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A Guide to

Suicide Prevention

For

American

Indian

and

Alaska Native

Communities

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Suicide Prevention

For American Indian and Alaska Native Communities

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One Sky Center

The American Indian/Alaska Native National Resource Center

for Substance Abuse and Mental Health Services



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Acknowledgements

Over the past four years, the staff at the One Sky Center has seen an increasing need for a practical document that would serve as a guide towards dealing with youth suicide in American Indian, Alaska Native, and First Nations communities across North America. The problems are unique and concerning. When a single suicide or a cluster of suicides occur in a Native community, the results are devastating and long lasting. These single or clustered suicide events are now acting as a catalyst across the Indian Nations to mobilize our efforts to stop the losses and help our young ones survive and prosper.

There are numerous individuals who should be acknowledged in this guide book effort. Denise Middlebrook and Richard McKeon assisted in SAMHSA funding support. The entire One Sky Center staff has tirelessly worked towards its completion. Our National Advisory Board approved our vision and gave us encouragement. Numerous IHS staff, the Regional Behavioral Health Directors, and IHS Central Office Leadership offered advice and support. Sally Smith, Chair of the National Indian Health Board, was always there for support and encouragement.

In a larger sense, we acknowledge the entire community: the children, parents, elders, teachers, healthcare and social service workers, along with law enforcement, and tribal leadership. Prevention and intervention of suicide lay in the hands of all community members. Working together in a true tribal partnership will assure the support and integration of services needed to overcome this Native National Crisis.



Introduction

The intent of this guidebook is to serve as a first of its kind broad-based resource for Native people at all community levels. Its purpose is to help us learn more about suicide and create a response plan for our communities. The guidebook is meant for tribal and community leaders, schools, religious institutions, mental health agencies, law enforcement, and any other organizations or individuals that desire to address this painful and critical problem. Contained within the book are background information, data on suicide, community strategic planning information, technical assistance strategies and referral resources. This booklet is not a prescription; rather, it is a resource for individuals and communities to develop an individualized plan for suicide prevention. We hope that this guide will ultimately help people reduce suicide and suicidal behavior in Native communities across the nation.

Local, state and regional sovereign governments will use this document as a tool to assess, identify, plan and implement policy changes to forge positive coordination and communication in otherwise potentially fragmented agencies and systems. Portions of all tribal assessments will necessarily include an evaluation of the working relationships internal to their community, i.e.: government, economic, social, health, judicial and educational administrative systems. It will also require assessment and planning with regard to external (state and federal) systems with which tribes must interact to provide services for their citizens. Non-reservation urban and rural Native communities, whether or not they are under the auspices of a Federally recognized sovereign government, can use the guidebook to evaluate their communities and plan collaboration with local, state and federal agencies to implement needed policy changes. Likewise, elements of the guide can be useful to their evaluation of the population they serve and to the location of resources to assist their providers.

Educators, primary and emergency medical care leaders, behavioral health directors, managers and providers, community health representatives, police, and judicial programs throughout Indian Country can use the guide to review, revise or plan and implement programs of benefit to their clientele, both at the system and the individual level. The guide will also give them a common framework from which to collaborate with tribal, state and federal agencies in the provision of culturally appropriate, high quality services. They will also find specific warning signs and questions to assess individuals at risk. Finally, individuals and consumer groups within communities will find information about what to watch for and report to providers as they seek help for their community, its member families, and individuals.

This guide is a work in progress. As we learn more, and as more resources become available, we will periodically update an online version of this guide available at www.oneskycenter.org.

Background

Suicide is a major concern across the United States, and a problem of tragic proportions in Indian Communities. In the United States, more than 30,000 people die by suicide a year.¹ Ninety percent of people who die by suicide have a diagnosable mental illness and/or substance abuse disorder.² According to the Centers for Disease Control, the suicide rate for American Indians and Alaska Natives is over twice the national average for other groups. It is the second leading cause of death (behind unintentional injuries and accidents) for Indian youth aged 15 to 24.

Suicide impacts the individual, family, peers, community and larger society.

- Each time a young person takes his or her life it dramatically affects the lives of at least six to eight other significant individuals-with sometimes permanent consequences to productivity, self-esteem, or physical or mental health (Maris & Silverman, 1995).
- There are higher rates of suicide among survivors (e.g., family members and friends of a loved one who died by suicide).³
- The risk of cluster suicide increases in communities that are closely linked to each other.

Though suicides have been attempted since the beginning of mankind, research and anecdotal evidence over the past three decades reveal that suicides are an emerging epidemic the world over. Suicide has been misunderstood, surrounded by silence and stigma. In recent years, however, our understanding of suicide has grown tremendously. We now know that suicide can often be predicted and prevented.

Suicide is due to a complex interaction of social, environmental, biological and cultural factors operating in an individual's life. These factors, as shown in the diagram, cross over personal, family, interpersonal, community, and societal environments. Logically, an intervention strategy that reinforces strengths and reduces risks will assist in preventing suicidal behavior. This approach is outlined in the following pages.

¹ The President's New Freedom Commission on Mental Health, 2003.

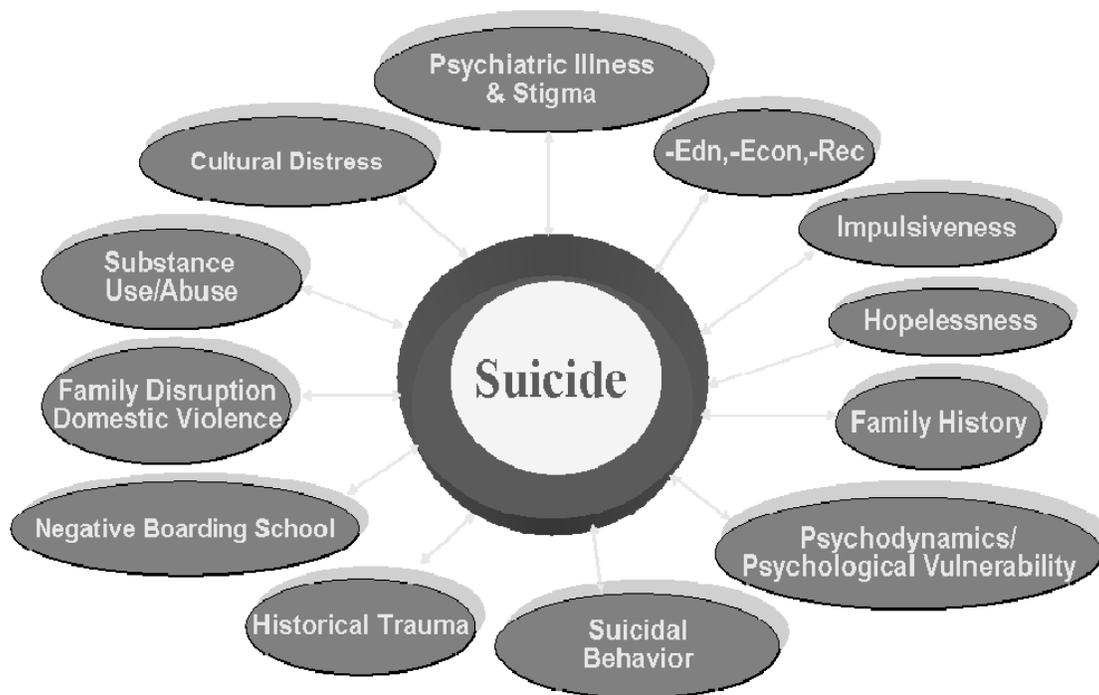
² National Center for Health Statistics, 2004.

³ National Institute of Mental Health, 2003.



Contributing Factors

Native Suicide: A Multi-factorial Event



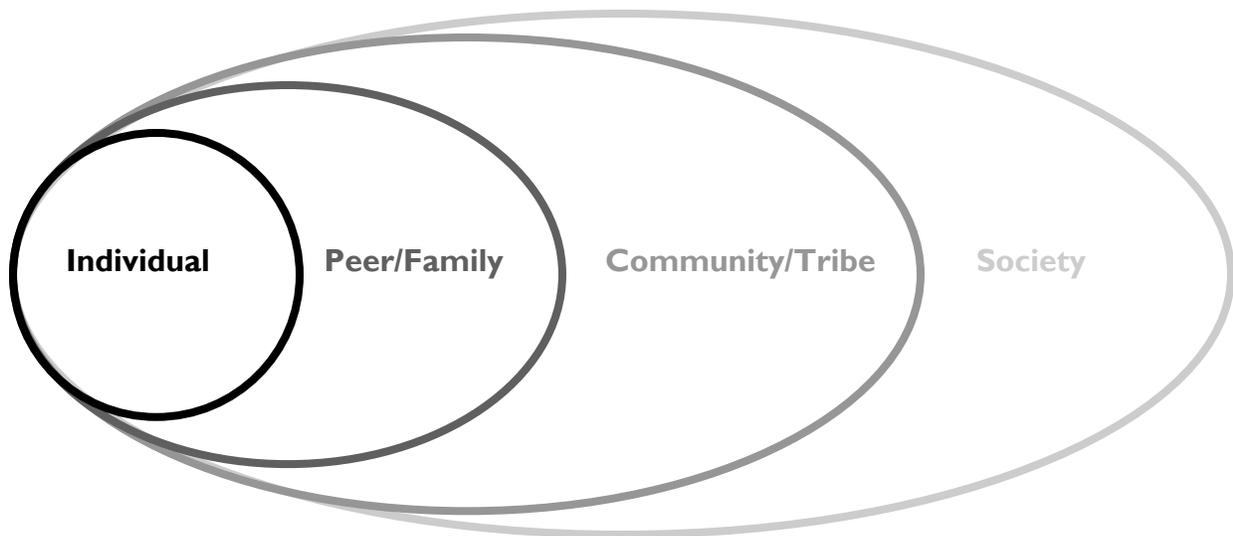
Douglas Jackobs, 2003
R. Dale Walker, MD, 2005

Risk/Protective Factors

As in many chronic illnesses, **risk factors** are thought of as leading to or being associated with suicide while **protective factors** are traits, situations or events that reduce the odds for suicidal thought or suicide. Generally, when risk factors outweigh protective factors, individuals are at higher risk for suicide or suicidal behavior. Thus, suicide prevention interventions are aimed at reducing risk and/or enhancing protective factors.

One way to assess risk and protective factors for suicide is to consider the domains of influence upon an individual's life. For a Native youth this may include; 1) Individual, 2) Peer/Family, 3) Community/Tribe, and 4) Society. An ecological model for this approach is shown below:

Domains Influencing Suicidal Behavior: a Native Ecological Model



Risk/Protective Factors

Suicide: Individual Factors

Risk

- Mental illness
- Age/gender
- Substance abuse
- Loss
- Previous suicide attempt
- Personality traits
- Incarceration
- Failure/academic problems

Protective

- Cultural/religious beliefs
- Coping/problem solving skills
- Ongoing health and mental health care
- Resiliency, self esteem, direction, mission, determination, perseverance, optimism, empathy
- Intellectual competence, reasons for living

Suicide: Peer/Family Factors

Risk

- History of interpersonal violence/abuse/
- Bullying
- Exposure to suicide
- No-longer married
- Barriers to health care/mental health care

Protective

- Family cohesion
- Sense of social support
- Interconnectedness
- Married/parent
- Access to comprehensive health care

Risk/Protective Factors

Suicide: Community/Tribal Factors

Risk

- Isolation/social withdrawal
- Barriers to health care and mental health care
- Stigma
- Exposure to suicide
- Unemployment
- Poverty

Protective

- Access to health care and mental health care
- Social support, close relationships, caring adults, participation and bond with school
- Respect for help-seeking behavior
- Skills to recognize and respond to signs of risk
- Traditional and cultural activities

Suicide: Societal Factors

Risk

- Rural/Remote
- Loss or conflict of cultural values and attitudes
- Stigma, racism
- Media influence
- Alcohol/drug misuse and abuse
- Social disintegration
- Economic instability

Protective

- Urban/Suburban
- Access to health care and mental health care
- Cultural values affirming life
- Media influence

Suicide Warning Signs

Suicidal behavior can fit into three distinguishable categories: those who have suicidal ideation, those who attempt suicide but do not complete, and those who complete suicide. Predicting an individual's suicidal outcome is difficult. However, it is important to know that in most cases, young people who complete suicide have communicated suicidal thoughts and feelings and their intent to kill themselves to someone prior to the suicidal act.

