders (see Exhibit 10). It classifies prevention strategies as universal, selective, or indicated. Each level of prevention targets a different population—from everyone in the population, to specific at-risk groups, to specific high-risk individuals—according to the population's increasing degree of risk for or vulnerability to a mental health or substance abuse problem.

Exhibit 10. IOM Classification System
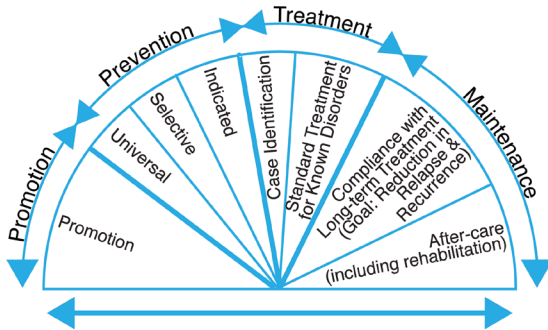
From the National Research Council and Institute of Medicine (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.*

Universal strategies involve an entire population, which could be all members of a Tribe or Village or all youth within a school. As the term implies, universal strategies are broad-brush efforts that are intended to affect everyone who may be at risk. A universal strategy, for example, might be to increase the population's access to counseling or to improve general social supports in the community, such as through after-school programs and youth centers. Other examples of universal strategies are:

- Public education campaigns;

- School-based suicide awareness and risk reduction programs, such as anti-drug use or anti-bullying programs;

- School-based programs that support the social and emotional development of youth;

- Means restriction, such as building barriers on bridges or reducing access to guns, poisons, ropes and items used for hanging, and other lethal means of self-harm; and

- Education programs for the media on reporting practices related to suicide.

Selective strategies address smaller groups within the total population who have a higher probability of suicide, and are meant to prevent group members from developing suicidal behaviors. This level of prevention includes:

- Screening programs to identify and assess at-risk groups;

- Gatekeeper training for adults or natural peer helpers so that they can identify individuals at risk of suicide and refer them to appropriate treatment or supporting services;

- Support and skill-building training for at-risk groups; and

- Crisis response and referral resources.

Indicated strategies address specific high-risk individuals within the population whose behavior shows early warning signs of suicide potential. Individuals who have some symptoms of a mental health problem, such as depression or hopelessness, or who are engaging in risky behaviors, such as alcohol and substance abuse, fit into this category. At this level, programs include:

- Skill-building support groups in high schools and colleges;

- Parent support training programs;

- Case management for individual high-risk youth at school; and

- Referrals to crisis intervention and treatment services.

Note that programs at all levels are designed to enhance protective factors and reduce risk factors. Ultimately, any comprehensive, community-based suicide prevention plan will need to address all levels of the IOM classification system.

Culturally Based and Culturally Sensitive

A second consideration in program selection is the degree to which existing programs reflect or may need to be adapted to a particular community's culture. Some programs are culturally based, meaning that they were specifically developed by and for AI/ANs. Some of these programs may not, as yet, have the support of rigorous evaluation and thus may not be considered to be evidence based. Other programs are culturally sensitive. Such programs were developed for the general population, achieved some level of evidence, and then were adapted for AI/AN populations.

Both culturally based and culturally sensitive programs have potential strengths and limitations in their application to AI/AN communities at large. Culturally based programs were created around a specific culture. The more narrow the original cultural focus, the more difficult it may be for another community to achieve the same outcomes if its culture differs significantly. Programs that have been developed by and for AI communities in the lower 48 States, for example, may have limited applicability in AN Villages. Similarly, programs developed for one Tribe may not transfer well to another Tribe if the basis of the program is a tradition or practice unique to the original Tribe. However, if a particular culturally based program has reduced suicidal behavior in one community, then further investigation is called for. A careful evaluation of the program might identify a protective cultural aspect that may be transferable to another community.

On the other hand, culturally sensitive programs should not take so general a view of Native culture as to lack relevance for any Tribe or Village. Cultural sensitivity means more than adding a generic Native American face to program materials. Appropriate programs should be flexible enough to integrate the values, beliefs, language, and practices of a particular community without a loss of effectiveness.

The need to honor and respect Native culture in programs to prevent suicide by AI/AN youth and young adults cannot be overemphasized. Research indicates that strong cultural identification makes adolescents less vulnerable to risk factors for drug use and more able to benefit from protective factors than adolescents who lack this identification.[120] In addition, having a purpose in life appears to help young people feel positively about their life and their ability to handle its challenges. In the worldview of Native culture, everything has a purpose, including trees, animals, and rocks. One of the most important developmental tasks for Native youth is to discover their own purpose, and AI/ANs have many culturally sanctioned practices (e.g., vision quest) for accomplishing this.

Exhibit 11 is a list of cultural practices that Native communities have been integrating into their approaches to preventing substance abuse, which is frequently present in suicide attempts. Ways in which programs might become more culturally sensitive is to make them home- or family-based and deliverable by paraprofessionals.

Program Adaptation and Fidelity

Differences by Tribal group, culture, degree of Native ancestry, and reservation or urban location make it difficult to develop a general prevention approach for all Native youth and young adults. Thus, it may be necessary to adapt an existing program—whether culture centered, culturally sensitive, or not yet tried in AI/AN communities—to the language, beliefs, values, and practices of an individual community. SAMHSA's principles of cultural competence for its Strategic Prevention Framework (see Chapter 6) can help guide this process.

Exhibit 11. Cultural Practices in American Indian Prevention Programs*

All activities assume the participation of Elders and include the transmission of Tribal history, values, and beliefs. Also, music, drumming, and singing are integral parts of most of these activities.

Ceremonies and Rituals

- Participating in sweatlodge ceremonies
- Smudging**
- Attending social dances
- Learning sacred dances
- Attending a Sundance
- Fasting
- Going on a vision quest***
- Paying attention to dreams
- Attending pow wows and other sober community activities
- Storytelling and listening to stories
- Participating in a Talking Circle

Tribal Crafts

- Making traditional attire for pow wows and other ceremonies

- Tanning hides
- Making ribbon shirts
- Sewing quilts
- Learning the native language
- Cooking traditional foods
- Picking and drying herbs
- Making jewelry and moccasins
- Making cradle boards

Traditional Forms of Living

- Hunting
- Fishing
- Shepherding
- Participating in Tribal sports
- Camping and participating in survival retreats
- Picking berries and harvesting crops

* From Sanchez-Way, R., & Johnson, S. (2000). Cultural practices in American Indian prevention programs. *Juvenile Justice*, 7(2), 21.

** Smudging involves the use of incense made of a local natural plant, such as sage, sweetgrass, or cedar, to cleanse the air and change the mood of everyday life to one of respect and reverence suitable for prayer.

*** A vision quest is an extended meditation or retreat (typically 4 days long) that takes place in an isolated area. The spiritual purposes of the vision quest are to renew faith, sacrifice, and seek guidance.

At the core of program adaptation is the need to recognize a worldview that is consistent with AI/AN cultures, with worldview defined as "the collective thought process of a people or culture."[121]

According to Cross, in *Understanding the Relational Worldview in Indian Families*, there are two predominant worldviews globally: linear and relational.

- **The linear worldview** finds its roots in Western European and American thought. It is logical, time-oriented, and systematic, with cause-and-effect relationships at its core. To understand the world is to understand the linear cause and effect relationship between events.

- **The relational worldview**, sometimes called the cyclical worldview, finds its roots in Tribal cultures. It is intuitive, not

time-oriented, and fluid. The balance and harmony in relationships between multiple variables, including spiritual forces, make up the core of the thought system. Every event exists in relation to all other events regardless of time, space, or physical existence. Health exists only when things are in balance or harmony.[122]

In terms of adaptation, those who work with Native youth can show respect for the Native worldview when programs:

> …build on young people's connection to all other living entities; encourage and openly discuss their spiritual development; and recognize the vital role played by Elders, aunts, uncles, and other blood or clan relatives and seek their involvement. We also can make use of the outdoors, encourage generosity of spirit, incorporate more cooperative learning activities, respect the individual, allow for a longer response time [in conversations], be more flexible with timelines, and respect that learning also can occur through listening and in silence.[123]

Many AI/AN people are able to incorporate and move between these two worldviews.

The primary constraint in adapting programs is to ensure that fidelity is maintained even while some program characteristics are altered to allow for cultural input. It can be difficult to establish a balance between fidelity and adaptation. To ensure that a program addresses everyone's real needs, there should be open communication between funders, staff members, and other community stakeholders during the implementation and ongoing evaluation of a suicide prevention plan.

"Our worldview is the cultural lens through which we understand where we have come from, where we are today, and where we are going. Our cultural identity is our source of strength."

— Iris Heavyrunner, Blackfeet
— Joann Sebastian Morris
Sault Ste. Marie Chippewa

Promising Program Databases and Descriptions

The following section identifies evidence- and culturally based programs for preventing suicide by AI/AN youth and young adults. Programs in the following list that have titles followed by two asterisks are included in SAMHSA's NREPP. Programs marked with one asterisk have been rated as best practices by SAMHSA's SPRC. Other programs are available through, or have been evaluated as being potentially useful to AI/AN communities by prevention specialists at the One Sky Center. SAMHSA has provided funding to this Center to identify, develop, and disseminate culturally sensitive materials for preventing and treating substance abuse and mental health problems in Indian Country.

Many of the programs in the following list are school-based. Schools, in partnership with families, are in a unique position to promote the overall mental health of all young people as well as to identify those who may be at risk of suicide. Schools can directly address some risk factors for suicide, such as bullying and academic failure, within the context of improving school achievement. Youth also appear more likely to take advantage of services that are offered through a school rather than in other settings. This difference may be due to easy access or to a decrease in the stigma of seeking help.[124] Other

research has shown that a sense of connection or belonging to their school community has a strong, protective effect against suicidal thoughts by youth.[125] Furthermore, AI/AN communities often are geographically isolated and lack access to behavioral health services. School-based programs enable communities to overcome these challenges by centering the program and its services in the community.

The following programs focus specifically on suicide prevention. Other programs aimed specifically at promoting the mental health of youth (e.g., programs to strengthen family bonds) or to reduce any of the risk factors for suicide (e.g., programs to prevent and treat substance abuse and mental health problems) also may be effective in reducing suicide. It is beyond the scope of this document to include the broadest range of programs possible, but readers are encouraged to consider them as part of their suicide prevention plan.

SAMHSA's NREPP, at http://www.nrepp. samhsa.gov, contains an extensive list of related programs. Other Federal agencies also maintain online databases. The U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, maintains a similar database—its *Model Programs Guide*—at http://www.dsgonline.com/mpg2.5/mpg_index.htm. This database offers evidence-based programs to address a variety of youth problems, including delinquency; violence; youth gang involvement; alcohol, tobacco, and drug use; academic difficulties; family functioning; trauma exposure; sexual activity/exploitation; and other mental health issues.

Twelve Federal agencies make up the Interagency Working Group on Youth Programs. This work group promotes the achievement of positive results for at-risk youth by identifying and disseminating promising and effective strategies and practices that support youth. The group also encourages collaboration at the Federal, State,

and local level, as well as with faith-based and community organizations, schools, families, and communities. It also has created a Web site on youth, at http://www.FindYouthInfo.gov, to help interested citizens and decisionmakers plan, implement, and participate in effective programs for at-risk youth. Resources and available on the Web site include:

- A searchable database of evidence-based programs to address risk and protective factors in youth;

- Key elements of effective partnerships, including strategies for engaging youth;

- Helpful community assessment tools;

- Mapping tools that generate maps of local and Federal youth programs; and

- An overview of Federal programs that serve youth, technical assistance resources, and grant application guidelines.

National Registry of Evidence-Based Programs and Practices

SAMHSA's NREPP is a searchable online registry of mental health and substance abuse programs that have been rated by independent reviewers. The purpose of this registry is to assist the public in identifying approaches to preventing and treating mental health and substance use disorders that have been scientifically tested and that can be readily disseminated to the field. This registry represents just one way that SAMHSA is working to improve a community's access to information on tested interventions. One goal of this effort is to reduce the lag time between the creation of scientific knowledge and its practical application in the field.

NREPP, however, is meant to be a decision support tool and not an authoritative list of effective interventions. Being included in

NREPP, or in any other resource listed in this guide, does not mean a program is recommended or that it has been demonstrated to achieve positive results in all circumstances. NREPP is a voluntary, self-nominating system in which program developers have chosen to participate. There always will be some programs that are not submitted to NREPP. Not all that are submitted are reviewed.

Programs in NREPP have been rated on two scales: Quality of Research and Readiness for Dissemination. Quality of Research ratings are indicators of the strength of the evidence supporting program outcomes. Each outcome is rated separately because interventions may target multiple outcomes (e.g., depression, feelings of hopelessness, drug involvement), and the evidence supporting the different outcomes may vary. NREPP uses very specific standardized criteria to rate programs and the evidence supporting their outcomes. All reviewers who conduct NREPP reviews are trained on these criteria and are required to use them to calculate their ratings.

Each reviewer independently evaluates the quality of research for a program's reported results using the following six criteria:

- Reliability;
- Validity;
- Intervention fidelity;
- Missing data and attrition;
- Potential confounding variables; and
- Appropriateness of analysis.

NREPP's Readiness for Dissemination ratings summarize the amount and general quality of the resources available to support program use. Higher scores indicate more and higher quality resources are available. Readiness for Dissemination ratings apply to the program as a whole. Reviewers evaluate readiness according to three criteria:

- Availability of implementation materials;
- Availability of training and support resources; and
- Availability of quality assurance procedures.

Additional details about the NREPP review process are available at http://www.nrepp.samhsa.gov/review.asp.

Suicide Prevention Resource Center Best Practices Registry

SAMHSA's SPRC (described more fully in the following chapter) also maintains a searchable online database of suicide prevention strategies. Its Best Practices Registry (BPR) is a collaboration between the SPRC and the American Foundation for Suicide Prevention (AFSP). The purpose of the registry is to identify, review, and disseminate information about best practices that address specific objectives of the *National Strategy for Suicide Prevention*. The BPR has three sections:

- **Section I: Evidence-Based Programs** describes programs that have undergone rigorous evaluation through NREPP or SPRC and have demonstrated positive outcomes;

- **Section II: Expert and Consensus Statements** summarizes the current knowledge in the field and provides "best practice" recommendations to guide program and policy development; and

- **Section III: Adherence to Standards** contains additional suicide prevention programs and practices, including awareness materials, educational and training programs, protocols, and policies that have been implemented in specific settings (as opposed to Section II statements, which offer general guidance to the field).

The three sections are not intended to represent levels of effectiveness. Instead, they include different types of programs and practices that have been reviewed according to specific criteria for that section.

SPRC no longer reviews program effectiveness, which now is conducted through NREPP. Programs that were reviewed previously by SPRC and are included in the BPR were evaluated according to 10 quality-based criteria: theory, intervention fidelity, design, attrition, psychometric properties of measures, analysis, threats to validity, safety, integrity, and utility. Additional information on the BPR is available at http://www.sprc.org/featured_resources/bpr/index.asp.

Promising Programs

The following programs are grouped according to their primary strategy for suicide prevention. The categories are:

- Life skills development;
- Screening;
- Public awareness/gatekeeper training;
- Counseling and support services; and
- Attempt response.

Each program description includes a note on the program's actual or potential use in AI/AN communities.

Life Skills Development

Life skills development programs help young people develop the social and emotional skills that promote healthy relationships and self-esteem. At the same time, these programs strengthen their resilience in coping with the challenges of life.

American Indian Life Skills Development**

IOM classification: Universal

Population of focus: Male and female high school students, ages 14 to 19.

Description: American Indian Life Skills Development is a school-based suicide prevention curriculum designed to reduce suicide risk factors and improve protective factors among AI adolescents.

The curriculum includes anywhere from 28 to 56 lesson plans covering topics such as building self-esteem, identifying emotions and stress, increasing communication and problem-solving skills, recognizing and eliminating self-destructive behavior, learning about suicide, role-playing around suicide prevention, and setting personal and community goals. The curriculum typically is delivered over 30 weeks during the school year, with students participating in lessons three times per week. Lessons are interactive and incorporate situations and experiences relevant to AI adolescent life, such as dating, rejection, divorce, separation, unemployment, and problems with health and the law. Most of the lessons include brief, scripted scenarios that provide a chance for students to problem-solve and apply the suicide-related knowledge they have learned.

Lessons are delivered by teachers working with community resource leaders and representatives of local social services agencies. This team-teaching approach ensures that the lessons have a high degree of cultural and linguistic relevance, even if the teachers are not AI/ANs or not of the same Tribe as the students. For example, the community resource leaders can speak to students in their own language to explain important concepts and can relate curriculum materials and exercises to traditional and contemporary Tribal activities, beliefs, and values. A school counselor (typically of the same Tribe) serves as the onsite curriculum coordinator.

Application to AI/AN communities: This curriculum is the currently available version of the Zuni Life Skills Development curriculum. This original curriculum was first implemented with high school students in the Zuni Pueblo, an AI reservation with about 9,000 Tribal members located about 150 miles west of Albuquerque, NM. The American Indian Life Skills Development curriculum, an adaptation of the Zuni version, has been implemented with a number of other Tribes, with appropriate and culturally specific modifications. Adaptations of the curriculum have been developed for middle school students on a reservation in the Northern Plains area; for Sequoyah High School in Tahlequah, OK, a boarding school on the reservation of the Cherokee Nation that enrolls students from about 20 Tribes across the country; and for young women of the Blackfeet Tribe. The process of cultural adaptation incorporated into the program appears transferable to other populations.

2009 Cost: The American Indian Life Skills Development manual is available for $30 plus shipping and handling from the Chicago Distribution Center (1–800–621–2736). Training for school staff costs about $3,000 for a 3-day training program conducted by the developer (exclusive of travel expenses).

Contacts:

For information about implementation or studies:
Teresa D. LaFromboise, Ph.D.
Senior Research Scientist
School of Education, Cubberley 216, 3096
Stanford University
Stanford, CA 94305
Phone: 650–723–1202
Fax: 650–725–7412
E-mail: lafrom@stanford.edu

Screening

Screening involves the identification of youth who may be at risk of suicide. Consent from parents of children younger than age 18 should be obtained before the children participate in a screening program.

Columbia University TeenScreen**

IOM classification: Universal

Population of focus: Male and female middle and high school students who may be at risk for suicide and undetected mental illnesses.

Description: The Columbia University TeenScreen program identifies middle school- and high school-aged youth in need of mental health services due to risk for suicide and undetected mental illness. The program's main objective is to assist in the early identification of problems that might not otherwise come to the attention of professionals. TeenScreen can be implemented in schools, clinics, doctors' offices, juvenile justice settings, shelters, or any other youth-serving setting. Typically, within a setting, all youth in the age group of focus are invited to participate.

The program involves the following stages.

- Before any school-based screening is conducted, parents' written consent is required. Parental consent is strongly recommended for screenings in non-school-based sites. Teens also must agree to the screening. Both the teens and their parents receive information about the process of the screening, confidentiality rights, and the teens' rights to refuse to answer any questions they do not want to answer.

- Each teen completes a 10-minute paper-and-pencil or computerized questionnaire covering anxiety, depression, substance and alcohol abuse, and suicidal thoughts and behavior.

- Teens whose responses indicate risk for suicide or other mental health needs participate in a brief clinical interview with an onsite mental health professional. If the clinician determines the symptoms warrant a referral for an indepth mental health evaluation, parents are notified and offered assistance with finding appropriate services in the community. Teens whose responses do not indicate a need for clinical services receive an individualized debriefing. The debriefing reduces the stigma associated with scores indicating risk and provides an opportunity for the youth to express any concerns not reflected in their questionnaire responses.

Application to AI/AN communities: The TeenScreen program has been studied in a variety of school settings and with students of diverse ethnicity. The program also has been implemented in foster care, primary and pediatric care, shelters, drop-in centers, and residential treatment facilities. Although its use in Native communities is unknown, the program is an option for AI/AN communities.

2009 Cost: Costs involved in implementing TeenScreen include staffing (screener, clinician, case manager), supplies and equipment (computers, headphones, printers, photocopies), and mailing. Costs will vary by site. The program manual includes a budget planning exercise. At this time, the developers of TeenScreen offer free consultation, training, and technical assistance to qualifying communities that wish to implement their own screening programs using the TeenScreen model.

Contacts:

Web site: http://www.teenscreen.org

For information about implementation or studies:
Director
Columbia University TeenScreen Program

1775 Broadway, Suite 610
New York, NY 10019
Phone: 212–265–4453
Fax: 212–265–4454
E-mail: teenscreen@childpsych.columbia.edu

QPR Institute Suicide Triage Training/QPRT Suicide Risk Assessment Training

IOM classification: Selective, Indicated

Population of focus: Any person at risk of suicide.

Description: The QPR (Question, Persuade, Refer) Institute is a multidisciplinary training organization with a primary goal of providing suicide prevention educational services and materials to professionals and the general public. The QPR Institute has developed an 8-hour QPR Suicide Triage Training Course for all "first responders," including crisis line workers, law enforcement, firefighters, emergency medical technicians, clergy, case managers, correctional personnel, school counselors, residential staff, and others who come in contact with people at risk for suicide.

The QPR Institute also offers the QPRT (Question, Persuade, Refer, Treat) Suicide Risk Assessment and Training Course. This course is an award-winning suicide risk assessment training program developed by clinicians for clinicians. The QPRT Suicide Risk Assessment and Training Course is for all primary health care professionals, counselors, social workers, psychiatrists, psychologists, substance abuse treatment providers, clinical pastoral counselors, and licensed and certified professionals who evaluate and treat suicidal persons.

