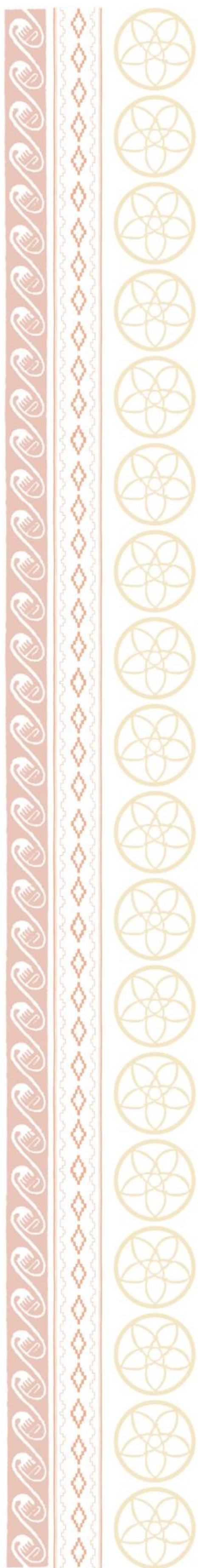
MARCH 2018

METHAMPHETAMINE AND SUICIDE PREVENTION INITIATIVE

IHS DIVISION OF BEHAVIORAL HEALTH
YEAR 2 NATIONAL EVALUATION REPORT
September 30, 2016 – September 29, 2017

Albuquerque Area Southwest Tribal Epidemiology Center
Albuquerque Area Indian Health Board



MARCH 2018

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PURPOSE

The purpose of this report is to provide findings from the year 2 national evaluation of the new cohort of Methamphetamine and Suicide Prevention Initiative (MSPI) Projects funded by the Indian Health Service Division of Behavioral Health. The data included in this report are from the period September 30, 2016 – September 29, 2017. Findings are aggregated from a total of 158 MSPI Projects that submitted a progress report during the reporting period.

ABOUT MSPI

The Methamphetamine and Suicide Prevention Initiative (MSPI) is a nationally-coordinated program by the Indian Health Service (IHS) Division of Behavioral Health, focusing on providing methamphetamine and suicide prevention and intervention resources for Indian Country. This initiative promotes the use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to methamphetamine abuse and suicide prevention from a community-driven context. In 2016, IHS funded an additional 42 projects, increasing the total of funded projects to 158 across the nation.

MSPI projects have been funded to meet the following six goals:

1. Increase tribal, Urban Indian Organization (UIO), and federal capacity to operate successful methamphetamine prevention, treatment, and aftercare and suicide prevention, intervention, and postvention services through implementing community and organizational needs assessment and strategic plans.
2. Develop and foster data sharing systems among tribal, UIO, and federal behavioral health service providers to demonstrate efficacy and impact.
3. Identify and address suicide ideations, attempts, and contagions among American Indian and Alaska Native (AI/AN) populations through the development and implementation of culturally appropriate and community relevant prevention, intervention, and postvention strategies.
4. Identify and address methamphetamine use among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, treatment, and aftercare strategies.
5. Increase provider and community education on suicide and methamphetamine use by offering appropriate trainings.
6. Promote positive AI/AN youth development and family engagement through the implementation of early intervention strategies to reduce risk factors for suicidal behavior and substance abuse.

Funded projects are not expected to address all of the MSPI goals, only those relevant to the Purpose Area for which they applied.

Four purpose areas have been established to help funded projects meet these goals:

- Purpose Area 1: Community and Organizational Needs Assessment and Strategic Planning
- Purpose Area 2: Suicide Prevention, Intervention, and Postvention
- Purpose Area 3: Methamphetamine Prevention, Treatment, and Aftercare
- Purpose Area 4: Generation Indigenous Initiative Support

MSPI PURPOSE AREAS

Purpose Area 1

MSPI Purpose Area 1 projects focus on community and organizational needs assessment and strategic planning. Funded projects address MSPI overall goals #1 and #2 and specifically address the following two required objectives:

1. Assess and develop strategic approaches of leveraging community and organizational resources to address suicide and methamphetamine use; and
2. Develop data sharing systems for continuous assessment and strategic planning.

Purpose Area 2

MSPI Purpose Area 2 projects address Suicide Prevention, Intervention and Postvention. Funded projects address MSPI overall goals #3 and #5 and specifically address the following eight required objectives:

1. Expand available behavioral health care treatment services;
2. Foster coalitions and networks to improve care coordination;
3. Educate and train providers in the care of suicide screening and evidence-based suicide care;
4. Promote community education to recognize the signs of suicide, and prevent and intervene in suicides and suicidal ideations;
5. Improve health system organizational practices to provide evidence-based suicide care;
6. Establish local health system policies for suicide prevention, intervention, and postvention;
7. Integrate culturally appropriate treatment services; and
8. Implement trauma informed care services and programs.

Purpose Area 3

MSPI Purpose Area 3 projects address Methamphetamine Prevention, Treatment, and Aftercare. Funded projects address MSPI overall goals #4 and #5 and specifically address the following eight required objectives:

1. Expand available behavioral health care treatment services;
2. Foster coalitions and networks to improve care coordination;
3. Educate and train providers in the care of methamphetamine and other substance use disorders;
4. Promote community education to prevent the use and spread of methamphetamine;
5. Improve health system organizational practices to improve treatment services for individuals seeking treatment for methamphetamine and other substance use disorders that contribute to suicide;
6. Establish local health system policies to address methamphetamine use and other substance use disorders that contribute to suicide;
7. Integrate culturally appropriate treatment services; and
8. Implement trauma informed care services and programs.

Purpose Area 4

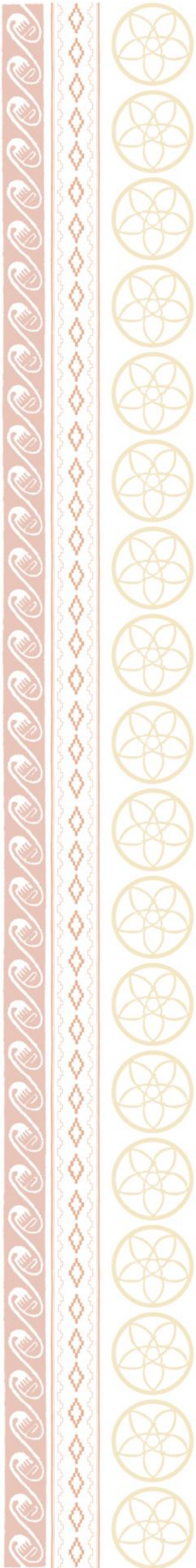
MSPI Purpose Area 4 projects promote early intervention strategies and implement positive youth programming aimed at reducing risk factors for suicidal behavior and substance abuse. Funded projects address MSPI overall goal #6 by working with Native youth, up to and including age 24, on the following four required objectives:

1. Implement evidenced-based and practice-based approaches to build resiliency, promote positive development, and increase self-sufficiency behaviors among native youth;
2. Promote family engagement;
3. Increase access to prevention activities for youth to prevent methamphetamine use and other substance use disorders that contribute to suicidal behaviors, in culturally appropriate ways; and
4. Hire additional behavioral health staff (i.e., licensed behavioral health providers and paraprofessionals, including but not limited to peer specialists, mental health technicians, and community health aides) specializing in child, adolescent, and family services who will be responsible for implementing project activities that address all of the required objectives listed.

EVALUATION METHODS

Each MSPI project submits an annual progress report utilizing a template that corresponds to those measures relevant to their scope of work and purpose area. Projects submit their reports via an online reporting system, also known as the MSPI Portal. Of the active IHS MSPI projects, all 158 projects submitted progress reports with relevant data for aggregation during this reporting period (2016-2017).

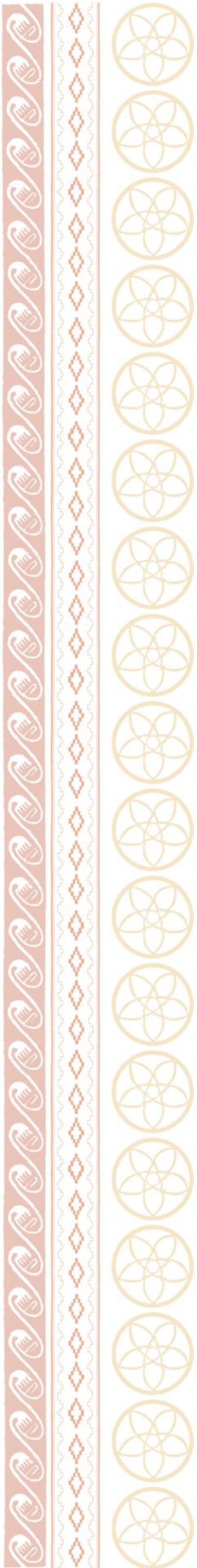
The first section of this report focuses upon data aggregated across all MSPI projects. Subsequent sections are stratified by MSPI Purpose Area, with the exception of Purpose Area 1 which encompassed less than 5 projects.



The data in this report are presented in figures and tables. Where applicable, annotations are provided following the figures and tables to share additional information related to a given topic. Missing data were handled by omitting those cases with missing data and running the analysis on what remained. Data were analyzed using SPSS v. 24 statistical software.

Data analysis was conducted by the Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC), one of 12 Tribal Epidemiology Centers serving the American Indian/Alaska Native population across the country.

Assistance with interpretation of this report is available from AASTEC staff at 1-800-658-6717.

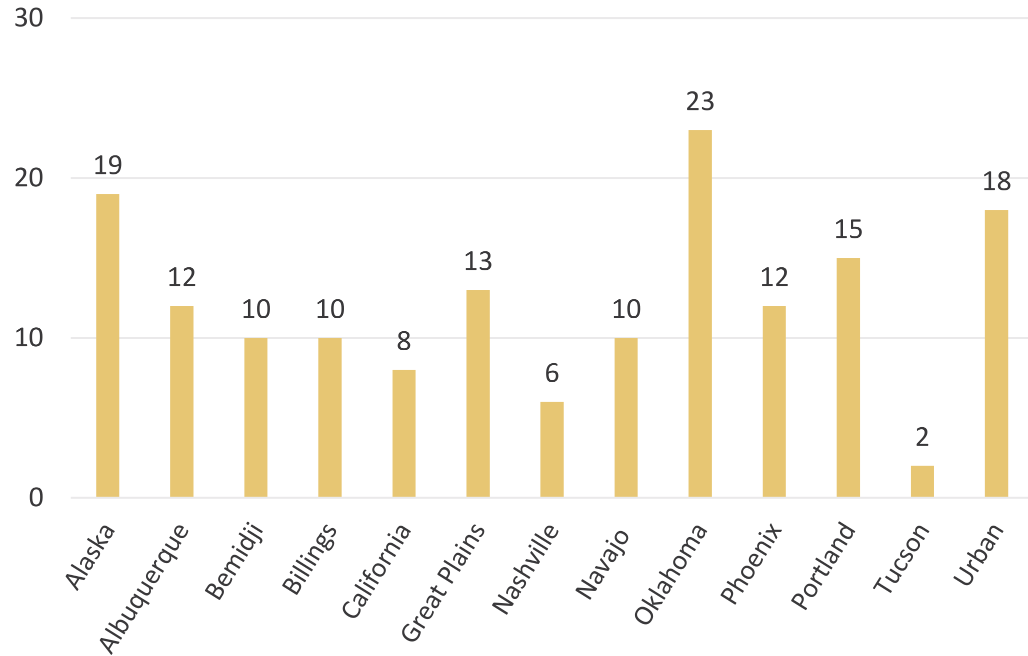


SECTION 1: POPULATION SERVED

POPULATION SERVED

MSPI PROJECTS BY AREA

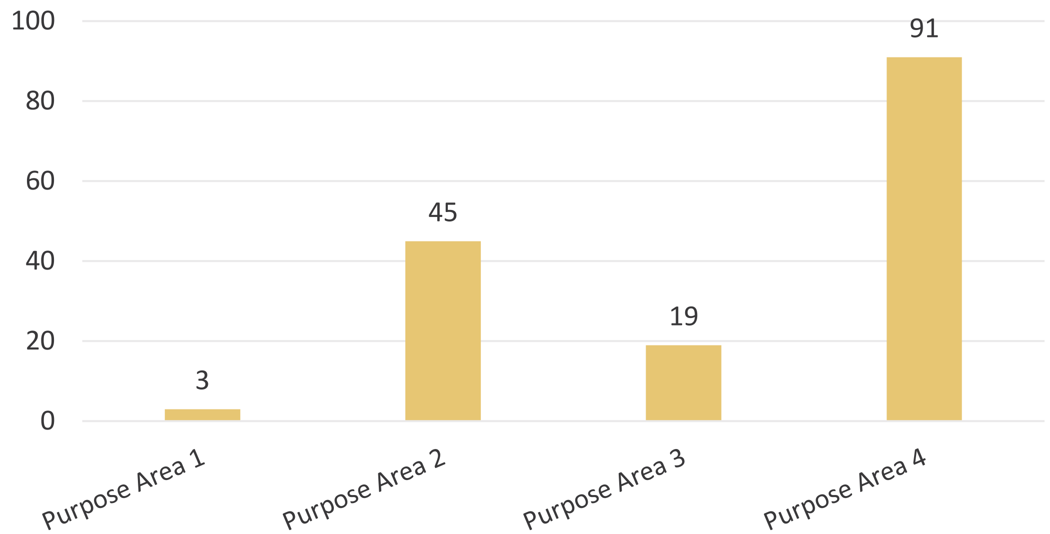
Figure 1: Number of MSPI Projects by Indian Health Service (IHS) Administrative Area, 2016-2017*



*Total number of projects (regardless of progress report submission) n= 158

PURPOSE AREA

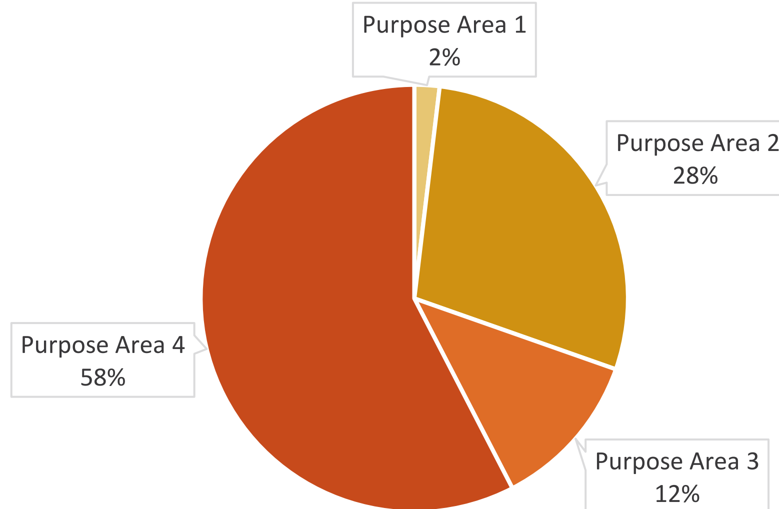
Figure 2: Number of MSPI Projects by Purpose Area, 2016-2017*



*Total number of programs (regardless of progress report submission) n= 158

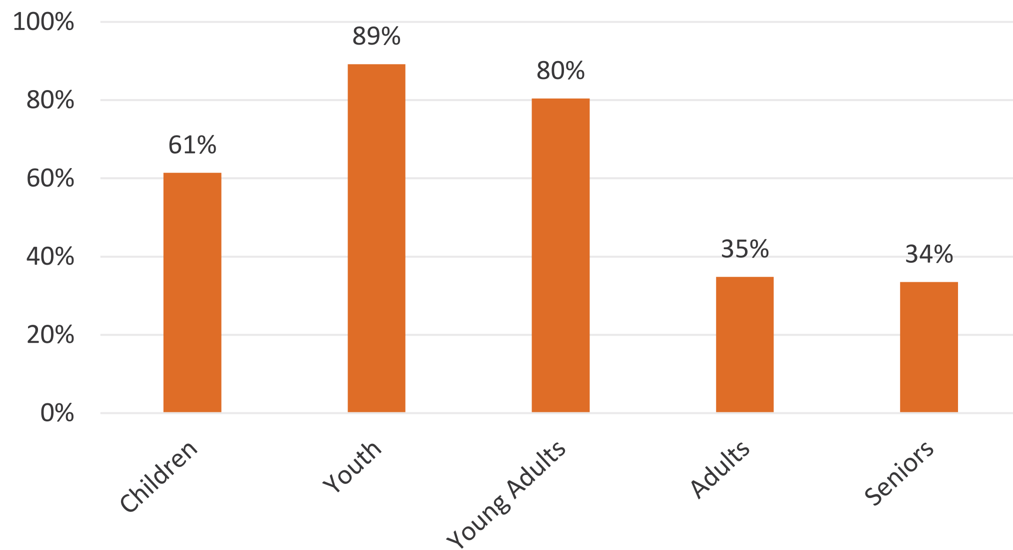
- Purpose Area 1: Community and Organizational Needs Assessment and Strategic Planning
- Purpose Area 2: Suicide Prevention, Intervention, and Postvention
- Purpose Area 3: Methamphetamine Prevention, Treatment, and Aftercare
- Purpose Area 4: Generation Indigenous Initiative Support

Figure 3: Percentage of MSPI Project by Purpose Area, 2016-2017



TARGET POPULATION

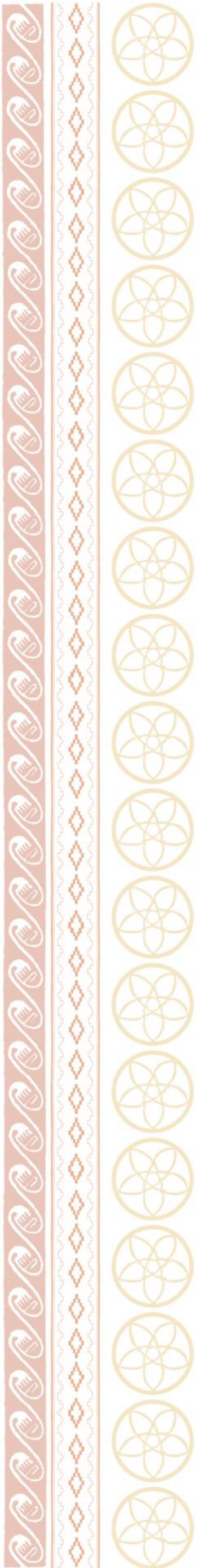
Figure 4. Target Population Served by MSPI Projects, 2016-2017*



**Projects were able to select multiple target populations.*

As evidenced in Figure 4, the most commonly served age groups among MSPI projects were youth (89%), young adults (80%), and children (61%).