Although it is not possible to prevent every suicide, it is possible to recognize changes in behavior and the existence of crises that may precipitate suicidal behavior. Friends, teachers, and relatives who come into contact with young people can help. Knowledge of warning signs and risk factors may help a community to intervene in the potentially destructive process in which a young person is involved. Action may then be taken to reduce the risks.

Risk factors may add together to place a person at even higher risk. In other words, the more observable signs, stressful episodes, and chronic life stresses that a young person shows, the greater the risk of suicidal behavior. It is important to note the duration and intensity of these factors. Further, one should consider any changes in observable behavior in light of the individual concerned rather than necessarily comparing one person with another. Depressed mood and drug or alcohol abuse is a particularly risky combination.

In the Classroom:

- Noticeable decline in school performance and achievement
- Skipping classes and opting out of school activities
- Poor concentration, sleepiness, inattentiveness
- Unusually disruptive or rebellious behavior
- Death or suicide themes dominate written, artistic or creative work
- Loss of interest in previously pleasurable activities
- Inability to tolerate praise or rewards

Warning Signs

In the Individual

- Giving away prized possessions
- Sudden changes in relationships
- Withdrawing from friends and social involvements
- Not wanting to be touched by others
- Apathy about dress and appearance
- Sudden change in weight
- Running away from home
- Risk-taking and careless behavior
- Sudden and striking personality and/or mood changes
- Overt signs of mental illness (for example, hallucinations)
- Loss of sense of humor or sudden compulsive joking
- Sleeping pattern changes
- Self-mutilation behaviors
- Noticeable increase in compulsive behavior
- Development of extreme dependency
- Sudden happiness after a prolonged period of depression
- Impulsive tendencies
- Depressive tendencies
- Unrealistic expectations held of self
- Direct statements, for example/ 'I wish I were dead', 'I'm going to end it all'.
- Indirect statements, such as, 'No one cares if I live or die', 'Does it hurt to die?'

Another way of looking at the warning signs is to consider acute and chronic stressful episodes or life events. While not usually internally derived, these events can build upon and challenge a youth's coping skills. Following are a few episodes broken out as acute versus chronic situations.

Acute Stressful Episodes

- In trouble with school authorities or police
- Loss or disappointment in school
- Change of school and/or address
- Strong demands from adults for show of strength, competence and effectiveness
- Loss of an important person through death or divorce
- Recent suicide of friend or relative
- Breaking up with boyfriend or girlfriend
- Exposure to violence, incest, rape
- Abusing drugs or alcohol
- Feared pregnancy
- Refusal by significant other to provide anticipated help, support or love
- Major disappointment or humiliation
- Major family dysfunction

Chronic Stressful Life Situations

Home Life

- Chronic depression or mental illness in parent(s)
- Incest or child abuse

Warning Signs

- Severe parental conflict
- Family involvement with drug or alcohol abuse
- Poor communication with parents
- Pressures for high achievement to gain parental approval or acceptance
- Exposure to suicide, suicidal behavior or violent death

Interpersonal Relations

- Involvement in physical violence
- Inability to relate well to peers
- Sexual promiscuity
- Inability to enjoy or appreciate friendships or to express affection openly
- Mood swings and occasional outbursts
- Feelings of worthlessness, being a burden or having let parents or others down
- Feelings of guilt, failure.
- Having no control over their lives



Prevention Strategies

The National Strategy for Suicide Prevention (US DHHS, 2001) recommends the public health approach to preventing suicide as "a rational and organized way to marshal prevention efforts and ensure that they are effective." It distinguishes the public health approach, which identifies patterns of risk and behavior in groups of people, from the medical model, which focuses on individuals. The public health approach to suicide prevention, as presented in the NSSP, has five basic steps:

1. Clearly define the problem, by collecting data and other information.
2. Identify risk and protective factors. Risk factors are associated with (or lead to) suicides and suicide attempts. Protective factors reduce the likelihood of suicide.
3. Develop and test interventions. Most interventions seek to reduce risk factors and/or enhance protective factors. Such preventive measures should be scientifically tested to determine if they actually work before being disseminated and implemented.
4. Implement interventions.
5. Evaluate effectiveness. Suicide prevention programs should always be evaluated to verify that they are working and to understand how to make them more effective in the particular situation in which they are being used.

The steps above lead to a number of strategies for suicide prevention. The following list is taken from *Suicide Prevention Strategies: A Systematic Review* (J. Mann et al., 2005).

- Awareness and education for the general public: Public education campaigns are aimed at improving recognition of suicide risk and help seeking through improved understanding of the causes and risk factors for suicidal behavior, particularly mental illness.
- Physician training: Primary care physicians' lack of knowledge about or failure to screen patients for depression may contribute to nontreatment seen in most suicides. Therefore, improving physician recognition of depression and suicide risk evaluation is a component of suicide prevention.
- Gatekeeper training: Suicide prevention includes a range of interventions focused on community or organizational gatekeepers whose contact with potentially vulnerable populations provides an opportunity to identify at-risk individuals and direct them to appropriate

School-based Strategies

assessment and treatment. Gatekeepers include clergy, first responders, pharmacists, geriatric caregivers, personnel staff, and those employed in institutional settings, such as schools, prisons, and the military.

- **Screening:** Screening aims to identify at-risk individuals and direct them to treatment. Screening instruments for depression, suicidal ideation, or suicidal acts administered to high school students, juvenile offenders, and youth in general have reliability and validity in identifying individuals at increased risk for suicidal behavior and are reported to double the number of known at-risk individuals.
- **Treatment interventions:** including pharmacotherapy, psychotherapy and follow-up care after a suicide attempt.
- **Means restriction:** Suicide rates have declined in a number of countries as a result of regulating or restricting items such as firearms, pesticides, domestic gas, and prescription medications.
- **Media guidelines or blackouts:** The media can help or hinder suicide prevention efforts by being an avenue for public education or by exacerbating suicide risk by glamorizing suicide or promoting it as a solution to life's problems. Media blackouts on reporting suicide have coincided with decreases in suicide rates.

School-based strategies

Approximately 2.2 million adolescents aged 12 to 17 reported a major depressive episode in the past year and nearly 60% of them did not receive any treatment (Substance Abuse and Mental Health Services Administration, 2005). Our nation's schools, in partnership with families and communities, are the obvious places to identify youth at risk of suicide. They are essential settings for suicide prevention programs. Schools are in a unique position to promote healthy development and protective buffers, offer risk prevention programs, and help to identify and guide students in need of special assistance.

For American Indian and Alaska Native communities in particular, the lack of behavioral health access and geographic isolation can be addressed more effectively by forming integrated care models that center suicide prevention/intervention activities around the schools. School-based behavioral health care is a promising solution to these issues. Whenever possible, the

School Based Strategies

best approach to school-based suicide prevention activities is teamwork that includes teachers, school health personnel, school psychologists and school social workers, working in close cooperation with behavioral health, community agencies, and families.

Suicide Program Development

One of the first steps a school must take is to establish a planning task force on suicide prevention and intervention. Ideally, this task force should have broad community participation and support. Policies and procedures and written guidelines on how to identify and respond to at-risk students should be developed in concert with community agencies. Plans can also be developed and practiced on how to respond during and after a crisis. Below are a few promising school-based strategies and tips for implementation gathered from the *Youth Suicide Prevention School-based Guide* (Lazear, Roggenbaum & Blase, 2003).

- **A suicide awareness curriculum** refers to educating students and their families about suicide. Curriculum generally focuses on the warning signs and risk factors for suicide, reviews statistics about suicide, and provides a list of community resources where students can turn for help. Schools implementing this type of curriculum should 1) avoid using a brief one-shot approach; instead use a more prolonged approach when using curriculum delivered to students 2) consider implementing suicide awareness curriculum within the context of established classes such as a health class or a life management skills class, and 3) consider incorporating problem-solving skills, coping skills, and self-esteem building skills into the curriculum.
- **Staff and faculty training (gatekeeper training)** teaches school staff 1) how to recognize a student potentially at-risk for suicide, 2) how to appropriately intervene and communicate with a student potentially at-risk for suicide, 3) how to determine the level of risk, and 4) how to refer a student who is potentially suicidal. Training may be accomplished in a brief in-service and should include the most current information on risk factors, warning signs, and the referral process. Staff who undergo this training generally feel more confident to recognize and assist at-risk students.
- **Screening** involves identifying potentially at-risk teens through interviews and administration of screening tools. There are numerous screening methods available that have been shown to be effective in identifying students who may be at-risk for suicide (please see Promising Programs section of this guide). To be effective, screenings must be conducted

School Based Strategies

multiple times per year. It is also important to remember that consent from parents must be obtained before initiating a school-wide screening.

- **On-site prevention and behavioral health programs/ services** should be offered. It is estimated that approximately 70 percent of children and adolescents in need of mental health treatment do not receive services. A recent longitudinal study provided strong empirical evidence that interventions that strengthen students' social, emotional, and decision-making skills also positively impact their academic achievement, both in terms of higher standardized test scores and better grades (Fleming et al., 2005). In addition, providing these services on site enhances access to care. Research has shown that students are substantially more likely to seek help when school-based mental health services are readily available (Slade, 2002).
- **Create a Crisis Intervention Team** consisting of a variety of individuals including counselors, administrators, teachers, school health personnel and appropriate community representatives. The team should be trained to effectively respond and intervene with a student potentially at risk of suicide. Regular meetings of the team should be held.
- **Postvention** (responding appropriately and effectively after a suicide event) A comprehensive suicide prevention program should include postvention guidelines and procedures to provide a more timely, effective, and appropriate response and review of a suicide event. This serves to reduce potential cluster (copycat) suicides, to reduce trauma among surviving students, and to return the school environment to its normal routine.

Instituting a suicide prevention program is a difficult task, especially given the multiple demands already placed on school systems and personnel. We hope that this section provides current, user-friendly guidelines and tools to assist schools in their suicide prevention efforts.





“Suicide is hard to understand. We aren't sure when it will happen, or why it happens. It gets complicated especially when depression occurs, usually when alcohol follows it. The families themselves need to understand it, (suicide) that it can happen to you.... I don't think anyone thinks it can happen to them. It's a fearful thing once it happens to them. The depression emotionally overwhelms, especially if you are young. When you are young and come from a dysfunctional setting, it is hard on our children and our youth. There needs to be more prevention.”

- Antone Minthorn, Confederated Tribes of the Umatilla



Promising Programs

A number of promising programs exist for suicide prevention, but few have been proven effective in Native communities within the United States. The cultural appropriateness of mental health services may be the single most important factor in the accessibility of services by Native people. Developing culturally sensitive practices can help reduce barriers to effective treatment utilization (Saldaña D., 2001) and can enhance program effectiveness. Too often, prevention programs are attempted without sufficient knowledge of the unique cultural aspects of a Native community. Differences by tribal group, culture, degree of Indian ancestry, and reservation/urban residency make it difficult to prescribe a general prevention approach for all Native youth (Moran & Reaman, 2002). It is widely recognized that the cultural uniqueness of American Indians and Alaska Natives should be reflected in the methods of diagnosing, preventing, and treating mental health problems (Manson, S., Walker, R.D., & Kivlahan, D. 1987).