Application to AI/AN communities: The QPR Institute, Eastern Washington University, and Camas Path, which is a Tribally chartered entity of the Kalispel Tribe of American Indians, have collaborated to offer both the QPR Suicide

Triage Training Course and the QPRT Suicide Risk Assessment and Training Course online, with or without college credit. Courses can be accessed through Eastern Washington University at http://www.ewu.edu/x40902.xml.

2009 Cost: Cost of training ranges from $125 for non-credit or continuing education credits to $229 for Eastern Washington University credits.

Contacts:

Web site: http://www.qprinstitute.com

For program information:
QPR Institute
P.O. Box 2867
Spokane, WA 99220
Phone: 509–536–5100 or 1–888–726–7926 (toll-free)
Fax: 509–536–5400
E-mail: qinstitute@qwestoffice.net

Public Awareness/Gatekeeper Training

A gatekeeper is someone in a position to recognize the warning signs that someone may be contemplating suicide. According to the *National Strategy for Suicide Prevention*, potential gatekeepers include parents, friends, neighbors, teachers, ministers, doctors, nurses, office supervisors, squad leaders, foremen, police officers, advisors, caseworkers, firefighters, and many others who are in a position to recognize someone at risk of suicide and refer them to services.

Applied Suicide Intervention Skills Training (ASIST)*

IOM classification: Universal

Population of focus: Any individual at risk of suicide.

Description: ASIST is a 2-day workshop designed to teach the skills that enable an adult to competently and confidently intervene with a person at risk of suicide. Developed by LivingWorks, Inc., the workshop is intended to help all caregivers (i.e., any person in a position of trust, including professionals, paraprofessionals, and laypeople) become more willing, ready, and able to help persons at risk. The workshop is suitable for mental health professionals, nurses, physicians, pharmacists, teachers, counselors, youth workers, police and correctional staff, school support staff, clergy, and community volunteers.

Workshops are 14 hours long and are held over 2 days. The ASIST curriculum includes suicide intervention skill development, confidential and trainer-facilitated small-group learning environments, established trainer protocols to address vulnerable or at-risk participants, knowledge of local resources that can be accessed, consistent use of positive feedback, a blend of larger group experiential challenges and the safety of small-group opportunities to test new skills, no-fault simulation exercises, and the use of adult learning principles.

Workshops are delivered to a maximum of 30 participants by a minimum of two trainers. Almost 2,000 ASIST workshops are conducted annually. In addition, a train-the-trainer program is available so that organizations can have their own trainers.

Application to AI/AN communities: The ASIST program has been implemented at several Native sites, both in reservation and urban settings.

2009 Cost: ASIST training is provided by LivingWorks Education, Inc., of Alberta, Canada. The average program cost is $175 (Canadian) per person, which includes program materials. The cost will vary depending on the availability of trainers and other circumstances. Visit the Web site for a schedule of upcoming training.

Contacts:

Web site: http://www.livingworks.net/AS.php

For program information:
LivingWorks Education, Inc.
P.O. Box 9607
Fayetteville, NC 28311
Phone: 910–867–8822
Fax: 910–867–8832
E-mail: usa@livingworks.net or info@
livingworks.net

Lifelines*

IOM classification: Universal

Population of focus: All students in a school, ages 12 to 17.

Description: Lifelines is a school-based prevention curriculum comprised of four 45-minute lessons. Lesson content includes:

- Information and attitudes about suicide, help seeking, and school resources;

- Discussion of warning signs of suicide and role-playing exercises for students who may encounter a suicidal peer (with an emphasis on seeking adult help); and

- Two videos, with one that depicts appropriate and inappropriate responses to a suicidal peer and one that documents the actual response of three 8th-grade boys to a suicidal peer after they had participated in Lifelines.

The program also includes model school-based policies and procedures for responding to at-risk youth, suicide attempts, and suicide completions; presentations for educators and parents; and a 1-day workshop to train teachers in the curriculum.

Application to AI/AN communities: The Lifelines program was studied in two suburban, middle-class schools in the Northeast, with

positive outcomes. Although its use in Native communities is unknown, the program is an option for AI/AN communities.

2009 Cost: The Lifelines curriculum manual is available from Rutgers University for $45.

Contacts:
Rutgers University
Graduate School of Applied and Professional Psychology
152 Frelinghuysen Road
Piscataway, NJ 08854
Phone: 732–445–2000, ext. 109

Native H.O.P.E. (Helping Our People Endure)

IOM classification: Universal

Population of focus: All Native youth.

Description: Native H.O.P.E. is a curriculum based on the theory that suicide prevention can be successful in Indian Country when Native youth become committed to breaking the "code of silence" that is prevalent among all youth. The program also is premised on the foundation of increasing "strengths" among Native youth as well as increasing their awareness of suicide warning signs. The program supports the full inclusion of Native culture, traditions, spirituality, ceremonies, and humor.

The 3-day Native H.O.P.E. youth leadership curriculum takes a proactive approach to suicide prevention. Training provided to natural peer helpers is designed to build their capacity and awareness to help youth through referral and support. Participants are taught to:

- Show they care by listening and acknowledging the other person's pain;

- Make the person aware that he or she does have choices;

- Get peers at risk to a counselor or other source of health support; and

- Set limits on their natural helper role in the peer counseling process.

This program also is used to train local community members to be facilitators who encourage Native youth to take a leading role in prevention. A key to mobilizing peer counseling programs for Native youth is to identify and train adults from their communities who will be committed to wellness. These adults also will assist their youth in leadership development.

Application to AI/AN communities: This curriculum was piloted in the Billings, MT, area and through the Indian Health Service (IHS) National Suicide Prevention Network in Standing Rock, ND and Red Lake, MN.

2009 Cost: The youth manual and faculitator guide are available free of charge through the One Sky Center and may be downloaded from http:/www.oneskycenter.org/education/documents/NativeHOPEYouthManualCoverandIndex.pdf.

Contacts:

Web site: http://www.oneskycenter.org

For program information:
One Sky Center
Oregon Health & Science University
3181 SW Sam Jackson Park Road, GH 151
Portland, OR 97239
Phone: 503–494–3703
Fax: 503–494–2907
E-mail: onesky@shsu.edu

QPR Gatekeeper Training

IOM classification: Universal

Population of focus: Any person at risk of suicide.

Description: QPR is an acronym for Question, Persuade, Refer—three steps that a person can take in helping to save a life. Topics covered by the online program are:

- How to get help for yourself or learn more about preventing suicide;

- Common causes of suicidal behavior;

- Warning signs of suicide;

- How to "Question, Persuade, and Refer" someone who may be suicidal; and

- How to get help for someone in crisis.

Course participants receive resources and a certificate of completion after completing a post-course survey and evaluation and passing a 15-item quiz. The online course takes approximately 1 hour to complete.

Application to AI/AN communities: The QPR training content identifies current resources and Web sites related to AI/AN suicides, including current research data. The Aberdeen Area IHS adapted the QPR suicide triage method by incorporating Native American scenarios and actors.

2009 Cost: An online course offered through QPR is $29.

Contacts:

Web site: http://www.qprinstitute.com

For program information:
QPR Institute
P.O. Box 2867
Spokane, WA 99220
Phone: 509–536–5100
Toll-free: 1–888–726–7926
Fax: 509–536–5400
E-mail: qinstitute@qwestoffice.net

Signs of Suicide (SOS)*

IOM Classification: Universal

Population of focus: All students within a high school.

Description: SOS incorporates two prominent suicide prevention strategies into a single program, combining a curriculum that aims to raise awareness of suicide and its related issues with a brief screening for depression and other risk factors associated with suicide.

This is a 2-day secondary school-based intervention. The basic goal of the program is to teach high school students to respond to suicide as an emergency, much as one would react to the signs of a heart attack. Students view a video that teaches them to recognize signs of depression and suicide in others. They learn that the appropriate response to these signs is to acknowledge them, let the person know they care, and tell a responsible adult (either with the person or on that person's behalf). Students also participate in guided classroom discussions about suicide and depression. For screening, students self-complete the SOS student screening form. A parent version of the screening form is provided for parents to use in evaluating possible depression in their children.

The intervention strives to prevent suicide attempts, increase knowledge about suicide and depression, and increase help-seeking behavior. Schools should be prepared to respond to an increased number of referrals for depression and suicide.

Application to AI/AN communities: The SOS program has been administered in more than 1,000 high schools and with culturally diverse students. Program effectiveness has been studied in urban settings, and efforts currently are underway to evaluate its effectiveness in suburban and rural populations. Although its use in Native communities is unknown, the program is an option for AI/AN communities.

2009 Cost: Teachers implementing the program will require 1 to 2 hours of training. The program also will require a site coordinator (usually a counselor). Program resources are provided through Screening for Mental Health for $300 for the high school kit, which includes materials for 300 students, parents, and school staff. (A middle school kit also is available for the same cost.)

Contacts:

Web site: http://www.mentalhealthscreening.org

For program information:
Screening for Mental Health, Inc.
One Washington Street, Suite 304
Wellesley Hills, MA 02481
Phone: 781–239–0071
Fax: 781–431–7447
E-mail: highschool@mentalhealthscreening.org

Sources of Strength

IOM classification: Universal

Population of focus: AI/AN youth and young adults.

Description: Sources of Strength is a strength-based, comprehensive wellness program initially developed for Tribal and rural settings, which has been expanded for diverse populations and settings. The program focuses on suicide prevention, but impacts other issues such as substance abuse and violence. Core elements for Tribal communities include:

- A move from a singular suicide prevention focus on mental health treatment referrals to a model of developing village-based supports and institutional health and mental health supports;

- A holistic model of eight sources of strength that encourages multiple strengths reflected in the Medicine Wheel, Red Road approach, and many other teachings of Elders in a variety of Tribal traditions;

- A core focus on strengths, with a realization that leading with risk factors

can be disempowering for many tribal communities; and

- A core value that health and healing is best passed through the interconnection of relationships within family, kinships, clans, and especially among teens and their friendship groups.

Application to AI/AN populations: Sources of Strength has worked with many different Tribal communities and schools and has developed middle school, high school, and college-level programs, including accredited classes in partnership with Tribal colleges. Sources of Strength is not intended as a stand-alone program but is designed to blend into other community efforts, especially those efforts strengthening cultural identity and language.

Sources of Strength currently is partnering with the University of Rochester, NY in one of the Nation's largest randomized evaluations of a population-based suicide prevention project. Opportunities exist for Tribal communities to partner in this community-based

research process.

2009 Cost: Training costs vary, depending on how many adult advisors and peer teams will be trained. Training costs for individual schools are approximately $1,500 plus trainer travel costs; costs for regional or multi-community trainings range from $5,000 to $12,000 plus trainer travel costs. Training includes regular follow-up teleconferencing calls. Materials are made available electronically for local printing at no cost or can be purchased. Contact Sources of Strength for more information about training options and program materials and their use.

Contacts:

Web site: http://www.sourcesofstrength.info

For program information:
Mark LoMurray
Executive Director

Sources of Strength
15506 Sundown Drive
Bismarck, ND 58503
Phone: 701–471–7186
E-mail: marklomurray@gmail.com

Yellow Ribbon Suicide Prevention Program

IOM classification: Universal

Population of focus: All members of a school and its community.

Description: The Yellow Ribbon Suicide Prevention Program is a school- and community-based suicide prevention program that uses a collaborative, grassroots model to decrease suicide risk by promoting help-seeking behavior. This is accomplished by (1) increasing public awareness of suicide prevention; (2) training gatekeepers; and (3) facilitating help-seeking behavior.

Yellow Ribbon expands public awareness of the problem of suicide through educational materials, school-wide assemblies, and community-wide collaboration efforts. Gatekeeper activities are promoted through use of a simple, three-step rubric of "stay, listen, and get help." This rubric is reinforced at all levels of training through *Yellow Ribbon's Be-A-Link®* curriculum and the distribution of *It's OK to Ask for Help®* cards that contain directions for seeking help and the phone number for the National Suicide Prevention Lifeline. Yellow Ribbon incorporates a community-wide prevention model that encourages the development of partnerships to increase program impact and sustainability.

Application to AI/AN communities: The Yellow Ribbon program has been widely used in schools and communities throughout the United States, including in Native communities and schools. A strength of this program is its inclusion of students and family involvement and leadership.

2009 Cost: Program costs are based on a sliding scale: contact Yellow Ribbon for details.

Counseling and Support Services

The following programs target youth who have been identified as being at high risk for suicide. They are designed to help the youth develop or strengthen positive social and coping skills (i.e., resilience) and reduce behaviors that place them at risk of suicide.

CARE (Care, Assess, Respond, Empower)**

IOM classification: Selective, Indicated

Populations of focus:

- Male and female high-school students, ages 14 to 20, who are at high risk of suicide; and

- Male and female young adults, ages 20 to 24, who are at high risk of suicide and are being counseled in non-school settings, such as health care clinics.

Description: CARE (formerly called Counselors CARE [or C-CARE] and Measure of Adolescent Potential for Suicide [or MAPS]) is a high school-based suicide prevention program targeting high-risk youth. CARE includes a 2-hour, individual computer-assisted suicide assessment interview. This interview is followed by a 2-hour motivational counseling and social support intervention. The counseling session is designed to deliver empathy and support, provide a safe context for sharing personal information, and reinforce positive coping skills and help-seeking behaviors. CARE makes it easier for youth to obtain help by connecting each high-risk youth to a school-based caseworker or a favorite teacher and by establishing contact with a parent or guardian chosen by the youth. The program also includes a follow-up reassessment of broad suicide risk and protective factors and a booster motivational counseling session 9 weeks after the initial counseling session.

The goals of CARE are threefold: to decrease suicidal behaviors, to decrease related risk factors, and to increase personal and social assets. CARE assesses the adolescent's needs, provides immediate support, and then serves as the adolescent's crucial communication bridge with school personnel and the parent or guardian of choice. The CARE program typically is delivered by school or advanced-practice nurses, counselors, psychologists, or social workers who have completed the CARE implementation training program and certification process.

Although CARE was originally developed to target high-risk youth in high school—particularly those at risk of school dropout or substance abuse—its scope has been expanded to include young adults (ages 20–24) in settings outside of schools, such as in health care clinics.

Application to AI/AN communities: CARE was piloted and tested with participants ages 14 to 20 and has since been adapted for young adults (ages 20 to 24). Originally tested with diverse racial and ethnic groups, the program also has been adapted specifically for Native American and Hispanic students.

2009 Cost: Required online training in CARE implementation is being developed for interventionists, program coordinators, and administrators. Costs include (1) the training registration fee, (2) the purchase of a license for the use of the computer-assisted CARE program; and, (3) follow-up training and certification process fees. Length of training

may vary depending on the competency levels of participants and the time required for them to achieve and maintain a level of "distinguished" implementation performance.

Contacts:

Web site: http://www.reconnectingyouth.com

For information about implementation or research studies:
Reconnecting Youth™ Inc.
P.O. Box 20343
Seattle, WA 98102
Phone: 425–861–1177
Fax: 1–888–352–2819

CAST (Coping and Support Training)**

IOM classification: Indicated

Population of focus: Male and female high school students, ages 14 to 19, who are at high risk of suicide.

Description: CAST is a high school-based suicide prevention program. CAST delivers life skills training and social support in a small-group format (6 to 8 students per group). The program consists of 12 55-minute group sessions administered over 6 weeks by trained, masters-level high school teachers, counselors, or nurses with considerable school-based experience. CAST serves as a follow-up program for youth who have been identified through screening as being at significant risk for suicide. In the original trials, identification of youth was done through a program known as CARE (Care, Assess, Respond, Empower), but other evidence-based suicide risk screening instruments can be used.

CAST's skills training sessions target three overall goals: increased mood management (depression and anger), improved school performance, and decreased drug involvement. Group sessions incorporate key concepts,

objectives, and skills that inform a group-generated implementation plan for the CAST leader. Sessions focus on group support,

goal setting and monitoring, self-esteem, decisionmaking skills, better management of anger and depression, "school smarts," control of drug use with relapse prevention, and self-recognition of progress through the program. Each session helps youth apply newly acquired skills and increase support from family and other trusted adults. Detailed lesson plans specify the type of motivational preparation, teaching, skills practice, and coaching activities appropriate for at-risk youth. Every session ends with "Lifework" assignments that call for the youth to practice the session's skills with a specific person in their school, home, or peer-group environment.

Application to AI/AN communities: Originally piloted and tested in youth ages 14 to 19 years old, the CAST program is currently being tested with middle school-aged youth. CAST has been evaluated with racially and ethnically diverse groups of high school youth at risk of dropping out of school. Although its use in Native communities is unknown, the program is an option for AI/AN communities.

2009 Cost: The CAST curriculum, which includes one copy of the CAST student notebook, CAST leader guide, and all related teaching aids, is $699 plus shipping and handling. CAST Student Notebooks are $26.50 each plus shipping and handling, or $190.80 for a set of 8 Student Notebooks.

Registration for a 4-day training workshop for CAST leaders and coordinators is $16,000 for 14 to 16 participants. A 1-day training workshop for the administrators responsible for establishing the infrastructure to support implementation of the CAST program runs $400 per person. A 2-day advanced training for CAST coordinators costs $800 per person and is designed to follow the prerequisite 4-day and 1-day trainings. The advanced training is intended for individuals

responsible for the day-to-day support and supervision of staff to ensure program fidelity. Consult the Reconnecting Youth™ Inc. Web site for costs of curriculum materials and evaluation tools.

Free consultation is available from the developer by phone, and many materials and information are available at no cost from the program Web site.

Contacts:

For information about implementation and research studies:
Reconnecting Youth™ Inc.
P.O. Box 20343
Seattle, WA 98102
Phone: 425–861–1177
Fax: 1–888–352–2819

Reconnecting Youth™ (RY)*

IOM classification: Selective, Indicated

Population of focus: Male and female students, grades 9 through 12, who demonstrate suicide risk behaviors.

Description: RY is a school-based prevention program that targets high school students who show signs of poor school achievement, potential for school dropout, and other at-risk behaviors including suicide-risk behaviors. RY teaches skills to build resiliency with respect to risk factors and to moderate early signs of substance abuse, depression, and aggression. The program incorporates social support and life skills training. Classes include 10 to 12 students who meet daily, or on a block schedule, for an entire semester. The class is part of the high school curriculum, and students receive credit for participation. The class is led by a teacher who excels in working with high-risk youth *and* has completed RY training. The focus of the class is on skills training within the context of adult and peer support.

The RY class is delivered in five modules:

1. Getting started;
2. Self-esteem enhancement;
3. Decisionmaking;
4. Personal control; and
5. Interpersonal communication.

Forty-one class sessions and 23 booster/review sessions are included in the curriculum, leaving 16 class sessions for the social activities/school bonding components. The class involves:

- Small-group work and life skills training models to enhance personal and social protective factors of high-risk youth;

- Social activities and school bonding for establishing drug-free social activities and friendships, and healthy, pleasant activities for decreasing depression as well as for improving the teens' relationship with school;

- School system crisis response plan that addresses schoolwide prevention and intervention approaches; and

- Parent involvement that includes active parental consent for student participation and at-home support of RY goals for their children.

Application to AI/AN communities: The program has been studied in six urban schools, but it has been put into place in a variety of schools in both urban and suburban settings and for diverse student populations. Although its use in Native communities is unknown, the program is an option for AI/AN communities.

2009 Cost: Costs vary depending on number of teachers trained, training-related costs (e.g., travel and substitute teacher payments), and materials. Cost estimates and a schedule of upcoming trainings are provided on the RY Web site.

Contacts:

Web site: http://www.reconnectingyouth.com

For RY™ Co. information, implementation consultation, or to schedule trainings:
Reconnecting Youth™ Inc.
P.O. Box 20343
Seattle, WA 98102
Phone: 425–861–1177
Fax: 1–888–352–2819

Attempt Response

A previous suicide attempt is a risk factor for suicide. According to one study of individuals who had survived a serious suicide attempt, almost half made another fatal or nonfatal attempt within 5 years.[126] The following programs are designed to ensure that parents understand the seriousness of an attempt (or their child's risk) and seek the help their children need.

Emergency Department Means Restriction Education for Parents*

IOM classification: Selective, Indicated

Population of focus: Youth at high risk and attempt survivors.

Description: The goal of this program is to educate parents of youth at high risk for suicide about limiting access to lethal means for suicide. Lethal means covered include firearms, over-the-counter and prescribed medications, and alcohol.

Education takes place in emergency departments and is conducted by department staff (an unevaluated model has been developed for use in schools). The content of the parent instruction includes:

- Informing parents, apart from the child, that their child is at risk of suicide and about the warning signs their child is exhibiting;

- Informing parents that they can reduce the risk by limiting access to lethal means, especially firearms; and

- Educating parents and problem-solving with them about how to limit access to lethal means.

Application to AI/AN communities: This program was evaluated with the parents of children of various ethnicities and with an average age of 14. Although its use in Native communities is unknown, the program is an option for AI/AN communities.

2009 Cost: Protocols are available free from the primary program developer. Training costs for emergency room staff will vary.

Contacts:

For materials and information on implementation:
Dr. Markus Kruesi
Department of Psychiatry and Behavioral Sciences
Medical University of South Carolina
171 Ashley Avenue
Charleston, SC 29425
Phone: 843–792–0135
E-mail: Kruesi@musc.edu

Specialized Emergency Room Intervention for Suicidal Adolescent Females*

IOM classification: Indicated

Population of focus: Adolescent females who have attempted suicide and their mothers.

Description: This intervention provides specialized emergency room care for adolescent suicide attempters and their mothers or female guardians. It involves three primary components.

1. Emergency room physicians and staff engage in a single 2-hour training session. The session has three goals: to enhance staff/patient interactions, reinforce the importance of outpatient

treatment, and recognize the seriousness of suicide attempts.

2. Suicide attempters and their mothers view a 20-minute video. The video is designed to highlight the importance of, and instill realistic expectations about, outpatient treatment.