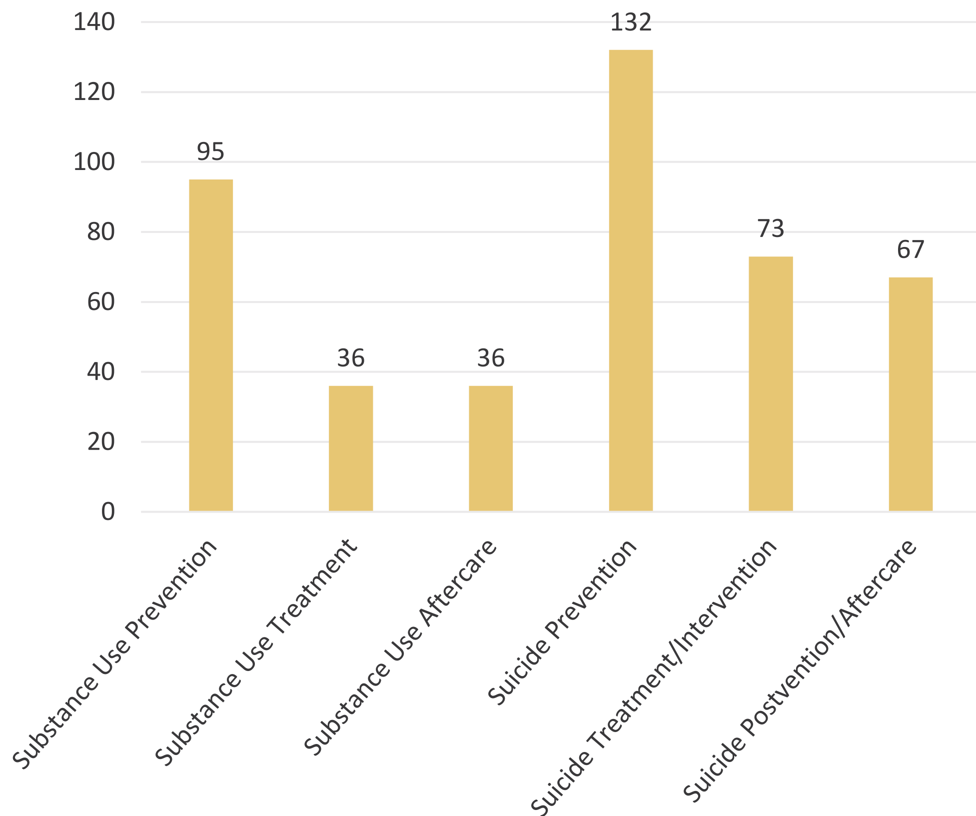
TARGET POPULATION DEFINITIONS
Children (up to age 11)
Youth (age 12-17)
Young Adults (age 18-24)
Adults (age 25-54)
Seniors (age 55+)



SECTION 2: SERVICE TYPES

TYPES OF SERVICES PROVIDED

Figure 5. Number of MSPI Projects by Service Type, 2016-2017*

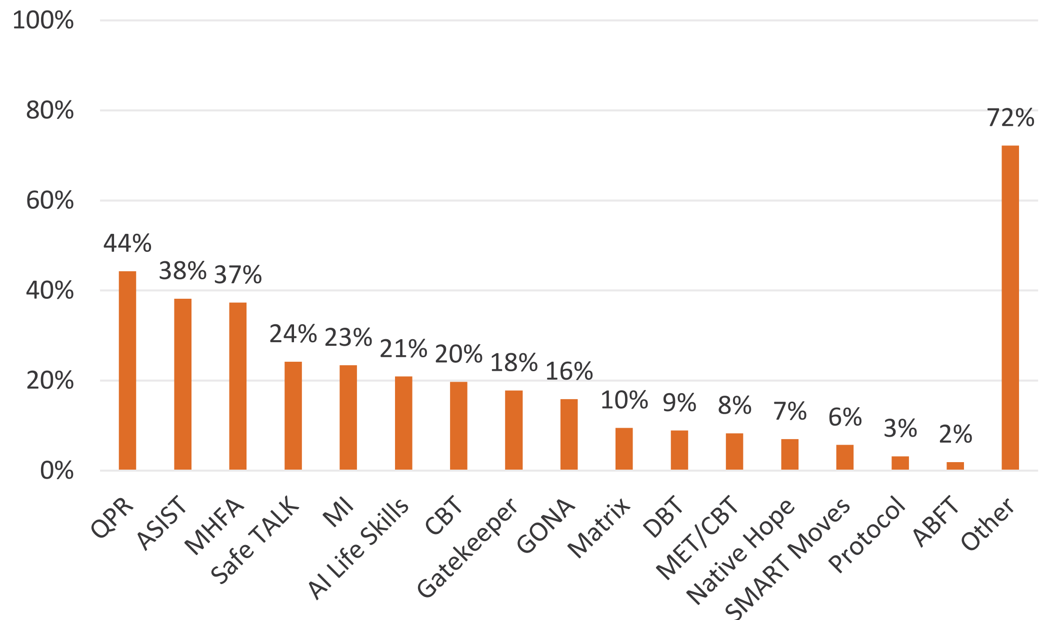


**Projects were able to select multiple types of service provision.*

As evidenced in Figure 5, the largest number of MSPI projects focused upon suicide-prevention (n=132) and substance use prevention (n=95), followed by other suicide-related service types, i.e., suicide treatment/intervention (n=73) and suicide postvention/aftercare (n=67).

EVIDENCE-BASED PRACTICES

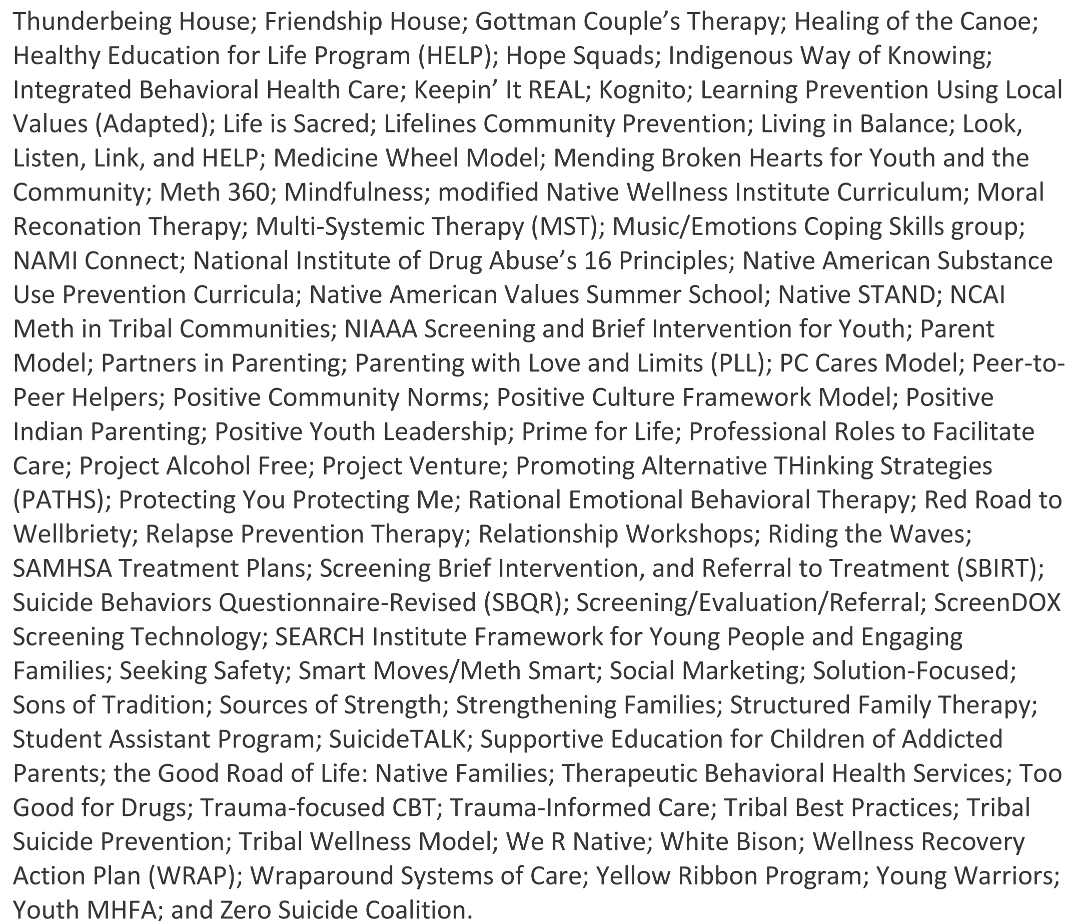
Figure 6. Type of Evidence-Based Practices and/or Practice-Based Models Currently Being Used for Suicide or Substance Use Prevention, 2016-2017.*



**Projects were able to select multiple types.*

As demonstrated in Figure 6, the most common Evidence-Based Practices and/or Practice-Based Models utilized among MSPI projects for prevention were Question, Persuade, Refer (44%), Applied Suicide Intervention Skills Training (38%), Mental Health First Aid (37%), and other practices (72%).

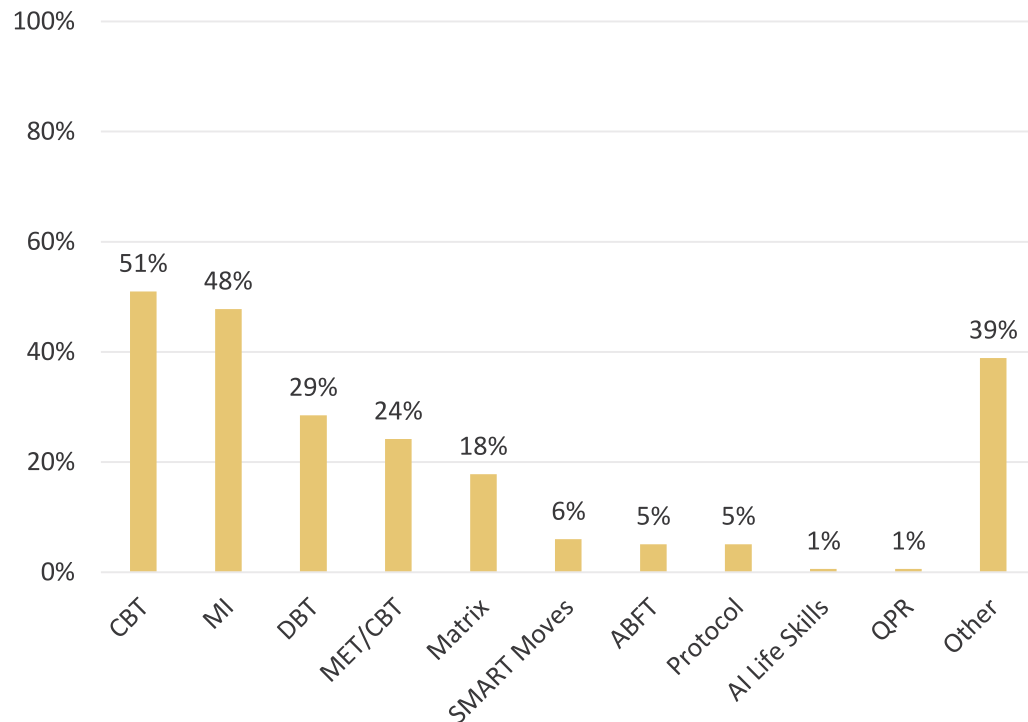
"Other" reported evidence and practice-based prevention practices included: 12 Step Program; 12 Teachings for Native Youth; 24/7 toll free crisis line; 40 Developmental Assets; Acceptance and Commitment Therapy; ACEs Model; Adolescent Community Reinforcement Approach (ACRA); Active Parenting; Alcohol True Stories; An Apple A Day; Art Therapy; Assessing and Managing Suicide Risk (AMSR); Beginning Awareness Basic Educational Studies (BABES); Boy's Running Program; Boys and Girls Club of America; BrainWise; Breaking the Silence; Building Communities of Hope; Bullying Prevention Program; C2: Character Challenge; Canoe Journey; Casey Life Skills; CAST program; Community Resilience Model; Community/Cultural Prevention; CONNECT Postvention Training of Trainers; Counseling on Access to Lethal Means (CALM); Courage to Care; Crisis Response; Critical Incident Stress Debriefing and Management; CSSRS tool; Cultural Practices and Revitalization; Culture Camp; Doorway to a Sacred Place; Daughters and Sons of Tradition; Eye Movement Desensitization and Reprocessing (EMDR); Equine Therapy; First


Thunderbeing House; Friendship House; Gottman Couple's Therapy; Healing of the Canoe; Healthy Education for Life Program (HELP); Hope Squads; Indigenous Way of Knowing; Integrated Behavioral Health Care; Keepin' It REAL; Kognito; Learning Prevention Using Local Values (Adapted); Life is Sacred; Lifelines Community Prevention; Living in Balance; Look, Listen, Link, and HELP; Medicine Wheel Model; Mending Broken Hearts for Youth and the Community; Meth 360; Mindfulness; modified Native Wellness Institute Curriculum; Moral Reconation Therapy; Multi-Systemic Therapy (MST); Music/Emotions Coping Skills group; NAMI Connect; National Institute of Drug Abuse's 16 Principles; Native American Substance Use Prevention Curricula; Native American Values Summer School; Native STAND; NCAI Meth in Tribal Communities; NIAAA Screening and Brief Intervention for Youth; Parent Model; Partners in Parenting; Parenting with Love and Limits (PLL); PC Cares Model; Peer-to-Peer Helpers; Positive Community Norms; Positive Culture Framework Model; Positive Indian Parenting; Positive Youth Leadership; Prime for Life; Professional Roles to Facilitate Care; Project Alcohol Free; Project Venture; Promoting Alternative THinking Strategies (PATHS); Protecting You Protecting Me; Rational Emotional Behavioral Therapy; Red Road to Wellbriety; Relapse Prevention Therapy; Relationship Workshops; Riding the Waves; SAMHSA Treatment Plans; Screening Brief Intervention, and Referral to Treatment (SBIRT); Suicide Behaviors Questionnaire-Revised (SBQR); Screening/Evaluation/Referral; ScreenDOX Screening Technology; SEARCH Institute Framework for Young People and Engaging Families; Seeking Safety; Smart Moves/Meth Smart; Social Marketing; Solution-Focused; Sons of Tradition; Sources of Strength; Strengthening Families; Structured Family Therapy; Student Assistant Program; SuicideTALK; Supportive Education for Children of Addicted Parents; the Good Road of Life: Native Families; Therapeutic Behavioral Health Services; Too Good for Drugs; Trauma-focused CBT; Trauma-Informed Care; Tribal Best Practices; Tribal Suicide Prevention; Tribal Wellness Model; We R Native; White Bison; Wellness Recovery Action Plan (WRAP); Wraparound Systems of Care; Yellow Ribbon Program; Young Warriors; Youth MHFA; and Zero Suicide Coalition.

KEY:

ABFT = Attachment-Based Family Therapy
ASIST = Applied Suicide Intervention Skills Training
CBT = Cognitive Behavioral Therapy
DBT = Dialectical Behavioral Therapy
GONA = Gathering of Native Americans
MET/CBT = Motivational Enhancement Therapy/Cognitive Behavioral Therapy
MHFA = Mental Health First Aid
MI = Motivational Interviewing
QPR = Question Persuade Refer

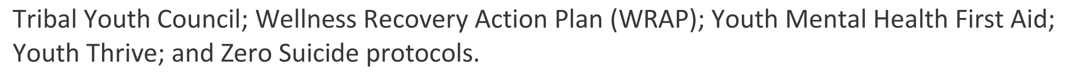
Figure 7. Type of Evidence-Based Practices and/or Practice-Based Models Currently Being Used for Intervention/Treatment, 2016-2017*



Projects were able to select multiple types.

As demonstrated in Figure 7, Cognitive Behavioral Therapy and Motivational Interviewing were the most commonly utilized evidenced-based practice types in intervention/treatment among MSPI Projects, 51% and 48% respectively.