Philip May and colleagues (2005) evaluated the efficacy of 15 years of a public health-oriented suicidal-behavior prevention program among youths living on an American Indian reservation. Efforts in this approach showed a remarkable downward trend in Native suicide. Focusing upon similar population based health strategies, the following programs were collected from a variety of sources, including the Suicide Prevention Resource Center website (<http://www.sprc.org>) and interviews with Behavioral Health Directors around the country. For a complete list of references, please visit the SPRC website. This list includes all promising programs in use. An asterisk* denotes that the program has been used effectively in a Native Community.

I. ASIST*

Program Description

ASIST is a two-day workshop designed to provide participants with gatekeeping knowledge and skills. Gatekeepers, as they are called after training, are taught to recognize the warning signs of suicide and to intervene with appropriate assistance. After training, ASIST participants should be able to:

- Recognize that caregivers and persons at risk are affected by personal and societal attitudes about suicide,
- Discuss suicide with a person at risk in a direct manner,
- Identify risk factor alerts and develop safe plans related to them,
- Demonstrate the skills required to intervene with a person at risk,
- List the types of resources available to a person at risk, including themselves,
- Make a commitment to improving community resources; and,

- Recognize that suicide prevention is broader than suicide first-aid and includes life promotion and self-care for the caregivers.

Workshops are 14 hours long (over two days). They are delivered to a maximum of 30 participants by a minimum of two trainers. Almost 2,000 ASIST workshops, with 50,000 participants, are conducted annually. In addition, a training program for ASIST trainers is available. This allows large institutions to have their own trainers.

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 could be accessed, consistent use of positive feedback, a blend of larger group experiential challenges and safety of small group opportunities to test new skills, no-fault simulation exercises, and the use of adult learning principles.

Program Costs

The average program cost is \$100 per participant, which includes program materials. The cost will vary depending upon the availability of trainers and other circumstances.

Generalizability

The ASIST program has been implemented at several Native sites both in reservation and urban settings.

Contact Information

ASIST training is provided by LivingWorks Education Inc., of Alberta, Canada. For additional information visit their website at www.livingworks.net, call (403) 209-0242, or email info@livingworks.net.

2. BRIEF PSYCHOLOGICAL INTERVENTION AFTER DELIBERATE SELF-POISONING

Program Description

This intervention provides four sessions of psychotherapy for adults who deliberately poisoned themselves. According to Guthrie et al. (2001), “This therapy entails identifying and helping to resolve interpersonal difficulties which cause or exacerbate psychological stress” (p. 1). It is adapted from a model developed by Hobson (1985) for the treatment of depression. The intervention is delivered by nurse therapists in the patient’s home. Four, 50-minute sessions are offered over the course of a month. During each session, therapists assessed the risk of suicide and communicated with the patient’s general practitioner.

Promising Programs

Evaluation Design and Outcomes

A randomized 2-group design was used by evaluators to determine the intervention effectiveness. One-hundred nineteen patients who deliberately poisoned themselves were assigned to either a psychotherapy (intervention) group or to a treatment as usual (control) group. Psychotherapy group members demonstrated statistically significant less suicidal ideation and depression compared to the treatment as usual group members. In addition, at the 6-month follow-up it was found that only 9% of psychotherapy group members had harmed themselves again compared with 28% of treatment as usual group members.

Generalizability

The study was conducted in Great Britain. Participants were evenly divided between men and women, and ranged in age from 18 to 65 years. No information was provided regarding participant ethnicity. To our knowledge this approach has not yet been specifically incorporated into any North American Native communities.

Implementation Essentials

Therapists skilled in interpersonal therapy.

Increased Protective Factors

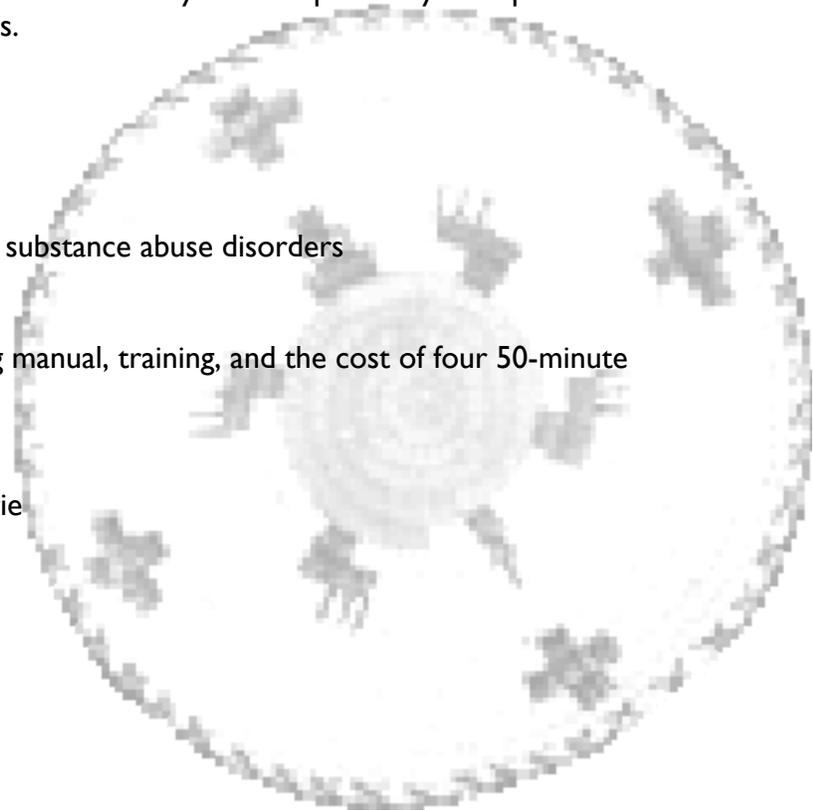
Effective clinical care for mental, physical and substance abuse disorders

Program Costs

Program costs include a standardized training manual, training, and the cost of four 50-minute therapy sessions held in the patients homes.

Program Contact Information

Program Developer/Evaluator: Elspeth Guthrie
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3. C-CARE/CAST*

Program Description

Promising Programs

C-Care/CAST is a school-based intervention for students at risk for suicide. It combines one-on-one counseling with a series of small-group training sessions. C-Care (Counselors-Care) provides an interactive, personalized assessment and a brief motivational counseling intervention. It is delivered in 2 sessions: a 2-hour, one-to-one computer-assisted suicide assessment called the Measure of Adolescent Potential for Suicide and a 2-hour motivational counseling intervention designed to:

- Deliver empathy and support;
- Provide personal information;
- Reinforce coping skills and help-seeking behaviors;
- Increase access to help; and,
- Enhance access to social support.

CAST (Coping and Support Training) is a small group skills training intervention. Twelve one-hour sessions incorporate key concepts, objectives, and skills that are outlined in a standardized implementation guide. Sessions target mood management (depression and anger management), drug use control, and school performance by helping youth apply newly acquired skills and gain support from family and other trusted adult leaders. The implementation guide also specifies the motivational preparation and coaching activities required of the CAST leader (generally a master's level high-school teacher, counselor, or nurse).

Evaluation Design and Outcomes

An evaluation incorporating randomized design and multiple follow-ups (4 weeks, 10 weeks, and 9 months) examined the relative impact of three conditions (C-CARE alone, C-CARE plus CAST, and treatment as usual) upon suicide risk behaviors, and related risk and protective factors. The evaluation found statistically significant declines in suicidal ideation and in favorable attitudes towards suicide for C-Care and CAST students compared to treatment-as-usual students. Greater reductions in anxiety and anger by C-Care and CAST students were also observed. Students participating in just the CAST program demonstrated enhanced and sustained personal control, problem-solving, and coping skills when compared with students from the other groups.

Generalizability

The C-Care/CAST interventions have been implemented in schools with diverse ethnic populations. While it has had limited use in Native communities, it does offer a structured and focused approach that could be quite useful. Greater reductions in anxiety and anger were observed in females than males when C-Care and CAST students were compared to treatment-as-usual students. (Thompson, et al., [2001] speculated that small-group settings were more effective in reducing anxiety and anger in females at risk for suicide than males at risk for suicide.)

Promising Programs

Implementation Essentials

- Identifying, recruiting and inviting at-risk students to participate
- CAST leader (high-school teacher, counselor, or nurse) recruitment, selection and supervision/support
- Training for C-CARE counselor and CAST leader

Targeted Protective and Risk Factors

The C-Care and CAST programs impacted the following risk and protective factors that have been targeted by the National Strategy for Suicide Prevention for the reduction of suicide in the United States.

Increased Protective Factors: Skills in problem solving, conflict resolution, and nonviolent handling of disputes

Decreased Risk Factors: Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders, hopelessness

Program Costs

C-CARE Protocols.....	Varies
CAST Protocols.....	Varies
Counselor Training.....	Varies
CAST Leader Training.....	Varies

Program Contact Information

Beth McNamara, MSW
Information and Training Coordinator
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Seattle, WA 98102
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4. COLUMBIA UNIVERSITY TEENSCREEN PROGRAM

Program Description

The purpose of the Columbia TeenScreen Program (CTSP) is to identify youth who are at-risk

Promising Programs

for suicide and potentially suffering from mental illness and then ensure they receive a complete evaluation. While screening can take place in any number of venues, including juvenile justice facilities, shelters, and doctor's offices, the program has been primarily conducted in school settings. The program involves the following stages:

1. All students who have appropriate parent permission and who themselves assent to participation complete one of three self-administered screening instruments: (1) the Columbia Health Screen (CHS), (2) the Columbia Depression Scale (CDS), or (3) the Diagnostic Predictive Scales (DPS). The CHS is a 14-item self-report measure of suicide risk; the CDS is a 22-item depression screen; and the DPS is a computerized screen for depression, anxiety, and substance abuse.
2. Students who screen "positive" on the selected screening tool are interviewed by a clinician to determine if further evaluation is necessary.
3. Students who are found to require additional services are connected with a case manager to arrange for appropriate intervention.

Recognizing that schools differ in regards to administrative structure and resources, TeenScreen provides examples of several intervention models for students who screen positive and are deemed "at-risk." These include existing staff, external team and one-person models.

Evaluation Design & Outcomes

The most complete evaluation of the Columbia TeenScreen Program used the CHS and DISC (Diagnostic Interview Schedule for Children) to assess 2,004 of 2,995 accessible students from eight high schools in the New York metropolitan area. (Reasons for non-participation by accessible students included parent refusal, 9%; student refusal, 10%; or absence on the screening day, 14%.) Of the 2,004 students who were administered the CHS, 546 screened "positive" for mood disorder, substance abuse, suicide, or a combination of these. These students were then administered the next level test, and, if results warranted, were evaluated by a child psychiatrist or psychologist. A total of 176 students were ultimately referred to a case manager to facilitate their acquisition of the services recommended by the clinician.

Out of the 546 students who initially screened positive, only 31% of those with major depression, 26% of those with recent suicide ideation, and 50% of those who had made a past suicide attempt were known by school personnel to have significant problems and receiving help. Additional studies have assessed the psychometric properties of the CHS and DPS screening instruments.