3. Suicide attempters and their mothers meet with a crisis therapist who discusses the video, screens for additional suicide risk, conducts a therapy session, and contracts for follow-up outpatient treatment.

Application to AI/AN communities: This program has been evaluated primarily with Hispanic mothers and is currently being used and evaluated by the White Mountain Apache Tribe working together with the Johns Hopkins University Center for American Indian Health.

2009 Cost: Protocols are free and available online at http://chipts.ucla.edu/interventions/manuals/interer.html. Training costs for emergency department staff training varies.

Contacts:

For program information:
Joan Asarnow, Ph.D.
University of California, Los Angeles
760 Westwood Plaza
Los Angeles, CA 90024-1759
Phone: 310–825–0408
E-mail: jasarnow@mednet.ucla.edu

Future Program Development

Research into programs that hold promise for AI/AN communities is expanding, bringing hope to many Native communities that solutions can be found that have both science and culture as their foundation. This research is an evolving process. The development of prevention programs that work is similar to life itself in that

it is a cycle. Within the scientific community, this is referred to as the science-to-service cycle (see Exhibit 12), in which programs are developed, tested, and improved in response to how effectively the program worked for the people being served. Far more feedback is needed from individual AI/AN communities on what they need and how well an existing program worked, given their own unique culture and values.

Exhibit 12. The Science-to-Service Cycle
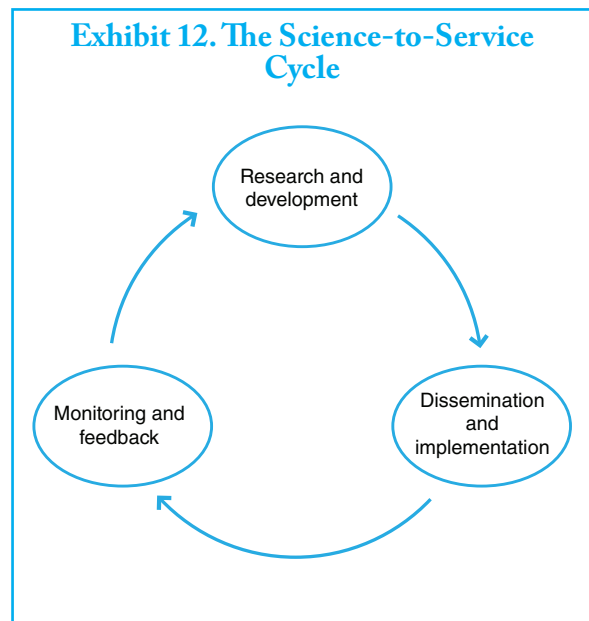
One potential bridge between program development that is evidence-based or culturally based may be through what is called practice-based evidence. This approach is gaining ground in many sectors because it emphasizes the study of what frontline people actually are doing to determine what is working. Practice-based research represents a significant shift in how research is conducted, including what is to be measured as evidence of effectiveness. It provides a greater voice to the people who actively engage in prevention and are applying practices that they believe are working. This practice-based approach may evolve into what the American Indian Policy

Center calls "reality-based research." As described by the Center, this approach:

> … reflects the reality of American Indians and tells their stories, from an Indian point of view and from an Indian oral history standpoint. This reverence for oral history is particularly important because American Indian societies are based on oral tradition. Oral tradition preserves history, language and culture for American Indian communities. Using a method of research which respects and incorporates such basic tenets of a people's culture makes our research more meaningful to Indian communities. In the past, Indians had a high distrust for researchers…. This ability to communicate with Indian communities and their leaders adds a critical component toward capacity building and self empowerment of American Indian communities.[127]

Another important aspect of engaging AI/AN communities in future program development and evaluation is the use of community-based participatory research. As the name implies, this form of research may involve the community in all aspects of the process, from determining what is to be studied to how the information is to be used. Under this approach, community-based organizations—such as a Tribal government— play a direct role in the design and conduct of the research study by:

- Bringing community members into the study as partners, not just as subjects;

- Using the knowledge of the community to understand health problems and to design activities (i.e., programs) to improve health care;

- Connecting community members directly with how the research is done and what comes out of it; and

- Providing immediate benefits from the results of the research to the community that participated in the study.[128]

Perhaps the best way to characterize the principle of participatory research is "research which recognizes the community as a social and cultural entity with the active engagement and influence of community members in all aspects of the research process."[129] The best programs will emerge from the broadest possible involvement of all members of a community in developing, implementing, evaluating, and improving prevention programs.

Chapter 8: Federal Suicide Prevention Resources

> "Substantial progress has been made in developing plans and delivering programs, but it is still only the beginning of a long-term, concerted effort among Federal, Tribal, State, and local community agencies to address the crisis. We have recognized [at the Federal level] that developing resources, data systems, and promising programs, as well as sharing information across the system, requires national coordination and leadership."
>
> — Robert G. McSwain, Director, Indian Health Service
> Testimony Before the U.S. Senate Committee on Indian Affairs,
> February 26, 2009

Introduction

Collaboration has been a key theme throughout this guide. Just as every child should have the support of family and others in dealing with life's challenges, every community should have help in promoting the mental health and well-being of its members. The Substance Abuse and Mental Health Services Administration (SAMHSA), as the Federal agency charged with leading national efforts to reduce, prevent, and improve treatment of mental and substance abuse disorders, takes its role in collaboration seriously. As directed by law, Federal mandate, and the compassion of its professionals, SAMHSA is working to provide States and communities with the tools that can help them prevent suicide.

The preceding chapter described suicide prevention programs listed in SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) and its Suicide Prevention Resource Center's (SPRC's) Best Practices Registry. This chapter describes SAMHSA programs open to American Indian and Alaska Native (AI/AN) community applicants. It also provides more detail about the SPRC, the National Suicide Prevention Lifeline, and other resources available to AI/AN

communities in developing, implementing, and evaluating their suicide prevention plans. All of SAMHSA's efforts are consistent with the 11 goals of the *National Strategy for Suicide Prevention* (see Exhibit 13).

The SAMHSA partner in many efforts is the Indian Health Service (IHS). The IHS views such collaboration as essential to its responsibility to uphold the Federal Government's obligation to promote healthy AI/AN people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes. This chapter also lists IHS suicide prevention resources and contact information for IHS regional offices.

Other Federal agencies that may offer possible funding of programs aimed at reducing risk factors related to suicide also are identified.

Suicide Prevention Programs

In 2005, Congress passed the Garrett Lee Smith Memorial Act (GLS) in memory of Garrett Smith, the son of former Senator Gordon Smith, who died by suicide while at college. This Act passed both houses of Congress unanimously.

> ### Exhibit 13. Goals of the *National Strategy for Suicide Prevention*
>
> 1. Promote awareness that suicide is a public health problem that is preventable.
>
> 2. Develop broad-based support for suicide prevention.
>
> 3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.
>
> 4. Develop and implement suicide prevention programs.
>
> 5. Promote efforts to reduce access to lethal means and methods of self-harm.
>
> 6. Implement training for recognition of at-risk behavior and delivery of effective treatment.
>
> 7. Develop and promote effective clinical and professional practices.
>
> 8. Improve access to and community linkages with mental health and substance abuse services.
>
> 9. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.
>
> 10. Promote and support research on suicide and suicide prevention.
>
> 11. Improve and expand surveillance systems.
>
> From U.S. Public Health Service, (1999). *The Surgeon General's Call To Action To Prevent Suicide.*

Under GLS, Congress charged SAMHSA with creating programs to enhance suicide prevention efforts at the State and local level and on college campuses. Since 2005, Congress has placed increasing emphasis on, and given increased funding for, suicide prevention among AI/AN youth and young adults. SAMHSA currently supports suicide prevention grants for AI/AN Tribes and Villages under GLS through its State and Tribal Youth Suicide Prevention and Early Intervention Grant Program, and for AI/AN communities through its Native Aspirations Program.

AI/AN youth also are served as members of a larger population through SAMHSA's Linking Adolescents at Risk of Suicide to Mental Health Services Grant Program and its Campus Suicide Prevention Grant Program. Additional information about all of SAMHSA's suicide prevention programs is below.

For up-to-date information on new requests for applications (RFAs), the application process, and due dates for each grant program, consult the grants homepage on the SAMHSA Web site at http://www.samhsa.gov/grants. Information also may be requested from:

> **Substance Abuse and Mental Health Services Administration**
> Center for Mental Health Services
> Division of Prevention, Traumatic Stress, and Special Programs
> Suicide Prevention Branch
> 1 Choke Cherry Road
> Rockville, MD 20857

State and Tribal Youth Suicide Prevention and Early Intervention Grant Program

This grant program supports States and Tribes in developing and implementing statewide or Tribal suicide prevention and early intervention strategies. Efforts funded by these grants must involve public and private collaboration among youth-serving systems, such as education, juvenile justice, and foster care, as well as substance abuse and mental health service providers.

Grant eligibility is open to:

1. States;

2. Federally recognized Indian Tribes, Tribal organizations (as defined in the Indian Self-Determination and Educational Assistance Act), or urban Indian organizations (as defined in the Indian Health Care Improvement Act) that are actively involved in the development and continuation of a Tribal youth suicide early intervention and prevention strategy; and

3. Public or private nonprofit organizations designated by a State, federally recognized Indian Tribe, Tribal organization, or urban Indian organization to develop or direct the State/Tribal-sponsored youth suicide prevention and early intervention strategy.

Successful applicants must:

- Develop and implement collaborative prevention and early intervention strategies in youth-serving organizations;

- Support public and private organizations actively involved in such efforts;

- Provide early intervention and assessment services to youth who are at risk for mental and emotional disorders that may lead to suicide or a suicide attempt;

- Provide timely referrals for appropriate community mental health care and treatment to youth who are at risk for suicide or suicide attempts;

- Provide immediate support and information resources to families of youth who are at risk for suicide;

- Offer timely post-suicide intervention services, care and information to families, friends, and organizations affected by a recent youth suicide; and

- Participate in data collection and analysis activities and prepare an evaluation report.

Summaries, successes, and contact information from ongoing State and Tribal Suicide Prevention and Early Intervention grants are available at http://www.sprc.org/grantees/statetribe/desc/S_Tdescriptions.asp.

Native Aspirations

In 2005, SAMHSA funded Native Aspirations, a training and technical assistance project that is designed to help AI/AN communities develop, implement, and evaluate a comprehensive, community-based youth violence, bullying, and suicide prevention program. To select eligible communities, the Native Aspirations project team developed a list of high-risk sites based on statistics for poverty, suicide, homicide, and motor vehicle accidents among youth. From that list, behavioral health experts from IHS, Bureau of Indian Affairs, and State programs identified those communities where the need for prevention resources appeared greatest.

For each of its selected communities, Native Aspirations provides consultation and financial support and conducts facilitated events and training to implement a community's prevention plan. Activities include site visits for project planning, passage of Tribal resolutions or executive orders, and an onsite Gathering of Native Americans (GONA). By providing a safe place to share, heal, and plan for action, the GONA offers hope and a positive start to communities. Additional onsite activities include a youth visioning event to gain youth input and involvement. GONA activities also include a community mobilization and planning event to engage as many stakeholders as possible—including Tribal Elders, youth, and representatives of local youth-serving systems—and to strengthen collaborations across IHS, States, and Native communities.

Native Aspiration grant sites are included in the ongoing cross-site evaluation of State and Tribal Youth Suicide Prevention and Early Intervention sites. Preliminary lessons learned that are applicable to current and future prevention efforts are:

- A grassroots focus is essential when working with Tribal communities;

- Programs and activities need to respond to the unique strengths and barriers that exist within each individual community;

- Program development must be community-driven so that community buy-in and ownership is fostered from the very beginning; and

- Involving youth leaders in community planning not only gets youth involved, but also has led to sustained funding for youth planning.

Linking Adolescents at Risk to Mental Health Services Grant Program

The Adolescents at Risk grant program provided funding to evaluate and document voluntary school-based suicide prevention programs being implemented in high schools. Its primary objective was to determine the extent to which these programs lead to successful referrals for treatment and other sources of help or the extent to which families are engaged in and accept the programs. All activities undertaken as part of this program were developed with respect to the ages of the adolescents, their cultural backgrounds, and the cultural backgrounds of their parents, legal guardians, and other caregivers.

Campus Suicide Prevention Grant Program

The Campus Suicide Prevention grant program provides funds to institutions of higher education to prevent suicide and suicide attempts and to enhance services for students who may experience academic challenges due to mental and behavioral health problems such as depression or substance abuse.

Activities funded by the program include:

- Providing gatekeeper training for students and campus personnel;

- Conducting educational seminars related to suicide;

- Creating informational materials for campus personnel and students and their families;

- Operating local hotlines or promoting the National Suicide Prevention Lifeline; and

- Increasing student access to mental health services on campus or in the community.

Summaries of individual campus programs are available through the SPRC at http://www.sprc.org/grantees/campus/desc/C_Udescriptions.asp.

Suicide Prevention Resource Center

The SPRC is a congressionally mandated, federally funded grant program that is managed through SAMHSA. The primary services offered by SPRC are to:

- Support the technical assistance and information needs of SAMHSA's State and Tribal Youth Suicide Prevention and Early Intervention and Campus Suicide Prevention grantees and associated programs;

- Develop and conduct training on prevention products, materials, services, and strategies;

- Assist States, Territories, and Tribes in their efforts to plan for the development, implementation, and evaluation of suicide prevention programs;

- Collect and distribute information on best prevention practices;

- Facilitate informational exchanges and peer-to-peer mentoring using listservs and other technologies;

- Support the field of suicide prevention by developing and providing access to needed resources for implementing a public health approach; and

- Promote suicide prevention as a component of mental health transformation.

In addition to the Best Practices Registry described in the previous chapter, services and resources available from the SPRC include the following.

- **Prevention support:** Prevention specialists are available to assist the suicide prevention efforts of State and Tribal suicide prevention coalitions and other agencies and organizations. These specialists can be consulted by telephone, e-mail and, in some situations, are available for presentations and training at meetings and conferences.

- **SPRC Training Institute:** The SPRC Training Institute offers an array of training programs, including a 1-day workshop for mental health professionals on assessing and managing suicide risk, periodic Web-based seminars (Webinars) to foster dialog on a variety of topics, and a series of self-paced online workshops about youth suicide prevention. A free online workshop, "Planning and Evaluation for Youth Suicide Prevention," is available at http://training.sprc.org.

- **Customized information:** Each customized page provides information on recognizing and responding to the warning signs of suicide, resources, and other information chosen for its relevance to a particular audience (including parents, teens, first responders, and attempt survivors).

- **Online library:** The online library is a searchable collection of Web-based resources, including data, State prevention plans, and information on interventions, funding, grant-writing, planning and evaluation, and public education.

- **Suicide prevention news:** This compilation of news, funding opportunities, and abstracts of selected research articles is updated weekly. A news archive also is available.

- **SPRC mailing list:** Individuals who sign up for the SPRC mailing list will receive the *Weekly Spark*, a newsletter with updates on current news and other resources, as well as other occasional announcements.

Additional information about the SPRC is available from:

> **SPRC/EDC**
> 55 Chapel Street
> Newton, MA 02458-1060
> Phone: 617–618–2572 or
> 1–877–GET-SPRC (1–877–438–7772)
> (toll-free)
> http://www.sprc.org

SPRC and State Resources

The SPRC Web site also provides links to individual State suicide prevention plans and data sheets, which can inform AI/AN communities about local activities, service gaps, and opportunities for funding and collaboration. SPRC maintains a complete listing of State planning team leaders and contact information. A printed copy of this list is included in Appendix D: Decisionmaking Tools and Resources.

National Suicide Prevention Lifeline

SAMHSA's National Suicide Prevention Lifeline initiative is aimed at crisis centers that respond to callers in extreme emotional crisis. Crisis center workers listen to callers, assess the nature and severity of their crisis, and link or refer callers to services. Accurate assessment and response can be life-saving.
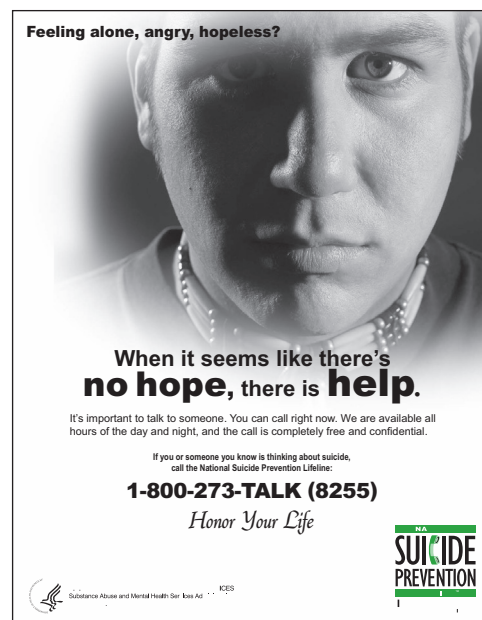
The goals of this initiative are to:

- Enhance the training of crisis workers;

- Increase the number of crisis centers that are certified in crisis intervention;

- Improve crisis center referrals and follow through on referrals; and

- Encourage a consistent and clinically accepted approach for callers who appear to be at imminent risk of suicide.

Certified crisis centers are linked together through the National Suicide Prevention Lifeline at 1–800–273–TALK (8255). Telephone technology enables anyone in the United States who is in crisis to call this number and be forwarded to the closest crisis center. As a result of this initiative, there now are more than 140 certified crisis centers in the national network.

To ensure that veterans in emotional crisis have round-the-clock access to trained professionals, the U. S. Department of Veterans Affairs (VA) operates a hotline for veterans in partnership with SAMHSA and the National Suicide Prevention Lifeline. Veterans can call 1–800–273–TALK (8255) and press "1" to reach the Veterans Suicide Prevention Hotline, which is staffed by mental health professionals.

The National Suicide Prevention Lifeline initiative provides organizations and communities with resources to make the public more aware of suicide and the help that is available through the Lifeline. For example, SAMHSA has wallet cards and brochures that list the warning signs of suicide. Items such as these can be distributed in community centers, school-based counseling centers, and other locations where they will be available to young people contemplating suicide and to those who may be concerned that someone they know may need help. Most materials, such as the poster developed for AI/AN communities (see image), can be customized by adding the logos and contact information for local collaborating organizations.

Feeling alone, angry, hopeless?

When it seems like there's **no hope**, there is **help**.

It's important to talk to someone. You can call right now. We are available all hours of the day and night, and the call is completely free and confidential.

If you or someone you know is thinking about suicide, call the National Suicide Prevention Lifeline:

1-800-273-TALK (8255)

Honor Your Life

The Lifeline also offers publications for local distribution, such as a series of brochures for attempt survivors and those who care for them, including:

- *After an Attempt—A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department;*

- *After an Attempt—A Guide for Taking Care of Your Family Member After Treatment in the Emergency Room; and*

- *After an Attempt—A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors.*

Although most Lifeline materials were developed for the general public, they provide valuable information for AI/AN communities. SAMHSA encourages these communities to adapt the materials and provide feedback to SAMHSA (Division of Prevention, Traumatic Stress, and Special Programs, Suicide Prevention Branch, 1 Choke Cherry Road, Rockville, MD 20857) on the need for and content of materials specially designed for their members.

Appendix E: Web Site Resources and Bibliography includes a complete listing of resources available through the National Suicide Prevention Lifeline and ordering information. Orders can be placed online at http://www.samhsa.gov/shin or by calling SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727). All orders are free.

The National Suicide Prevention Lifeline reaches out to new media users through a variety of social networking sites. Its online *Lifeline Gallery: Stories of Hope and Recovery* (http://www.lifeline-gallery.org) is a safe space for survivors of suicide, suicide attempt survivors, those who struggled with suicidal thoughts, and those in the suicide prevention field to share their stories of hope and recovery.

National Suicide Prevention Lifeline Initiative for AI/AN Communities

Providing access to AI/AN communities remains a Lifeline challenge. For some communities, phone service is lacking and the community has limited resources to start a crisis center. There also are cultural concerns. Off-reservation service providers may be unfamiliar with Tribal culture, and on-reservation service providers may feel constrained from taking action by issues of confidentiality.

In 2006, SAMHSA initiated a pilot program to enhance Lifeline access in Indian Country. Lifeline crisis centers in Montana, Wyoming, Minnesota, North Dakota, and South Dakota participated in the pilot. Objectives of the pilot program were to:

- Facilitate relationships between crisis center staff and stakeholders in Tribal communities;

- Develop cultural awareness and sensitivity training for crisis workers that serve a designated community;

- Strengthen the effectiveness of the local referral systems;

- Promote culturally sensitive social marketing and educational materials for Tribal communities; and

- Identify lessons learned from the pilot initiative for wider application to other AI/AN communities.

SAMHSA also is working collaboratively with IHS to promote the Lifeline nationwide in Indian Country.

Additional information about SAMHSA's Lifeline initiative for AI/AN communities is available from:

Lifeline/Link2Health Solutions
Project Director
50 Broadway, 19th Floor
New York, NY 10004
Phone: 212–614–6357
http://www.suicidepreventionlifeline.org

Indian Health Service Resources

The following resources are available through the IHS, in support of its mission to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level.

IHS National Suicide Prevention Initiative

The IHS has sponsored a National Suicide Prevention Initiative since 2003. This initiative:

- Builds on the goals and objectives of the *National Strategy for Suicide Prevention*;

- Strives to ensure that its efforts honor and respect AI/AN traditions and practices;

- Acknowledges the role and wisdom of Elders and spiritual leaders in healing and wellness; and

- Works to create collaborative, holistic, culturally appropriate efforts between AI/AN communities, government agencies, and nonprofit organizations in order to prevent suicide effectively.