"Other" evidence and practice-based intervention/treatment models reported by MSPI projects included: Acceptance and Commitment Therapy; Adolescent Community Reinforcement Approach (ACRA); Eye Movement Desensitization Processing (EMDR); Art Therapy; Boys and Girls Club of America; Brief Treatment Services; Cognitive Energy Work; Cognitive Processing Therapy; Collaborative Assessment and Management of Suicidality; Community Resiliency Model; Creator's Game Family Healing Camp; Crisis Support Planning; CSSRS tool; DBT-Informed; Equine Therapy (ELI); Evaluations and Medication Management; Eye-Movement Desensitization and Reprogramming; Finding Hope; First Responder Collaboration; Friendship House; Grief Recovery Model; Integrated Care; Mending Broken Hearts for Youth; Mindfulness; Multi-Systemic Therapy (MST); Nurturing Parenting; Parent Model; Patient Safety Planning; PHQ-9 tool; Project Venture; SAFE-T screening tool; Screening Brief Intervention, and Referral to Treatment (SBIRT); Seeking Safety; Smart Moves/Meth Smart; SMART Recovery; Solution-focused Therapy; Spiritual Guidance; Stanley Brown Safety Plan; Strengthening of the Spirit; Structured Family Therapy; Suicidal Crisis Response Protocol; Suicide Postvention Training; Suicide Screenings; Trauma-Informed Care;



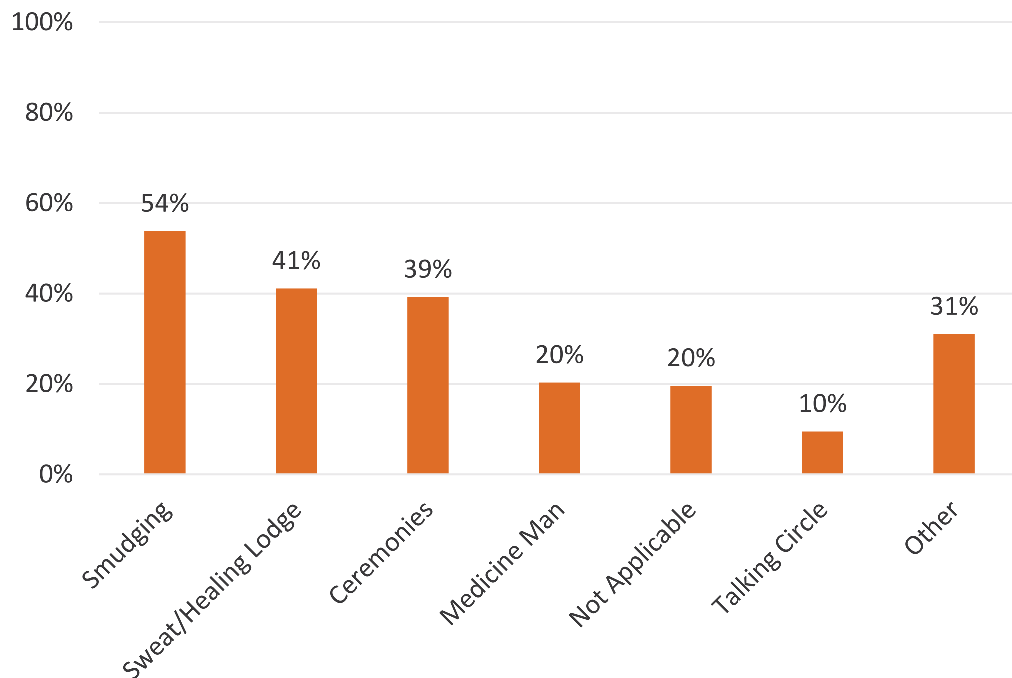
Tribal Youth Council; Wellness Recovery Action Plan (WRAP); Youth Mental Health First Aid; Youth Thrive; and Zero Suicide protocols.

KEY:

ABFT = Attachment-Based Family Therapy
CBT = Cognitive Behavioral Therapy
DBT = Dialectical Behavioral Therapy
MET/CBT = Motivational Enhancement Therapy/Cognitive Behavioral Therapy
MI = Motivational Interviewing
QPR = Question Persuade Refer

HOLISTIC APPROACHES TO SERVICES

Figure 8. Percentage of MSPI Projects Integrating Traditional Healing into Project Services, by Practice Type, 2016-2017*

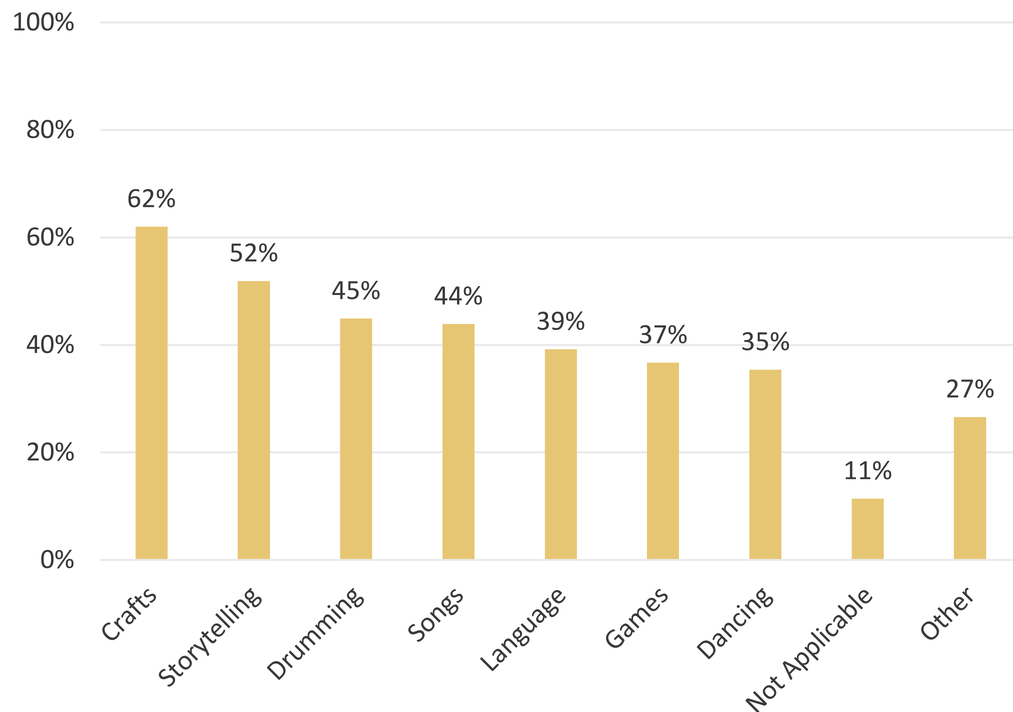


**Projects were able to select multiple types.*

Figure 8 demonstrates that the most common traditional healing related practices incorporated into MSPI activities included smudging (54%), sweat/healing lodge (41%), and ceremonies (39%). The majority of MSPI projects reported integrating at least one of these traditional healing practices into their project services (73%).

"Other" traditional healing practices cited included: Aroma therapy; Art Therapy; Building Longhouses; Canoe Journey; Circle of Life Healing Methods; Clan System; Community Cultural Celebrations; Creating Family Trees; Cultural Camp; Cultural Healing Support Group; Cultural Identification; Cultural Mentorship; Cultural Presentations; Cultural Revitalization; Elder Teas; Evenings with Elders; Healing Circles; Healing our Families; Integrative Care; Medicine Wheel; Mending Broken Hearts; Multidisciplinary Tea; Naming Ceremonies; Native American Life Skills; Natural Healing in Local Language; Nature Walks; Patient groups with elders; Planting; Potlucks; Powwow; Red Road; Referral to Cultural Specialist; Round Dance; Sacred Fatherhood and Families; Seat Fasting; Smoke Blessings; Sundance; Tipi Teachings; Traditional Healing Practices; Traditional Positive Parenting; Traditional Praying Sites; Traditional Tobacco; Wheel of Health; Women's Talking Circle; and Young Warriors Groups.

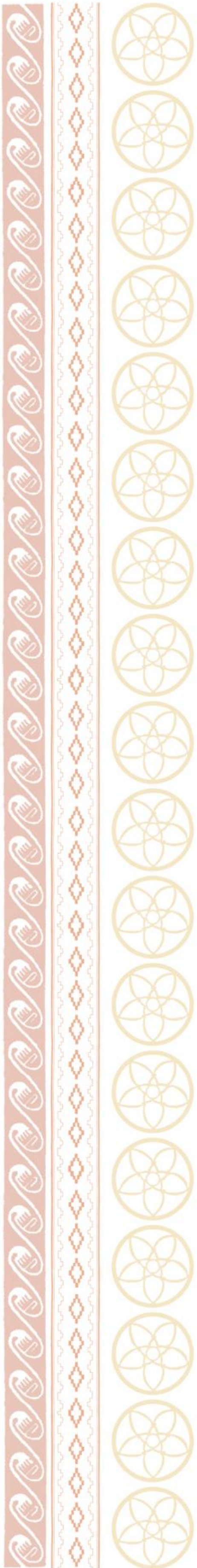
Figure 9. Cultural Practices Offered as a Component of MSPI Project Services, 2016-2017*



**Projects were able to select multiple types.*

As evidenced in Figure 9, the most common cultural services included in MSPI projects were crafts (62%) and storytelling (52%). The vast majority of MSPI projects reported integrating at least one of these cultural practices into their project services (86%).

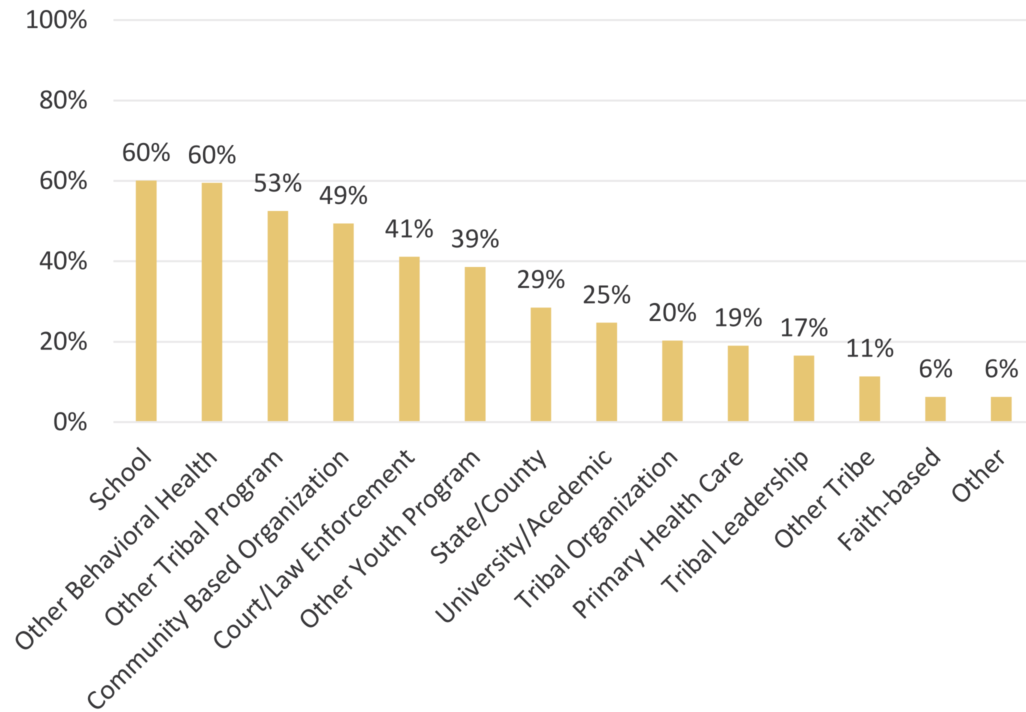
“Other” cultural practices cited included: 7 Grandfather Teachings; Aftercare Services: picking, medicine making, berrypicking, fishing, hiking; Archery; Boys with Braids; Canoeing and Canoe Building; Meet with Spiritual Leaders; Community Traditional Gardening; Community Tribal Circle; Cultural Mentorship; Culturally-based Reflective Discussions; Family Values; Fatherhood/Motherhood is Sacred; Flute Circles; Healing Circles; Honoring of Our Elders; Horsemanship; Hunting; Journey to Healing; Medicine Wheel; Mending Broken Hearts; Narrative Therapy; Native Plant Recognition and Gathering; Navajo Wellness Model; Referral to Cultural Specialist; Teepee/Camp setup; Traditional Foods Cooking Classes; Traditional Recovery Camp; Traditional Tobacco; Traditional Wellness Activities; Wellness Team; Wellbriety Group; White Bison 12 Step Program.



SECTION 3: PROJECT OPERATIONS

PARTNERSHIPS

Figure 10. Most Common Types of Partners Enlisted among MSPI Projects 2016-2017*



**Projects were able to select multiple types.*

The "other" category included: community volunteers; cultural entities/instructors.

Table 1. Number of Partners and Memorandum of Agreements (MOAs) Reported among

	N
Total Partners (All Projects)	1325
Average per project	8.6
Range	0 – 63
Total Memorandum of Agreements (MOAs)	150

STAFFING

Figure 11. Percentage of MSPI Projects that Experienced Staff Turnover, 2016-2017

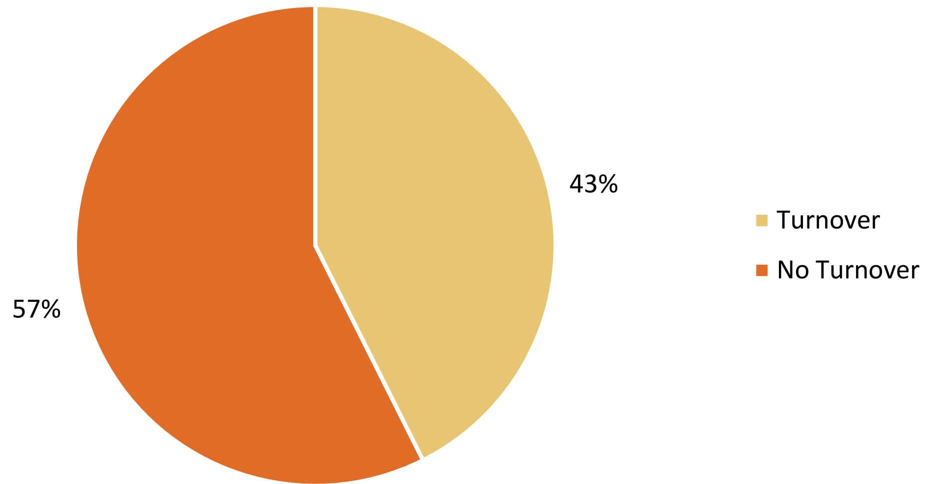


Figure 12. Percentage of MSPI Projects that Have Been Able to Recruit, Hire, and Onboard Staff, 2016-2017

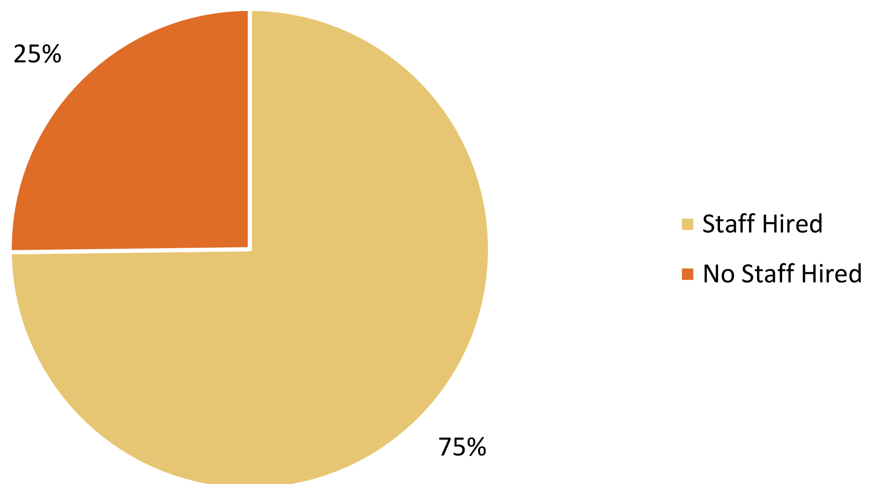
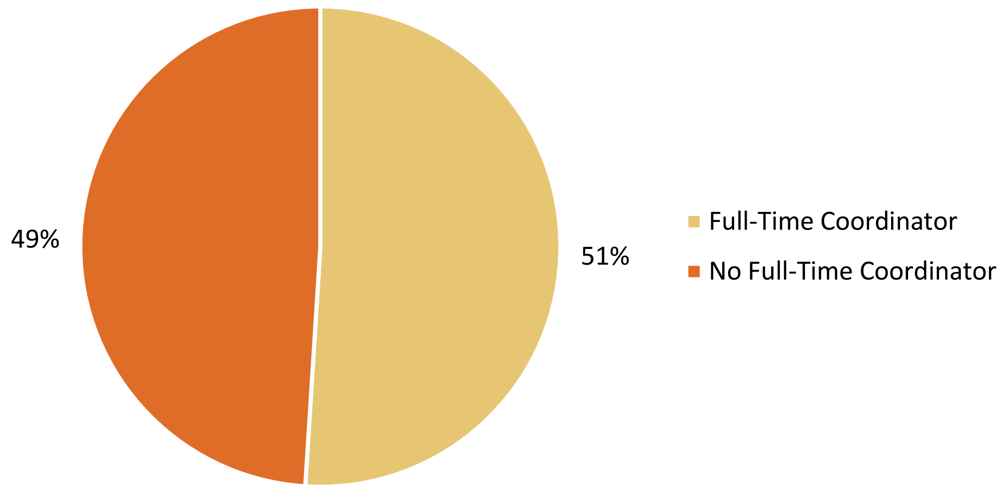
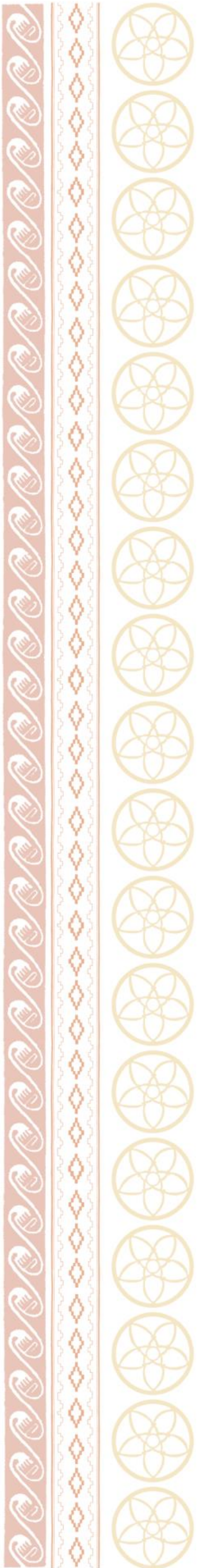