Generalizability

The Columbia TeenScreen Program has been studied in a variety of school settings with divergent student populations. The program has also been implemented in foster care, primary care and pediatric practices, shelters, drop-in centers and residential treatment facilities. While no

Promising Programs

known Teen Screen program has been implemented in Native communities, the program should be considered.

Implementation Essentials

Implementation essentials include the following:

- Appropriate parent permission
- Participant assent
- Columbia TeenScreen Getting Started Guide and Workbook
- Screening instrument(s)
- Staff availability to conduct screenings
- An adequate and appropriate plan for intervening with students who screen “positive” and require full evaluation after the screening

Program Costs

At this time, Columbia provides consultation, training and technical assistance around the implementation of the TeenScreen program for free. The screening and assessment instruments are also offered at no cost.

Program Contact Information

Columbia University TeenScreen® Program

1775 Broadway

Suite 715

New York, NY 10019

Phone: 1-866-TEENSCREEN (833-6727).

E-mail: teenscreen@childpsych.columbia.edu

Website: www.teenscreen.org



5. RECONNECTING YOUTH

Program Description

Reconnecting Youth (RY) is a school-based selective/indicated prevention program that targets young people in grades 9–12 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, and depression/aggression. The program incorporates social support and life skills training with the following components:

- The RY class is a semester-long (~ 80-90 days) class that is divided into the following five modules: (1) getting started, (2) self-esteem enhancement, (3) decision making, (4) per-

sonal control, and (5) interpersonal communication. Forty-one class sessions and 23 booster/review sessions are included in the curriculum; this leaves 16 class sessions for the social activities/school bonding components. The class integrates 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, healthy pleasant activities for abating depression, as well as improving a teen's relationship to school;
- School system crisis response plan that addresses important school-wide suicide prevention and intervention approaches; and,
- Parent involvement that includes active parental consent for student participation and at-home support of RY goals for their youth.
- The RY program has been recognized by numerous governmental agencies as an effective, model program for reducing substance abuse and similar at-risk behaviors in youth. It was evaluated by EBPP for its effect on risk and protective factors related to suicide risk.

Evaluation Design and Outcomes

A three-group, repeated measures design was used to examine program effects. One-hundred-six at-risk students in grades 9 to 12 were randomly assigned to one of two treatment conditions or a control group. Analysis supported the program's central hypothesis that teacher and peer group support, facilitated through the RY class, increased personal control, which in turn decreased behaviors associated with suicide risk. In addition, RY appears to contribute to decreased drug involvement and depression, risk factors associated with suicide, and increased school achievement.

Generalizability

While the RY program was studied in six urban schools, it has been implemented in a variety of schools in both urban and suburban settings representing a cross section of ethnic enrollments. While not yet known to be used in Native communities, this is another program that could be considered for adaptation.

Implementation Essentials

- Identifying, recruiting and inviting RY students according to the RY design
- Small class size (1:10 teacher-to-student ratio), class taken for credit as a regular course in the student's school schedule, providing at least 4,000 minutes of instruction and implemented as designed; no "rolling" admission into RY—i.e., no changes in enrollment after the first 1-2 wks.
- Teacher recruitment, selection and supervision/support as designed in the RY model
- RY training for teachers, program coordinators and school/community administrators
- Implementing the RY class and social activities/school bonding components with fidelity

- Follow-up consultation visits at 6-month periods (optional).

Program Costs

Curriculum Guide (2nd Edition).....	\$299.95 (plus shipping & handling)
Student Workbook (set of 10).....	\$211.95
Budget for Activities component/Transportation.....	~ \$450.00
RY Class Classroom supplies/copying costs/miscellaneous expenses	varies
Four days of RY teacher/program coordinator training (8 participants/trainer)	\$4,800.00
Additional one-day administrator/program coordinator training.	\$1,200.00
Trainer travel and expenses	Varies

Additional expenses include: (1) RY teacher salary, (2) substitute salary, (3) supplemental salary for participation in RY training and ongoing supervision.

Program Contact Information

Program Information & Scheduling

Program Publisher

Beth McNamara, MSW, Information and Training Coordinator

Reconnecting Youth Co TM

Phone: 425-861-1177

Fax: 206-726-6049

Email: ry.info@comcast.net

6. SPECIALIZED EMERGENCY ROOM INTERVENTION FOR SUICIDAL ADOLESCENT FEMALES

Program Description

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

1. Emergency room physicians and staff (psychiatrists, pediatricians, nurses, security guards and admitting clerks) engage in a single two-hour training session. The sessions have three goals: to enhance positive staff/patient interactions, reinforce the importance of outpatient treatment, and to recognize the seriousness of suicide attempts.
2. Suicide attempters and their parents view a 20-minute video. The video is designed to highlight the importance of and instill realistic expectations regarding outpatient treatment. (A Spanish language version of the video is available.)
3. Suicide attempters and their parents 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.

Evaluation Design and Outcomes

The emergency department intervention was evaluated using a quasi-experimental design to assess its long-term impact (Rotheram-Borus, et al., 2000). One-hundred-forty adolescent female suicide attempters were consecutively assigned to treatment as usual (the control group) and specialized emergency room care (the experimental group). The intervention occurred exclusively during the emergency room visit. Afterwards, both groups received a standardized outpatient follow-up treatment (SNAP: Successful Negotiation Acting Positively). Suicide attempters and their mothers, who received the specialized treatment, had significantly lower levels of depression following their emergency department visits than suicide attempters and their mothers who did not receive the intervention. These differences persisted for the 18-month follow-up period. Participation in the specialized care condition was also associated with greater attendance and completion of outpatient treatment.

Generalizability

Study participants were all female, between the ages of 12-18 years old, and were predominantly Hispanic (63% of participants spoke only Spanish). Program is focused within a health care setting and as such should transfer into a workable approach in Native communities.

Implementation Essentials

The specialized emergency room intervention requires the following:

1. Prior to program implementation, a two-hour training session should be provided to all emergency department staff (a standardized training manual is available);
2. As part of the intervention, a 20-minute video presentation is provided to suicide attempters and their mothers; and,
3. A meeting with a crisis therapist should follow the video; the therapist conducts a brief therapy session and contracts for follow-up outpatient treatment.

Program Costs

Protocols are freely available online at <http://chipts.ucla.edu/interventions/manuals/interer.html>.

Training costs for emergency department staff varies.

Program Contact Information

Program Developer & Evaluator
Mary Jane Rotheram-Borus, PhD
Department of Psychiatry
University of California, Los Angeles

10920 Wilshire Blvd., Suite 350
Los Angeles, CA 90024
Email: rotheram@ucla.edu

7. SOS: SIGNS OF SUICIDE*

Program 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 suicidal behavior. In the didactic component of the program, SOS promotes the concept that suicide is directly related to mental illness, typically depression, and that it is not a normal reaction to stress or emotional upset. The basic goal of the program is to teach high school students to respond to the signs of suicide as an emergency, much as one would react to signs of a heart attack. Students are taught to recognize the signs and symptoms of suicide and depression in themselves and others and to follow the specific action steps needed to respond to those signs.

Program Activities

Program activities include a 50-minute classroom presentation that features a 25-minute video, a teacher-led discussion, and the administration and scoring of the SOS Student Screening Form. Support materials such as posters, handouts, and cards are provided.

Evaluation Design & Outcomes

An experimentally designed study found that program participants were 40% less likely to report a suicide attempt in the three months following program implementation than were students in a control group. A separate pre-post study reported increases in the number of school-wide referrals for suicidality/depression.

Generalizability

The evaluation results reported above were taken from primarily urban populations. However, the SOS Program has been administered in over one-thousand high schools containing a diversity of students. Evaluation efforts are currently underway to evaluate program effects in suburban and rural populations. It has experienced limited use in Native communities.

Implementation Essentials

Essential components of the SOS program are (1) a student video: Friends for Life: Preventing Teen Suicide, (2) a teacher training video; and (3) a teacher discussion guide. Schools should be prepared to appropriately handle an increased number of referrals for depression and sui-

cide. Other components include a brief student self-report for depression and a parent version of the same instrument that can be used by parents to evaluate possible depression in their children.

Language Availability

Spanish language versions of the student screening form and parent instrument are available.

Program Materials and Costs

Teachers implementing the program will require 1-2 hours of training and a site coordinator (usually a counselor).

The following program materials are supplied by the developer for a cost of \$200.

- Procedure manual (40 pages)
- Teacher training video (28 minutes)
- Student video (25 minutes)
- Teacher discussion Guide
- Student self-screening form and administrator protocols
- Parent version of the student screening form and directions for parent use
- Support Materials (anti-suicide posters, hand-outs, cards, etc.)

For Additional Program Information Contact

Barbara S. Kopans

Screening for Mental Health Inc.

One Washington Street, Suite 304

Wellesley Hills, MA 02481

Phone: (781) 239-0071

Fax: (781) 431-7447

Webpage: www.mentalhealthscreening.org

Email: highschool@mentalhealthscreening.org



8. U.S. AIR FORCE PROGRAM

Program Description

The U.S. Air Force suicide prevention program is a comprehensive, institution-wide intervention that focuses on enhancing protective factors and decreasing risk factors for suicide. Major goals of the program include:

- Promoting awareness of the range of risk factors related to suicide;
- Educating the community regarding available mental-health services; and,
- Reducing the stigma related to help-seeking behavior.

Promising Programs

These goals were achieved through the development of eleven initiatives that targeted strengthening social support, promoting development of effective coping skills, and changing policies and norms so as to encourage effective help-seeking behaviors. Because of the universal nature of the risk and protective factors targeted by the program, reductions in other violent behavior can also be expected.

Evaluation Design and Outcomes

The U.S. Air Force program was evaluated using an interrupted time series design (Knox, et al., 2003). Rates of suicide deaths, as well as other violence related statistics, were examined for 6 years prior to and after program implementation. Analysis of post-implementation rates (1997-2002) revealed a 33% risk reduction for suicide. Reductions in rates of homicide (-51%), accidental death (-18%), and severe and moderate family violence (-54% and - 30% respectively) were also observed. The only variable to increase was mild family violence (+18%), likely due to the reduction of severe and moderate family.

Eleven Key Initiatives of the US Air Force Program

1. Leadership Involvement
2. Professional Military Education
3. Guidelines for Commanders on Use of Mental Health Services
4. Community Preventive Services
5. Community Education and Training
6. Investigative Interview Policy
7. Critical Incident Stress Management
8. Integrated Delivery System for Human Services Prevention
9. Limited Patient Privilege
10. Behavioral Health Survey
11. Epidemiological Database and Surveillance System

Generalizability

Although this intervention occurred within a unique population, the U.S. Air Force, the program should be generalizable to other communities including Native or institutions for the following reasons: (a) the program is based on a public health model that has successfully been employed against other health threats, (b) the program is supported by existing theory; and, (c) members of the U.S. Air Force represent tremendous ethnic, geographical, and socioeconomic diversity.

Implementation Essentials

Because of the comprehensive nature of the program, there are a variety of critical implementation components. Foremost among these is leadership buy-in. Leader awareness education

and training formed the first of the eleven initiatives developed for the program. Other important aspects include the incorporation of suicide prevention into required training, improvement of the referral process, and the improved identification of at-risk individuals. Perhaps the most essential ingredient was the reduction of stigma associated with help-seeking.