The IHS has made substantial progress in planning and delivering suicide prevention programs, but recognizes that this is just the beginning of a long-term, concerted, and coordinated effort among Federal, Tribal, State, and local community agencies. National coordination and leadership is required for the development of resources, data systems, and promising programs, as well as sharing information across the system.

As a result, the IHS initiative focuses on three approaches:

- Assist IHS, Tribes, Tribal organizations, or urban Indian organizations (I/T/Us) in addressing suicide through cultural approaches at the community level;

- Strengthen and enhance IHS' epidemiological and research capabilities in the areas of suicide and suicide prevention; and

- Promote collaboration between I/T/Us regarding suicide prevention.

To guide overall IHS/Tribal efforts under the initiative, the IHS has established a National Suicide Prevention Committee (SPC). Members of the SPC represent affected AI/AN communities through a variety of clinical professions, including therapists, psychologists, psychiatrists, agency administrators, injury prevention specialists, social workers, and traditional practitioners from a broad geographic distribution and from mixed IHS, Tribal, and urban settings. It is the responsibility of the SPC to provide recommendations and guidance to the IHS regarding suicide prevention and intervention in Indian Country.

SPC efforts include the development of an IHS National Suicide Prevention Strategic Plan and the development of Guidelines for Responding to I/T/U Requests for Assistance. The IHS National Suicide Prevention Strategic Plan is a first step in describing and promoting the accumulated practice-based wisdom in AI/AN communities. At its best, the plan will be a living and constantly changing reflection of the collaborative and focused efforts of the many people throughout AI/AN communities who are working to reduce suicide. The response guidelines will establish procedures and responsibilities for responding to requests for assistance from I/T/U organizations in the area of suicide prevention.

The IHS Suicide Prevention Initiative is complemented by the IHS Behavioral Health Initiative, which also seeks to address suicide prevention through a holistic, community-centered approach. Two other focus areas that are closely linked to the Behavioral Health Initiative are the IHS Chronic Disease Management and Health Promotion and Disease Prevention Initiatives. All three of these initiatives are pertinent to suicide prevention efforts and seek to address the underlying causes of poor physical and mental health rather than just treat the symptoms. They also stress the empowerment and full engagement of individuals, families, and communities in their own health care.

IHS Community Suicide Prevention Web Site

IHS maintains a Community Suicide Prevention Web site to provide AI/AN communities with culturally appropriate information about best and promising practices, training opportunities, and other relevant information regarding suicide prevention and intervention. This site is an information portal in that it does not list existing suicide prevention programs but, instead, links users to the sites of program developers and to current research articles. The goal of the Web site, at http://www.ihs.gov/NonMedicalPrograms/nspn, is to provide Native communities with the tools and information to create or adapt their own suicide prevention programs.

Additional information about the IHS Suicide Prevention Initiative and the Community Suicide Prevention Web site is available from:

> **Indian Health Service Headquarters**
> Office of Clinical and Preventive Services
> 801 Thompson Avenue, Suite 300
> Rockville, MD 20852
> E-mail: http://www.ihs.gov/
> NonMedicalPrograms/nspn

Additional resources and information about local IHS activities may be available through IHS area offices. Contact information follows. You also can find a current listing at http://www.ihs.gov/FacilitiesServices/AreaOffices/AreaOffices_index.asp.

IHS Regional Area Offices

North Dakota, South Dakota, Iowa, and Nebraska
Aberdeen Area Indian Health Service
Office of Professional Services
115 4th Avenue, SE
Aberdeen, SD 57401
Phone: 605–226–7582
Fax: 605–226–7321

Alaska
Alaska Area Native Health Service
4141 Ambassador Drive, Suite 300
Anchorage, AK 99508-5928
Phone: 907–729–3686
Fax: 907–729–3689

New Mexico, Colorado, and portions of Texas
Albuquerque Area Indian Health Service
5300 Homestead Road, NE
Albuquerque, NM 87110
Phone: 505–248–4500
Fax: 505–248–4115

Indiana, Minnesota, Michigan, and Wisconsin
Bemidji Area Indian Health Service
522 Minnesota Avenue, NW, Room 119
Bemidji, MN 56601
Phone: 218–444–0458
Fax: 218–444–0461

Montana and Wyoming
2900 4th Avenue North
Billings, MT 59101
or
P.O. Box 36600
Billings, MT 59107
Phone: 406–247–7248
Fax: 406–247–7230

California and Hawaii
California Area Indian Health Service
650 Capitol Mall, Suite 7–100
Sacramento, CA 95814
Phone: 916–930–3927
Fax: 916–930–3952

Eastern United States and portions of Texas
Nashville Area Indian Health Service
711 Stewarts Ferry Pike
Nashville, TN 37214-2634
Phone: 615–467–1500
Fax: 615–467–1501

Arizona, New Mexico, and portions of Utah
Navajo Area Indian Health Service
P.O. Box 9020
Window Rock, AZ 86515
Hwy. 264 and St. Michael Road
St. Michael, AZ 86511
Phone: 928–871–5811
Fax: 928–871–5866

Oklahoma, Kansas, and portions of Texas
Oklahoma City Area Indian Health Service
701 Market Drive
Oklahoma City, OK 73114
Phone: 405–951–3820
Fax: 405–951–3780

Arizona, Nevada, and portions of Utah
Phoenix Area Indian Health Service
Two Renaissance Square
40 North Central Avenue
Phoenix, AZ 85004-4424
Phone: 601–634–5039
Fax: 601–634–5042

Idaho, Oregon, and Washington
Portland Area Indian Health Service
1220 SW Third Avenue, #476
Portland, OR 97204
Phone: 503–326–2020
Fax: 503–326–7280

Southern Arizona
Tucson Area Indian Health Service
7900 S. J. Stock Road
Tucson, AZ 85746-7012
Phone: 520–295–2405
Fax: 520–295–2602

Other Federal Resources

Support for prevention programs that reduce suicide risk factors may be available from other Federal agencies, such as the online databases of prevention programs described in the previous chapter. Some agencies have funding available for prevention programs. Possible funding sources include the Office of Safe and Drug-Free Schools (OSDFS), part of the U.S. Department of Education, which funds school-based efforts that include projects designed to decrease drug involvement and youth violence. The Web site homepage for OSDFS is http://www.ed.gov/about/offices/list/osdfs/index.html.

The National Center for Injury Prevention and Control (NCIPC), part of the Centers for Disease Control and Prevention (CDC), offers extensive information about the nature of the problems of youth violence and youth suicide, both at the local and national levels, as well as funding opportunities for prevention research. There is a direct link to CDC funding initiatives on the NCIPC homepage at http://www.cdc.gov/ncipc.

The Office of Juvenile Justice and Delinquency Prevention (OJJDP), U.S. Department of Justice, has as a focus the prevention of juvenile delinquency and victimization. Possible support

for community-based prevention efforts may be identified by visiting http://ojjdp.ncjrs.org and clicking on "funding" or "programs." The Title V Community Prevention Grants Program, for example, funds collaborative, community-based delinquency prevention efforts designed to reduce risk factors associated with juvenile delinquency and decrease the incidence of juvenile problem behavior. Many risk factors associated with juvenile delinquency, such as excessive exposure to violence, family disharmony, and school dropout, also are risk factors for suicide. Similarly, protective factors that help youth avoid delinquency and suicide, such as strong family bonds, are shared.

U.S. Federal/Canada Collaboration

In 2003, the U.S. Department of Health and Human Services and Health Canada first signed a Memorandum of Understanding (MOU) to promote the health of AI/ANs in the United States and First Nations people and Inuit in Canada. A direct outcome of the MOU is the Ad Hoc Working Group on Suicide Prevention. The purpose of the working group is to make it easier for the countries to share knowledge about suicide prevention and intervention and the relationship of alcohol abuse to suicidal behavior. Working group activities may include the exchange of personnel as well as information and the hosting of workshops, conferences, seminars, and meetings.

The two government agencies renewed the MOU in 2007. Since then, Health Canada has launched its youth suicide prevention Web site, at http://honouringlife.ca. This trilingual Web site (English, French, and Inuktitut) provides a place for Aboriginal youth to read about others dealing with similar issues and for those working with Aboriginal youth to connect, discuss, and share suicide prevention resources and strategies.

Conclusion

SAMHSA has established a clear vision for its work—a life in the community for everyone. To realize this vision, SAMHSA is gearing all of its resources—programs, policies, and grants—toward that outcome.

SAMHSA currently maintains four suicide prevention programs that directly or indirectly serve AI/AN youth and young adults: State and Tribal Youth Suicide Prevention and Early Intervention, Native Aspirations, Linking Adolescents at Risk for Suicide to Mental Health Services, and Campus Suicide Prevention. Regardless of whether a community has one of these grants, its members can access planning, implementation, and evaluation support through SAMHSA's SPRC. Additional services and resources that encourage individuals experiencing an emotional crisis to seek help are available through the National Suicide Prevention Lifeline.

SAMHSA's prevention efforts aimed at AI/AN communities are still evolving as new information and opportunities become available. For example, SAMHSA is exploring the potential of using telepsychiatry to make mental health care more accessible to residents, including AI/ANs, living in remote and underserved areas. An overarching goal of all of these efforts is to develop a better knowledge base of what works best in promoting mental health and preventing mental illnesses and suicide among AI/ANs. To achieve this goal, collaboration and information sharing among AI/AN communities and the organizations and government agencies involved is necessary. Breaking the code of silence around suicide is one crucial step forward in helping AI/AN youth and young adults on their path toward a mentally healthy and promising future. Communities have a variety of resources to draw from after taking this first step.

Chapter 9: Conclusion to the Guide

This guide is more than a summary of available information about preventing suicide by American Indian and Alaska Native (AI/AN) youth and young adults. It also is an acknowledgement that more is yet to be discovered about culturally appropriate prevention and far more is yet to be done. One of the Substance Abuse and Mental Health Services Administration's (SAMHSA's) objectives in developing this guide is to create a document that will serve as a starting point for both discovery and action.

It is our hope that any discussions about suicide prevention that this guide stimulates will go beyond the narrow definitions of prevention and risk factors. Instead, we encourage you to move the conversation toward mental health promotion and a more positive focus on protective factors. The goal of any community should be to help its members achieve a state of mental health called "flourishing."[130] Flourishing is characterized not only by an absence of mental illness but also by a person's emotional well-being and positive functioning in daily life. It supports a life that is well-lived. Approaching suicide prevention from this perspective can transform mental health care in this country.

Many of you who read this guide already will know a great deal about suicide prevention. Some of you will possess wisdom that exceeds what this guide offers. We encourage you to share your knowledge with us so that we can continue to learn and can help others learn more about what works in preventing suicide by young people. You can send your input directly to:

Captain Maria Dinger, R.N., M.S.
Chief, Suicide Prevention Branch
Substance Abuse and Mental Health
Services Administration
Center for Mental Health Services
Division of Prevention, Traumatic Stress,
and Special Programs
1 Choke Cherry Road
Rockville, MD 20857
Phone: 240–276–2016
E-mail: maria.dinger@samhsa.hhs.gov

For others who read this guide, the idea that suicide can be prevented or that you can have any involvement in its prevention may be new. We urge you to speak with those who are working to prevent suicide. Many lives have been saved because someone similar to you offered caring and hope to those who had lost hope or felt alone.

Regardless of your past experience, your future involvement in prevention efforts within your community is crucial. Suicide is a complex issue, and it will take an entire community coming together to address it successfully. Everyone is needed, and everyone has a role in suicide prevention.

As we began this guide by quoting Inuit wisdom, we will end it by quoting the wisdom of White Buffalo Calf Woman of the Lakotas:

> When one sits in the Hoop of People,
> One must be responsible because
> All of Creation is related.
> And the hurt of one is the hurt of all.
> And the honor of one is the honor of all. And whatever we do affects everything in the universe.[131]

Appendix A: List of Contributors and Reviewers

Contributors

Ben Camp, M.S. Ed. was principal author; Charlotte Ball, M.P.A. was coauthor.

SAMHSA gratefully acknowledges the impetus and foundational work provided by the One Sky Center and R. Dale Walker, M.D., the center director, in creating a guide that specifically addresses suicide prevention of American Indian and Alaska Native youth and young adults. The One Sky Center has conducted groundbreaking work aimed at improving the prevention and treatment of substance abuse and mental health disorders for Native Americans. As a leader in this area, the center is contributing significantly to the development of programs that both recognize and build upon the traditional values, practices, and strengths of Native cultures.

SAMHSA Contributors

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Reviewers

CMHS also wishes to acknowledge the following individuals for contributing their time and expertise in the development, review, and revisions of this guide. Their input was invaluable in developing a guide to promote the mental health and well-being of American Indian and Alaska Native youth, young adults, and communities.

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Appendix B: Glossary of Terms[a]

Access to services – The extent to which an individual who needs behavioral health care and services is able to receive them. Access is not defined simply as having insurance coverage or the ability to pay for services. Instead, access also is determined by the availability and acceptability of services as well as their cultural appropriateness, location, hours of operation, transportation needs, and cost.

Acculturation – The process by which individuals choose to remain firmly rooted in their natal cultural group but also may adapt or adopt attitudes, beliefs, and norms of a new (perhaps dominant) cultural group or groups.

Adaptation – Modification of a program or intervention so that it incorporates specific cultural values of a community while still maintaining the program's principal characteristics.

Advocacy groups – Organizations that work in a variety of ways to foster change with respect to a societal issue.

Alternation – The notion that an individual (who may be bi-racial, mono-racial, or multi-racial) can be anchored securely in one primary cultural identity (usually of a "minority status" group) while also having mastered the culture of a secondary group (usually, a "dominant status" group). In alternation, the individual will have formed the capacity and skills to seamlessly, or nearly seamlessly, shift between the two identity statuses with ease and comfort, depending on social context.

American Indian or Alaska Native – A person having origins in any of the original peoples of North and South America (including Central America) and who maintains Tribal affiliations or community attachment.

Appropriateness – The extent to which a particular procedure, treatment, test, or service is needed, adequate, and provided in the setting best suited to the needs of each individual.

Assimilation – The process by which individuals voluntarily or involuntarily give up their identity with their natal cultural group and become absorbed into a new (usually dominant) cultural group.

Behavioral health disorder – Mental health or substance abuse disorder that affects a person's ability to realize his or her full potential as a contributing member of the community.

Best practices – Activities or programs that are in keeping with the best available evidence regarding what is effective.

Biculturalism – The idea that individuals can hold and integrate two different cultural identities (typically, one that is of a minority status and one that is a majority status), taking from the two cultures attitudes, beliefs, and norms that are purposeful and meaningful to them.

Causal factor – A condition that alone is sufficient to produce a disorder.

Community – A group of people residing in the same locality or sharing a common interest.

Community assessment – A comprehensive examination of factors that can contribute to or reduce the risk of behavioral health disorders, including suicide. A community assessment also identifies who is most at risk and the resources and partnerships that a community can access to reduce risk factors and increase protective factors.

Community-based services – Services that are provided in a community setting.

Comprehensive suicide prevention plans – Plans that use a multifaceted approach to addressing the problem; for example, including interventions targeting social and environmental factors.

Connectedness – Closeness to an individual, group, or people within a specific organization; perceived caring by others; satisfaction with relationship to others or feeling loved and wanted by others.

Consumer – A person using or having used a health service.

Culture – The integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith, or social group.

Cultural sensitivity (also known as cultural competence or cultural appropriateness) – A set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

Culturally based – Programs based on traditional beliefs, values, and practices of a specific ethnic or cultural group.

Depression – A constellation of emotional, cognitive, and somatic signs and symptoms, including sustained sad mood or lack of pleasure.

Early intervention – A process used to recognize and respond to warning signs for mental health problems. Early intervention can reduce a person's risk of developing a mental illness or reduce its symptoms and consequences.

Effective – Programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial one in the target group more than in a comparison group.

Environmental approach – An approach that attempts to influence either the physical environment (such as reducing access to lethal means) or the social environment (such as providing work or academic opportunities).

Evaluation – The systematic investigation of the value and impact of an intervention or program.

Evidence-based – Programs that have undergone scientific evaluation and have proven to be effective. "Evidence" often is defined as findings established through scientific research, such as controlled clinical studies, but other methods of establishing evidence are considered valid as well. Evidence-based practice stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.

Evidence-based practice (EBP) – A term generally used in the health care field to refer to approaches to prevention or treatment that are validated by some form of documented scientific evidence.

Fidelity – The degree to which a program is implemented as designed.

First responders – Law enforcement officers, firefighters, emergency medical technicians (EMTs), Tribal leaders, and others who may be the first to respond to a medical emergency such as suicide.

Flourishing – A state of mental health that is characterized not just by the absence of mental illness but by feelings of emotional well-being (e.g., happiness, satisfaction with life) and positive functioning (e.g., self-acceptance, purpose in life, rewarding relationships with others) in daily life.

Frequency – The number of occurrences of a disease or injury in a given unit of time; with respect to suicide, frequency applies only to suicidal behaviors that can repeat over time.

Gatekeepers – Those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services.

Goal – A broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work.

Health – The complete state of physical, mental, and social well-being and not merely the absence of disease or infirmity.

Indicated prevention intervention – Intervention designed for individuals at high risk for a condition or disorder or for those who have already exhibited the condition or disorder.

Intervention – A strategy or approach that is intended to prevent an outcome or alter the course of an existing condition (such as providing lithium for bipolar disorder or strengthening social support in a community).

Means – The instrument or object whereby a self-destructive act is carried out (e.g., firearms, poison, medication).

Means restriction – Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm, such as building barriers on bridges to prevent jumping.

Methods – Actions or techniques that result in an individual inflicting self-harm (e.g., asphyxiation, overdosing, or jumping).

Mental disorder – A diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional, or social abilities; often used interchangeably with mental illness.

Mental health – The capacity of individuals to interact with one another and the environment in ways that promote subjective well-being, optimal development, and use of mental abilities (e.g., cognitive, affective, and relational).

Mental health problem – Diminished cognitive, social, or emotional abilities that exist but do not meet the criteria for a mental disorder.

Mental health services – Health services that are specially designed for the care and treatment of people with mental health problems, including mental illnessness; includes hospital, emergency department, and other 24-hour services, intensive community services, ambulatory or outpatient services, medical management, case management, intensive psychosocial rehabilitation services, and other intensive outreach approaches to the care of individuals with severe disorders.

Mental illness – See mental disorder.

National Registry of Evidence-Based Programs and Practices (NREPP) (http://nrepp.samhsa. gov) – Online database maintained by the Substance Abuse and Mental Health Services Administration of peer-reviewed programs and practices that have achieved measurable outcomes in reducing and preventing behavioral health disorders in children and adults.

Objective – A specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when, and where or clarifies by how much, how many, or how often.

Outcome – A measurable change in the health of an individual or group of people that is attributable to an intervention.

Outreach programs – Programs that send staff into communities to deliver services or recruit participants.

Postvention – A strategy or approach that is implemented after a crisis or traumatic event has occurred.

Prevention – A strategy or approach that reduces a person's risk of developing a mental illness, including a substance abuse problem, that may contribute to suicidal and self-harm behaviors.

Protective (or buffering) factors – Factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological, or social factors in the individual, family, and environment.

Public information campaigns – Large-scale efforts designed to provide facts to the general public through various media such as radio, television, advertisements, newspapers, magazines, and billboards.

Rate – The number per unit of the population with a particular characteristic, for a given unit of time.

Resilience – Capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Risk factors – Those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological, or social factors in the individual, family, and environment.

School-based services – School-based treatment and support interventions designed to identify and respond to emotional disturbances in children. School-based services may include counseling or other school-based programs for emotionally disturbed children, adolescents, and their families within the school, home, and community environment.

Screening – Administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

Screening tools – Those instruments and techniques (e.g., questionnaires, checklists, self-assessment forms) used to evaluate individuals for increased risk of certain health problems.

Selective prevention intervention – Intervention targeted to subgroups of the population whose risk of developing a health problem is significantly higher than average.

Self-harm – The various methods by which individuals injure themselves, such as self-laceration, self-battering, overdoses, or deliberate recklessness.

Self-injury – See self-harm.

Social services – Organized efforts to advance human welfare, such as home-delivered meal programs, support groups, and community recreation projects.

Social support – Assistance that may include companionship, emotional backing, cognitive guidance, material aid, and special services.

Stakeholders – Entities, including organizations, groups, and individuals, who are affected by and contribute to decisions, consultations, and policies.

Stigma – An object, idea, or label associated with disgrace or reproach.

Substance abuse – A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substances such as alcohol; prescription drugs such as analgesics, sedatives, tranquilizers, and stimulants; and illicit drugs such as marijuana, cocaine, inhalants, hallucinogens, and heroin.

Suicidal act (also referred to as suicide attempt) – A potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries.

Suicidal behavior – A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.

Suicidal ideation – Self-reported thoughts of engaging in suicide-related behavior.

Suicidality – Suicidal thoughts, ideation, plans, suicide attempts, and completed suicide.

Suicide – Death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death.

Suicide attempt – A potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.

Suicide attempt survivors – Individuals who have survived a prior suicide attempt.

Suicide cluster – When a group of suicides or suicide attempts occur closer together in time and space than would normally be expected in a given community.

Suicide contagion – A phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

Suicide survivors – Family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors.

Surveillance – The ongoing, systematic collection, analysis, and interpretation of health data with timely dissemination of findings.

Telephone hotline (or crisis line) – A dedicated telephone line that is advertised and may be operated for emergency counseling or as a referral resource for callers with mental health problems. The number for the National Suicide Prevention Lifeline is 1–800–273–TALK (8255).

Traditional healing – Ways of restoring a person to physical and mental health that are based on a group's spiritual and cultural beliefs.

Universal preventive intervention – Intervention targeted to a defined population, regardless of risk; this could be an entire school, for example, and not the general population per se.