Figure 13. Percentage of MSPI Projects with a Full-Time Project Coordinator, 2016-2017



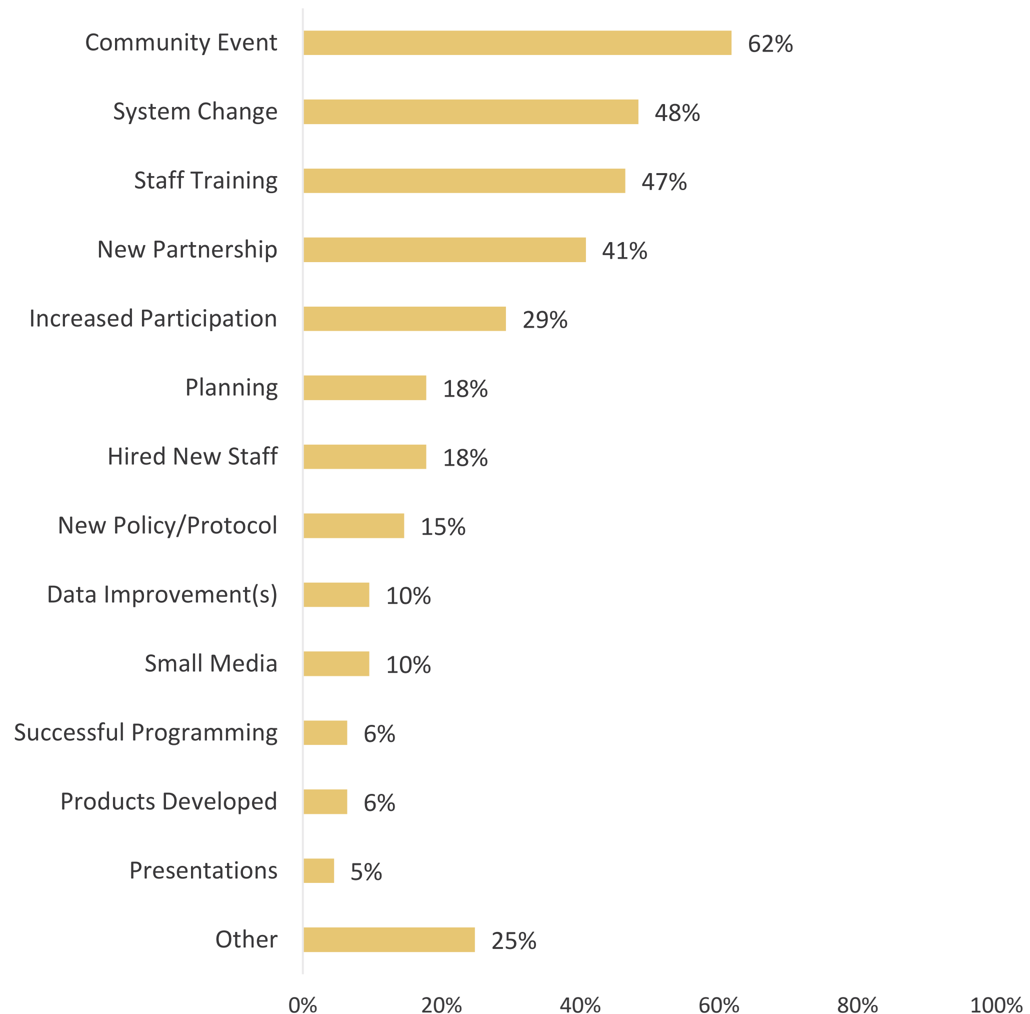


SECTION 4: PROJECT ACCOMPLISHMENTS & BARRIERS

PROJECT ACCOMPLISHMENTS AND BARRIERS

PROJECT ACCOMPLISHMENTS

Figure 14. Type of Accomplishments Reported among MSPI projects, 2016-2017



As evidenced in Figure 14, the most commonly reported MSPI project accomplishments in project year 2 included implementing successful community events (62%), creation of a systems change (48%), and completion of staff training (47%). Definitions and examples for each accomplishment type are provided on the following pages of this report.

Note: These data were gathered through project narratives. There were no limits on the number or type of accomplishments that each project could report.

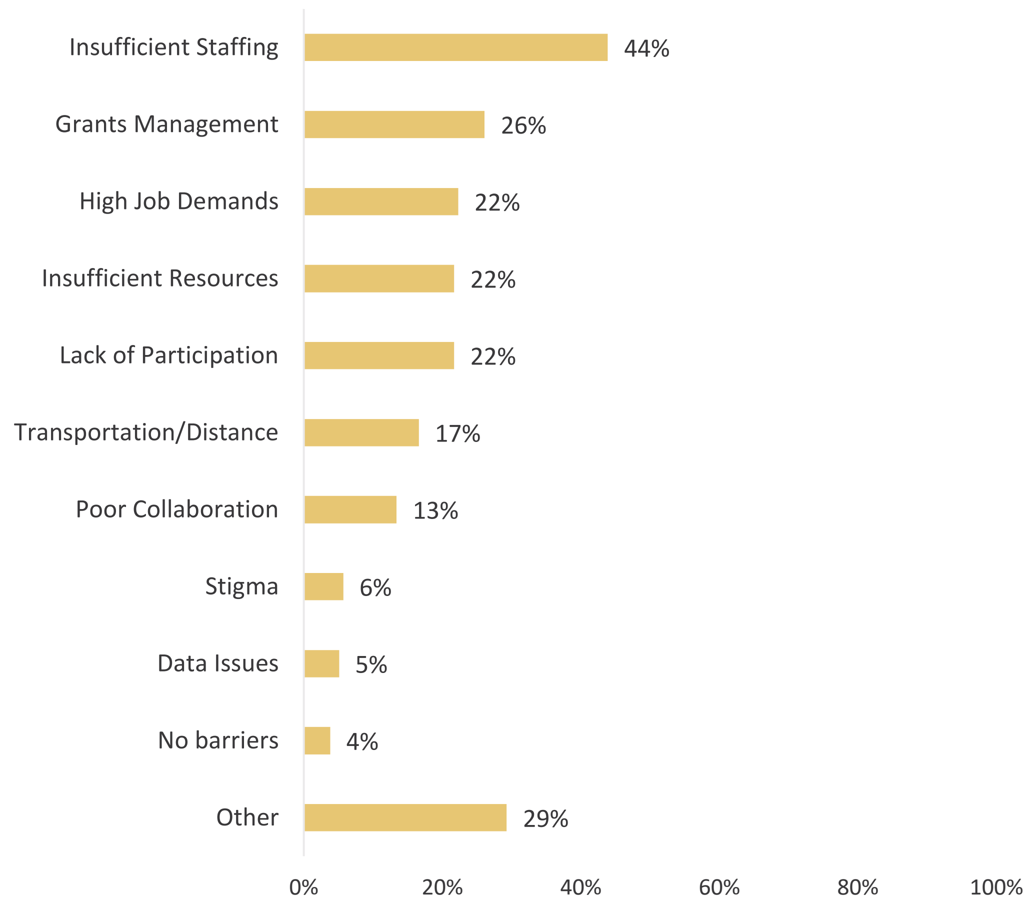
Table 2. MSPI Project Accomplishment Definitions

ACCOMPLISHMENT	DEFINITION
COMMUNITY EVENT	Project has identified at least one community event or activity sponsored by the MSPI project as a success during the reporting period. Common community event types included: school education events, health fairs, camps, run/walk, community presentations/workshops, contests, photovoice/art galleries, movie nights, and cultural activities (e.g., arts and crafts, archery, drumming, traditional games, storytelling, etc.).
NEW PARTNERSHIPS	Project has identified at least one new/enhanced partnership during the reporting period as a measure of success. These partnerships may be formal (as evidenced through MOUs or MOAs) or informal. Common new/enhanced partner categories included: schools, law enforcement, courts, hospitals/clinics, social services, correctional facilities, other tribal agencies/departments, tribal organizations, and external partners (non-profit organizations, referral sites, and universities).
STAFF TRAINING	At least one project staff member attended at least one training, conference or workshop during the reporting period. Common training topics listed as successes included: AI Life Skills, ASIST, Mental Health First Aid, Sources of Strength, CONNECT, safeTALK, MATRIX, QPR, CISM, Project Venture, Trauma Incident Reduction Training, etc.
SYSTEM CHANGE	Project has identified at least one new or expanded/improved service that it offers as a success during the reporting period. Examples include: support groups, traditional ceremonies/practices (talking circles), extended hours, aftercare/follow-up, group treatment, new/expanded counselling and case management services, equine therapy, expanded number of facilities offering services, classes (self-defense, parenting, self-care, stress management, mindfulness, art therapy), etc.
PLANNING	Project cited success in planning for future program opportunities. Staff researched new strategies, engaged in networking opportunities, furthered program preparation, etc.

SMALL MEDIA	Project has developed one or more small media products or implemented a media-related activity during the reporting period and identified it as a success. Examples include: billboards, radio or television public service announcements (PSAs), radio shows, documentary development, newsletter/newspaper, brochures, posters, digital stories, and social media (e.g. Facebook).
PRESENTATIONS	Program presented on project information at local/national level.
SUCCESSFUL PROGRAMMING	Project described supporting participant progress through program activities and/or successful progression through/completion of project objectives.
HIRED NEW STAFF	Project has identified at least one new staff person (part-time, full-time or contractual) joining its MSPI project during the reporting period.
INCREASED PARTICIPATION	Project has noted an increase in community participation in MSPI sponsored activities and/or an increase in referrals to its services during the reporting period.
NEW POLICY or PROTOCOL	Project identified the development/implementation of at least one new, updated, or enhanced policy or protocol related to MSPI project aims during the reporting period. Examples include: new patient screening tools (ER and clinic), tribal suicide response protocols, new referral policies and procedures, new enforcement laws, and enhanced wrap-around and post-treatment protocols.
DATA IMPROVEMENTS	Project has identified improvements in data access or data systems related to MSPI project aims. Examples include: new electronic reporting systems, new data management system, completed needs assessment, audit of existing suicide surveillance systems, improved coding, database development, data reports, and development of a suicide surveillance initiative.
OTHER	The other category included unique successes reported by five or fewer MSPI projects during the reporting period. These included: acceptance into Zero Suicide Academy; accurate data collection; enhanced ability to provide transportation; enhanced opportunities for youth in community; good location; increased community awareness; increased use of local language; leveraged additional funding; positive community response/support; program recognition/award; retention of staff; successful treatment/completion of program; and reduction in/no completed suicides.

PROJECT BARRIERS

Figure 15. Types of Barriers Reported among MSPI projects, 2016-2017



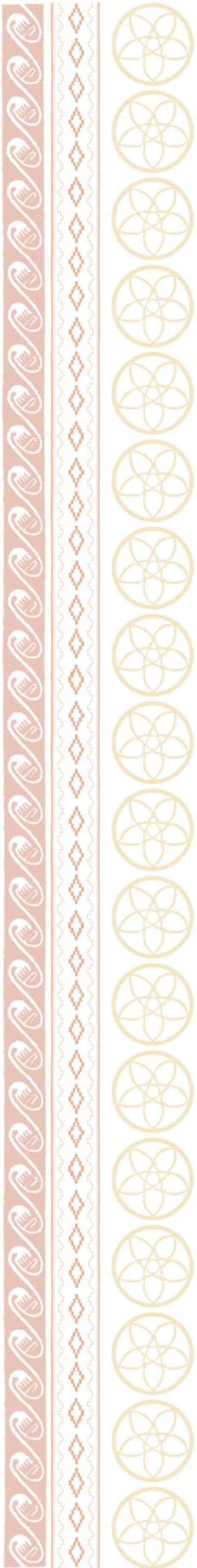
As evidenced in Figure 15, the most commonly reported MSPI project barriers included insufficient staffing (44%) and grants management (26%). Definitions and examples for each barrier category are provided on the following pages of this report.

Note: These data were gathered through project narratives. There were no limits on the number or type of barriers that each project could report.

Table 3: MSPI Project Barrier Definitions

BARRIER	DEFINITION
INSUFFICIENT STAFFING	Project identified a lack of staff within its MSPI project as a barrier during this reporting period. This barrier category included staff turnover, difficulty recruiting for vacant positions, lack of qualified applicants (education, certifications, AI/AN), and understaffing, where existing staff are burdened with excessive job duties due to insufficient staffing.
INSUFFICIENT RESOURCES	Project cited a lack of funding or poor infrastructure as barriers to meet high local demand for services and activities.
LACK OF PARTICIPATION	Project cited insufficient community participation/support in project services and/or activities as a significant challenge.
TRANSPORTATION/ DISTANCE	Project identified rurality, insufficient transportation, large geographic service areas, and/or excessive travel times as major challenges to the delivery of project services and patient access to these services.
POOR COLLABORATION	Project identified gaps or challenges in collaboration and/or coordination with other agencies/departments as a significant barrier during this reporting period. The most commonly cited entities included schools, law enforcement, clinics/hospitals (including IHS), and other tribal agencies/departments.
GRANTS MANAGEMENT	Project noted challenges with grants management including local bureaucracies, new directives from tribal administration, long delays in securing procurement and contract approval, poor record keeping, and challenges in procuring needed equipment and training.
HIGH DEMANDS	Project identified high demands (staff and partners) as a barrier to optimal service delivery and routine meeting/coalition participation. High demands encompass competing priorities, busy schedules, excessive workload, difficulties coordinating schedules with partners, and situations where the need for services exceeded local capacity.
DATA CHALLENGES	Program noted poor access to relevant/reliable data or insufficient local data management systems/IT capacity as significant challenges.

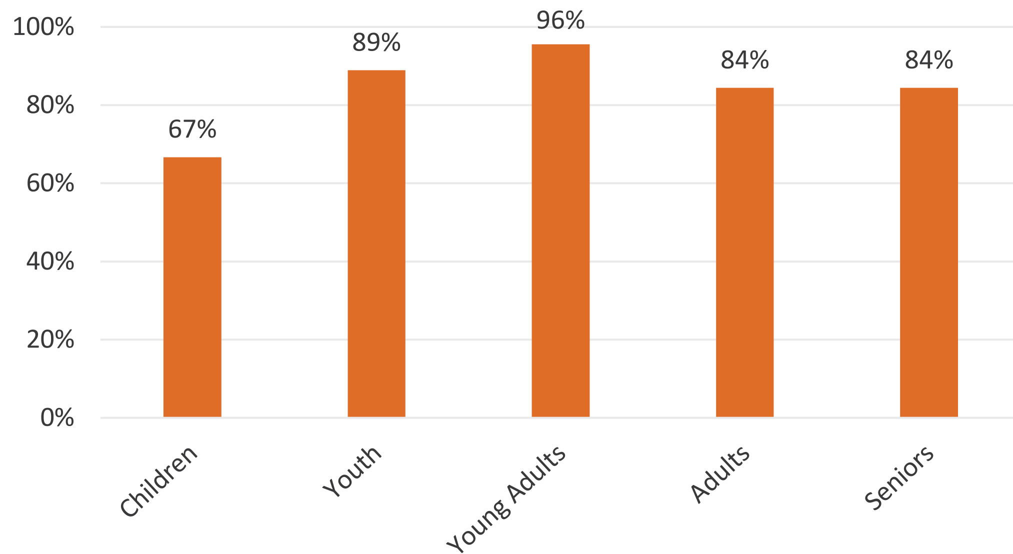
STIGMA	Program cited the ongoing stigmatization of mental health concerns among community members as a program barrier. In some instances, programs noted that stigma limits open discussion about these topics in community settings.
OTHER	The other category included unique challenges reported by five or fewer MSPI projects during the reporting period. These included: completed suicide/suicide cluster; external requirements/infrastructure; difficulties arising from the disease of addiction; inability to establish protocols/policies; ineffective programming; local requirements/infrastructure; lack of local care services; restriction in purchasing food; and weather.