Program Costs

The U.S. Air Force Suicide Prevention Program Manual.....Free (USAF, 2001)
TrainingVaries

Program Contact Information

Program Developer
Lt. Col. Rick Campise
U.S. Air Force suicide prevention program
Voice: 202-767-4285
Email: rick.campise@pentagon.af.mil

8. YELLOW RIBBON SUICIDE PREVENTION PROGRAM*

Program Description

Yellow Ribbon is a school and community-based suicide prevention program that incorporates a collaborative, grass-roots 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 by distributing “Ask for Help” cards. Yellow Ribbon expands public awareness of the problem of suicide through promotional materials, school-wide assemblies, and community-wide collaboration efforts. Gatekeeper activities are promoted through use of a simple three-step rubric: stay, listen, and get help; and, that It’s OK to Ask for Help! ®. This rubric is reinforced at all levels of training through Yellow Ribbon’s Be-A-Link! ® curriculum and the distribution of “Ask for Help” cards that contain directions for help-seeking and a toll-free helpline phone number. Yellow Ribbon incorporates a community-wide prevention model that encourages the development of partnerships to increase program impact and sustainability.

Generalizability

The Yellow Ribbon Program has been widely used in schools and communities throughout the United states including Native communities and schools. A major advantage of this program is the inclusion of student/family involvement and leadership.

Implementation Essentials

Promising Programs

The Yellow Ribbon program contains four essential stages:

1. Planning sessions with school and community leaders.
2. Training for staff and youth leaders, followed by school-wide assemblies.
3. Booster training and training for new staff members and students.
4. Establishment of community task forces to ensure on-going resource connections, awareness reminders, event coordination, and expanded gate-keeper training.

Program Costs

Program costs vary and are offered on a sliding scale. Contact Yellow Ribbon for details.

Contact Information

Additional information concerning the Yellow Ribbon program can be found by accessing their website at www.yellowribbon.org, Ask4help@yellowribbon.org, or calling (303) 429-3530.

9. AMERICAN INDIAN LIFE SKILLS DEVELOPMENT*

Program Description

The American Indian Life Skills Development (AILSD) curriculum is a culturally tailored intervention that targets high school students. It is based upon social cognitive theory, which proposes that suicidal behavior is affected through the interaction of modeling influences (peer and community), environmental factors, and individual characteristics. By developing competency in a range of life skills, program participants decrease known risk factors while increasing protective factors.

The AILSD curriculum contains the following seven units:

1. Building self-esteem,
2. Identifying emotions and stress,
3. Increasing communication and problem-solving skills,
4. Recognizing and eliminating self-destructive behavior such as pessimistic thoughts or anger reactivity,
5. Receiving suicide information,
6. Receiving suicide intervention training; and
7. Setting personal and community goals.

In its evaluated state, the curriculum was presented three times a week for 30 weeks in a required language arts class.

Evaluation Design and Outcomes

Promising Programs

The AILSD evaluation employed a quasi-experimental design with intervention and non-intervention conditions (LaFromboise, 1995). A variety of measures were used to identify program effects; these included the Suicide Probability Scale, the Hopelessness Scale, the Indian Adolescent Health Survey, student self-ratings of program skills, behavioral observations of program skills, and peer ratings of program skills. Statistically significant differences were found in decreased hopelessness (effect size = -.40) and in program student's ability to role-play suicide intervention skills (mean effect size of 1.00) and problem-solving skills (mean effect size of 0.61). Role-playing data were collected from reviewers blind to group assignment.

Generalizability

The program was originally tailored towards the Zuni culture; its effectiveness beyond that population has been generalized to other American Indian tribes. The process of cultural adaptation incorporated in the program appears transferable to other populations.

Implementation Essentials

The success of the AILSD curriculum is based upon several factors; critical among these are the following:

- The program should only be implemented after extensive community involvement that adapts cultural norms within the curriculum and establishes community support;
- Each lesson should consist of the following training techniques: (a) providing information about the effects of target behaviors, (b) modeling of appropriate skills, (c) behavior rehearsal of appropriate skills, and (d) providing feedback; and,
- Teachers should receive adequate training in utilizing the curriculum.

These factors could be equally important for all the listed promising programs when considering implementation.

Program Costs

American Indian Life Skills Development Curriculum text.....	\$29.95
Teacher Training.....	Variable
Cultural Adaptation.....	Variable

Program Contact Information

Program Developer

Teresa D. LaFromboise PhD
Associate Professor of Education
Stanford University
Cubberley 216, 3096
Stanford, California, 94305-3096
Voice: 650-723-1202
Fax: 650-725-7412

Promising Programs

Email: lafrom@stanford.edu

10. The Jason Foundation/BIA-OLES Region V Youth Suicide Prevention Project*

In January 2005, The Jason Foundation joined with the BIA-OLES Region V to begin collaboration to develop a youth suicide awareness and prevention plan based on current JFI clinically based programs. This plan is to be piloted in the Region V area and then offered to all BIA regions.

JFI and BIA-OLES Region V are working together to gather information from tribal leaders, tribal educators / youth workers, health workers, and the youth themselves concerning youth suicide's impact as seen from the grass-root level. This information will help in utilizing JFI's current programs (school-based curriculum, staff training seminars, and parent seminars) for use in the Indian Nation by making the programs more ethnic sensitive (also, the actual design and look will be modified for use in the Indian Nation). The programs will be presented by trained presenters / educators from the Native American and Alaska Native population.

Program Contact Information:

The Jason Foundation, Inc.
181 East Main Street . Jefferson Bldg. . Suite 5
Hendersonville, TN 37075
www.jasonfoundation.com
E-mail: info@jasonfoundation.com

11. Native Hope (Helping Our People Endure)*

Program Description

The manual is a curriculum based on the theory that suicide prevention can be successful in Indian Country by Native Youth being committed to breaking the "Code of Silence" prevalent among all youth. The program also aims to increase "strengths" as well as awareness of suicide warning-signs among Native youth. The program supports the full inclusion of Native Culture, traditions, spirituality, ceremonies, and humor. A Native H.O.P.E Training Facilitators Manual is also available to assist adults and experienced youth to serve as facilitators, rovers, and clan leaders in delivering the Native H.O.P.E. Curriculum.

Program Cost: free

Contact Information:

One Sky Center, www.oneskycenter.org
3181 SW Sam Jackson Park Road, Portland, Oregon 97239
503-494-3703

There are a number of prevention programs located throughout the United States. For a review of programs available in your area, you may want to contact your local Indian Health Service representative. The list below identifies Regional IHS contacts.

I.H.S. BEHAVIORAL HEALTH AREA CONSULTANTS

Aberdeen Area

Vicki Claymore-Lahammer 605-226-7518 vicki.claymore-lahammer@ihs.gov

Albuquerque

Tony Danielson 505-248-4538 tony.danielson@ihs.gov

Alaska

Scot Prinz 907-729-3643 Sprinz@anmc.org

Bemidji

Mary Fairbanks 218-444-0491 mary.fairbanks@ihs.gov

Billings

Susan Fredericks 406-247-7114 susan.fredericks@ihs.gov

California

David Sprenger 916-930-3937x321 david.sprenger@ihs.gov

Nashville

Palmeda Taylor 615-467-1530 palmeda.taylor@ihs.gov

Navajo

Jayne Talk-Sanchez 505-368-7420 jayne.talk-sanchez@ihs.gov

Promising Programs

Oklahoma

Don Carter 405-951-3817 don.carter@ihs.gov

Phoenix

David Atkins 602-364-5179 david.atkins@ihs.gov

Portland

Connie Hunt 503-326-2005 connie.hunt@ihs.gov

Tucson

Patricia Nye 520-295-2469 patricia.nye@ihs.gov

Youth Regional Treatment Centers

Anthony Yepa 248-4550/552-5505 anthony.yepa@ihs.gov

Eleven I.H.S. regional youth treatment facilities are located throughout the country. These centers may have advice for a local or regional program near you.

Youth Regional Behavioral Health Treatment Centers—arranged by state

Alaska: Graf-Healing Place FNA/TCC

Ph: 907-966-8714, Fax: 907-455-4730

Director: Rita Ellington, Psy. D, e-mail: rellington@fairbanksnative.org

P.O. Box 80450 , Fairbanks, Alaska 99709

Alaska: Raven's Way Treatment Center

Ph: 907-966-8714, Fax: 907-966-8723

Director: Anita Didrickson, Ph.D, e-mail: anita.didrickson@searhc.org

222 Tongass Drive, Sitka, Alaska 99835

Arizona: Desert Visions Youth Treatment Center

Ph. 1-888-431-4096 ext 224, Fax: 505-552-5530

Director: Anne Susan, A/CEO, MPH, MSW, e-mail: Anne.Susan@mail.ihs.gov

P.O. Box 458, Sacaton, Arizona 85247

Arizona : Hayool K'aal Adolescent Treatment Center

Ph. 928-674-3735, Fax: 928-674-2339

Acting Director Anthony Begay, e-mail: ambegayl@yahoo.com

P.O. Box 3525, Chinlee, Arizona 86503

Promising Programs

New Mexico: New Sunrise Regional Treatment Center

Ph: 505-552-5500, Fax: 505-552-5530

Anthony Yepa, Acting Director, e-mail: anthonyy@abq.ihs.gov

P.O. Box 219, San Fidel, New Mexico 87049

New Mexico: Shiprock Adolescent Treatment Center

Ph. 505-368-1501, Fax: 505-368-1467

Director: Carolyn Morris, Ph.D., e-mail: dr_morris2000@yahoo.com

P.O. Box 3997, Shiprock, New Mexico 87420

North Carolina: Unity Regional Youth Treatment Center

Ph. 828-497-3958, Fax: 828-497-6826

Director: Hillane (Rebecca) Lambert, email: Rebecca.Lambert@ihs.gov

P.O. Box C-201, Cherokee, North Carolina 28719

Oklahoma: Jack Brown Youth Regional Treatment Center

Ph: 918-458-0496, Fax: 918-458-0499 ext. 203

Mike Fisher, Director, email: Mike-Fisher@cherokee.org

P.O. Box 948, Tahlequah, Oklahoma 74465

Oregon: Wemble Naalam T'at'aksni Native Youth Regional Treatment Center

Ph. 541-273-0711, Fax: 541-273-7323

Director: Angie Pool, e-mail: aepool@klm.portland.ihs.gov

121 Iowa Street, Klamath Falls, Oregon 97601

South Dakota: Chief Gall Youth Regional Treatment Center

Ph. 605-845-7181, Fax: 605-845-5072

Tom Eagle Staff, Director e-mail: Tom.EagleStaff@mail.ihs.gov

P.O. Box 680, 12451 Highway 1806, Mobridge, South Dakota 57601

Washington: The Healing Lodge of the Seven Nations

Ph: 509-533-6910, Fax: 509-535-2863

Director: Louella Heavy Runner, MSW, CDP, NCACI, e-mail: louellah@healinglodge.org

5600 East 8th Avenue, Spokane, Washington 99212



Garret Lee Smith Programs

Garrett Lee Smith Memorial Act

In 2005, SAMHSA provided awards for Youth Suicide Prevention and Early Intervention Programs. This grant program is authorized under the Garrett Lee Smith Memorial Act, which provides funding for programs to combat suicide. There are now twelve programs funded nationally that direct their services towards Native youth.

As a result of the Garrett Lee Smith Memorial Act, SAMHSA is now working with state and local governments and community providers to stem the number of youth suicides in our country. Each of these new grantees will help fill a significant need in their community.

Further grants will be awarded under announcements of available funding for campus suicide prevention grants, state-sponsored suicide prevention and post-hurricane Katrina suicide prevention. These grants are listed as resources for all families, school staff, and health care staff not just in your vicinity but as regional resources as well

Tribal

Alaska: Maniilaq Association -- To provide a variety of prevention approaches to a region that has one of the highest youth suicide rates in the world. The project will include both a cultural and educational component. A media campaign will help to underscore the fact that suicide is preventable and unacceptable within an Inupiat context. A cultural renewal film project will enhance cultural continuity and increase youth resilience-- two factors linked to lower suicide rates. The educational component will focus on school and community prevention training and will increase community level protective factors and decrease risk factors.