Unmet needs – Identified treatment needs of the people that are not being met; also refers to treatment that is inappropriate or not optimal for improving a person's behavioral health.

Appendix C: Statistics Related to Suicide by American Indian and Alaska Native Youth and Young Adults

This appendix presents general statistics related to suicide and self-harm among American Indian and Alaska Native (AI/AN) youth and young adults. Statistics related specifically to Alaska Natives also are given.

These statistics are useful in directing media attention to the issue of suicide—without a precipitating tragedy—and in completing a needs assessment for grant applications to address the broad spectrum of factors known to contribute to or protect against suicidal behavior. To the maximum extent possible but without violating family or Tribal privacy, statistics should be accompanied by real-life stories to ensure that the faces behind the numbers always are remembered.

Local statistics should be used whenever possible to increase relevancy and impact and to eliminate the perception that all Tribes and Villages can be viewed as one culture or community. There are 562 federally recognized Tribes; of these, 229 are AN Villages.[a] The circumstances of each Tribe or Village are shaped by its own unique location, culture, economy, social services, and history. Organizations that may have community-based statistics include State and county departments of health and Indian Health Service (IHS) regional and area offices and local universities.

Note that, while grim, suicide-related statistics are not the primary reason that Tribal communities need and deserve immediate, better behavioral health programs for their youth and young adults. Instead, the reason is more basic and enduring: AI/AN youth and young adults are the living spirit of their people, their culture, and our Nation's history. We must value and protect their health as the foundation for ensuring that

they have equal access to the same promising future that we wish for all of America's children.

> "Suicide is not a single problem; rather, it is a single response to multiple problems."
>
> — Former U.S. Surgeon General Richard Carmona
> Testimony Before the U.S. Senate Committee on Indian Affairs,
> June 15, 2005

Suicide and Self-Harm Among American Indians and Alaska Native Youth and Young Adults[b]

- Injuries and violence—intentional or accidental—were the leading causes of death in 2004 for AI/AN youth and young adults from ages 10 through 34. Injuries and violence account for:

    - 71.6 percent of the deaths of 10–14 year olds;

    - 84.6 percent of the deaths of 15–19 year olds;

    - 79.3 percent of the deaths of 20–24 year olds; and

    - 60.2 percent of the deaths of 25–34 year olds.

- Suicide was the second leading cause of death (after accidents) for AI/ANs for all age groups in 2004, and exceeded the

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[a] *Federal Register*: April 4, 2008, Vol.73, No. 66, pp. 18553-18667. Available online at http://edocket.access.gpo.gov/2008/E8-6968.htm.

[b] Statistics represent the most recent reports as of January 2009. For more recent or additional information, check the cited data source. Web site links are given for all citations.

rates for the general population for all age groups. Suicide was the reported cause of:

– 13.5 percent of the deaths of 10–14 year olds (nearly double the percent of 7.2 percent for all races);

– 26.5 percent of the deaths of 15–19 year olds;

– 15.9 percent of the deaths of 20–24 year olds; and

– 14.7 percent of the deaths of 25–34 year olds.[c]

• Suicide rates were highest for AI/AN male youth and young adults. (Comparison percentages for all males are in parentheses.) The rate of suicide for AI/AN males was:

– More than 2½ times higher than the average rate for 15–19 year olds (32.2 percent vs. 12.6 percent);

– Nearly 1½ times higher than the average rate for 20–24 year olds (29.1 percent vs. 20.8 percent); and

– More than 1½ times higher than the average rate for 25–34 year olds (31.1 percent vs. 20.4 percent).[d]

• Young people ages 15–24 make up 40 percent of all suicides in Indian Country.[e]

• 234 AI/AN youth and young adults died by suicide in 2004 alone: 174 males and 60 females.[f] These numbers most likely were under-reported.

• The patterns of suicide among AI/AN youth and young adults suggest that they usually and most frequently were responding to external stimuli (including significant family or interpersonal problems); had been using alcohol, drugs, or both; and tended not to have been seen previously in any behavioral health clinical setting.[g]

• Lack of available, high-quality behavioral health care has a profound effect on suicide: evidence suggests that more than 90 percent of all youth who die by suicide had mental health needs before their deaths.[h]

Suicide and Self-Harm Among Alaska Native Youth[i]

Readers should give special attention to the way in which suicide and self-harm statistics are reported for Alaska youth overall. Youth violent death rates in Alaska are based on a small number of actual deaths. This is due, in part, to the fact that both the total population of Alaska and the actual number of children ages 1 through 14 are relatively small compared to other States. In addition, rates are reported by deaths per 100,000. Given the small number of actual deaths by suicide among ANs, (an average of 30.7 per year from 2001–2005)[j], even a small change in the actual number of deaths can cause the rates to fluctuate substantially. For this reason, many of the rates reported in this section will be either in 5- or 10-year periods.

Alaska had the highest death rate for youths ages 15–19 in the Nation for 3 of the 5 years between

[c] Centers for Disease Control and Prevention. (2007). Deaths: Leading causes for 2004, *National Vital Statistics Reports*, 56(5), November 20, 2007. Available online at http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_05.pdf.

[d] Ibid.

[e] Carmona, R. H. (2005). *U.S. Surgeon General's testimony on suicide prevention among Native American youth, before the Indian Affairs Committee, U.S. Senate, June 15, 2005*. Available online at http://www.surgeongeneral.gov/news/testimony/t06152005.html.

[f] Centers for Disease Control and Prevention. (2007). Deaths: Leading causes for 2004, *National Vital Statistics Reports*, 56(5), November 20, 2007. Available online at http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_05.pdf.

[g] Carmona, R. H. (2005). *U.S. Surgeon General's testimony on suicide prevention among Native American youth, before the Indian Affairs Committee, U.S. Senate, June 15, 2005*. Available online at http://www.surgeongeneral.gov/news/testimony/t06152005.html.

[h] National Indian Child Welfare Association. (2005). *Testimony on suicide prevention among Native American youth, before the Indian Affairs Committee, U.S. Senate, June 22, 2005*. Available online at http://www.nicwa.org/legislation/S556_HR2440/T24000-0.pdf.

[i] Much of the information in this section comes from Kids Count Alaska, a multiyear project to report on the health and safety of Alaska children. The project is a collaboration between the Annie E. Casey Foundation and the Institute of Social and Economic Research at the University of Alaska-Anchorage. For more information about the project and its publications, visit http://www.kidscount.alaska.edu.

[j] Alaska Bureau of Vital Statistics, http://www.hss.state.ak.us/DPH/bvs.

2001 and 2005. In 2004, the rate was almost 70 percent higher than the national average.

Of the 269 Alaska teenagers who died during this period, more than three-quarters died violently. Accidents were the most common cause (38 percent), followed closely by suicide (31 percent).

Some of these deaths can be attributed to environmental factors. Young people in Alaska face environmental conditions that may not be experienced by young people living in the lower 48 States. As described in *Kids Count Alaska 2006–2007: Children in Danger*,

> We have very long winters with extended periods of darkness and cold, and icy roads create dangerous driving conditions for much of the year. Alaska has thousands of lakes and rivers, as well as a very long coastline—so Alaskans spend a lot of time on the water. But waters in Alaska are deadly cold year-round. Also, much of the State is remote and sparsely populated, and dozens of small communities are accessible only by air or water. Advanced medical or trauma care can be hours away. The use of snow machines and all-terrain vehicles (ATVs) is widespread in rural areas, among both children and adults—and every year children are hurt or even killed using off-road vehicles.[k]

- The 5-year average for violent death rates across Alaska for youth (2001–2005) was 79 per 100,000. However, violent death rates, including suicide, varied widely. Rates by region were:
    - 54.1 in Anchorage;
    - 64.2 in Mat-Su Borough;
    - 61.9 Gulf Coast;
    - 71.7 Interior;
    - 240 Northern;
    - 36.7 Southeast; and
    - 258.5 Southwest.[l]

- Violent deaths appear to be on the increase. The 10-year average for violent death rates across Alaska for youth (1996–2005) was 34 per 100,000. Rates by region were:
    - 14.7 in Anchorage;
    - 23.2 in Mat-Su Borough;
    - 14.6 Gulf Coast;
    - 34.8 Interior;
    - 204.9 Northern;
    - 8.9 Southeast; and
    - 132.4 Southwest.[m]

- Further analysis of the Alaska Bureau of Vital Statistics information for this 10-year period shows that, just as in other areas in the Nation:
    - Suicide rates are higher in the rural areas than in urban areas such as Anchorage;
    - The suicide rate for teen males (51 per 100,000) was more than triple the rate for teen females (16 per 100,000);
    - AN males represent 53 percent of all youth suicides in Alaska compared to 24 percent for non-Native male youth;
    - AN females represent 16 percent of all youth suicides compared to 6 percent for non-Native female youth; and
    - Similar trends exist for suicide attempts and other nonfatal injuries throughout Alaska.[n]

- Hospital admissions for various kinds of nonfatal injuries for Alaska youth (ages 1 to 19) by race from 2000–2005 indicate

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[k] University of Alaska-Anchorage, Institute of Social and Economic Research (2007). *Kids Count Alaska 2006–2007: Children in Danger*, available online at http://kidscount.alaska.edu/2006-2007db/Children%20in%20dangerLL.pdf.

[l] Alaska Division of Public Health, Alaska Bureau of Vital Statistics, http://www.hss.state.ak.us/dph/bvs/data/default.htm.

[m] University of Alaska-Anchorage, Institute of Social and Economic Research (2007). *Kids Count Alaska 2006–2007: Children in Danger,* available online at http://kidscount.alaska.edu/2006-2007db/Children%20in%20dangerLL.pdf.

[n] Ibid.

that while admissions of children of all races equaled 5.6 per 1,000:

- – AI/AN equaled 11.7 per 1,000;

- – Whites equaled 3.9 per 1,000;

- – Asian/Pacific Islander equaled 3.3 per 1,000; and

- – Black equaled 3.4 per 1,000.[o]

- – As a point of reference, 67 percent of Alaska youth ages 1 to 19 are White, about 23 percent are Alaska Native, and 10 percent are of other races.

- Out of 1,011 hospital admissions for suicide attempts in Alaska Native youth ages 1 to 19 from 2000–2005:

- – 564 or 55.8 percent were AN;

- – 364 or 36 percent were White; and

- – 83 or 8.2 percent were other races.[p]

Background Statistics

The following statistics present a general overview of AI/ANs and their circumstances. Statistics on issues such as poverty, substance abuse, and child neglect are included only for the purpose of illustrating the complex issues that AI/AN communities confront in reducing risk factors that may contribute to suicide. Nurturing of children is one of the most basic aspects of Native cultures. Protection of children against harm is embedded in centuries-old spiritual beliefs, child-rearing methods, extended family roles, and systems of clans, bands, or societies. It is these very traditional values that will lend strength to Tribal and Village efforts to prevent suicide among their youth and young adults.

General Demographics

Unless otherwise noted, general demographic figures are from the U.S. Census Bureau's *American Community—AI and ANs: 2004. American Community Survey Reports*.[q] Refer to this publication for a broader picture of AI/AN lifestyle characteristics.

- There are approximately 1.7 million American Indians. The largest Tribal group is Cherokee, with 331,000 Tribal members.

- There are approximately 89,000 Alaska Natives. The largest Village is Eskimo, with about 36,000 members.

- About one-third of AI/ANs live on designated reservations or Tribal and Village areas.[r]

- In 2003, nearly 80 percent (76.6 percent) of AI/ANs had at least a high school diploma, while 14.2 percent had at least a bachelor's degree. (In comparison, the statistics for non-Hispanic White were 88.6 and 29.7 percent, respectively.)

Health Care, Employment, and Poverty

- In 2006, 38 percent of AI/ANs under age 65 lacked health insurance coverage.[s]

- The majority of those who receive IHS services live mainly on reservations and in rural communities in 35 States, mostly in the western United States and Alaska. Thirty-six percent of the IHS service area population resides in non-Indian areas. Urban Natives tend to have less access to hospitals, health clinics, or contract health services provided through the IHS and Tribal health programs. Studies on the

[o] University of Alaska-Anchorage, Institute of Social and Economic Research (2007). *Kids Count Alaska 2006-2007: Children in Danger*, available online at http://kidscount.alaska.edu/2006-2007db/Children%20in%20dangerLL.pdf.

[p] Ibid.

[q] U.S. Census Bureau. (2007). *American Community—American Indian and Alaska Natives: 2004. American Community Survey Reports*. Issued May 2007. ACS-07. Available online at http://www.census.gov/prod/2007pubs/acs-07.pdf.

[r] Snipp, C. M. (2005). *American Indian and Alaska Native Children: Results from the 2000 Census*. August 2005. Prepared by the Population Reference Bureau with support from the Annie E. Casey Foundation. Available online at http:// www.prb.org/pdf05/AmericanIndianAlaskaChildren.pdf.

[s] Adams, P. F., Lucas, J. W., & Barnes, P. M. (2008). *Summary Health Statistics for the U.S. Population: National Health Interview Survey, 2006*. National Center for Health Statistics. Vital Health Stat 10(236). Available online at http://www.cdc.gov/nchs/data/series/sr_10/sr10_236.pdf.

urban AI/ANs have documented frequent poor health and limited health care options for this group.[t]

- There are fewer than 200 doctoral-level AI psychologists in the U.S., far fewer than are needed to serve the approximately 1.6 million AI/ANs eligible for health care from the IHS.[u]

- In 2003, the AI/AN unemployment rate was 15 percent, in comparison to the unemployment rate of 6 percent for the general population.[v] These rates are higher among non-gaming Tribes and may be as high as 80 percent on some reservations.[w]

- In 2003, about 29.6 of the AI/AN population was under age 18. (In comparison, about 22.3 percent of the non-Hispanic Whites were under age 18.)

- In 2003, about 1 out of every 4 AI and ANs were living below the poverty level, compared to 1 out of 10 non-Hispanic Whites. In numbers, more than 608,000 AI and ANs were living in poverty. The poverty rate among AI/AN families is highest among families on reservations.[x]

- In 1999, 20.7 percent of AI/AN families with children lived in poverty (compared with 13.6 percent for all families and 9.4 percent for non-Hispanic White families). The poverty rate was higher for AI/AN families with children under age 5.

- In 2003, over 30 percent of AI/AN children under the age of 18 were living in poverty. In numbers, more than 250,000 AI/AN children were living in poverty.

- Poverty among children is strongly linked to poorer mental health, and minority and uninsured children have high unmet needs for mental health services.[y]

- Compared with children living in families at or above the poverty line, children living below the poverty line are more likely to have difficulty in school, to become teen parents, and, as adults, to earn less and be unemployed more frequently.[z, aa]

- In 2003, the percentage of 16- to 24-year-old AI/ANs who were out of school and who had not earned a high school diploma or General Educational Development (GED) credential was 15 percent—higher than the 6 percent for Whites and 4 percent for Asian/Pacific Islanders. Young adults who do not finish high school are more likely to be unemployed and earn less when they are employed than those who complete high school.[bb]

- In 2004, the rate of teenage pregnancy for AI/ANs ages 15–19 was 53 per 1,000 births. While lower than the rate for Hispanic females (83/1000) and Black (63/1000), this rate was higher than that for all teenage females ages 15–19. Teenagers who have children are less likely to complete high school than their peers who do not have children.[cc]

[t] U.S. Department of Health and Human Services, Office of Minority Health. (n.d.) *American Indian, Alaska Native Profile*. Available online at http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=52.

[u] American Psychological Association. (2003). Psychology in Indian Country. *The Rural Psychologist, 34*(6), 56. June 2003. Available online at http://www.apa.org/monitor/jun03/indian.html.

[v] National Center for Education Statistics, U.S. Department of Education. (2005). *Status and Trends in the Education of American and Alaska Natives*. August 2005. Available online at http://nces.ed.gov/pubs2005/nativetrends/ind_8_2.asp.

[w] North American Indian Housing Council. (n.d.) *Indian Housing Fact Sheet*. Available online at http://www.naihc.net/news/index.asp?bid=6316.

[x] National Center for Education Statistics, U.S. Department of Education. (2005). *Status and Trends in the Education of American Indians and Alaska Natives*. August 2005. Available online at http://nces.ed.gov/pubs2005/nativetrends/ind_8_2.asp.

[y] Agency for Healthcare Research and Quality. (2003). *Assessing Health Care Quality for Minority and Other Disparity Populations.* AHRQ Pub. No. 03-007-EF. May 2003. Available online at http://www.ahrq.gov/qual/qdisprep.pdf.

[z] National Center for Education Statistics, U.S. Department of Education. (2005). *Status and Trends in the Education of American Indians and Alaska Natives*. August 2005. Available online at http://nces.ed.gov/pubs2005/nativetrends/ind_8_2.asp.

[aa] Ibid.

[bb] Ibid.

[cc] Ibid.

Other Factors Contributing to Suicide and Behavioral Health Disorders

- Among AN students ages 15–18 who participated in the 2007 Youth Risk Behavioral Surveillance System (YBRSS) survey:

  - 31.7 percent reported feeling so sad or hopeless almost every day for 2 weeks or more in a row during the past year that they stopped doing some usual activities;

  - 22.5 percent had seriously considered attempting suicide during the previous 12 months;

  - 18.8 percent had made a plan for attempting suicide during the previous 12 months; and

  - 20.2 percent reported that they had actually attempted suicide one or more times during the previous 12 months.[dd]

- Alcohol abuse is an intergenerational problem:

  - More than 28 percent (28.2) of AI/ANs ages 12 and over binge drink, the highest rate of all racial groups. (Comparative rates are 24.6 percent for Whites, 23.4 percent for Hispanics, 19.1 percent for Blacks, and 12.6 percent for Asians.)[ee]

  - AI/AN youth ages 12–17 have the highest rate of drinking of all racial groups. In 2006, 20.5 percent of AI/AN youth were current drinkers. (Comparative rates are 7.6 percent of Asian youth, 10.5 percent of Black youth, 15.3 percent of Hispanic youth, and 19.2 percent of White youth.)[ff]

- Substance abuse is an intergenerational problem:

  - In 2007, the rate of current illicit drug use by AI/ANs ages 12 and older (12.6 percent) was higher than that of any other racial/ethnic group. (Comparative rates are 9.5 percent for Blacks, 8.2 percent for Whites, 6.6 percent for Hispanics, and 4.2 percent for Asians.)[gg] In 2007, the rate of substance abuse or dependence by persons ages 12 or older was higher for AI/ANs at 13.4 percent than for any other racial/ethnic group. (Comparative rates are 9.4 percent for Whites, 8.5 percent for Blacks, 8.3 percent for Hispanics, and 4.7 percent for Asians.)[hh]

  - In 2006, past month marijuana use, at 9.8 percent, was higher among AI/ANs ages 12 and older than for all other racial groups. (Comparative rates are 1.6 percent of Asians, 7.6 percent of Blacks, 5.1 percent of Hispanics, and 6.1 percent of Whites.)[ii]

  - In 2006, past month marijuana use, at 14.9 percent, among AI/ANs ages 12–17 was more than double the rate for

[dd]Centers for Disease Control and Prevention. (2008). Youth Risk Behavior Surveillance—United States, 2007. *Morbidity and Mortality Weekly Report*, 57(SS-4). June 6, 2008. Available online at http://www.cdc.gov/HealthyYouth/yrbs/pdf/yrbss07_mmwr.pdf.

[ee]U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2008). *Results from the 2007 National Survey on Drug Use and Health: National Findings* (NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Available online at http://oas.samhsa.gov/nsduhLatest.htm.

[ff]U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *National Survey on Drug Use and Health, 2006*. Available online at http:// http://www.oas.samhsa.gov/NSDUH/2k6NSDUH/2k6Results.pdf.

[gg]U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2008). *Results from the 2007 National Survey on Drug Use and Health: National Findings* (NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Available online at http://oas.samhsa.gov/nsduhLatest.htm.

[hh]Ibid.

[ii]U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *National Survey on Drug Use and Health*, 2006. Available online at http:// http://www.oas.samhsa.gov/NSDUH/2k6NSDUH/2k6Results.pdf.

any other racial group. (Comparative rates were 1.5 percent of Asian youth, 7.2 percent of Black youth, 6.3 percent of Hispanic youth, and 7.2 percent of White youth.)[jj]

- Violence and trauma—both historical and current—have significant and long-term effects on the mental health and well-being of AI/ANs across generations. AI/AN youth and young adults experience violence as witnesses and as victims at rates higher than those for the general population.

  – According to the National Violence against Women survey, at least one out of every three AI/AN females has been subject to intimate partner violence. Intimate partner violence includes rape, physical assault, or stalking. AI/AN women have the highest rates of intimate partner violence compared to all other groups.[kk]

  – In Alaska, 36 percent of the victims of domestic violence between 2000-2003 were AN, compared with a Native share of less than 20 percent of the adult population. Alcohol was a factor in an estimated 85 percent of reported cases of domestic violence.[ll]

  – During the years 2000 and 2001, ANs were 7.6 times more likely than others to be victims of sexual assault.[mm]

  – There are approximately 405,000 AI children in the United States today.

An estimated 7 percent (28,000) may be at risk for abuse and neglect each year. According to the National Indian Child Welfare Association Web site, 95 percent of these cases are related to substance abuse.[nn]

– About 40 percent of AI/AN child abuse and neglect is not reported to State authorities. Available statistics suggest rates that are more than twice that for other racial groups. According to the National Child Abuse and Neglect Data System, child maltreatment rates for Native children were 19.8 cases per 1,000 children. The U.S. Children's Bureau recorded rates of 8.5/1,000 for White children and 10.6 for Hispanic children.[oo]

– According to the Office of Children's Services, Alaska Department of Health and Social Services, 1,859 or 51 percent of all victims of substantiated abuse (including mental injury, neglect, physical abuse, and sexual abuse) under the age of 18 in 2006 were AN. Out of these cases of substantiated abuse 1,192 or 64 percent were from neglect.[pp]

– Alcohol plays a part in an estimated 80 percent of all child abuse cases in Alaska.[qq]

– Between 1993 and 2001, 31.2 percent of AI high school students in grades 9–12 reported carrying a weapon.[rr]

[jj]Ibid.