SECTION 5:
MSPI PURPOSE AREA 2 ONLY

TARGET POPULATION

Figure 16. Target Population Served by MSPI Purpose Area 2 Projects, 2016-2017*



**Projects were able to select multiple target populations.*

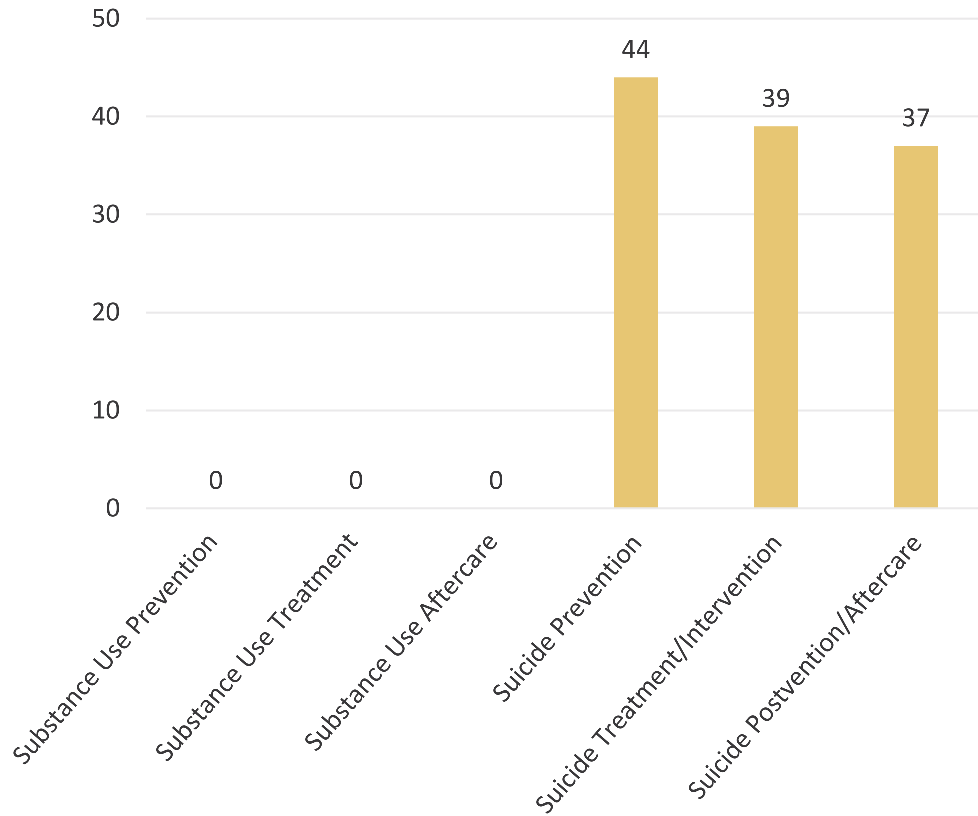
A total of 45 MSPI Purpose Area 2 MSPI projects reported on their progress in the areas of suicide prevention, intervention and postvention. As evidenced in Figure 16, the majority of MSPI projects in this purpose area focused upon all age groups in their respective communities.

TARGET POPULATION DEFINITIONS

Children (up to age 11)
Youth (age 12-17)
Young Adults (age 18-24)
Adults (age 25-54)
Seniors (age 55+)

SERVICE TYPES

Figure 17. Number of MSPI Purpose Area 2 Projects by Service Type, 2016-2017*

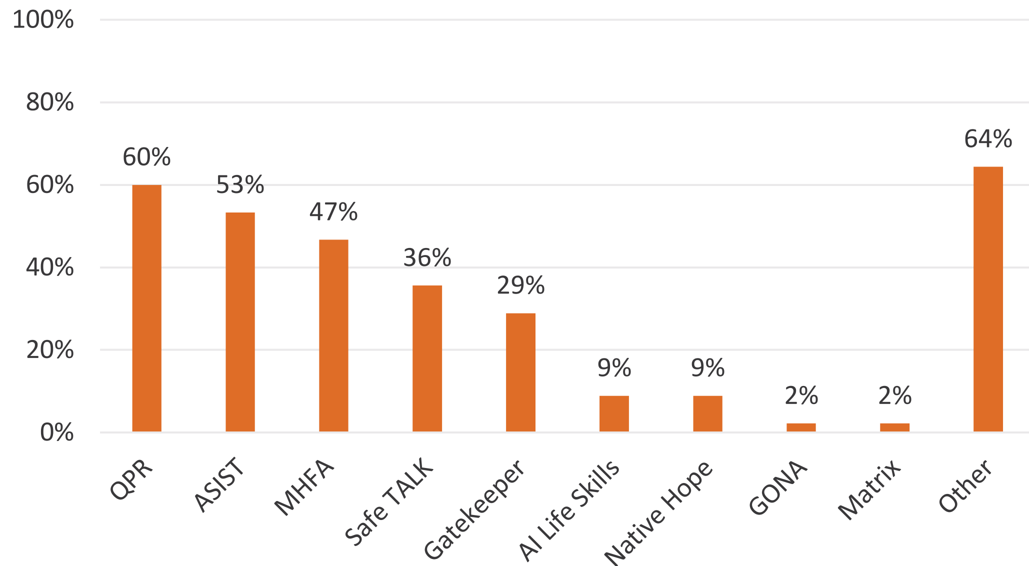


**Projects were able to select multiple types of service provision.*

As evidenced in Figure 17, nearly all MSPI Purpose Area 2 projects focused upon suicide-prevention (n=44) and other suicide-related service types, i.e., suicide treatment/intervention (n=39) and suicide postvention/aftercare (n=37).

EVIDENCE-BASED PRACTICES

Figure 18. Type of Evidence-Based Practices and/or Practice-Based Models Currently Being Used for Suicide or Substance Use Prevention – MSPI Purpose Area 2 Only, 2016-2017.*



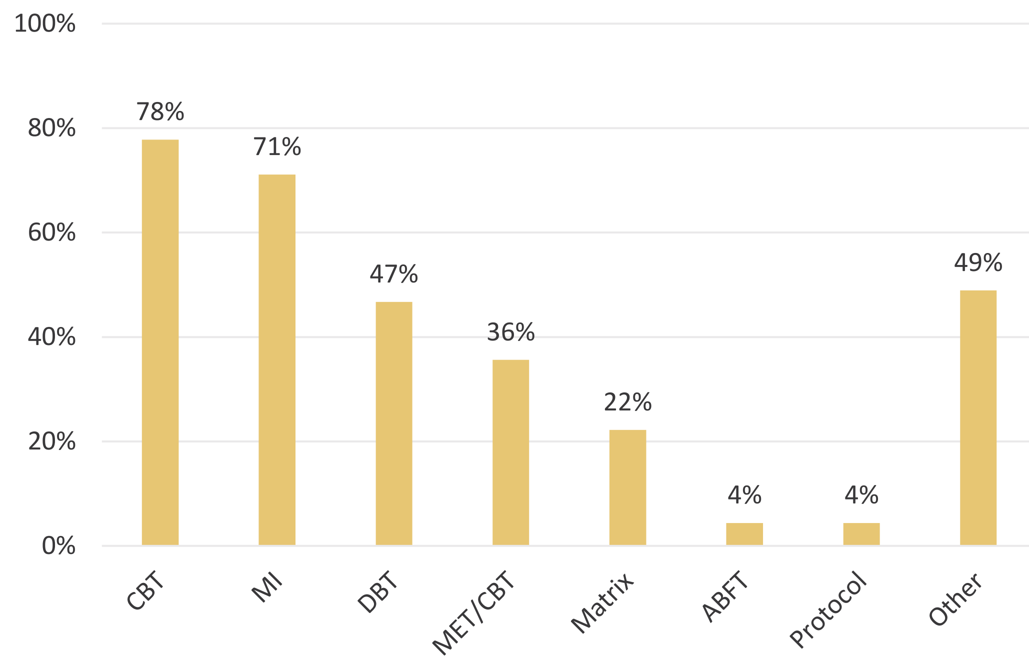
**Projects were able to select multiple types.*

As demonstrated in Figure 18, the most common Evidence-Based Practices and/or Practice-Based Models utilized among MSPI Purpose Area 2 projects for prevention were QPR (60%), ASIST (53%), and Mental Health First Aid (47%).

"Other" evidence-based practices for prevention reported included: 24/7 toll free crisis line; AA Literature; Acceptance and Commitment Therapy Assessing and Managing Suicide Risk (AMSR); Breaking the Silence; CASE Approach; CONNECT Postvention Training of Trainers; Counseling on Access to Lethal Means (CALM); Courage to Care; Critical Incident Stress Debriefing and Management; CSSRS; Cultural Activities; Doorway to a Sacred Place; Equine-assisted Psychotherapy; Healthy Education for Life Program (HELP); Hope Squads; Lifelines Community Prevention; Medicine Wheel; NAMI Connect; PC Cares Model; Prevention Lifeline; Positive Indian Parenting Red Road to Wellbriety; Strengthening Families; SuicideTALK; Trauma-focused Cognitive Behavioral Therapy; Tribal Best Practices; White Bison 12 Steps; Yellow Ribbon Program; Youth MHFA; and Zero Suicide Coalition.

KEY:
ASIST = Applied Suicide Intervention Skills Training
GONA = Gathering of Native Americans
QPR = Question Persuade Refer

Figure 19. Type of Evidence-Based Practices and/or Practice-Based Models Currently Being Used for Intervention/Treatment - MSPI Purpose Area 2 Only, 2016-2017*



**Projects were able to select multiple types.*

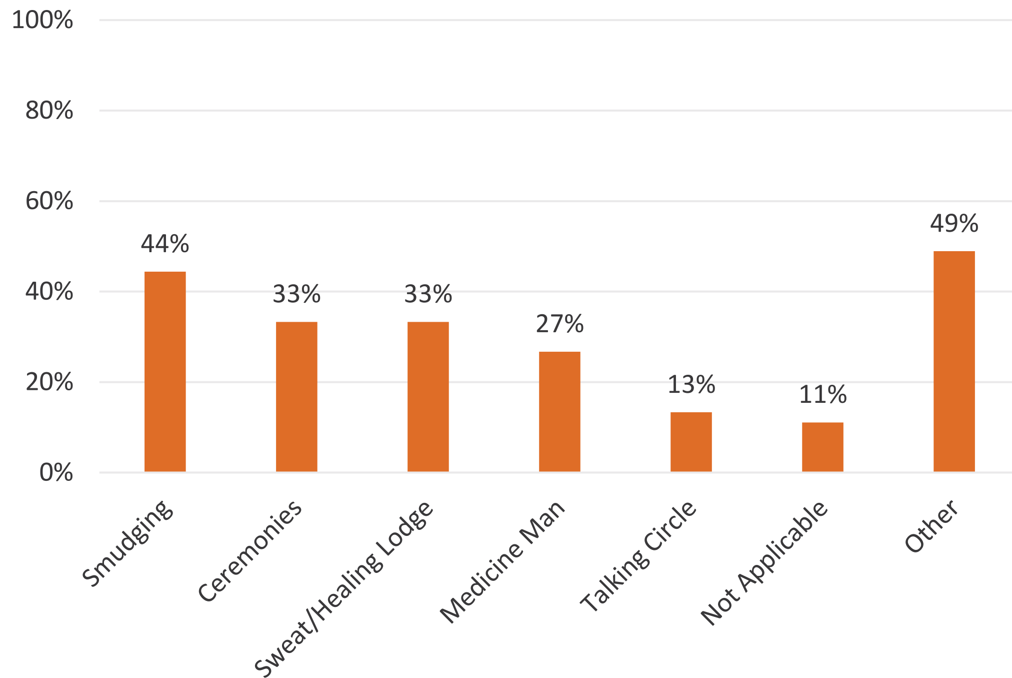
As demonstrated in Figure 19, Cognitive Behavioral Therapy (78%) and Motivational Interviewing (71%) were the most commonly utilized evidenced-based practice types in treatment among MSPI Purpose Area 2 Projects for intervention/treatment.

"Other" evidence-based practices for intervention reported included: Acceptance and Commitment Therapy; Brief Treatment Services; Cognitive Processing Therapy; Collaborative Assessment and Management of Suicidality; CSSRS tool; DBT-Informed; Eye Movement Desensitization and Reprocessing(EMDR); Finding Hope; Mending Broken Hearts; PHQ-9 tool; SAFE-T tool; Screening, Brief Intervention, and Referral to Treatment (SBIRT); Seeking Safety; SMART Recovery; Solution-focused Therapy; Stanley Brown Safety Plan; Strengthening of the Spirit; Youth Thrive; Tobacco Cessation; and Zero Suicide protocols.

KEY:
ABFT = Attachment-Based Family Therapy
CBT = Cognitive Behavioral Therapy
DBT = Dialectical Behavioral Therapy
MET/CBT = Motivational Enhancement Therapy/Cognitive Behavioral Therapy
MI = Motivational Interviewing

HOLISTIC APPROACHES TO SERVICES

Figure 20. Percentage of MSPI Purpose Area 2 Projects Integrating Traditional Healing into Services, by Practice Type, 2016-2017*

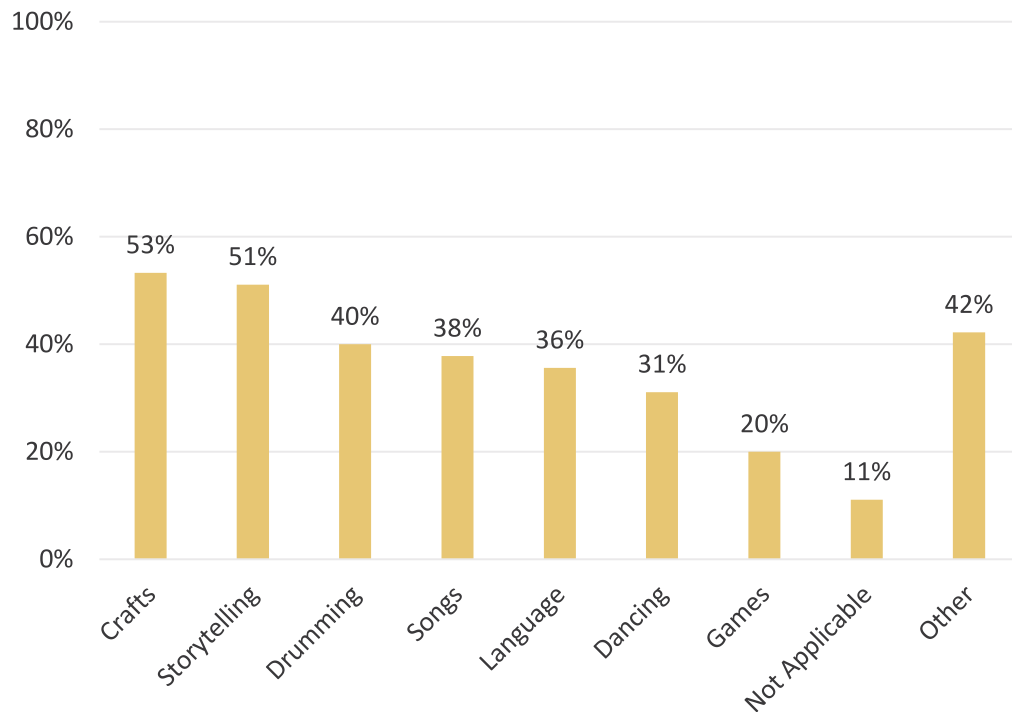


**Projects were able to select multiple types.*

Figure 20 demonstrates that a range of traditional healing related practices have been incorporated into MSPI Purpose Area 2 project activities included smudging (44%), ceremonies (33%), and sweat/healing lodges (33%). The majority of MSPI Purpose Area 2 projects reported integrating at least one of these traditional healing practices into their project services (84%). "Not Applicable" was reported by programs that did not integrate traditional healing practices into their services.

"Other" traditional healing practices reported included: Aroma therapy; Cultural Camp; Cultural Healing Support Group; Cultural Mentorship; Elder Teas; Healing our Families; Multidisciplinary Tea; Native American Life Skills; Natural healing in local language; Patient groups with elders; Private Ceremonies; Traditional Healing Clinic; Traditional Healing Practices; Traditional Praying Sites; Tribal Best Practices.

Figure 21. Cultural Practices Offered in MSPI Purpose Area 2 Project Services, 2016-2017*



**Projects were able to select multiple types.*

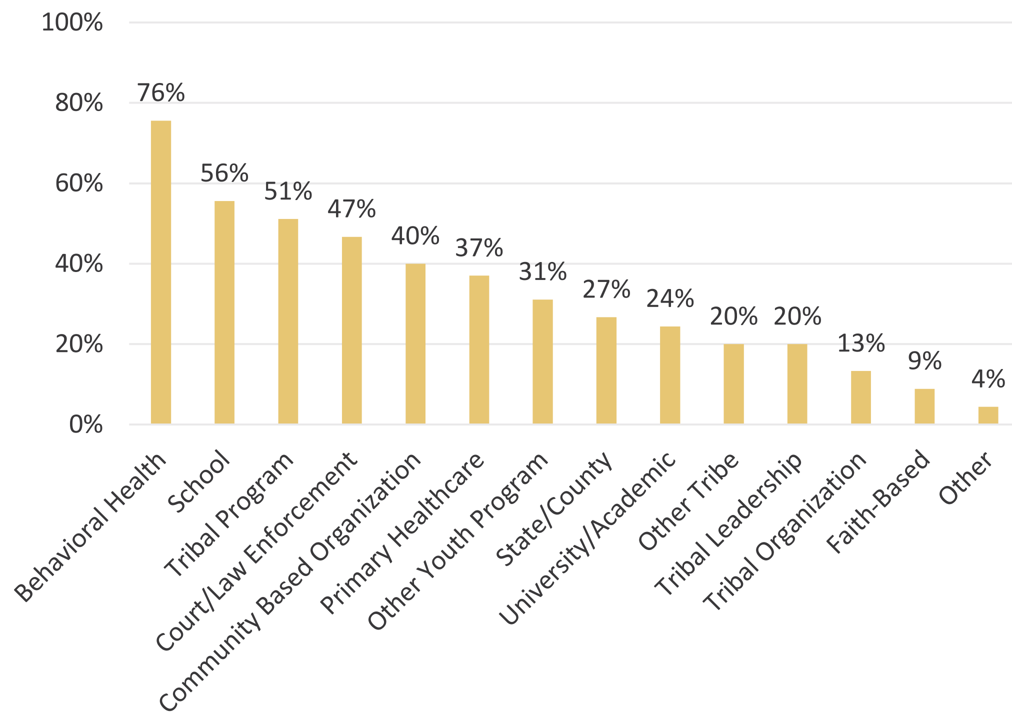
As evidenced in Figure 21, the most common cultural services included in MSPI Purpose Area 2 project activities were crafts (53%) and storytelling (51%). The majority of MSPI Purpose Area 2 projects reported integrating at least one of these cultural practices into their project services (89%). "Not Applicable" was reported by programs that did not integrate cultural practices into their services.