Montana: Wyoming Tribal Leaders Council -- To increase tribal awareness of suicide-related issues, reduce suicidal behavior among tribal youth, and improve access to suicide prevention services for American Indian people. This project will bring prevention efforts to six Montana and Wyoming American Indian Reservations, serving the Blackfeet, Crow, Northern Cheyenne, Fort Peck, Fort Belknap and Wind River populations.

Oregon: Native American Rehabilitation Association of NW, Inc., Portland, Oregon --To implement "No More Fallen Feathers," a statewide, nine reservation adolescent suicide prevention program. Each community and urban area will design their own prevention focus unique to their own traditional, spiritual, and cultural beliefs. Interventions will integrate the evidence

Garret Lee Smith Programs

of science with the knowledge of tradition.

North and South Dakota: Standing Rock Sioux Tribe, Fort Yates -- To implement Okolakiciye Unyukinipi ("Revitalizing our Societies") that will bring together tribal leaders, service providers, youth and faith community leaders to implement a comprehensive tribal youth suicide prevention and early intervention plan that will identify and increase youth referral to mental health services and programs, increase protective factors and reduce risk factors for youth suicide, and improve access to prevention and early intervention programs.

Arizona: Tohono O'odham Nation, Sells -- To implement a public private partnership-built program to address the risk factors leading to youth suicide, including substance abuse, using evidence-based practices appropriate to the Tohono O'odham Nation.

California: United American Indian Involvement, Inc. -- To implement a Youth Suicide Prevention and Early Intervention Project targeting American Indian and Alaska Native children and youth ages 10-24 in Los Angeles County. The program will collaborate with other agencies, providers and organizations to share information and resources by promoting awareness that suicide is preventable. The program will develop a culturally appropriate youth suicide prevention and intervention effort to include screening, gatekeeper training, and enhanced, accessible crisis services and referrals sources.

Arizona: White Mountain Apache Tribe, in collaboration with Johns Hopkins University, White River -- To collaborate to expand its suicide prevention initiative by implementing an integrated three-tier suicide prevention approach using culturally adapted, piloted and evaluated evidence-based interventions that address youth suicide risk and protective factors on the individual, family and community levels. Tier one focuses on community education about suicide risk factors and prevention. Tier two addresses the needs of youth with suicide risk factors. Tier three serves youth who have attempted suicide.

State

Idaho: Idaho State University -- To reduce suicide attempts and completions among Idaho youth ages 10-24, regardless of ethnic or racial heritage by implementing a public/private partnership. The partnership will utilize cultural best practices, provide statewide suicide prevention referral sources, develop low-cost campaign materials to increase awareness, and create a system for providing information and statistics on youth suicide in Idaho.

Garret Lee Smith Programs

South Dakota, Pierre-- To implement suicide prevention and early intervention programs in high schools and universities targeting youth ages 14-24, parents, staff and community "gatekeepers." The program will provide awareness, training and education, and establish linkages among schools, mental health centers and substance abuse treatment providers through referral and post-intervention protocols. Among the partners are Sinte Gelska University on the Rosebud Indian Reservation and Wakanyeja Pawicayapi on the Pine Ridge Indian

Washington, Olympia-- To reduce suicides among high-risk groups, including Native American youth, by establishing and sustaining a statewide coalition to coordinate prevention activities and to provide opportunities for traditional and nontraditional partners to collaborate on suicide prevention strategies. This will be accomplished by implementing specific strategies targeting youth suicide with Native American- and youth-serving organizations, and by implementing evidence-based suicide prevention strategies on university campuses across the state.

Wisconsin: Mental Health Association of Milwaukee -- To develop culturally sensitive, cross systems and consumer- inclusive projects in 10 communities with elevated risk of youth suicide. The project will build an infrastructure and increase capacity to support the development of further projects. This process will educate and identify at-risk groups in their communities, focusing particular attention on three targeted populations with elevated risk for suicide, including: Native American youth; youth who are deaf; and youth in rural areas. The project includes 55 local entities and four tribes.

Wyoming, Cheyenne -- To reduce the rate of suicidality among state youth, ages 10-24, with a special emphasis on Native American youth and college students, through better statewide coordination (including the establishment of a statewide youth suicide prevention advisory council), school-based programming, community-based prevention programming, a pilot program for high-risk youth and anti-stigma/public awareness.

"The tribe is always hopeful we have a solution, but the problem with intervention is that it comes up on the backside of a suicide; usually after the fact. Tribes need to find out what is leading tribal people and the youth to suicide. They need to look at what is causing the despair." - Ron His Horse Is Thunder, Standing Rock Sioux

Consultation and Technical Assistance

Consultation and Technical Assistance

An immense need exists for technical assistance regarding suicide in our communities. The One Sky Center maintains a database of mental health consultants with experience working in Native Communities. This directory was developed under a contract from the Center for Mental Health Services (CMHS: SAMSHA) to identify individual consultants of multiple levels of expertise for Indian Country. The primary focus of CMHS was for consultants who could provide support on suicidal behavior. However, suicidal behavior occurs in conjunction with alcohol and drug use, depression and other social, environmental and health difficulties. Thus, this directory includes lay people, Elders, program directors, skilled, licensed and certified clinicians, grant writers, and program evaluators. It also includes individuals from many ethnic groups, including many American Indians.

This directory is an initial collection of providers, with data available through fall of 2006. Collection for consultant names is an ongoing project that will be kept current in an online directory at www.oneskycenter.org/oscservices/.

Criteria for Inclusion

Inclusion in this directory represents those who were “nominated” from a number of reputable sources. The objective was to identify people who are respected and trusted by their peers and have expertise useful to Indian Country. Inclusion into this directory is the result of polling the following:

- I.H.S. Area Service Directors
- I.H.S. Area Mental Health Directors
- State Directors of Mental Health and Substance Abuse Programs
- American Indian Professional Organizations
- Networks of respected colleagues

The staff at the One Sky Center provides this information as a resource service only. To our knowledge, this listing includes people with experience and skills working in Native communities. However, It is the responsibility of the individuals who elect to work with a consultant to perform background checks and gather additional information as needed.



Consultants

Data Collection and Directory Organization

Data are collected for each consultant using a data collection sheet developed for this purpose. In many cases, data was obtained via phone calls; in other cases it was acquired via email attachments or searching websites for nominated individuals. The individuals below gave expressed permission for inclusion of their professional contact information in published sources (i.e. printed documents and One Sky Center's web site).

The Consultant Directory

Name: Gregory Blevins, PhD
Address: 1 University Parkway, University Park, Illinois, 60466
Employer: Governor State University
Phone #: 708.534.4920
Email address: g-blevins@govstate.edu

Specialty areas

Substance abuse: prevention, treatment
Co-occurring disorders
Health education
Program: Planning, development, management, evaluation
Needs assessment
Research
Evidence-based practices: MET, Stages of Change, Harm Reduction

Certifications/Affiliations

Name: Maria Yellow Horse Brave Heart, PhD
Address: 4550 Cherry Creek South Drive # 803, Denver, CO 80246
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Associate Research Professor, University of Denver
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Email address: TakiniNet@aol.com

Specialty areas:

Violence/trauma

Certifications/Affiliations

License: LSCW

Name: Bobbi Bruce

Address: 115 4th Avenue SE, Room 309, Aberdeen, SD, 57401

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Specialty areas

Suicidal behavior: prevention

Health education

Methamphetamine prevention

Violence/trauma

Certifications/Affiliations

LSCW (pending) - South Dakota

Name: Debbie Carter, MD

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Specialty areas

Substance abuse

Criminal justice

Traditional health practices

Consultants

Suicidal behavior: prevention, treatment, crises intervention
Program: planning, development, management, evaluation
HIV/AIDS
Mental health/psychiatric treatment
Rural Health
Violence/trauma
Co-occurring disorders
Needs assessment
Two spirit

Certifications/Affiliations

Board Certified: General Psychiatry and Child Psychiatry
Licensed: Medicine, Colorado (34850)

Name: Vickie Claymore-LaHammer, PhD

Address: 115 Fourth Avenue SE

Employer: Aberdeen Area I.H.S. Office

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Email address: Vicki.claymore-lahammer@ihs.gov

Specialty areas

Substance abuse prevention, treatment, co-occurring disorders
Suicidal behavior: prevention, treatment, crises intervention
Mental health treatment
Health education
Program: planning, development, management, evaluation
Rural health
Chronic disease management
Needs assessment
Violence/trauma
Adolescents
Veterans
PTSD

Certifications/Affiliations

Name: Carol Nice Conner, PhD

Address: 100 N. Second Street, Fairfax, OK 74637

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Email address: paradox@valornet.com

Specialty areas

Substance abuse: prevention, treatment, co-occurring disorders

Mental health treatment

Health education

Program: planning, development, management, evaluation

Grant writing

Rural health

Needs assessment

Research

Certifications/Affiliations

License: Clinical Psychology: Oklahoma

Name: Ray Daw, MS

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Employer:

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Specialty areas

Substance abuse: prevention, treatment, co-occurring disorders

Mental health treatment

Criminal justice

Health education

Program: planning, development, management, evaluation

Grant writing

Rural health

Needs assessment

Research

Traditional health practices

HIV/AIDS

Violence/trauma

Evidence-based practices: MET, Stages of Change, Brief Family Therapy, Community Reinforcement Approaches

Certifications/Affiliations

Name: Lemyra DeBruyn, PhD

Address: 8 Rinaldi Place, Bernalillo, NM 87004

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Specialty areas

Substance abuse prevention

Suicide prevention, treatment

Program: planning, development, management, evaluation

Needs assessment

Health education

Research

Violence/trauma

Criminal justice

Grant writing

Chronic disease prevention/management

Certifications/Affiliations

American Evaluation Association

American Public Health Association

International Society for Traumatic Stress Studies

Name: Nell Eby, MSPR

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Employer:

Phone #: 406.671.6054

Specialty areas

Program: planning, development, management, evaluation

Grant writing

Needs assessment

Research

Traditional health practices

Violence/trauma: Traumatic brain injury

Cultural competency

Historical trauma

Certifications/Affiliations

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Employer:

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Email address:

Specialty areas

Suicidal behavior: treatment

Mental health/psychiatric treatment (adult)

Health education

Program: planning, development, management, evaluation

Rural health

Chronic disease management

Certifications/Affiliations

Psychiatry

Name: Alice Franks, PsyD

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Employer:

Consultants

Phone #:

Email address: rafnorth@aol.com

Specialty areas

Substance abuse: prevention, treatment

Health education

Two spirit

Suicidal behavior: prevention, treatment, crises intervention

Program: planning, development

Violence/trauma

Mental health treatment

Rural health

Co-occurring disorders

HIV/AIDS

Certifications/Affiliations

Licensed: Clinical Psychology

State License: Colorado; Idaho; North Carolina (pending)

Name: Linda D. Frizzell , PhD

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Specialty areas

Program: development, planning, management, evaluation

Needs assessment

Mental health disorders

Health education

Rural health

Research

Grant writing

Certifications/Affiliations

Teaching: Minnesota

Personal Trainer, Am. Council on Exercise
CNA State of Minnesota
TMA
Certified Leisure Therapist, State of Minnesota
Am. Academy of Fitness Professionals
National Recreation and Park Association

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Specialty areas

Substance abuse: prevention, treatment, co-occurring disorders
Suicidal behavior: prevention, treatment, crises intervention
Mental health/psychiatric treatment
Program planning, management, development, evaluation
Rural health
Chronic disease management
Traditional health practices
Violence/trauma
Two spirit
Child psychiatry diagnosis/treatment
Tele-psychiatry