[kk]National Women's Health Information Center, U.S. Department of Health and Human Services. (n.d.) *Minority Women's Health: Violence.* Available online at http://www.4woman.gov/minority/americanindian/violence.cfm.

[ll]University of Alaska-Anchorage, Institute of Social and Economic Research, (2004). *The Status of Alaska Natives Report 2004.* Available online at http://www.iser.uaa.alaska.edu/Home/ResearchAreas/statusaknatives.htm.

[mm]Rosay, A., & Langworthy, R. (2003)., *Descriptive Analysis of Sexual Assaults in Anchorage, Alaska.* Alaska Justice Statistical Analysis Center, Justice Center, University of Alaska-Anchorage.

[nn]National Indian Child Welfare Association. (n.d.) *Child Abuse Prevention.* Available online at http://www.nicwa.org/child_abuse_prevention.

[oo]Earle, K. (2000). *Child Abuse and Neglect: An Examination of American Indian Data.* National Indian Child Welfare Association. December 2000. Available online at http://web.archive.org/web/20061006184212/http://www.nicwa.org/resources/catalog/research/2001/04.Child%20Abuse01. Rpt.pdf.

[pp] Kids Count Alaska (n.d.). *Children in Danger, Kids Count Alaska 2006–2007.* Available online at http://kidscount.alaska.edu/2006-2007db/Children%20in%20dangerLL.pdf.

[qq] University of Alaska-Anchorage, Institute of Social and Economic Research. (2004). *The Status of Alaska Natives Report 2004,* Available online at http://www.iser.uaa.alaska.edu/Home/ResearchAreas/statusaknatives.htm.

[rr] U.S. Census Bureau. (2007). *American community—American Indian and Alaska Natives: 2004.* American Community Survey Reports. Issued May 2007. ACS-07. Available online at http://www.census.gov/prod/2007pubs/acs-07.pdf.

Federal Sources for State and Local Statistical Data

Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health (NSDUH)

The National Survey on Drug Use and Health (NSDUH) provides yearly national and state-level data on the use of alcohol, tobacco, illicit, and non-medical prescription drugs in the United States. Other health-related questions also appear from year to year, including questions about mental health. http://nsduhweb.rti.org/.

Indian Health Service (IHS) Area Offices

http://www.ihs.gov/FacilitiesServices/ AreaOffices/AreaOffices_index.asp.

Suicide Prevention Resource Center

This SAMHSA-sponsored center offers information on suicide and suicide prevention activities by State as well as contact information for State suicide prevention planning team leaders. http://www.sprc.org.

Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Youth Risk Behavior Surveillance System

The Youth Risk Behavior Surveillance System (YRBSS) monitors priority health-risk behaviors and the prevalence of obesity and asthma among youth and young adults. The YRBSS includes a national school-based survey conducted by the CDC and State, Territorial, Tribal, and local surveys conducted by State, Territorial, and local education and health agencies and Tribal governments. YRBSS information is available online at http://www.cdc.gov/HealthyYouth/ yrbs/index.htm.

U.S. Census Bureau

The U.S. Census Bureau conducts regular surveys of the U.S. population. It analyzes and presents demographic data according to numerous variables. http://www.census.gov.

Some U.S. Census Bureau reports on AI/ANs and their communities are:

- *American Community Survey – American Indians and Alaska Natives: 2004.* The American Community Survey is a new nationwide survey by the U.S. Census Bureau designed to provide reliable timely information to communities on how they are changing. The ACS survey is conducted every year. http://www.census.gov/prod/2007pubs/ acs-07.pdf.

- *American Indian and Alaska Native Populations: 2000.* This report provides data on Tribal numbers and State locations as well as general information about how the U.S. Census Bureau compiled this information. http://www.census.gov/prod/2002pubs/ c2kbr01-15.pdf.

- *We the People: American Indians and Alaska Natives in the United States, February 2006.* This report presents a portrait of AI/ANs in the United States and discusses the largest specific Tribal groupings, reservations, and AN Village statistical areas as well as areas outside of these boundaries. It is part of the Census 2000 Special Report series that presents demographic, social, and economic characteristics collected from the 2000 census. http://www.census.gov/prod/2006pubs/ censr-28.pdf.

Appendix D: Decisionmaking Tools and Resources

AMERICAN INDIAN COMMUNITY
SUICIDE PREVENTION ASSESSMENT TOOL

Contents:

1. Community Identification
2. History of the Reservation
3. Life on the Reservation
4. Population Data
5. Government
6. Land
7. Environment
8. Reservation Water System
9. Tribal Economy
10. Recreation Activities
11. Medical Facilities
12. Housing
13. Education
14. Mortality Data
15. Community Cohesion
16. Family Integration Factors
17. Identification of the Current Status of the Community
18. Healing Process
19. Review of Community, Tribal, Social, and Mental Health Services Delivery
20. Community Self-Helping Process
21. Identification of Community Infrastructure Issues
22. Review of Self-Continuity Factors
23. Community Treatment Plan

One Sky Center

INSTRUCTIONS:

This document is designed as a TEMPLATE for use by a variety of American Indian organizations. **BLUE TEXT** is used to highlight information and phrases that differ across organizations. This text is included in this assessment tool as an EXAMPLE of content that can be revised to fit specific Tribal or organizational needs.

SUGGESTED USES OF THIS TOOL:

- ◆ Use for internal program assessment and planning
- ◆ Use as background material for grant applications
- ◆ Extract selected sections and include in grant applications
- ◆ Use the entire tool as an appendix to a grant applications

Please let us know your experience with this tool.
Also, you may contact us at the One Sky Center for information on how to access an interactive Word document or with questions about the uses of this tool.

Phone: 503.494.3703

Fax: 503.494.2907

E-mail: oneskycenter@ohsu.edu

1. COMMUNITY IDENTIFICATION

Original _____ (Insert Tribe(s) Name_____ Lands

Insert photograph of map showing original Tribal lands

The ___ (Insert Tribe(s) Name _____ Reservation or Community

Insert photograph of map showing Current Tribal lands or Reservation

2. HISTORY OF THE RESERVATION (COMMUNITY)

The terms of the _(name)_____ Treaty of _(Date)____ placed the __(tribe)_____ on one large reservation that encompassed parts of _(State)_____, and _(#)___ other states. After the United States defeated the Indian (tribe's name) the U.S. Government broke the _____(Tribe's name)_____ original reservation into several smaller ones. Not only did the U.S. government reduce the Indians' acreage, it also splintered the Tribe. In _(year)____ the United States reclaimed ____ million acres of the ___(tribe's)___ and moved the _____ to the _____ Reservation. Although the Reservation originally occupied ____ million acres, subsequent land confiscations by the government reduced the Reservation's size to ____ million acres.

3. LIFE ON THE RESERVATION (IN THE COMMUNITY; NATION)

The main economic activities on the _____ Reservation are _____. The Tribe has established various industries including a fairly successful casino and some light industry. Despite these efforts to establish greater economic activity on the Reservation, Tribal members still face high unemployment and poverty. As a matter of principle, the _____ tribes never complied with the Indian Reorganization Act of 1935 and therefore do not receive their full share of government funding. This lack of government dollars, meager per capita income, and high unemployment intensify the housing and health problems on the Reservation. Many residents live in remote areas, far away from medical care and healthy food. Housing, both in remote areas and in towns, is in short supply, forcing many families to live in overcrowded conditions. Two out of three Tribal members are jobless and residents' annual income averages only $_____.

Insert photograph of typical picture of the environment

4. POPULATION

Total Population:

                                            Residing "On Reservation":   _____

                                            "Registered":   _____

Insert photograph of typical picture of the environment

Reservation: (insert Number) Districts and District Population:

Insert District names & Population Data

District Name	Population	District Name	Population

5. TRIBAL GOVERNMENT

The Tribal Council consists of a _____, _____, a _____ and _____ additional Council people who are elected by the Tribal members. The Tribal Council Chair is the head of administration of the Tribe. The Tribal Council Chair and Council serve a term of four years, six of them without regard to residence in any district or state. Each of the remaining members is elected from their District. The At-large Council members are elected by the Tribe.

Statistics at a Glance

Tribal/Agency Headquarters: (Insert name of town/city)
Counties: (List Counties)
Federal Reservation established: (List Year)
Population of enrolled members: _____#_____
Reservation Population: _____#__
Density: _____ persons per square mile
Labor Force: ___-____
Unemployment percentage rate: _____ (#%)
Language: and English
_____ Bands (or Clans):   (give names of bands/clans)

6. LAND

The _____ Tribal members are descendants of the _____. The Reservation is __(name non-rez city or town & state)_____. The _____ River runs along the _____ of the reservation and _____Creek in the _____. The reservation ends at the _____ County lines in the west and the _____ on its east side. The southern line of _____ Reservation ends with the _____ line. The total land area of the _____ is _____ million acres and of that _____ million is Tribally owned. The land is an important part _____ people's life. ____(insert other pertinent facts)_____.

Land Status:	Acres
Total Area	###,###
Tribal Owned	
Tribal Owned Allotted	
Total Tribal owned	
Non-Indian Owned	
Reservoir Taken area	

7. ENVIRONMENT

The following infrastructure (exists or was lost) to _____ Tribes due to _____
(insert treaty, Act, other reasons for loss of land)_____:

# domestic water systems	# acres of waterbed	# rodeo arenas
# ranch water systems	# miles of main roads	# race tracks
# acres of land	# housing units	# sawmills

8. WATER

Water is the key to increasing the quality of life and promoting full economic development on the _____ Reservation. An adequate supply of good quality water is needed by many of the ___ (#) ___Indians and __(#)__ non-Indians living on the reservation. Problems with water quality and inadequate supply are common throughout the reservation and have a detrimental effect on health and quality of life as well as deterring economic growth. The availability of a plentiful and high quality water supply is vital to the health and well being of those living on the _____ Reservation. The level of health and quality of life of the general population is directly related to the quality of their domestic water supply. Many residents currently depend on poorly constructed or low capacity individual wells or have water hauled to __(underground cisterns, Other locations)___. These sources are often contaminated with bacteria or undesirable minerals, provide an inadequate quantity of water, and are costly to maintain and operate.

_(Surface; Ground)_____ water is the major water source for the reservation with the __(Water source)_____ providing by far the largest part of the surface water supply. Other reservation streams have extremely variable flow patterns and are not reliable enough for a year-round water supply. Groundwater is not as abundant as surface water and where available it is usually adequate for only small-scale use. For these reasons, __(Name)__ is the obvious sources for a reservation water supply system.

There has been a serious water shortage over the past three years with drinking water being imported. The US and the Tribal government are trying to resolve the difficulties using _____(insert information as appropriate)_____.

9. TRIBAL ECONOMY

The _____ Tribe's major economic occupation is _____.
_____ Tribe established various industries for the Tribe on the reservation (in the Nation) and plans to develop more enterprises. In the area of economic development, the Tribe currently operates the _____(name economic enterprises)_____.
The district also operates businesses such as the _____their local districts. _____ has a grocery store, _____ has a convenience store/ gas station, _____ has a trading post and _____ has a laundromat. Enrolled

members of _____ own their own businesses: ___(name business owned by Tribal members)_____. There are non-Indian owned businesses throughout the reservation, primarily in _____.

(List type of industry, e.g., agriculture)_____is the primary industry on the _____ Reservation and the key to the full development of this industry is water. Surface water in small streams, lakes, and dugouts is scattered throughout the area. Surface water, however, is an unreliable year-round supply and generally available only during the wet periods of spring. During drought periods, these sources of ten dry up, and livestock must be sold or moved off the reservation. Shallow groundwater is scarce and unreliable and deep groundwater, while generally more plentiful, is highly mineralized and of poor quality. This lack of an adequate water supply has also reduced the livestock production on the reservation. The grazing lands cannot be fully utilized and valuable resource is wasted. The lack of stability in the production of feeder-cattle also discourages related industrial development such as packing plants, cattle feeding and canneries.

Hydrologic Setting: Shallow groundwater is not obtainable on much of the _____Indian Reservation, and where it is found, it is often of poor quality. Surface water, with the exception of the _____ Rivers, though valuable and widely distributed resources, are undependable because of scanty and erratic precipitation. Artesian water from deeply buried bedrock aquifers underlies all of the reservation. These aquifers are not, and probably will not become highly developed sources of water because of the high-to-very-high salinity of artesian water in most of the area.

10. RECREATION ACTIVITIES

The _____ Tribe has __(#)___ Casinos, the _____ Casino located near _____ and the _____ near _____.

Give information about when recreational facilities were developed. They are developing plans to build an _____. Hotel and motel accommodations are located in _____, the _____ largest towns nearest the reservation.

Tribe/District Pow Wows (or major cultural events)

Date	Type of event/Name	Location
2nd Weekend in June	Memorial Day Pow Wow	Any town, State

_____College sponsors a Graduation Pow Wow _____.
Chemical Prevention Program Annual Sobriety _____
Elementary School _____
Veteran's Day _____
Tribal Days _____

Other recreational and honoring activities that have special meaning:
1.   _____ in _____ in memory of _____
2.   _____ in _____ in memory of _____
3.   Annual _____ events are held in the surrounding _____
4.   Annual _____at _____ (when)_____
5.   _____

During the year, other sports activities such as basketball, softball, volleyball and horseshoe tournaments are also held in the districts. Water sports such as boating and fishing are popular along _____ River.

11. MEDICAL FACILITIES

The reservation is located in the U.S. Indian Health Service's _____ Area. The I.H.S. operates a hospital at _____ and smaller clinics in the _____ districts. The Tribal Health Department provides a number of health services including the Community Health Representative Program, health education, eye examinations, eyeglasses, and Emergency Health Care including ambulance services. The Tribe also provides an elderly nutrition program and youth recreational activities.

_____Reservation Hospital: The 12-bed hospital at _____, has a staff of _____ physicians and a _____ unit that opened in _____. Dental care is provided in the main hospital clinic by _____ dental officers, and in a mobile clinic by one dental officer. There are three LPN nurses and 13 registered nurses. An outpatient health center at _____ has _____staff physician. There are also health stations at _____. The health stations provide minimal outpatient care and are staffed by a physician's assistant, a public health nurse, and a community health representative. The health stations are visited at least once per week by a physician from the _____ hospital.

12. HOUSING

The _____Housing Authority constructs and manages over 650 homes for Tribal members living on the reservation. This includes homes on scattered sites built through the HUD Mutual Help home ownership program on individual land or Tribal land leased for home sites. The other housing in the districts is low-income HUD Low Rent for individual Indian residents in reservation communities. As private housing stock is limited, some of the _____members own their own homes in the rural areas through other private financing. The Bureau of Indian Affairs and the Indian Health Service have some housing available in _____ and _____ for their employees. The Tribe plans to build a number of apartment complexes in the future.

The need for housing is great on _____. The Tribe is looking into Habitat for Humanity homes and the government Home Grant project. The average number of persons per household in the _____Service Area is _____ compared to _____ for ___(name state(s) or counties as appropriate)_____. The average number of persons per household for all races in the U.S. is __(obtain data from Census Bureau)_____.

13. EDUCATION

Schools providing K-12 educational services are located in every community on the reservation. The Bureau of Indian Affairs operates elementary and secondary schools in _____. The Tribe also provides preschool education through the Head Start program. Public schools located in _____. A private parochial school, _____, provides K-6 education in _____. Post secondary education is available on reservation at _____, which offers Associate Degrees including _____. A bachelor's degree in teacher education is also offered in conjunction _____ on the _____ Reservation in South Dakota. Four year colleges include:_____
For the _____ school year, there were _____ students enrolled in K – 12 schools on the _____ reservation. Of this group, _____(__%) are American Indian students. Three elementary schools (_____-) and one high school (_____ High School) have a student population that is ____% American Indian. Two school districts (_____ and _____- Public Schools) have school populations that are ___% American Indian. On the other end of the spectrum, one school district (____ Public Schools) has an American Indian enrolment of ___%.

Within all the schools on the _____ reservation, for the 200_ – 200_ school year, there were _____ teachers. There were _____ American Indian teachers, or _____% of the total faculty. _____ schools had no American Indian teachers. _____ schools have _____ American Indian teacher. The greatest number of American Indian teachers was found in the Bureau of Indian Affairs School that has _____American Indian teachers in a faculty of _____.

Districts		Funding Source				Type of School		
Name	Number	Tribal	Federal (BIA)	State	Church	Elemen-tary	Middle	High
State or								
County								

14.   MORTALITY DATA

Descriptive information is provided _____ of the ____ completed suicides on or at the _____.

1) (Give history of medical, mental health, substance use, family, academic achievement, previous attempts and method used. Completed through_____ (method used).
2)
3)
4)

Aggregated Suicide Data
_____Reservation
Act Occurred: Month Day, 200X – Month Day, 200X

Age Range: 15-19 years	**Total: 54**	**Report Totals**	
		(N)	**(%)**
Self-Destructive Act:	Ideation with Plan	___	___
	And attempt	___	___
	Complete Suicide	___	___
	Data not Entered	___	___
Event Logged by:	Medical Social Worker	___	___
	Mental Health Tech	___	___
Sex:	Male	___	___
	Female	___	___
Employed:	No	___	___
	Yes	___	___
	Data Not Entered	___	___
Community of Residence:	_____	___	___
	_____	___	___
	_____	___	___
	_____	___	___
	_____	___	___
	_____	___	___
	_____	___	___
	_____	___	___
	_____	___	___
Relationship:	Single	___	___
	Data Not Entered	___	___
Education:	Less than 12 years	___	___
	Some College	___	___
	_____	___	___
	High School Grad/GED1	___	___
	Data Not Entered	___	___
Method:	Gunshot	___	___
	Hanging	___	___
	Stabbing/Laceration	___	___
	Overdose	___	___

	Car crash	___	___
	Other	___	___
Previous Attempts:	None	___	___
	1	___	___
	2	___	___
	3	___	___
	4	___	___
	_____	___	___
	Data Not Entered	___	___
Substance Abuse Involved:	None	___	___
	Alcohol	___	___
	Drugs	___	___
	_____	___	___
Location of Act:	Home or Vicinity	___	___
	Other	___	___
	Jail/Prison	___	___
	Data Not Entered	___	___
Contributing Factors:	Suicide of Friend/ relative	___	___
	Death of Friend/Relative	___	___
	Victim of Abuse (current)	___	___
	Victim of Abuse (past)	___	___
	Occupational/education prob.	___	___
	History of Substance Abuse/ Dependence	___	___
	Divorce/Separation/Breakup	___	___
	Financial Stress	___	___
	History of Mental Illness	___	___
	History of Physical Illness	___	___
	_____	___	___
	Other	___	___
Intervention (Ideation/Att):	No Action Taken	___	___
	Inpatient (voluntary)	___	___
	Inpatient (involuntary)	___	___
	Outpatient	___	___
	Other	___	___
	Data Not Entered	___	___

15. COMMUNITY COHESION

a) *Number of high-risk individuals (e.g., previous attempts as identified by community workers):* Please explain:
(Example: With high unemployment, isolation and a fragile economy, the use of alcohol and drugs are a major problem).

b) *Number of "children in care", "in community" placements*:
____(#) reported from child protective services.

c) ____(#) "out of community" placements at a given point in time.

d) *Number of non suicide deaths in the past two years through "non-natural means" by type (i.e., vehicle crashes, accidents, violence):*
_____

e) *Percentage of youth/children with addiction issues*: at least ___%

f) *Percentage of adults with addiction issues*: __%

g) *___ (#) of family units with more than one family member with addiction issues (____ %, by issue)*

h) *Anecdotal accounting by community workers of abuse indicators present (i.e., physical, sexual and emotional):* _____

i) *Number of reported sexual assaults in past two years:* _____

j) *Number of reported physical assaults in past two years*: _____

k) *Number of family violence reports in past two years:* _____

l) *Traumatic events that have happened in and to community include:* _____
_____
_____
_____
_____

m) *Loss of respected Elders, leaders or others:* Loss is _____, but there have been some _____
_____
_____

16. FAMILY INTEGRATION FACTORS

a) *Role of Elders in extended family systems (advisors, counselors, healers)?*
_____
_____
_____

b) *Interaction patterns (conflict, cooperation) between extended family systems/factions?*

_____
_____
_____

c) *Familial instability (marital & family breakups)?*

_____
_____
_____

d) *Childhood separation and loss?*

_____
_____
_____

e) *Interpersonal and inter-familial conflict?*

_____
_____
_____

17.   **IDENTIFICATION OF THE CURRENT-STATUS OF THE COMMUNITY**

a) *Community ownership over "child-in-care" decision-making, involvement in supporting "at-risk" families, role and functioning of social support systems.*

_____
_____
_____

b) *Role of community Elders in community decision-making processes?*

_____
_____
_____

c) *Role of positive adult role models in assisting children/youth "at-risk"?*

_____
_____
_____

d) *Extent to which the community embraces individual members as belonging to the collective (as opposed to "not belonging")?*

_____
_____
_____

e) *Extent of customary healing practices within the community based on traditional customary practices?*

_____
_____
_____

f) *Accepting responsibility for and addressing past sexual or physical abuse at the community level (e.g., healing circles)?*

_____
_____
_____

g) *Identifying and supporting individuals with friends or relatives that have committed suicide?*

_____
_____
_____

18.   HEALING PROCESS

a) *Community ownership over "child-in-care" decision-making, involvement in supporting "at-risk" families, role and functioning of social support systems.*