"Other" cultural practices reported included: Berrypicking; Boys with Braids; Canoeing and Canoe Building; Meetings with Spiritual Leaders; Cultural Mentorship; Family Values; Fishing; Healing Circles; Hiking; Horse Culture; Medicine Making; Mending Broken Hearts; Patient Groups with Elders; Referrals to Local Cultural Development Services; Traditional Wellness Activities; Tribal Best Practices; and White Bison 12 Step Program.

PROJECT OPERATIONS

PARTNERSHIPS

Figure 22. Most Common Types of Partners Enlisted among MSPI Purpose Area 2 Projects, 2016-2017*



**Projects were able to select multiple types.*

"Other" partner types included: community volunteers.

Table 4. Number of Partners and Memorandum of Agreements (MOAs) Reported among MSPI Purpose Area 2 Projects, 2016-2017

	N
Total Partners (All Projects)	420
Average per project	9.55
Range	1 – 63
Total Memorandum of Agreements (MOAs)	77

STAFFING

Figure 23. Percentage of MSPI Purpose Area 2 Projects that Experienced Staff Turnover, 2016-2017

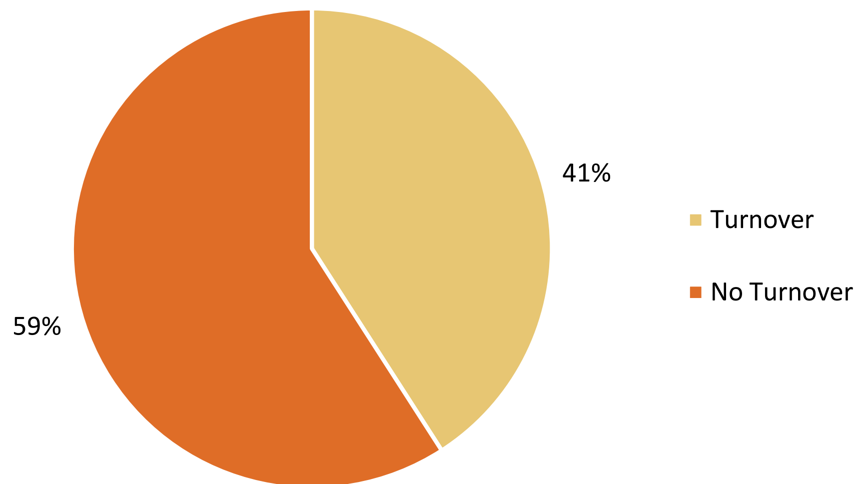


Figure 24. Percentage of MSPI Purpose Area 2 Projects that Have Been Able to Recruit, Hire, and Onboard Staff, 2016-2017

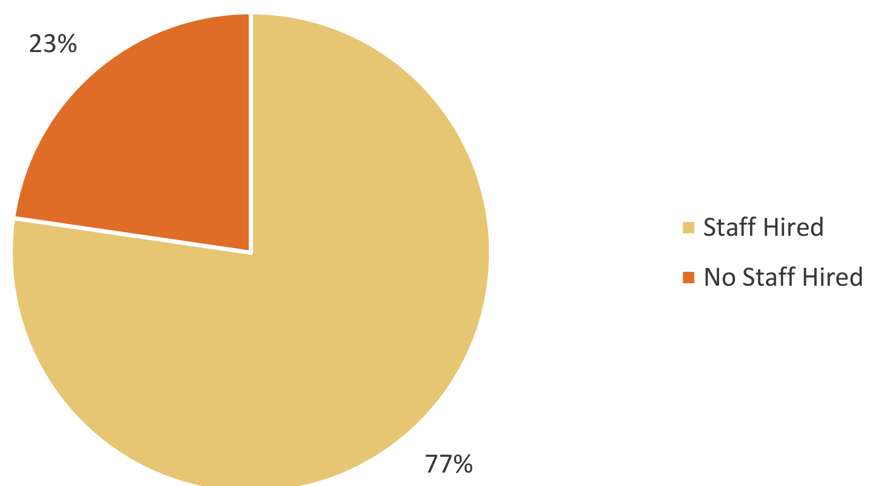
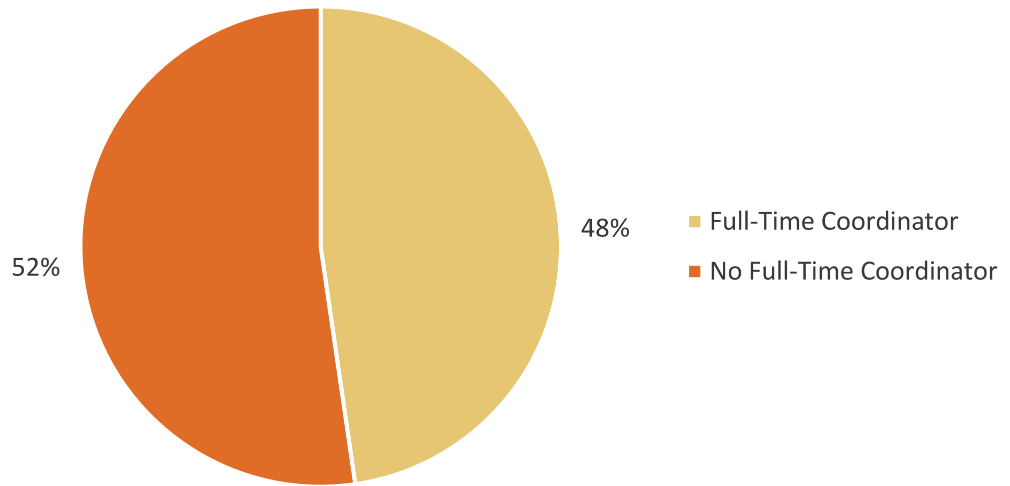


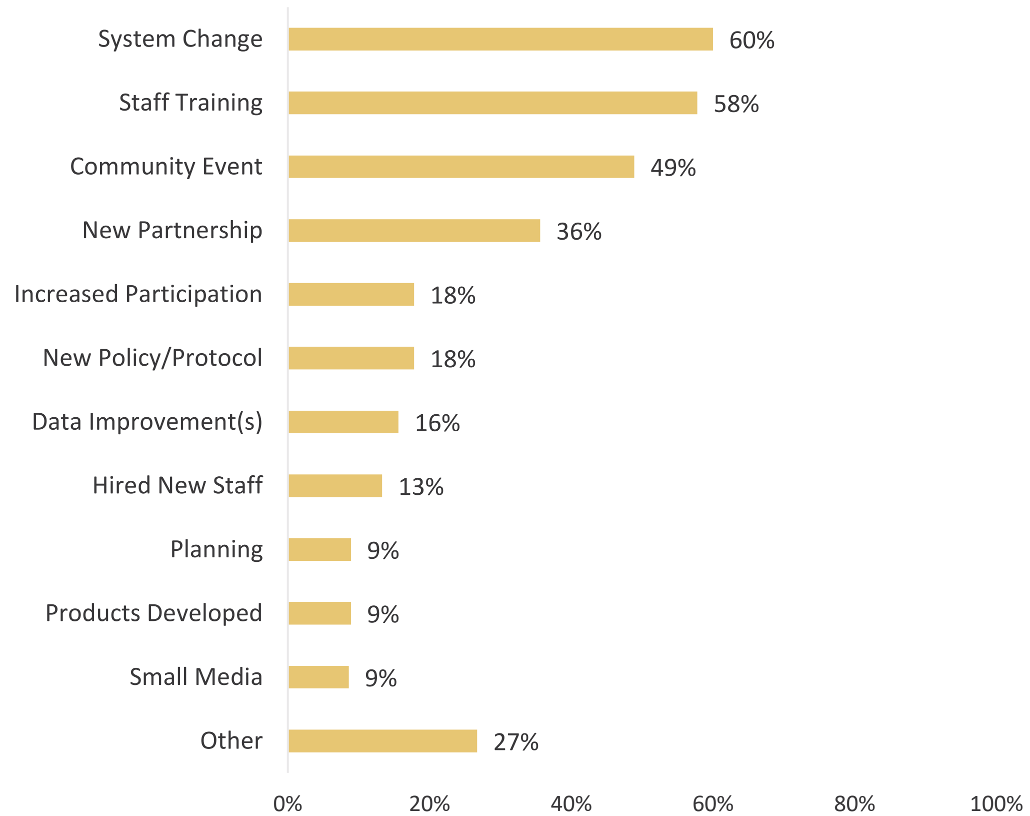
Figure 25. Percentage of MSPI Purpose Area 2 Projects with a Full-Time Project Coordinator, 2016-2017



PROJECT ACCOMPLISHMENTS AND BARRIERS

PROJECT ACCOMPLISHMENTS

Figure 26. Type of Accomplishments Reported among MSPI Purpose Area 2 Projects, 2016-2017



As evidenced in Figure 26, the most commonly reported accomplishments among MSPI Purpose Area 2 Projects in project year 2 included implementing a system change (60%), providing or supporting staff training (58%), hosting a successful community event/activity (49%), and developing new partnerships (36%). Definitions and examples for each accomplishment category are provided on the following pages of this report.

Note: These data were gathered through project narratives. There were no limits on the number or type of accomplishments that each project could report.

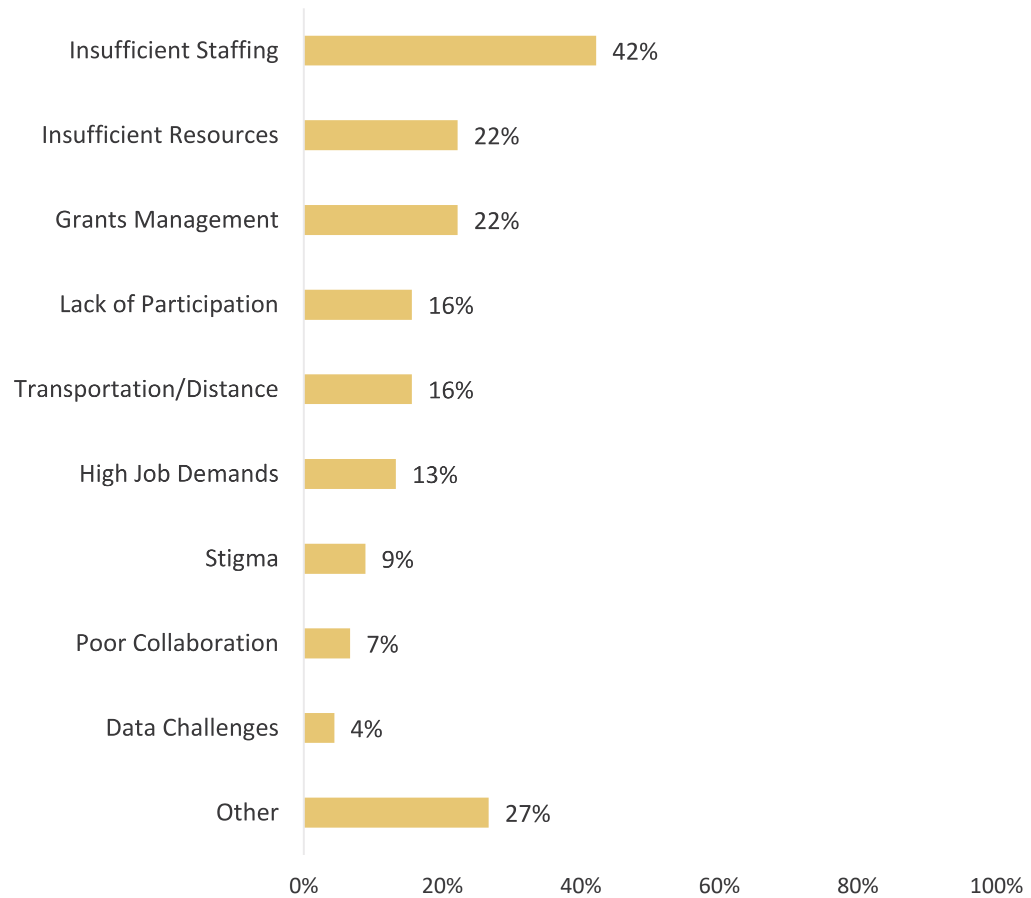
Table 5. MSPI Purpose Area 2 Project Accomplishment Definitions

ACCOMPLISHMENT	DEFINITION
COMMUNITY EVENT	Project has identified at least one community event or activity sponsored by the MSPI project as a success during the reporting period. Common community event types included: school education events, health fairs, camps, run/walk, community presentations/workshops, contests, photovoice/art galleries, movie nights, and cultural activities (e.g., arts and crafts, archery, drumming, traditional games, storytelling, etc.).
NEW PARTNERSHIPS	Project has identified at least one new/enhanced partnership during the reporting period as a measure of success. These partnerships may be formal (as evidenced through MOUs or MOAs) or informal. Common new/enhanced partner categories included: schools, law enforcement, courts, hospitals/clinics, social services, correctional facilities, other tribal agencies/departments, tribal organizations, and external partners (non-profit organizations, referral sites, and universities).
STAFF TRAINING	At least one project staff member attended at least one training, conference or workshop during the reporting period. Common training topics listed as successes included: AI Life Skills, ASIST, Mental Health First Aid, Sources of Strength, CONNECT, safeTALK, MATRIX, QPR, CISM, Project Venture, Trauma Incident Reduction Training, etc.
SYSTEM CHANGE	Project has identified at least one new or expanded/improved service that it offers as a success during the reporting period. Examples include: support groups, traditional ceremonies/practices (talking circles), extended hours, aftercare/follow-up, group treatment, new/expanded counselling and case management services, equine therapy, expanded number of facilities offering services, classes (self-defense, parenting, self-care, stress management, mindfulness, art therapy), etc.
PLANNING	Project focused on planning for future program opportunities. Staff researched new strategies, engaged in networking opportunities, furthered program preparation, etc.

SMALL MEDIA	Project has developed one or more small media products or implemented a media-related activity during the reporting period and identified it as a success. Examples include: billboards, radio or television public service announcements (PSAs), radio shows, documentary development, newsletter/newspaper, brochures, posters, digital stories, and social media (e.g. Facebook).
SUCCESSFUL PROGRAMMING	Project described supporting participant progress through program activities and/or successful progression through/completion of project objectives.
HIRED NEW STAFF	Project has identified at least one new staff person (part-time, full-time or contractual) joining its MSPI project during the reporting period.
INCREASED PARTICIPATION	Project has noted an increase in community participation in MSPI sponsored activities and/or an increase in referrals to its services during the reporting period.
NEW POLICY or PROTOCOL	Project identified the development/implementation of at least one new, updated, or enhanced policy or protocol related to MSPI project aims during the reporting period. Examples include: new patient screening tools (ER and clinic), tribal suicide response protocols, new referral policies and procedures, new enforcement laws, and enhanced wrap-around and post-treatment protocols.
DATA IMPROVEMENTS	Project has identified improvements in data access or data systems related to MSPI project aims. Examples include: new electronic reporting systems, new data management system, completed needs assessment, audit of existing suicide surveillance systems, improved coding, database development, data reports, and development of a suicide surveillance initiative.
OTHER	The “other” category included unique successes reported by five or fewer MSPI projects during the reporting period. These included: acceptance into Zero Suicide Academy; increased community awareness; leveraged additional funding; positive response to treatment by participants; presentations on program information and successes; program recognition/award; reduction in/no completed suicides in the community; and retention of program staff.

PROJECT BARRIERS

Figure 27. Types of Barriers Reported among MSPI Purpose Area 2 Projects, 2016-2017

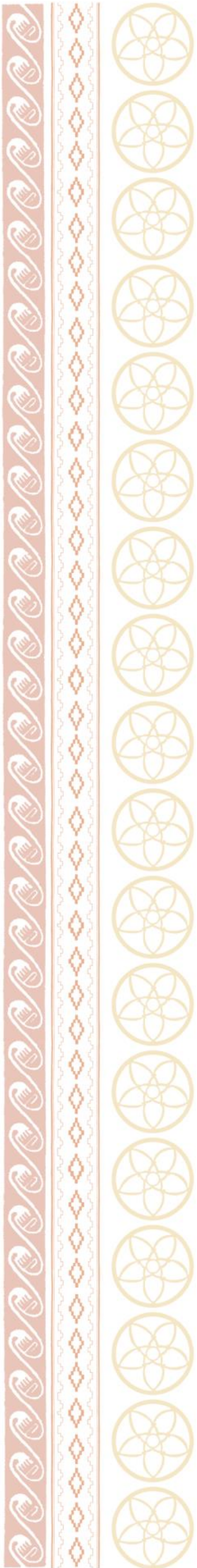


As evidenced in Figure 27, the most commonly reported MSPI project barriers included insufficient staffing (42%), insufficient resources (22%), and issues with grants management (22%). Definitions and examples for each barrier category are provided on the following pages of this report.