Certifications/Affiliations

Psychiatry

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Consultants

Specialty areas

Mental health/psychiatric treatment
Health education
Grant writing
Program: planning, development, management, evaluation
Rural health
Needs assessment
Research
Violence/trauma
Two spirit
American Indian well-being indicators
Child welfare;
Strengths perspective

Certifications/Affiliations

Licensed clinical social work, Arizona

Name: Frank Gonzales, PhD

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Specialty areas

Substance abuse prevention, treatment, co-occurring disorders
Mental health/psychiatric disorders
Forensics
Program planning, management, development, evaluation
Rural health
Needs assessment
HIV/AIDS
Violence/trauma
FASD
Evidence Based Practices: Critical Incidence Stress Management

Certifications/Affiliations

Clinical Psychology, California

Name: Jackie Gray, PhD

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Specialty Areas

Suicidal behavior: prevention, treatment, crises intervention

Mental health/psychiatric treatment

Health education

Program planning, development, management, evaluation

Grant writing

Rural health

Needs assessment

Research

Violence/trauma

Evidence based practice: Parent Child Interaction Therapy

Crises management

Depression

Certifications/Affiliations

Licensed Psychologist, North Dakota, Oklahoma

Name: Deloris Gregory, MD

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Employer: I.H.S. (Retired)

Phone #: 503.645.8214

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Specialty areas

Substance Abuse: prevention, treatment

Health education

Criminal justice

Suicidal behavior: prevention, treatment, crises intervention

Program: planning, development

Violence/trauma

Mental health treatment
Rural health
Grant writing
Co-occurring disorders
HIV/AIDS

Certifications/Affiliations

Board Certified: General Psychiatry; Preventive Medicine
(ASAM) Addiction Substance Abuse Medicine
Licensed: Medicine: Oregon; California

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Specialty areas

Substance abuse: prevention, treatment
Program evaluation
Grant writing
Needs assessment

Certifications/Affiliations

American Evaluation Association

Name: Donald Hilty, MD
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Specialty areas

Substance abuse: Co-occurring disorders

Suicidal behavior: prevention, treatment, crises intervention
Mental health/psychiatric treatment
Health education
Program planning, development, management, evaluation
Grant writing
Rural health
Chronic disease management
Needs assessment
Violence/trauma

Certifications/Affiliations

Psychiatry, State of California

Name: Elizabeth H. Hawkins , PhD
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Specialty areas

Substance abuse prevention, treatment
Suicide
Mental health disorders
Program development, planning, evaluation
Needs assessment
Research

Certifications/Affiliations

American Psychological Association
Society of Indian Psychologists

Name: Ethleen Iron Cloud Two Dogs
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Employer:

Consultants

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Specialty areas

Substance abuse

Criminal justice

Traditional health practices

Suicidal behavior: prevention, treatment, crises intervention

Program: planning, development, management, evaluation

HIV/AIDS

Mental health treatment

Rural health

Violence/trauma

Co-occurring disorders

Needs assessment

Two spirit

Certifications/Affiliations

Name: Craig Love, PhD

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Specialty areas

Substance abuse: prevention, treatment, co-occurring disorders,

Criminal justice

Program: planning, development, management, evaluation

Grant writing

Needs assessment

Research

HIV/AIDS

Certifications/Affiliations

American Psychological Association
American Evaluation Association

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Specialty areas

Substance abuse prevention, treatment

Health education

Program evaluation, development

Needs assessment

HIV/AIDS

Research

Certifications/Affiliations

Health Education- Natl. Comm. for HE Credentialing (#0857)

American Anthropological Association

Research Society on Alcoholism

American Association for Advancement of Science

Society for Public Health Education

American Public Health Association

Society for Applied Anthropology (Fellow)

American Academy of Health Behavior

Society of Medical Anthropology



Name: G. Alan Marlatt , PhD

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Employer: University of Washington

Phone #:

Email address:

Specialty areas

Substance Abuse Prevention

Substance Abuse Treatment

Certifications/Affiliations

American Psychological Association

Research Society on Alcoholism

Licensed: Clinical Psychology, Washington

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Specialty areas

Demography/epidemiology

Community prevention

Behavioral risk factors

Substance Abuse Prevention

Program Development

Program Evaluation

Suicide Prevention

Criminal Justice

Program Planning

Grant Writing

Research

Certifications/Affiliations

American Public Health Association

American Association of Suicidology

Research Society on Alcoholism

Population Reference Bureau

American Sociological Association
College on Problems of Drug Dependence

Name: Michael Munnell

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Phone #: 218.727.7699

Email address: mmunnell6@msn.com

Specialty areas

Substance abuse treatment

Mental health/psychiatric treatment

Rural health

Traditional health practices

Evidence based practices: Rational Emotive Treatment, Brief Therapy, Reality Therapy, Goal

Oriented Therapy

Certifications/Affiliations

Name: Dennis Norman, EdD

Address: 60 Staniford Street, Boston, MA 02144

Employer: Massachusetts General Hospital

Phone #: 617.726.2977

Email address: dnorman@partners.org

Specialty areas

Suicidal behavior: treatment

Mental health/psychiatric treatment

Health education

Rural health

Chronic disease management

Certifications/Affiliations

Clinical Psychology, State of Massachusetts

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Specialty areas

Substance abuse: co-occurring disorders

Suicidal behavior: prevention, treatment, crises intervention

Mental health/psychiatric treatment

Criminal justice

Forensics

Chronic disease management

Needs assessment

HIV/AIDS

Violence/trauma

Two Spirit

Certifications/Affiliations

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Specialty areas

Substance abuse prevention

Program evaluation

Grant writing

HIV/AIDS

Research

Certifications/Affiliations

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Specialty areas

Substance abuse: prevention, treatment, co-occurring disorders

Suicidal behavior: prevention, treatment

Criminal justice

Health education

Program: planning, development, management, evaluation

Rural health

Needs assessment

Traditional health practices

HIV/AIDS

Violence/trauma

Native men's wellness

Community mobilization

Certifications/Affiliations

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Specialty areas

Substance abuse prevention, treatment

Program development, management, evaluation

Needs assessment

Research

Criminal justice

Program planning

Grant writing

Certifications/Affiliations

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Specialty areas

Substance abuse

Criminal justice

Traditional health practices

Suicidal behavior: prevention, treatment, crises intervention

Program: planning, development, management, evaluation

HIV/AIDS

Mental health treatment

Rural health

Violence/trauma

Co-occurring disorders

Needs assessment

Two spirit

Certifications

CAC-III – Arizona; Oregon, ICADC - International

Licensed: Clinical Psychology, Oregon, Washington

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Specialty areas



Substance abuse prevention, treatment
Mental health disorders
Program evaluation
Research
Violence/trauma

Certifications/Affiliations

American Psychological Association
AA Behavioral Therapists

Name: R Dale Walker, MD
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Specialty areas

Substance Abuse: prevention, treatment, co-occurring disorders
Mental health treatment
Criminal Justice
Health education
Program: planning, development, management, evaluation
Grant writing
Rural health
Needs assessment
Research
Traditional health practices
HIV/AIDS
Violence/trauma
Evidence-based practices: MET, Stages of Change, Brief Family Therapy, Community Reinforcement Approaches

Consultants

Certifications/Affiliations

American Psychiatric Association, Distinguished Fellow

Licensed to practice medicine in Oklahoma, Colorado, California, and Oregon



"Tribes do not understand what is at the root of what problems our children face. We tend to mount our culture and heritage very high, and we say we value them, but we don't demonstrate these values on a daily basis, for example: traditional language. There are mixed signals to our youth and the community, and we need to embrace these values in our everyday actions. Also, our people and youth are surrounded in a world by multimedia. The children see what the rest of the world has acquired. They see these things and often realize that they or their parents can't get the same things and low self-esteem kicks in and suicide comes into play; suicide speaks to the poverty rate. Along with poverty, alcoholism, health disparities, these all play a part in suicide. Tribes are trying to shore up their economies and address the poverty rate, but the world does not understand how they fit in. Unless tribes shore up their economies, the poverty rate will lend itself to suicide in tribal communities."

- Ron His Horse Is Thunder, Standing Rock Sioux

Community Assessment Tool

The American Indian/Alaska Native Community Suicide Assessment Tool

The One Sky Center developed a Community Suicide Assessment Tool Kit that has proven to be effective and useful in tribal communities. This toolkit supports a “system of care” approach to organizing planning, policy, and services. The community-based system of care approach is a best practice in Indian Country. A plan that is developed for the community by the community with cultural relevancy and sensitivity rooted in tribal custom and values works best for tribes and their members.

This document is designed as a **TEMPLATE** for use by a variety of American Indian organizations. It is a combination of two separate instruments designed for Community assessment of suicide prevention components of the community: The Suicide Prevention Community Assessment Tool (available at <http://www.sprc.org/library/catool.pdf>) and Acting On What We Know: Preventing Youth Suicide in First Nations (available at http://www.hc-sc.gc.ca/fnih-spni/pubs/suicide/prev_youth-jeunes/index_e.html).

Suggested uses of this tool:

- Internal program assessment and planning
- Background material for grant applications
- Extract selected sections and include in grants
- Use the entire tool as an Appendix in grant applications

How to use this document:

Please visit www.oneskycenter.org/education to access an electronic version of this template.

Open this document and Download it to your computer using the Save As drop down option of File on your word processor tool bar.

Select the File Folder of your choice (example: tool kit) and hit Enter (or click Save).

Community Assessment Tool

(Example: File/Save As/Tool Kit/Filename: American Indian Community Suicide Prevention Assessment Tool)

The document contains text in grey and automatic font colors. The Automatic font is the tool outline with sample text to guide you. Grey text signals information that varies from community to community and is included as an example. Make the grey font examples reflect specific information for your community.

REMEMBER: When finished, change the font from grey to the color used in the rest of your document and remove unnecessary underlining.

Please let us know your experience with this tool. Also, you may contact us for information or questions.

Phone: 503.494.3703

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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

Community Assessment Tool

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 Service Delivery
20. Community Self-Helping Process
21. Identification of Community Infrastructure Issues
22. Review of Self-Continuity Factors
23. Community Treatment Plan

I. 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)

Community Assessment Tool

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 US Government broke the _(name tribe's)_____ 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 graph of population data for the rez or community

Reservation: (insert Number) Districts and District Population:

Insert district names & population data

Community Assessment Tool

District Name	Popula- tion	District Name	Popula- tion

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 admini-

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)

stration 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

6. LAND

The _____ Tribal members are descendants of the _____. The Reserva- tion is located ___ (near 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 _____

Community Assessment Tool

Land Status:	Acres
Total Area	###,###
Tribal Owned	
Tribal Owned Allotted	
Total tribal owned	
Non-Indian Owned	
Reservoir Taken area	

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)_____.

7. ENVIRONMENT

The following infrastructure (exists or was lost) to _____ Tribes due to _____ (insert treaty, Act, other reasons for loss of land)_____:

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

# domestic water systems	# acres of waterbed	# rodeo arenas
# ranch water systems	# miles of main roads	# race tracks
# acres of land	# housing units	# sawmills

Community Assessment Tool

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.

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.

_(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 _____ in 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 _____.



Community Assessment Tool

(Agriculture? , list type of industry) _____ is the primary industry on the _____ Reserva-
 tion 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 often 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 wa-
 ter supply has also reduced the livestock production on the reservation. The grazing lands can-
 not 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.