_____
_____
_____

b) *Role of community Elders in community decision-making processes?*

_____
_____
_____

c) *Role of positive adult role models in assisting children/youth "at-risk"?*

_____
_____
_____

d) *Extent to which the community embraces individual members as belonging to the collective (as opposed to "not belonging")?*

_____
_____
_____

e) *Extent of customary healing practices within the community based on traditional customary practices?*

_____
_____
_____

f) *Accepting responsibility for and addressing past sexual or physical abuse at the community level (e.g., healing circles)?*

_____
_____
_____

g) *Identifying and supporting individuals with friends or relatives that have committed suicide?*

_____
_____
_____

19. **REVIEW OF COMMUNITY AND TRIBAL SOCIAL AND MENTAL HEALTH SERVICE DELIVERY**

a) *Community relationship with the Indian Health Service (IHS)*:

_____
_____
_____

b) *State support and funding:*

_____
_____
_____

c) *Mental health therapist contract:*
   1. Community level:
   2. Tribal Council level:
   3. 1HS-funded:

d) *Is access to the 1HS-funded mental health therapist on a per client fee for service basis?*
_____

e) *Access to State mental health services:* _____

f) *Alcohol and Drug Abuse Program:*

_____
_____

g) *Describe community recreation facilities or programming*:

_____
_____

20. COMMUNITY SELF HELPING PROCESSES

a) *Is there a linkage between suicidal behaviors and youth development processes: response from community workers to youth in crises; youth activities community inclusion and involvement?*

_____
_____
_____

b) *Efficacy of current community worker resources in identifying and monitoring high-risk individuals; level of support proactively provided to high-risk individuals?*

_____
_____
_____

c) *Worker or volunteer response to suicide attempts/verbalizations/gestures, organization of response strategy, allocation of resources, community education and outreach efforts?*

_____
_____
_____

d) *Frequency of community worker team meetings, effectiveness in identifying and serving high risk clients, case conferencing and management procedures, task assignment and monitoring, remedial mechanisms to improve service delivery?*

_____
_____
_____

e) *Community worker team commitment to promoting positive mental health of high-risk individuals by connecting them to community social structure (individual home visits, assertive outreach, facilitating Elder involvement with high risk individuals)?*

_____
_____
_____

f) *Strengths and weaknesses of community health and suicide service delivery system?*
   1. Strengths: _____
   _____
   _____

   2. Weaknesses: _____
   _____
   _____

21. IDENTIFICATION OF COMMUNITY INFRASTRUCTURE ISSUES

a) *Number of persons who are homeless and "near homeless" (especially adolescents/ young adults previously "in -care"):*

_____
_____
_____

b) *Does the community resource team ensure that its team members carry out the work?*

_____
_____
_____

c) *Are steps being taken to ensure the continuity of culture in the community (e.g., assisting youth to feel connected to their traditional and cultural origins)?*

_____
_____
_____

d) *Existence of cultural facility, traditional customary practices, involvement of youth in community culture?*

_____
_____
_____

e) *Community history:*

_____
_____
_____

f) *Does the community have control over finances?*

_____
_____
_____

22. REVIEW OF SELF-CONTINUITY FACTORS:

a) *Does the community have the ability to maintain and support a sense of self-continuity by adolescents? (e.g., help youth feel "rooted" in the customs of the community)*:

_____
_____
_____

b) *Does the community support, through individuals, transitional challenges - adolescence to adulthood?* (e.g., sense of belonging/connectedness):

_____
_____
_____

c) *Self identify promotion within cultural context (degree of integration/traditional customs and practices exercised); is a cultural home provided?*

_____
_____
_____

d) *Capacity of community culture to ground adolescents undergoing self-identity/ transitional issues; how is this addressed?*

_____
_____
_____

e) *Degree of loss of sense of connectedness to the future (e.g., multiple placements of children/youth in care?*

_____
_____
_____

f) *Describe how well the current social and mental health delivery system is responding to the community problem situation:*

_____
_____
_____

23.   COMMUNITY TREATMENT PLAN

a) *What challenges need to be addressed?*

b) *What strengths does the community have, that can be built on to address the current situation?*

c) *How can "cultural continuity" within the community be strengthened?*

d) *What is the "treatment plan" for the community?*

e) *What is the estimated duration/timeline of the plan?*

f) *What resources are needed based on effective use of existing resources?*

g) *What are the desired outcomes and when and how progress towards these outcomes will be measured? Please explain.*

State Prevention Planning Contact Information[a]

The following is an alphabetical listing of States and Territories along with contact information for the persons who are taking the lead in the State plan development or implementation process. This information is intended for use by anyone who would like to be involved in his or her State team. Some States have multiple leaders, and we have made an effort to include all of them. State coalition members may send updated contact information to info@sprc.org. Individuals also may request updated contact information for their area from info@sprc.org.

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[a] Contact information current as of 2009. Updated contact information can be found at www.sprc.org/stateinformation.

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(Note: Contact information current as of 2009. Updated contact information can be found at www.sprc.org/stateinformation.)

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(Note: Contact information current as of 2009. Updated contact information can be found at www.sprc.org/stateinformation.)

Additional Tools for Assessment and Planning, School-Based Program Planning, and Coalition Building

Assessment and Planning Tools

Assessing and Planning Toolkit for Suicide Prevention in First Nations Communities

This publication has been developed to help individuals and groups interested in addressing the issue of suicide in their communities. It is a framework to guide First Nations in assessing and planning a suicide prevention plan. Communities are encouraged to adapt the tool to meet their own needs. The toolkit also provides information and research on suicide prevention to increase awareness and encourage discussion. http://www.naho.ca/firstnations/english/documents/toolkits/FNC_SuicidePreventionToolkit.pdf.

Coming Together To Care: A Suicide Prevention Toolkit for Texas Communities

This suicide prevention toolkit for Texas communities is organized in two parts. The first covers the basic knowledge that people need to have in order to act effectively on this issue, and the second covers actions they can take once they have that basic knowledge. The authors' goal is to make this a very practical resource that community leaders can easily use in efforts to prevent suicide deaths in Texas. http://www.mhatexas.org/SuicidePreventToolkit8_04.htm.

Updates to the toolkit will be posted periodically on the Mental Health Association in Texas Web site and the Texas State Strategic Health Partnership Web site. http://www.mhatexas.org http://mhatexas.org/2006SuicidePreventToolkit UPDATE.htm.

Data-Driven Prevention Planning Model

This model has been developed by Richard Catalano and David Hawkins at the University of Washington. The model is based on certain assumptions:

1. A broad-based coalition of stakeholders has been formed;
2. The coalition has identified suicide prevention as the area that it would like to focus on; and
3. The coalition is sufficiently organized and has the infrastructure necessary to take on a project. A Strengths, Weaknesses, Opportunities, and Threats (SWOT) assessment can ensure this.

http://www.sprc.org/featured_resources/trainingandevents/conferences/co/pdf/DataDrivenModel.pdf.

Embrace Life Resources Toolkit

The idea behind the "Embrace Life" approach is that people and organizations within communities will cooperate in finding solutions that meet real local needs and circumstances. The Embrace Life Council was created to support communities in sharing ideas and resources to create their own solutions. http://www.gov.nu.ca/education/COEWebsite/images/library/Arctic%20suicide%20%C9%20workshop%20e.pdf.

Preventing Youth Suicide in Rural America: Recommendations to States

The Suicide Prevention Resource Center and the State and Territorial Injury Prevention Directors Association formed a workgroup to generate recommendations to prevent suicide among rural youth. This report details the recommendations for State-level agencies to address promotion of help-seeking behaviors, data and surveillance, services, screening and identification, gatekeeper training, bereavement, and survivor issues. http://www.sprc.org/library/ruralyouth.pdf.

Prevention Suicide: Program Activities Guide

This publication by the Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control is designed to move the injury and violence prevention field toward primary prevention and early intervention by exploring ways to prevent suicide before it occurs.
http://www.cdc.gov/ncipc/dvp/PreventingSuicide.htm.

Suicide Prevention Community Assessment Tool

This tool, available from the Substance Abuse and Mental Health Services Administration (SAMHSA) Suicide Prevention Resource Center, is intended to be used in collaboration with a local Prevention Network. Prevention Networks are coalitions of change-oriented organizations and individuals working together to promote suicide prevention. Prevention networks might include statewide coalitions, community task forces, regional alliances, or professional groups. Prevention networks may be organized at the national, State, regional, Tribal, or local level.
http://www.sprc.org/library/catool.pdf.

School-Based Program Planning Tools

Youth Suicide Prevention: Strengthening State Policies and School-Based Strategies

This publication is an April 2005 Issue Brief from the National Governors Association. It describes five main areas in which Governors and other State officials can take action to prevent suicide: increasing public awareness, being involved in suicide prevention planning, giving schools a greater role in identifying students at risk and in providing services, appropriating funds to prevention, and fostering State-level collaborations.
http://www.spanusa.org/files/General_Documents//0504suicideprevention.pdf.

Youth Suicide Prevention School-Based Guide

This online resource was developed by the Florida Mental Health Institute at the University of South Florida. It provides a framework for schools to assess their existing or proposed suicide prevention efforts (through a series of checklists) and provides resources and information that school administrators can use to enhance or add to their existing program. Information is offered in a series of issue briefs corresponding to a specific checklist. Each brief offers a rationale for the importance of the specific topic together with a brief overview of the key points. The briefs also offer specific strategies that have proven to work in reducing the incidence of suicide, with references that schools can use to explore these issues in greater detail.
http://theguide.fmhi.usf.edu/pdf/Research-Materials.pdf.

Coalition Building Tools

Coalitions 101: Getting Started

This guide presents a seven-step approach to organizing a coalition and is published by Community Anti-Drug Coalitions of America (CADCA), a membership organization of more than 5,000 community coalitions whose purpose is to prevent substance abuse and violence.
http://cadca.org.

Community Coalition Suicide Prevention Checklist

This document is the result of a Scientific Consensus Meeting, held in 2001, that was sponsored by several of the National Institutes of Health, SAMHSA, and the CDC through grants to the University of Rochester Center for the Study and Prevention of Suicide. The document is a list of suggested actions that various community-based organizations (e.g., schools and businesses) can take to prevent suicide.
http://www.sprc.org/library/ccspchecklist.pdf.

Community Mobilization for Prevention Online Guide

This is a Web-based guide for community coalitions and prevention providers that was developed with funding from SAMHSA's Center for Substance Abuse Prevention. It provides information, tools, and resources for supporting leveraged community organizing, planning, and action. http://captus.samhsa.gov/southwest/cmpguide/cmpguide.cfm.

Community Toolbox

This toolbox is available through a Web site created and maintained by the Work Group on Health Promotion and Community Development at the University of Kansas, in collaboration with AHEC/Community Partners in Amherst, MA. The "Create Coalitions and Partnerships" section of the site includes:

- An outline of how to create a coalition;

- Case studies;

- Guidance on creating and maintaining coalitions; and

- Tools for defining membership, diversity, and principles for success.
http://ctb.ku.edu/en.

Partnership Self-Assessment Tool

This tool is a Web-based resource from the Center for the Advancement of Collaborative Strategies in Health at the New York Academy of Medicine. The tool assesses how well a collaborative process is working in three areas: leadership, efficiency administration and management, and sufficiency of resources. Coalitions can use the tool to:

- Assess how well the collaborative process is working;

- Learn how to improve this process;

- Demonstrate the strengths of the coalition to partners, funders, and the community;

- Make the coalition more responsive to its partners and the community; and

- Involve partners in the leadership and management of the coalition.
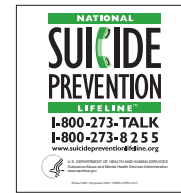http://www.partnershiptool.net.

Help Prevent *Suicide*

Promotional Materials Available From the National Suicide Prevention Lifeline

You can play a valuable role in helping to reduce suicide by promoting the National Suicide Prevention Lifeline, 1-800-273-TALK (8255). To assist you, the Lifeline has developed a full set of materials, available free of charge, to help raise awareness about the Lifeline. Please see the reverse side of this form for information on how to order the materials from SAMHSA's Health Information Network. These materials are also available to download in camera-ready and customizable formats on our Web site, www.suicidepreventionlifeline.org/materials.

After an Attempt Booklets

Intended to be given out in emergency departments, these booklets are for attempt survivors, families, and medical care providers. Spanish versions of the booklets for survivors and families are also available.
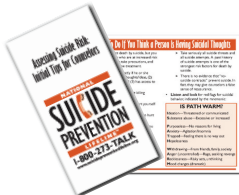
Lifeline Magnet

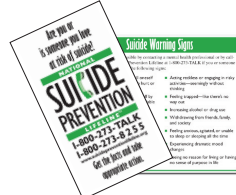3.5 x 4-inch magnet features the Lifeline logo and contact number.

Lifeline Posters

There are three different posters intended for males ages 25–54, males ages 65+, and American Indian/Alaska Native youth. Spanish versions of the males ages 25–54 and males ages 65+ posters are also available.

Other Lifeline Materials

Lifeline Pen and Writing Pad

Pens and writing pads feature the Lifeline logo and number.

Lifeline Co-Pilot Cards

The Lifeline Co-Pilot cards help crisis line workers assess suicide risk and offer intervention options to those who could be at risk of suicide.

Lifeline Stress Ball

Designed to look like a basketball, this squeezable stress ball features the Lifeline logo and number.

Counselor Wallet Card

Gives risk assessment tips for counselors and other professionals.

Warning Signs Wallet Card

Lists suicide warning signs for the general public. Available in both English and Spanish.

Coping Tips Wallet Cards

These cards identify problems associated with having difficulty coping with challenging situations, such as a disaster. Two versions are available. One version includes "disaster" on the cover (available in English and Spanish). The other version does not (available in English only).

Complete order form on reverse to fax or mail

National Suicide Prevention Lifeline Promotional Materials Order Form

National Suicide Prevention Lifeline Promotional Materials Order Form

	Quantity		Quantity
Lifeline Warning Signs Wallet Card		**A Guide for Funeral Directors**	
English SVP05-0126	_____	SVP09-0194	_____
Spanish SVP05-0126SP	_____	**After an Attempt Booklets**	
Lifeline Counselor Wallet Card		**For Attempt Survivors:**	
SVP06-0153	_____	English SVP06-0157	_____
Lifeline Coping Tips Wallet Cards		Spanish SVP06-0158SP	_____
English (Disaster) SVP06-0155	_____	**For Families:**	
Spanish (Disaster) SVP06-0155S	_____	English SVP06-0159	_____
English (Coping—no "Disaster")		Spanish SVP08-0160S	_____
SVP08-0155R	_____	**For Medical Care Providers:**	
Lifeline Magnet		English SVP06-0161	_____
SVP05-0125	_____	**Lifeline Posters**	
Lifeline Co-Pilot Cards		Men 25-54 SVP06-0162	_____
SVP08-0187	_____	Men 25-54 (Spanish) SVP06-0166SP	_____
Lifeline Stress Ball		Men 65+ SVP06-0163	_____
SVP08-0171	_____	Men 65+ (Spanish) SVP06-0167SP	_____
Lifeline Writing Pad		American Indian/Alaska Native	
SVP06-0172	_____	SVP06-0164	_____
Lifeline Pen			
SVP06-0173	_____		

You can order up to 50 pieces of each item. If you are a Lifeline crisis center, a grantee funded under the Garrett Lee Smith Memorial Act, or a VA Suicide Prevention Coordinator, you can order up to 500 pieces of each item. Please indicate your affiliation by checking the applicable box below.

☐ Lifeline crisis center   ☐ Garrett Lee Smith grantee   ☐ VA Suicide Prevention Coordinator

Ship to:

Name: _____ Title: _____

Organization: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ E-mail: _____

(please provide this information so we can update you on the order status)

To order material, please fax this form to SAMHSA's Health Information Network at 240-221-4292 or mail it to the address below. You can also order by phone at 1-877-726-4727 or 1-800-487-4889 (TDD), by email (shin@samhsa.hhs.gov) or online (www.mentalhealth.samhsa.gov). Please note that not all products will be in stock at all times. Delivery of materials can take up to 4 weeks. You can request more than 500 items by sending an email to lifeline@samhsa.hhs.gov and specifying the item code, quantity needed, and distribution plan.

Appendix E: Web Site Resources and Bibliography

Suicide Prevention Web Sites

U.S. and Canadian Government

SAMHSA's Health Information Network

This resource provides information about mental health services and topics by phone, on its Web site, and through more than 600 available publications. Staff members will direct callers to Federal, State, and local organizations dedicated to treating and preventing mental illness, as well as fulfilling orders for helpful resources and publications.
http://www.samhsa.gov/shin.

Centers for Disease Control (CDC) and Prevention Injury Center: Suicide Prevention

This Web site offers general information about suicide in different formats, including podcasts, on terminology, risk and protective factors, consequences of suicide, and prevention strategies. The site also contains links to numerous statistical reports and databases on suicide prevalence.
http://www.cdc.gov/ncipc/dvp/Suicide/default.htm.

Indian Health Service (IHS) Community Suicide Prevention Web Site

The purpose of the IHS Web site is to provide American Indian and Alaska Native (AI/AN) communities with culturally appropriate information about best and promising practices, training opportunities, and other relevant information regarding suicide prevention and intervention. The goal of the Web site is to provide Native communities with the tools and information to create, or adapt to, their own suicide prevention programs.
http://www.ihs.gov/NonMedicalPrograms/nspn/index.cfm.

National Suicide Prevention Lifeline

The National Suicide Prevention Lifeline provides immediate assistance to individuals in suicidal crisis by connecting them to the nearest available crisis center through a toll-free telephone number: 1-800–273–TALK (8255). Technical assistance, training, and other resources are available to the crisis centers that participate in the network of services linked to the National Suicide Prevention Lifeline.
http://www.suicidepreventionlifeline.org.

Suicide Prevention Resource Center

The Suicide Prevention Resource Center (SPRC) provides prevention support, training, and materials to strengthen suicide prevention efforts. Among the resources found on its website is the SPRC Library Catalog (http://library.sprc.org/), a searchable database containing a wealth of information on suicide and suicide prevention, including publications, peer-reviewed research studies, curricula, and Web-based resources. Many of these items are available online.
http://www.sprc.org.

Honouring Life Network

This site, funded by Health Canada, is a project of the National Aboriginal Health Organization. The Web site offers culturally relevant information and resources on suicide prevention to help Aboriginal people deal with a problem that has reached crisis proportions in some First Nations, Inuit, and Métis communities in Canada. In addition to providing a place for Aboriginal youth to go and read about others dealing with similar issues, the site allows those working with Aboriginal youth to connect, discuss, and share suicide prevention resources and strategies. The site's directory of suicide prevention resources will be updated on a regular basis with the hopes of providing Aboriginal communities with a comprehensive inventory of suicide prevention materials.
http://honouringlife.ca.

Non-Federal

American Association of Suicidology

The American Association of Suicidology is a nonprofit organization dedicated to the understanding and prevention of suicide. It promotes research, public awareness programs, public education, and training for professionals and volunteers and serves as a national clearinghouse for information on suicide. http://www.suicidology.org.

American Foundation for Suicide Prevention

The American Foundation for Suicide Prevention (AFSP) is dedicated to advancing our knowledge of suicide and our ability to prevent it. AFSP's activities include supporting research projects; providing information and education about depression and suicide; promoting professional education for the recognition and treatment of depressed and suicidal individuals; publicizing the magnitude of the problems of depression and suicide and the need for research, prevention, and treatment; and supporting programs for suicide survivor treatment, research, and education. http://www.afsp.org.

Jason Foundation, Inc.

The Jason Foundation, Inc., educates young people, parents, teachers, and others who work with young people about youth suicide. The foundation offers programs, seminars, and support materials on suicide awareness and prevention. http://www.jasonfoundation.com.

One Sky Center

One Sky Center is a national resource center for AI/ANs. It is dedicated to improving prevention and treatment of substance abuse and mental health across Indian Country. Current initiatives of the center include meth and suicide prevention. http://www.oneskycenter.org.

Suicide Prevention Action Network USA

Suicide Prevention Action Network USA (SPAN USA) is the Nation's only suicide prevention organization dedicated to leveraging grassroots support among suicide survivors (those who have lost a loved one to suicide) and others to advance public policies that help prevent suicide. http://www.spanusa.org.

Survivors of Suicide.com

This Web site is designed to help those who have lost a loved one to suicide resolve their grief and pain in their own personal way. http://www.survivorsofsuicide.com/help_heal.shtml.

Turtle Island Native Network

The Turtle Island Native Network is an online source of Aboriginal news and information. The Web site includes a Healing and Wellness Suicide Prevention Page. http://www.turtleisland.org/healing/healing-suicide.htm.

Suicide Prevention Crisis Lines

National Suicide Prevention Lifeline

(1–800–273–TALK [8255]) is a 24-hour, toll-free suicide prevention service available to anyone in the United States in suicidal crisis or emotional distress. Callers are routed to the closest crisis center. http://www.suicidepreventionlifeline.org.

Veterans Suicide Prevention Hotline

To ensure veterans in emotional crises have round-the-clock access to trained professionals, the U.S. Department of Veterans Affairs (VA) operates a national suicide prevention hotline for veterans in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Suicide Prevention Lifeline. Veterans can call 1–800–273–TALK (8255) and press "1" to reach the VA hotline, which is staffed by mental health professionals. http://www.suicidepreventionlifeline.org/Veterans/Default.aspx.