Note: These data were gathered through project narratives. There were no limits on the number or type of barriers that each project could report.

Table 6: MSPI Purpose Area 2 Project Barrier Definitions	
BARRIER	**DEFINITION**
INSUFFICIENT STAFFING	Project identified a lack of staff within its MSPI project as a barrier during this reporting period. This barrier category included staff turnover, difficulty recruiting for vacant positions, lack of qualified applicants (education, certifications, AI/AN), and understaffing, where existing staff are burdened with excessive job duties due to insufficient staffing.
INSUFFICIENT RESOURCES	Project cited a lack of funding or poor infrastructure as barriers to meet high local demand for services and activities.
LACK OF PARTICIPATION	Project cited insufficient community participation/support in project services and/or activities as a significant challenge.
TRANSPORTATION/ DISTANCE	Project identified rurality, insufficient transportation, large geographic service areas, and/or excessive travel times as major challenges to the delivery of project services and patient access to these services.
POOR COLLABORATION	Project identified gaps or challenges in collaboration and/or coordination with other agencies/departments as a significant barrier during this reporting period. The most commonly cited entities included schools, law enforcement, clinics/hospitals (including IHS), and other tribal agencies/departments.
GRANTS MANAGEMENT	Project noted challenges with grants management including local bureaucracies, new directives from tribal administration, long delays in securing procurement and contract approval, poor record keeping, and challenges in procuring needed equipment and training.
HIGH DEMANDS	Project identified high demands (staff and partners) as a barrier to optimal service delivery and routine meeting/coalition participation. High demands encompass competing priorities, busy schedules, excessive workload, difficulties coordinating schedules with partners, and situations where the need for services exceeded local capacity.
DATA CHALLENGES	Program noted poor access to relevant/reliable data or insufficient local data management systems/IT capacity as significant challenges.

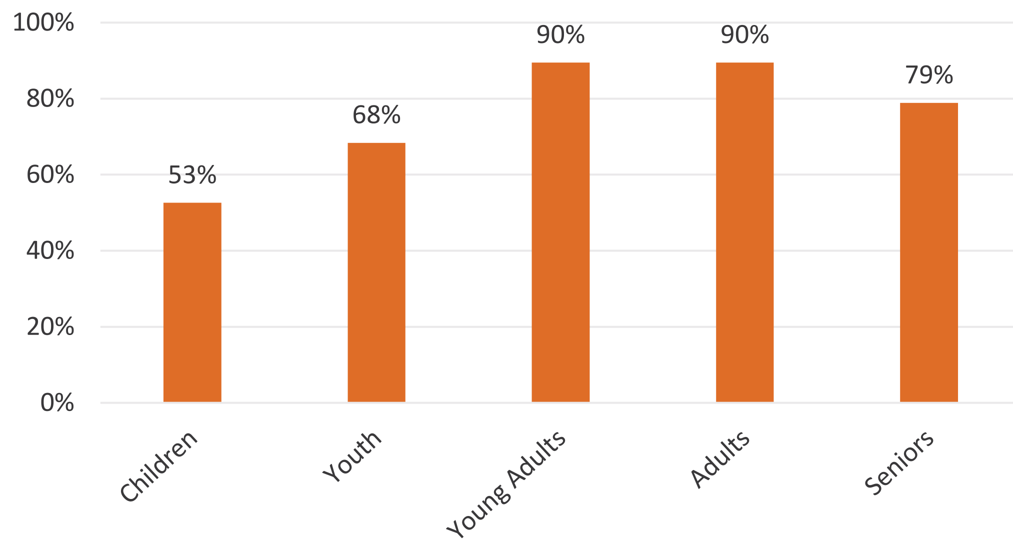
STIGMA	Program cited the ongoing stigmatization of mental health concerns among community members as a program barrier. In some instances, programs noted that stigma limits open discussion about these topics in community settings.
OTHER	The "other" category included unique challenges reported by five or fewer MSPI projects during the reporting period. These included: completed suicide/suicide cluster; difficulties inherent to target population; establishing protocols/policy; ineffective programming; lack of community support; local infrastructure; and restriction in purchasing food.



SECTION 6:
MSPI PURPOSE AREA 3 ONLY

TARGET POPULATION

Figure 28. Target Population Served by MSPI Purpose Area 3 Projects, 2016-2017*



**Projects were able to select multiple target populations.*

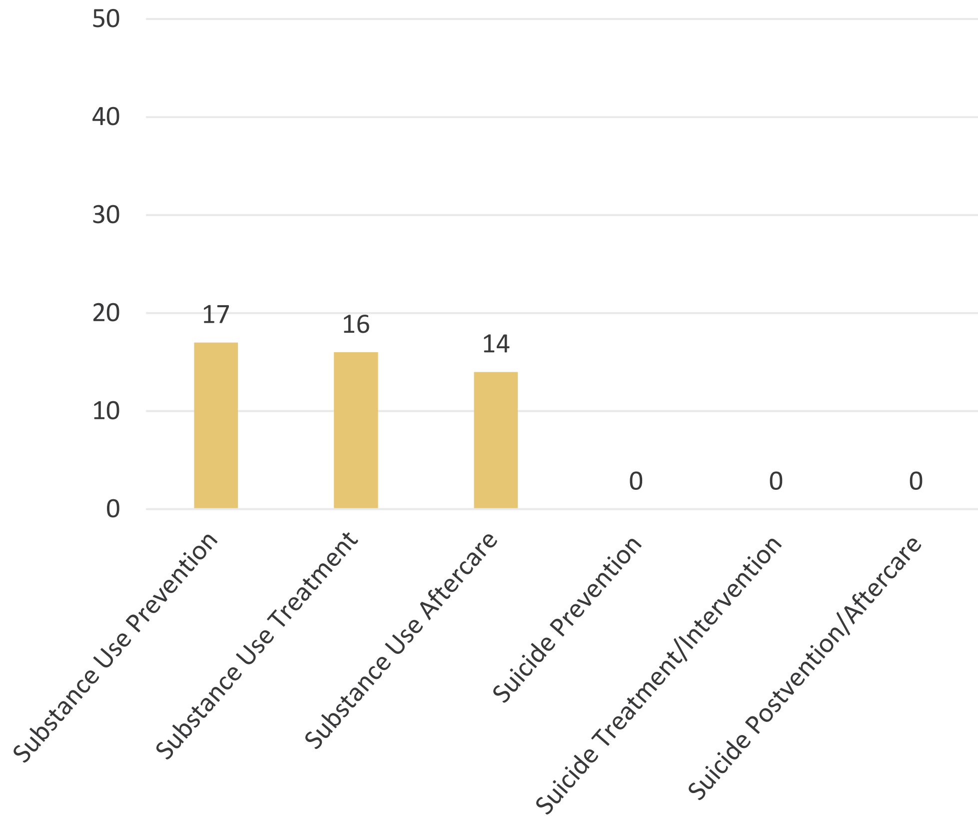
A total of 19 MSPI Purpose Area 3 projects reported upon their progress in the areas of methamphetamine prevention, treatment, and aftercare. As evidenced in Figure 28, MSPI Purpose Area 3 project services and resources are distributed across all age groups within their communities.

TARGET POPULATION DEFINITIONS

Children (up to age 11)
Youth (age 12-17)
Young Adults (age 18-24)
Adults (age 25-54)
Seniors (age 55+)

SERVICE TYPES

Figure 29. Number of MSPI Purpose Area 3 Projects by Service Type, 2016-2017*

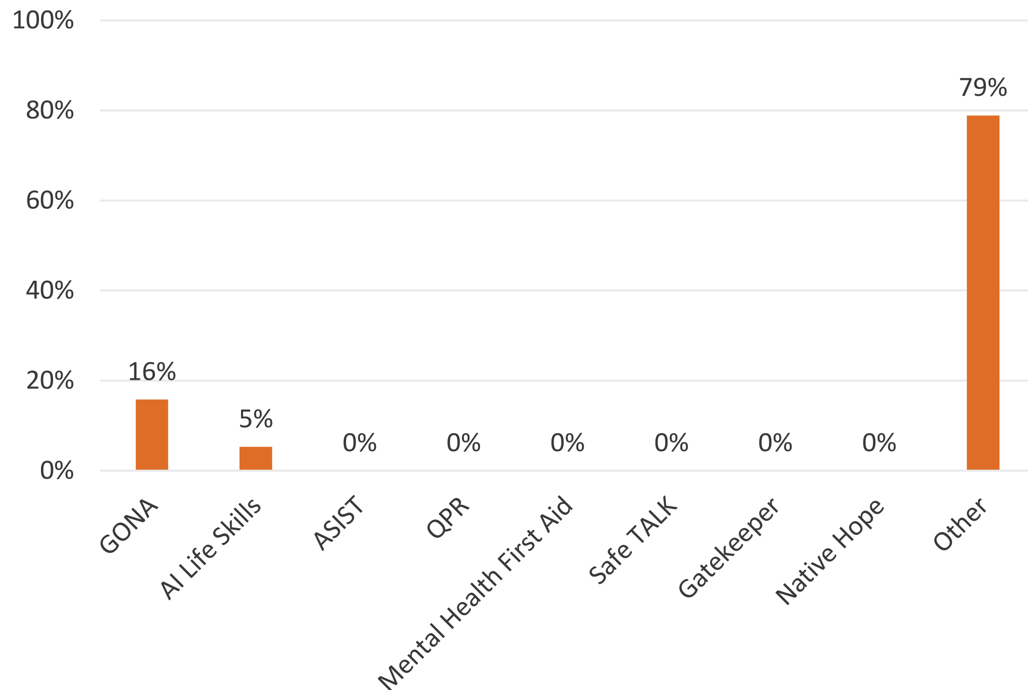


**Projects were able to select multiple types of service provision.*

As evidenced in Figure 29, the largest number of MSPI Purpose Area 3 projects focused upon substance useprevention (n=17), treatment (n=16) and aftercare (n=14).

EVIDENCE-BASED PRACTICES

Figure 30. Type of Evidence-Based Practices and/or Practice-Based Models Currently Being Used for Substance Use Prevention – MSPI Purpose Area 3 Only, 2016-2017.*



**Projects were able to select multiple types.*

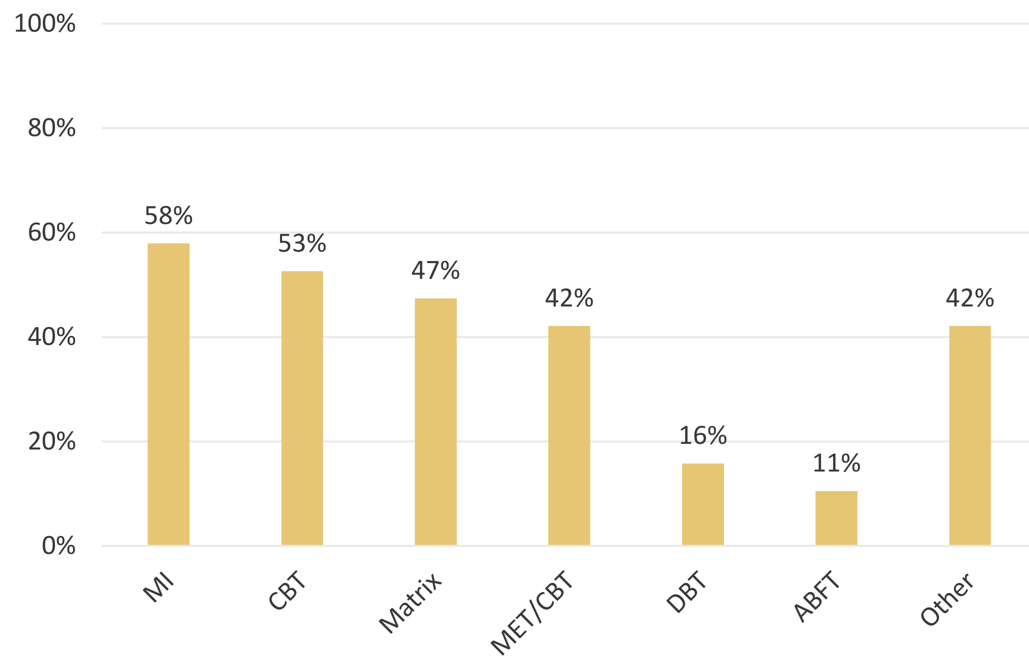
As demonstrated in Figure 30, the majority of MSPI Purpose Area 3 projects do not use these Evidence-Based Practices for prevention in their routine scope of services.

"Other" evidence-based practices utilized for prevention included: Active Parenting; Coping and Support Training (CAST); EMDR; Family Spirit; Fatherhood/Motherhood is Sacred; Local Traditional Spiritual Practices; Mothers Against Drunk Driving (MADD); METH 360 program; Native STAND curriculum; Native Wellness Institute Native Youth Leadership; Prevention Powwow; Prevention through the Arts; Prime for Life; Reconnecting Youth; Second Step Bullying; Solution-Focused Treatment; Sons of Tradition; Strategic Prevention Framework; Too Good for Drugs; Traditional Activities; and Trauma-Informed Care.

KEY:

ASIST = Applied Suicide Intervention Skills Training
GONA = Gathering of Native Americans
QPR = Question Persuade Refer

Figure 31. Type of Evidence-Based Practices and/or Practice-Based Models Currently Being Used for Intervention/Treatment - MSPI Purpose Area 3 Only, 2016-2017*



**Projects were able to select multiple types.*

As demonstrated in Figure 31, Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) were the most commonly utilized evidenced-based practice types in intervention/treatment among MSPI Purpose Area 3 Projects, 58% and 53% respectively.

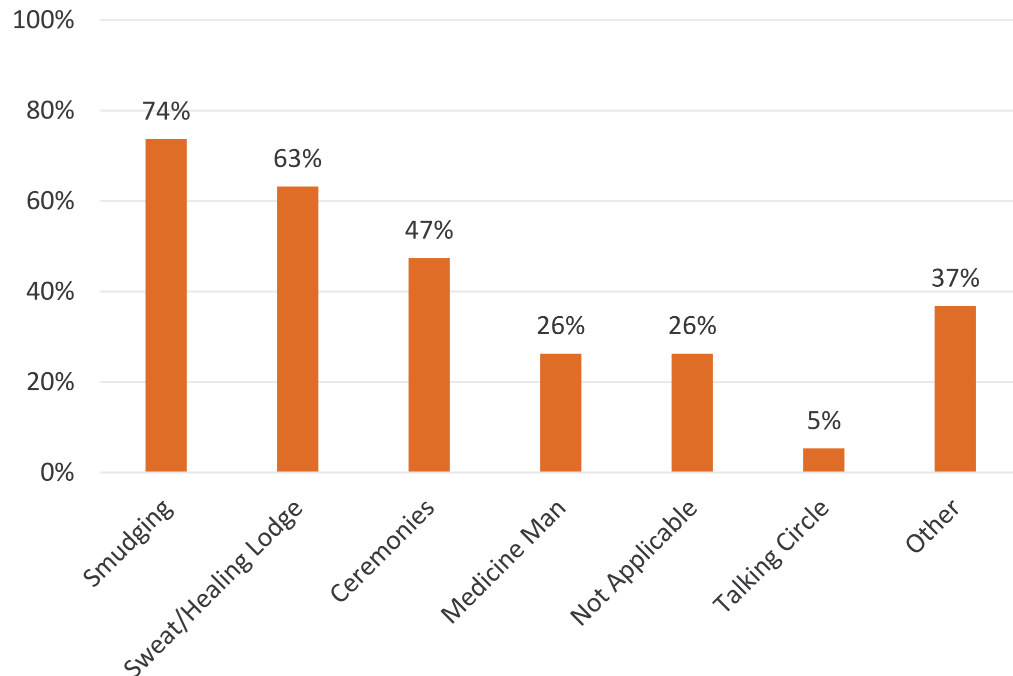
“Other” evidence-based practices for intervention/treatment included: Adolescent Community Reinforcement Approach (ACRA); Integrated Care; Medicinal Practices; Mindfulness; Multi-Systemic Therapy (MST); Parent Model; Spiritual Guidance; Trauma-Informed Care.