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

Date	Type of Event/Name	Location
2nd Weekend in June	Memorial Day Pow Wow	Any town, State

_____, the _____ largest towns nearest the reservation.

The Tribe District (Pow Wows (or major cultural events))

_____ College sponsors a Graduation Powwow _____.

Chemical Prevention Program Annual Sobriety _____
 Elementary School _____

Community Assessment Tool

Veteran's Day _____
Tribal Days _____

Other recreational and honoring activities that have special meaning:

_____ in _____ in memory of _____
_____ in _____ in memory of _____
Annual _____ events are held in the surrounding _____
Annual _____ at _____ (when) _____

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 _____ 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

Community Assessment Tool

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 Bachelors Degree in Teacher Education is also offered in conjunction _____ on the _____ Reservation in state _____. Four year colleges include: _____.

For the _____ school year, there were _____ students enrolled in K – 12 schools

Districts		Funding Source				Type of School		
Name	Number	Tribal	Federal	State	Church	Elementary	Middle	High
State or								
County								

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 In-

Community Assessment Tool

dian. 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 _____.

14. MORTALITY DATA

Descriptive information is provided for _____ 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 __ (cause of death ____).
- 2)
- 3)

Aggregated Suicide Data

_____ Reservation

Act Occurred: Jan 00, 2000 – Feb 00, 2005

Age Range: 15-19 years

Total: 54

Report Totals

(N) (%)

Community Assessment Tool

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 yrs — —
 Some College — —
 _____ — —
 High School Grad/GED — —
 Data Not Entered — —

Community Assessment Tool

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 — —

Community Assessment Tool

	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/Dep	—	—
	Divorce/Separation/Break-up	—	—
	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

Number of high-risk individuals (e.g. previous attempts as identified by community workers):
Please explain:

Community Assessment Tool

(Example: With high unemployment, isolation and a fragile economy, the use of alcohol and drugs are a major problem).

Number of "children in care", "in community" placements:

 # reported from child protective services. "Out of community" placements: # at a given point in time.

Number of non suicide deaths in the past two years through "non-natural means" by type (i.e. vehicle crashes, accidents, violence): _____

Percentage of youth/children with addiction issues: at least ____%

Percentage of adults with addiction issues: ____%

Number of family units with more than one family member with addiction issues: ____%

Anecdotal accounting by community workers of abuse indicators present (physical, sexual and emotional): _____

Number of reported sexual assaults in past two years: _____

Number of reported physical assaults in past two years: _____

Number of family violence reports in past two years: _____

Traumatic events that have happened in and to community include:

Loss of respected Elders, leaders or others: Loss is _____, but there have been some

16. FAMILY INTEGRATION FACTORS

Role of Elders in extended family systems (advisors, counselors, healers)?

Interaction patterns (conflict, co-operation) between extended family systems/factions?

Community Assessment Tool

Familial instability (marital & family break-ups)?

Childhood separation and loss?

Interpersonal and inter-familial conflict?

17. IDENTIFICATION OF THE CURRENT-STATUS OF THE COMMUNITY

Community ownership over “child-in-care” decision-making, involvement in supporting "at-risk" families, role and functioning of social support systems.

Role of community Elders in community decision-making processes?

Role of positive adult role models in assisting children/youth “at-risk”?

Extent to which the community embraces individual members as belonging to the collective (as opposed to "not belonging")?

Extent of customary healing practices within the community based on traditional customary practices?

Community Assessment Tool

Accepting responsibility for and addressing past sexual or physical abuse at the community level (e.g. healing circles)?

Identifying and supporting individuals with friends or relatives that have committed suicide?

18. HEALING PROCESS

Community ownership over “child-in-care” decision-making, involvement in supporting “at-risk” families, role and functioning of social support systems.

Role of community Elders in community decision-making processes?

Role of positive adult role models in assisting children/youth “at-risk”?

Extent to which the community embraces individual members as belonging to the collective (as opposed to “not belonging”)?

Extent of customary healing practices within the community based on traditional customary practices?

Accepting responsibility for and addressing past sexual or physical abuse at the community level (e.g. healing circles)?

Community Assessment Tool

Identifying and supporting individuals with friends or relatives that have committed suicide?

19. REVIEW OF COMMUNITY AND TRIBAL SOCIAL AND MENTAL HEALTH SERVICE DELIVERY

Community relationship with the IHS:

State support and funding:

Mental health therapist contract:

Community level:

Tribal Council level:

IHS funded:

Is access to the IHS funded mental health therapist on a per client fee for service basis?

Access to State mental health services: _____

Alcohol and Drug Abuse Program:

Describe community recreation facilities or programming:

20. COMMUNITY SELF HELPING PROCESSES

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?

Community Assessment Tool

Efficacy of current community worker resources in identifying and monitoring high-risk individuals; level of support proactively provided to high-risk individuals?

Worker or volunteer response to suicide attempts/verbalizations/gestures, organization of response strategy, allocation of resources, community education and outreach efforts?

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?

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)?

Strengths and weaknesses of community health and suicide service delivery system?
Strengths:

Weaknesses:

21. IDENTIFICATION OF COMMUNITY INFRASTRUCTURE ISSUES

Number of homeless and “near homeless” (especially adolescents/young adults previously “in - care”):

Community Assessment Tool

Does the community resource team ensure that its team members carry out the work?

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)

Existence of cultural facility, traditional customary practices, involvement of youth in community culture?

Community history:

Does the community have control over finances?

22. REVIEW OF SELF-CONTINUITY FACTORS:

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):

Does the community support, through individuals, transitional challenges - adolescence to adulthood? (e.g. sense of belonging/connectedness):

Self identify promotion within cultural context (degree of integration/traditional customs and practices exercised); is a cultural home provided?

Community Assessment Tool

Capacity of community culture to ground adolescents undergoing self-identity/transitional issues; how is this addressed?

Degree of loss of sense of connectedness to the future (e.g. multiple placements of children/youth in care?)

Describe how well the current social and mental health delivery system is responding to the community problem situation:

23. COMMUNITY TREATMENT PLAN

- *What challenges need to be addressed?*
- *What strengths does the community have, that can be built on, to address the current situation?*
- *How can "cultural continuity" within the community be strengthened?*
- *What is the "treatment plan" for the community?*
- *What is the estimated duration - time line?*
- *What resources are needed based on effective use of existing resources?*
- *Please explain what outcomes, when, how measured.*



Appendices



Resources

Websites

The Center for Aboriginal Health Research:

http://www.umanitoba.ca/centres/cahr/cahr-research/present_research/presentresearch.html

The Center for Civic Education's School Violence Prevention Demonstration Program-
The Native American Initiative: http://www.civiced.org/school_violence.php?link=native

The Center for School Mental Health Analysis and Action: <http://csmha.umaryland.edu/>

Centre for Suicide Prevention <http://www.suicideinfo.ca/>

Suicide Prevention Resource Center: <http://www.sprc.org/>

Suicide Prevention Action Network: <http://www.spanusa.org/>

Turtle Island Native Network Suicide Prevention Project: <http://www.turtleisland.org/healing/healing-suicide.htm>

NATIONAL STRATEGY FOR SUICIDE PREVENTION <http://mentalhealth.samhsa.gov/suicideprevention/strategy.asp>

Suicide Among Diverse Populations <http://mentalhealth.samhsa.gov/suicideprevention/diverse.asp>

National Center for Suicide Prevention Training: <http://www.ncspt.org/>

The Community Guide: Evidence-based recommendations for programs and policies to promote population health: www.thecommunityguide.org

United States Department of Health and Human Services—Testimony on Suicide Prevention Programs and Their Application in Indian Country before The Senate Committee on Indian Affairs (2006) : <http://www.hhs.gov/asl/testify/t060517c.html>

Publications

Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies. Available from <http://>

www.ihs.gov/nonmedicalprograms/dirinitatives/documents/promstrat%5Fmanual.pdf

Acting On What We Know: Preventing Youth Suicide in First Nations: http://www.hc-sc.gc.ca/fnih-spni/pubs/suicide/prev_youth-jeunes/index_e.html

Assessment and Planning Tool Kit for Suicide Prevention in First Nations Communities. Available at http://www.naho.ca/firstnations/english/documents/NAHO_Suicide_Eng.pdf

PERSPECTIVES ON SUICIDE PREVENTION AMONG AMERICAN INDIAN AND ALASKA NATIVE CHILDREN AND ADOLESCENTS: A CALL FOR HELP. from the Online Journal of Issues in Nursing, 2005: http://www.nursingworld.org/ojin/hirsh/topic4/tpc4_3.htm

Resource Directories and Guides

The Alaska Suicide Prevention Plan: <http://www.hss.state.ak.us/suicideprevention/pdfs/spcstateplan.pdf>

“Acting On What We Know: Preventing Youth Suicide in First Nations” http://www.hc-sc.gc.ca/fnihb/cp/publications/preventing_youth_suicide.htm

The School-Based Youth Suicide Prevention Guide: <http://theguide.fmhi.usf.edu/>

“Youth Suicide Prevention Programs: A Resource Guide” (CDC, 1992) <http://www.cdc.gov/ncipc/pub-res/youthsui.htm>

“Nevada 2003 Suicide Prevention Resource Directory” <http://mhds.state.nv.us/pdfs/2003SuicideResourceDirectory.pdf>

National Data Sources

Centers for Disease Control
www.cdc.gov/ncipc/wisquars/ (an interactive database)
www.cdc.gov/nchs/fastats/suicide.htm

American Association of Suicidology: www.suicidology.org

Suicide Prevention Resource Center: www.sprc.org

Resources

Suicide Prevention and Advocacy Network www.spanusa.org/ (not just data, lots of useful information about suicide prevention and links to other sites)

American Foundation for Suicide Prevention: www.afsp.org

National Institute of Mental Health: www.nami.org

National Institute of Mental Health Suicide Research Consortium
www.nimh.nih.gov/research/suicide.cfm

Indian Health Services: <http://www.ihs.gov/>

Suicide Awareness Voices of Education: www.save.org/

World Data Sources

United Nations World Health Organization
www.who.int/mental_health/prevention/suicide/country_reports/en/

Practice Guidelines and Evidence-Based Practices and Programs

Practice Guidelines and Best or Evidence-Based Practices represent the most current thinking about what works best to prevent and treat suicidal behavior.

Effective Substance Abuse and Mental Health Programs for Every Community: the National Registry of Evidence-based Programs and Practices (NREPP): <http://www.modelprograms.samhsa.gov/textonly.cfm?page=nreppover>

Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors The American Psychiatric Association 2003. It is available at: www.psych.org/psych_pract/treatg/pg/pg_suicidalbehaviors.pdf

Reducing Suicide: A National Imperative The Institute of Medicine, 2002
Includes chapters on medical and psychotherapeutic interventions and program for suicide prevention. It is available at: www.nap.edu/catalog/10398.html

The Harborview Injury Prevention and Resource Center in Washington reviews some best practices in adolescent suicide prevention. The article is located here: <http://depts.washington.edu/hiprc/practices/topic/suicide/>



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The Suicide Prevention Resource Center has begun a project to identify evidence-based practices in suicide prevention. You can read about the project at: www.sprc.org/whatweoffer/ebp.asp

Aboriginal Youth: A manual of Promising Suicide Prevention Strategies is distributed by the Centre for Suicide Prevention in Alberta Canada. It is available to order at: www.suicideinfo.ca/csp/assets/promstrat_order.pdf or as a free (but almost 300 page) download at: www.suicideinfo.ca/csp/go.aspx?tabid=144



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Recent Peer Reviewed Suicide & Suicide Related Publications & Resources

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One Sky Center

*The American Indian/Alaska Native National Resource Center for
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