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Indian Health Service
The Reyes Building
801 Thompson Avenue, Suite 400
Rockville, MD 20852–1627
Phone: 301–443–3593
http://www.ihs.gov

Association of American Indian Physicians
1225 Sovereign Row, Suite 103
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Fax: 405–946–7651
http://www.aaip.com

California Rural Indian Health Board
Native American AIDS Advisory Board
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Phone: 916–929–9761
http://www.crihb.org

Center for American Indian Health
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Denver, CO 80220
Phone: 303–372–0000
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National Center for American Indian and Alaska Native Mental Health Research
University of Colorado Health Sciences Center
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4455 East 12th Avenue, Campus Box A011-13
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Phone: 303–315–9232
http://www.uchsc.edu/ai/ncaianmhr/
ncaiainmhr_index.htm

National Indian Child Welfare Association
5100 S. Macadam Avenue, Suite 300
Portland, OR 97201
Phone: 503–222–4044
Fax: 503–222–4007
http://www.nicwa.org

National Indian Health Board
101 Constitution Avenue NW, Suite 8B09
Washington, DC 20001
Phone: 202–742–4262
http://www.nihb.org

National Native American AIDS Prevention Center
436 14th Street, Suite 1020
Oakland, CA 94612
Phone: 510–444–2051
http://www.nnaapc.org

Native American Fatherhood & Families Association (NAFFA)
123 North Centennial Way, Suite 150
Mesa, AZ 85201
Phone: 480–833–5007
Fax: 480–833–009
E-mail: aznaff@aol.com
http://nativeamericanfathers.org

Tri-Ethnic Center for Prevention and Research
Colorado State University
100 Sage Hall
Fort Collins, CO 80523-1879
Phone: 1–800–835–8091
or 970–491–7902
Fax: 970–491–0527
E-mail: tecweb@lamar.colostate.edu
http://www.triethniccenter.colostate.edu
about.shtml

Suicide Legislation

The Library of Congress Web site offers a searchable database of legislation related to national suicide prevention that is currently proposed in Congress. Visit http://thomas.loc.gov and enter "suicide" as the search word.

For the most recent State legislative action, readers should refer to the corresponding State legislature's home page at http://www2a.cdc.gov/phlp/suicidelegislation.asp.

Suggested Bibliography, by Chapter

The following journal articles, reports, books, and Web-based resources provide additional information on topics discussed throughout the guide. Links to the publications are provided whenever this information is available online.

Chapter 1: Introduction to the Guide

Achieving the Promise: Transforming Mental Health Care in America. President's New Freedom Commission on Mental Health. (2003). http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/downloads.html.

National Strategy for Suicide Prevention. The National Strategy for Suicide Prevention (NSSP) represents the combined work of advocates, clinicians, researchers, and survivors around the Nation. It lays out a framework for action to prevent suicide and guides development of an array of services and programs that must be developed. It is designed to be a catalyst for social change with the power to transform attitudes, policies, and services. The NSSP was published by the U.S. Department of Health and Human Services in May of 2001, with leadership from the Surgeon General. A summary can be ordered from SAMHSA's Health Information Network (Inventory No. SMA01-3518). The full document also is available (Inventory No. SMA08-3517). Both documents are free. Place orders online at http://www.samhsa.gov/shin or call 1-877-SAMHSA-7 (1-877-726-4727).

Reducing Suicide: A National Imperative. Institute of Medicine (2002). Goldsmith, S. K., Pellmar, T. C., Kleinman, A.M., & Bunney, W. E. (Eds.) Washington, D.C.: National Academies Press. http://www.nap.edu/catalog.php?record_id=10398.

Fostering Resiliency in Kids: Protective Factors in the Family, School, and Community. Bonnie Benard, National Resilience Resource Center National Resilience Resource Center, 202 Wesbrook, 77 Pleasant Street S. E., Minneapolis, MN http://www.cce.umn.edu/nrrc/research/index.html#cartercenter.

Chapter 2. Culture, Community, and Prevention

Cultural continuity as a hedge against suicide in Canada's First Nations. Lalonde, C., & Chandler, M. J. (1998). *Transcultural Psychiatry*. http://web.uvic.ca/~lalonde/manuscripts/1998TransCultural.pdf.

Culture, selves, and time: Theories of personal persistence in Native and non-Native youth. Lalonde, C., & Chandler, M. J., (2004). In C. Lightfoot, C. Lalonde, & M. Chandler (Eds.), *Changing Conceptions of Psychological Life,* Vol. 30, 207-229. Jean Piaget Symposium Series. Mahwah, NJ: Lawrence Erlbaum.

Culture, continuity, and the limits of narrativity: A comparison of the self-narratives of Native and Non-Native youth. Chandler, M., Lalonde, C., & Teucher, U. (2004). In C. Daiute & C. Lightfoot (Eds.), *Narrative Analysis: Studying the Development of Individuals in Society*, pp. 245-265. New York: Sage Publications.

Personal persistence, identity development, and suicide: A study of Native and Non-Native North American adolescents. Chandler, M. J., Lalonde, C., Sokol, B., & Hallett, D. (2003). *Monographs of the Society for Research in Child Development,* Serial no. 273, 68 (2). http://web.uvic.ca/~lalonde/manuscripts/2003-Monograph.pdf.

Counting the costs of failures of personal and cultural continuity. Lalonde, C. (2003). *Human Development*, 46(2-3). Available for order from the journal at http://content.karger.com/ ProdukteDB/produkte.asp?Doi=68586.

Chapter 3: Breaking the Silence Around the Suicide Conversation

Darkness Calls: Suicide Prevention Comic Book for Native Americans. The Healthy Aboriginal Network. http://www.thehealthyaboriginal.net.

Lifting the Silence on Suicide: Together We Can Make a Difference. (Conference Report from the Aboriginal Suicide Prevention Conference in Alberta, Canada, February 6–7, 2002.) http://www.suicideinfo.ca/csp/assets/ sptpabconfreport.pdf.

Chapter 4: Responding to Suicide

Community Resources

The Basics: Facilitating a Suicide Survivors Support Group. Flatt, L. (2007). http://www.spanusa.org/files/General_ Documents/The_Basics_Facilitator_Guide.pdf.

The Story of the Community of West Carleton: How the Community Helpers Program Evolved from a Community's Experience with Youth Suicide. This paper explores key concepts in youth mental health promotion, demonstrating how these concepts can and have been put into practice at the community level. Key concepts in youth mental health promotion are first defined, including community capacity building, community mobilization, and youth mental health promotion. The experience of youth suicide in a rural community is used to illustrate, in practical terms, how these concepts have real-life application. Specifically, in the context of a community's response to a tragic event, the importance of developing a shared vision and creating a common community language around youth mental health will

be emphasized. http://www.phac-aspc.gc.ca/mh-sm/mhp-psm/ pub/community-communautaires/pdf/comm- cap-build-mobil-youth.pdf.

White Earth Suicide Intervention Team, White Earth Chippewa Tribe. The White Earth Suicide Intervention Team was created in 1990 in response to an extraordinarily high rate of suicide attempts and completions on the White Earth Reservation. The all-volunteer team provides many services previously absent or lacking, including 24-hour support for the attempter and his/her family, encouragement of voluntary or involuntary hospital admission for all attempters, referrals to mental health services, and suicide education. http://www.hks.harvard.edu/hpaied/hn/ hn_2000_intervention.htm.

Winnebago Response to Crisis. This document provides example of crisis protocols, including suicide crisis. Protocols link found on the IHS Web site. http://www.ihs.gov/Misc/ links_gateway/sub_categories.cfm?sub_cat_ id=06080914.

School Resources

Crisis response and postvention. Lerner, M., Volpe, J., & Lindell, B. (2003). In *A Practical Guide for Crisis Response in Our Schools* (5th ed.). This book is a guide to preparing for and managing crises in schools. It covers traumatic stress management, responding to suicidal or violent students, grief counseling, and other issues. Of special interest to teachers will be the section titled "Teacher Guidelines for Crisis Response." Commack, NY: American Academy of Experts in Traumatic Stress.

Sherman Indian High School (SIHS) Holistic Health Program Mental Health Crisis Protocol. This protocol is designed to assist dorm staff, counselor techs, and other SIHS staff with guidelines and resources to assess the severity of a mental health crisis on this campus and to find the most appropriate manner of resolving the crisis. http://www.ihs.gov/Misc/ links_gateway/sub_categories.cfm?sub_cat_ id=06080914.

Youth Suicide Prevention Intervention and Postvention Guidelines: A Resource for School Personnel. These guidelines were developed by the Maine Youth Suicide Prevention Program and designed for schools to use within existing protocols to assist at-risk students and to intervene appropriately in a suicide-related crisis. http://www.state.me.us/suicide/guidelines02.pdf.

Suicide Survivor Resources

The Survivors of Suicide Handbook. This handbook is designed to be a pocket-sized, quick-reference booklet for suicide survivors. Written by fellow survivor Jeffrey Jackson, it is brief, clear, and packed with essential information covering nearly every aspect of the survivor ordeal—from the emotional roller-coaster, to the elusive quest for "Why?," to how to find support groups in your area. http://www.suicidology.org/associations/1045/files/SOS_handbook.pdf.

After an Attempt: A Guide for Taking Care of Your Family Member after Treatment in the Emergency Department. This brochure may be downloaded from http://www.suicidepreventionlifeline.org/App_Files/Media/PDF/Lifeline_AfterAnAttempt_ForFamilyMembers.pdf. Free copies also can be ordered online at http://www.samhsa.gov/shin or by calling SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727).

Suicide Attempt Survivor Resources

After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department. This brochure may be downloaded at http://www.suicidepreventionlifeline.org/App_Files/Media/PDF/Lifeline_AfterAnAttempt_ForYourself.pdf. Free copies also can be ordered online at http://www.samhsa.gov/shin or by calling SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727).

Media Guidance

At-a-Glance: Safe Reporting on Suicide. This two-page guide for reporters and editors provides a list of recommendations on how to report on suicide while minimizing the risk of contributing to "copycat" suicides. In addition to offering guidelines (based upon Reporting on Suicide, below), this publication includes additional resources on suicide and suicide prevention for reporters, editors, and others in the media. http:// www.sprc.org/library/at_a_glance.pdf

Guide to Engaging the Media in Suicide Prevention. http://www.spanusa.org/files/General_Documents//media.pdf.

Reporting on Suicide: Recommendations for the Media. A collaborative effort of the CDC and Prevention, National Institute of Mental Health, Office of the Surgeon General, SAMHSA, American Foundation for Suicide Prevention, American Association of Suicidology, and the Annenberg Public Policy Center. http://www.sprc.org/library/sreporting.pdf.

The Role of the Media in Preventing Suicide. This guide includes information on how the media can help with a community's efforts to prevent suicide, their reporting responsibilities, and resources for the media. http://www.sprc.org/featured_resources/customized/pdf/media.pdf.

Safe and Effective Messaging for Suicide Prevention. This document offers evidence-based recommendations for creating safe and effective messages to raise public awareness that suicide is a serious and preventable public health problem. http://www.sprc.org/library/SafeMessagingfinal.pdf.

Chapter 5: Community Readiness

Community Readiness and Prevention Programs. Donnermeyer, J. F., Plested, B. A., Edwards, R. W., Oetting, E. R., & Littlethunder, L. (1997). *Journal of the Community Development Society*, *28* (1), 65-83. http://www.triethniccenter.colostate.edu/docs/Article1.pdf.

Community Readiness: Research to Practice. Edwards, R. W., Jumper-Thurman, P., Plested, B.

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Using the Community Readiness Model in Native Communities. Jumper Thurman, P., Plested, B. A., Edwards, R. W., Helm, H. M., & Oetting, E. R. (2001). In J. E. Trimble & F. Beauvais (Eds.), *Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence* (CSAP Monograph, Cultural Competence Series No. 9, DHHS Publication No. SMA 99-3440, pp. 129-158). Rockville, MD: U.S. Department of Health and Human Services. http://www.triethniccenter.colostate.edu/docs/Article7.pdf.

(Additional articles on community readiness are available through the Tri-Ethnic Center for Prevention at http://www.triethniccenter.colostate.edu.)

Chapter 6: Community Action

From the Ground Up: Improving Community Health, Inspiring Community Action. This article is part of Grantmakers in Health's (GIH's) portfolio, *From the Ground Up: Improving Community Health, Inspiring Community Action.* Each article focuses on an approach grantmakers

are using to improve health in communities. The entire portfolio is available at the GIH Web site. http://www.gih.org.

Suicide Prevention: Prevention Effectiveness and Evaluation. This document, a collaborative effort by the CDC National Center for Injury Prevention and Control, SPAN USA, Inc., and Educational Development Center, Inc., contains evidence-based and best practice methods for developing State suicide prevention plans. http://www.spanusa.org/files/General_Documents/prevtoolkit.pdf.

The Tension of Turf: Making It Work for the Coalition. Developed by the Prevention Institute, this paper builds upon the article *Developing Effective Coalitions: An Eight Step Guide.* and it also responds to a concern repeatedly encountered in training on this approach, a concern generally described as among the hardest issues faced in collaborating: turf struggle. http://www.preventioninstitute.org/pdf/TURF_1S.pdf.

Chapter 7: Promising Suicide Prevention Programs

Program Evaluation

Report of the Workshop on Best Practices in Suicide Prevention and the Evaluation of Suicide Prevention Programs in the Arctic. (2003). http://www.gov.nu.ca/education/COEWebsite/images/library/Arctic%20suicide%20%C9%20workshop%20e.pdf.

Transferring whose knowledge? Exchanging whose best practices?: On knowing about indigenous knowledge and aboriginal suicide. Chandler, M. J., & Lalonde, C. (2004). *In Aboriginal Policy Research: Setting the Agenda for Change,* Vol.II, pp.111-123. J. White, P. Maxim, & D. Beavon (Eds.). Toronto: Thompson Educational Publishing. http://web.uvic.ca/~lalonde/manuscripts2003INAC.pdf.

Cultural Adaptation of Programs

Cultural Practices in American Indian Prevention Programs. Sanchez-Way, R., & Johnson, S. (2002). *Juvenile Justice*, VII(2). http://www.ncjrs.gov/html/ojjdp/jjnl_2000_12/cult.html.

Making Cultural Adaptations to Model Substance Abuse Prevention Programs. This document describes why issues of inclusion and marginalization need to be addressed when training for cultural competence and adaptation. http://captus.samhsa.gov/western/resources/tip/documents/tip-2004-04.rtf.

Suicide Prevention Inuit Traditional Practices That Encourage Resilience and Coping. Published by the Ajunnginiq Centre of the National Aboriginal Health Organization, which was established to promote practices that will restore a healthy Inuit lifestyle and improve the health status of Inuit through research and research dissemination, education and awareness, human resource development, and sharing information on Inuit-specific health policies and practices. http://www.naho.ca/inuit.

Native American Programs in Action

Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies is distributed by the Centre for Suicide Prevention in Alberta, Canada.
Free for downloading (but almost 300 pages) at http://www.suicideinfo.ca/csp/go.aspx?tabid=144
Available for ordering at http://www.suicideinfo.ca/csp/assets/promstrat_order.pdf.

Aboriginal Healing and Wellness Strategy (AHWS): Draft Guidelines for Traditional Healing Programs. The Aboriginal Healing and Wellness Strategy (AHWS) promotes a culturally based and holistic environment addressing the physical, emotional, mental and spiritual aspects of Aboriginal community members growth and development. As part of this process, AHWS-funded projects are committed to having Aboriginal Elders and Traditional people participate as an integral part

of their approach to healing and wellness. http://www.ahwsontario.ca/publications/Traditional%20Healing%20Guidelines_2004.pdf.

National Inuit Youth Suicide Prevention Framework. This document describes the work and research undertaken by the Qikiqtani Inuit Association, on behalf of the Inuit Tapiriit Kanatami and the National Inuit Youth Council, on the National Inuit Youth Suicide Prevention Project. It also presents background information on how the project came about, how it has been managed and coordinated and presents recommendations for future action on suicide prevention for Inuit Youth. http://www.communitylifelines.ca/niyspf-en[1].pdf.

Planting Seeds of Hope (PSOH). This is the Montana Wyoming Tribal Leaders Council program that is funded by SAMHSA through the Garrett Lee Smith Memorial Act. The PSOH program includes Montana's Blackfeet, Crow, Northern Cheyenne, Fort Peck and Fort Belknap, and Wyoming's Wind River Indian populations. http://www.mtwytlc.com/plantingseedsofhope.htm.

What Is Working, What Is Hopeful: Supporting Community-Based Suicide Prevention Strategies Within Indigenous Communities (and Any Other Community That Is Interested). This work represents one part of the work by the author and others who are interested in learning about what communities are doing to prevent suicide and more specifically, those efforts that have been successful in reducing suicide; and its impact. http://www.communitylifelines.ca.

American Indian/Alaska Native Resource Manual. This manual, produced by the National Alliance on Mental Illness (NAMI), emphasizes the need for outreach to AI/ANs so that their needs also are represented in efforts to improve mental health services in the United States. The manual covers issues such as the importance of cultural competence and how to develop it, creation of an AI/AN outreach plan, evaluation of outreach, and sharing experiences with other NAMIs. http://www.nami.org/Content/ContentGroups/Multicultural_Support1/CDResourceManual.pdf.

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National Suicide Prevention Lifeline Promotional Materials Order Form
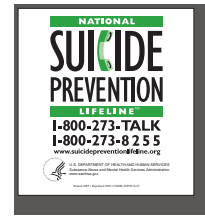
Help Prevent *Suicide*

Promotional Materials Available From the National Suicide Prevention Lifeline
You can play a valuable role in helping to reduce suicide by promoting the National Suicide Prevention Lifeline, 1-800-273-TALK (8255). To assist you, the Lifeline has developed a full set of materials, available free of charge, to help raise awareness about the Lifeline. Please see the reverse side of this form for information on how to order the materials from SAMHSA's Health Information Network. These materials are also available to download in camera-ready and customizable formats on our Web site, www.suicidepreventionlifeline.org/materials.

After an Attempt Booklets
Intended to be given out in emergency departments, these booklets are for attempt survivors, families, and medical care providers. Spanish versions of the booklets for survivors and families are also available.
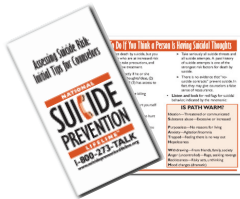
Lifeline Magnet
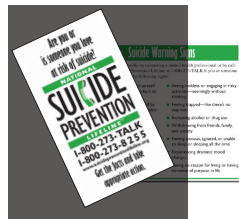3.5 x 4-inch magnet features the Lifeline logo and contact number.

Lifeline Posters

There are three different posters intended for males ages 25–54, males ages 65+, and American Indian/Alaska Native youth. Spanish versions of the males ages 25–54 and males ages 65+ posters are also available.

Other Lifeline Materials

Lifeline Pen and Writing Pad

Pens and writing pads feature the Lifeline logo and number.

Lifeline Co-Pilot Cards
The Lifeline Co-Pilot cards help crisis line workers assess suicide risk and offer intervention options to those who could be at risk of suicide.

Lifeline Stress Ball
Designed to look like a basketball, this squeezable stress ball features the Lifeline logo and number.

Counselor Wallet Card
Gives risk assessment tips for counselors and other professionals.
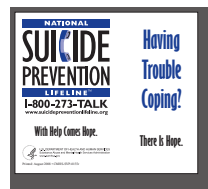
Warning Signs Wallet Card
Lists suicide warning signs for the general public. Available in both English and Spanish.

Coping Tips Wallet Cards
These cards identify problems associated with having difficulty coping with challenging situations, such as a disaster. Two versions are available. One version includes "disaster" on the cover (available in English and Spanish). The other version does not (available in English only).

Complete order form on reverse to fax or mail

	Quantity		Quantity
Lifeline Warning Signs Wallet Card		**A Guide for Funeral Directors**	
English SVP05-0126	_____	SVP09-0194	_____
Spanish SVP05-0126SP	_____	**After an Attempt Booklets**	
Lifeline Counselor Wallet Card		**For Attempt Survivors:**	
SVP06-0153	_____	English SVP06-0157	_____
Lifeline Coping Tips Wallet Cards		Spanish SVP06-0158SP	_____
English (Disaster) SVP06-0155	_____	**For Families:**	
Spanish (Disaster) SVP06-0155S	_____	English SVP06-0159	_____
English (Coping—no "Disaster")		Spanish SVP08-0160S	_____
SVP08-0155R	_____	**For Medical Care Providers:**	
Lifeline Magnet		English SVP06-0161	_____
SVP05-0125	_____	**Lifeline Posters**	
Lifeline Co-Pilot Cards		Men 25-54 SVP06-0162	_____
SVP08-0187	_____	Men 25-54 (Spanish) SVP06-0166SP	_____
Lifeline Stress Ball		Men 65+ SVP06-0163	_____
SVP08-0171	_____	Men 65+ (Spanish) SVP06-0167SP	_____
Lifeline Writing Pad		American Indian/Alaska Native	
SVP06-0172	_____	SVP06-0164	_____
Lifeline Pen			
SVP06-0173	_____		

You can order up to 50 pieces of each item. If you are a Lifeline crisis center, a grantee funded under the Garrett Lee Smith Memorial Act, or a VA Suicide Prevention Coordinator, you can order up to 500 pieces of each item. Please indicate your affiliation by checking the applicable box below.

☐ Lifeline crisis center   ☐ Garrett Lee Smith grantee   ☐ VA Suicide Prevention Coordinator

Ship to:

Name: _____ Title: _____

Organization: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ E-mail: _____

(please provide this information so we can update you on the order status)

To order material, please fax this form to SAMHSA's Health Information Network at 240-221-4292 or mail it to the address below. You can also order by phone at 1-877-726-4727 or 1-800-487-4889 (TDD), by email (shin@samhsa.hhs.gov) or online (www.mentalhealth.samhsa.gov). Please note that not all products will be in stock at all times. Delivery of materials can take up to 4 weeks. You can request more than 500 items by sending an email to lifeline@samhsa.hhs.gov and specifying the item code, quantity needed, and distribution plan.

SAMHSA's Health Information Network
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