KEY:

ABFT = Attachment-Based Family Therapy
CBT = Cognitive Behavioral Therapy
DBT = Dialectical Behavioral Therapy
MET/CBT = Motivational Enhancement Therapy/Cognitive Behavioral Therapy
MI = Motivational Interviewing

HOLISTIC APPROACHES TO SERVICES

Figure 32. Percentage of MSPI Purpose Area 3 Projects Integrating Traditional Healing into Services, by Practice Type, 2016-2017*

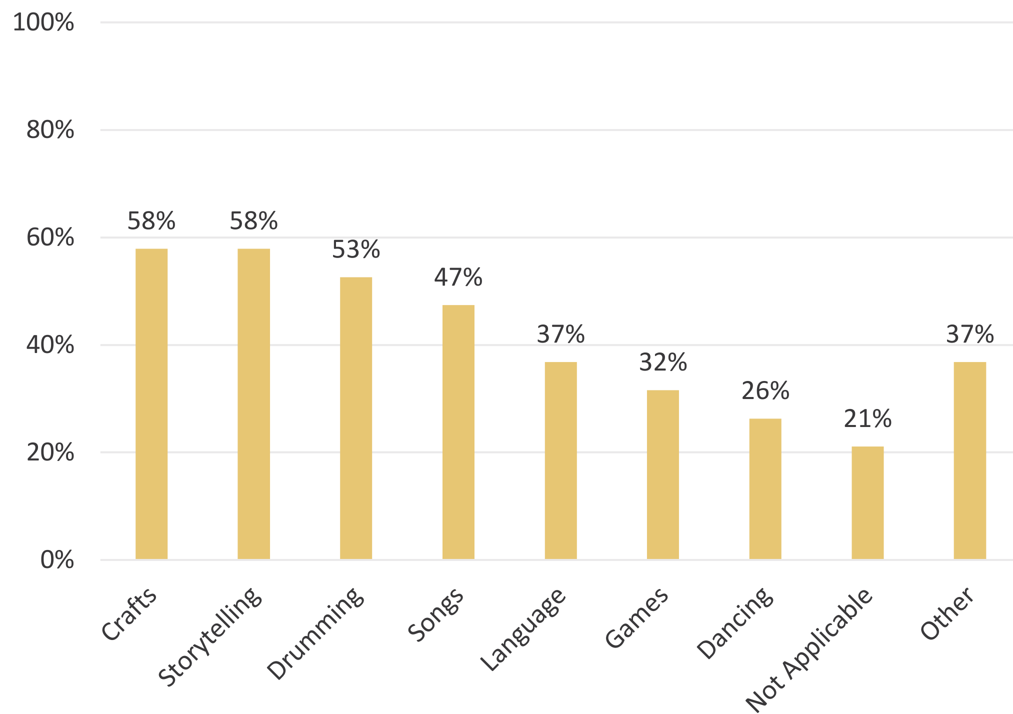


**Projects were able to select multiple types.*

Figure 32 demonstrates that a range of traditional healing related practices have been incorporated into MSPI Purpose Area 3 project activities, with the most frequently utilized practices being smudging (74%) and sweat/healing lodge (63%). The majority of MSPI Purpose Area 3 projects reported integrating at least one of these traditional healing practices into their project services (79%).

“Other” traditional practices reported included: Medicine Wheel; Mending Broken Hearts; Sacred Fatherhood and Families; Smoke Blessings; Sundance; and Women’s Talking Circle.

Figure 33. Cultural Practices Offered in MSPI Purpose Area 3 Project Services, 2016-2017*



**Projects were able to select multiple types.*

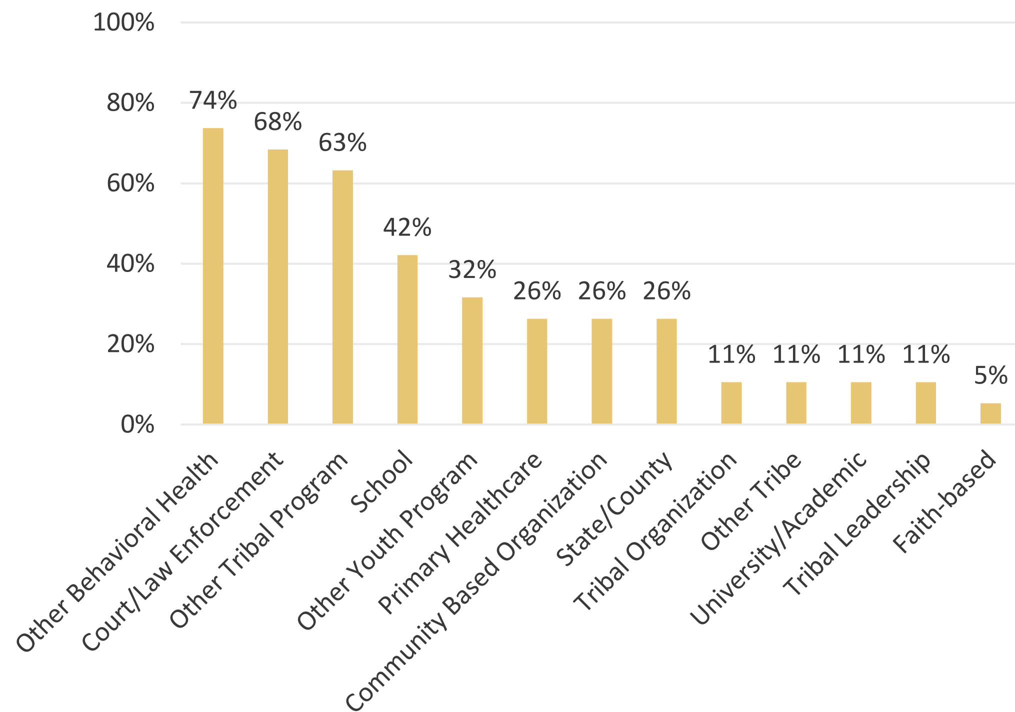
As evidenced in Figure 33, the most common cultural services included in MSPI Purpose Area 3 project activities were crafts (58%), storytelling (58%), and drumming (53%). The vast majority of MSPI Purpose Area 3 projects reported integrating at least one of these cultural practices into their project services (90%).

"Other" cultural practices reported included: Medicine Wheel, Mending Broken Hearts; Narrative Therapy; Referral to Cultural Specialist; Traditional recovery camp; and Wellbriety Group.

PROJECT OPERATIONS

PARTNERSHIPS

Figure 34. Most Common Types of Partners Enlisted among MSPI Purpose Area 3 Projects, 2016-2017*



**Projects were able to select multiple types.*

Table 7. Number of Partners and Memorandum of Agreements (MOAs) Reported among MSPI Purpose Area 3 Projects, 2016-2017

	N
Total Partners (All Projects)	149
Average per project	7.84
Range	0 – 24
Total Memorandum of Agreements (MOAs)	0

STAFFING

Figure 35. Percentage of MSPI Purpose Area 3 Projects that Experienced Staff Turnover, 2016-2017

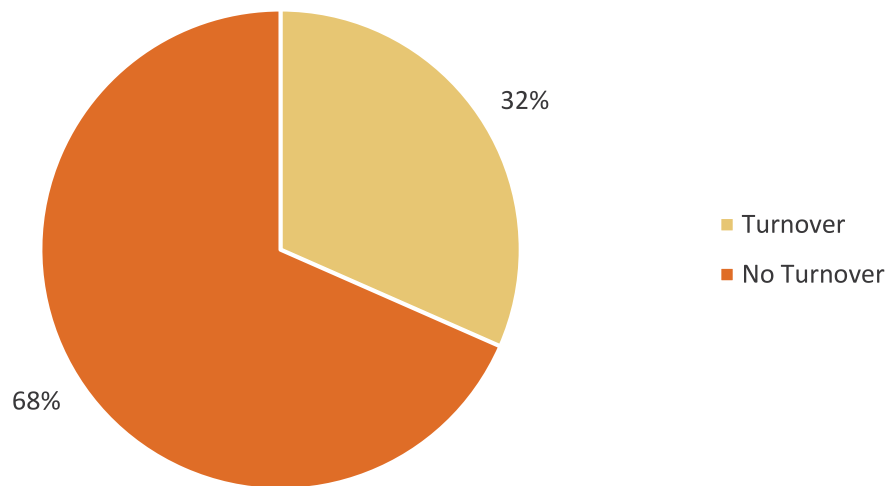


Figure 36. Percentage of MSPI Purpose Area 3 Projects that Have Been Able to Recruit, Hire, and Onboard Staff, 2016-2017

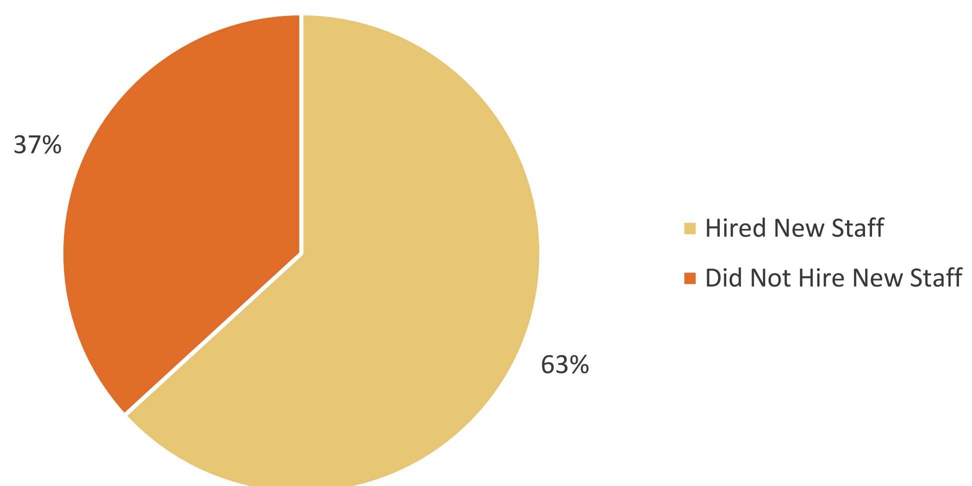
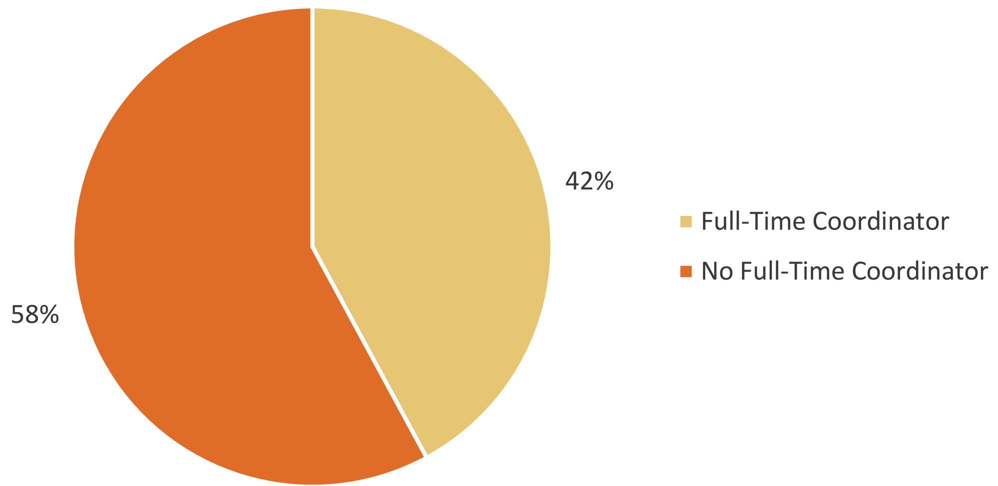


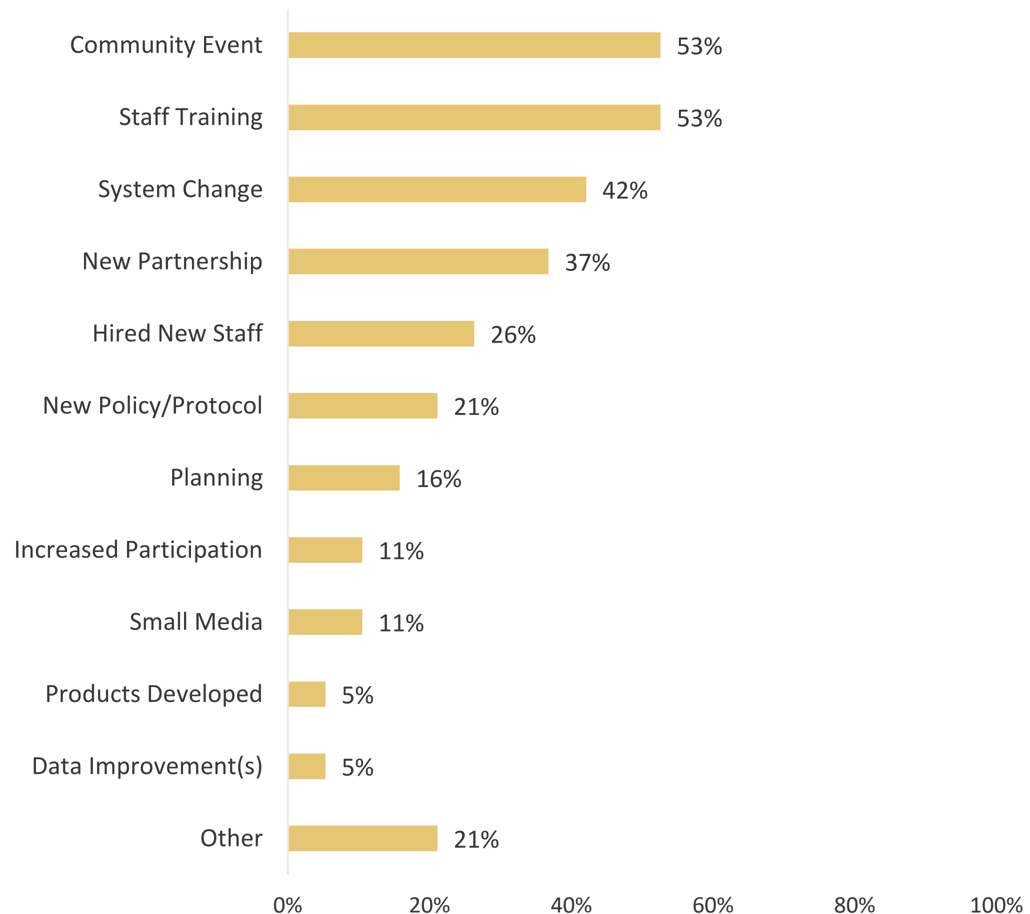
Figure 37. Percentage of MSPI Projects among MSPI Purpose Area 3 Projects with a Full-Time Project Coordinator, 2016-2017



PROJECT ACCOMPLISHMENTS AND BARRIERS

PROJECT ACCOMPLISHMENTS

Figure 38. Type of Accomplishments Reported among MSPI Purpose Area 3 Projects, 2016-2017



As evidenced in Figure 38, the most commonly reported accomplishments among MSPI Purpose Area 3 Projects in year 2 included implementing successful community events (53%), completion of staff training (53%), implementing a system change (42%), and establishing one or more new/enhanced partnerships (37%). Definitions and examples for each accomplishment category are provided on the following pages of this report.

Note: These data were gathered through project narratives. There were no limits on the number or type of accomplishments that each project could report.

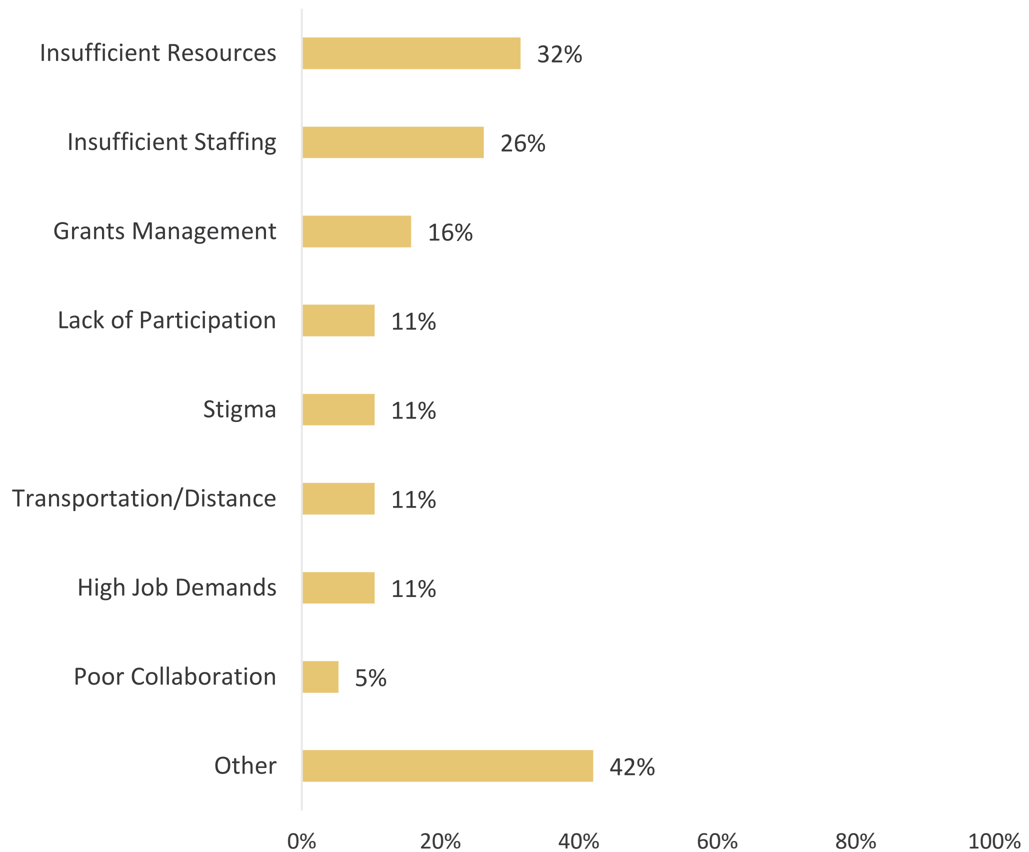
Table 8. MSPI Purpose Area 3 Project Accomplishment Definitions

ACCOMPLISHMENT	DEFINITION
COMMUNITY EVENT	Project has identified at least one community event or activity sponsored by the MSPI project as a success during the reporting period. Common community event types included: school education events, health fairs, camps, run/walk, community presentations/workshops, contests, photovoice/art galleries, movie nights, and cultural activities (e.g., arts and crafts, archery, drumming, traditional games, storytelling, etc.).
NEW PARTNERSHIPS	Project has identified at least one new/enhanced partnership during the reporting period as a measure of success. These partnerships may be formal (as evidenced through MOUs or MOAs) or informal. Common new/enhanced partner categories included: schools, law enforcement, courts, hospitals/clinics, social services, correctional facilities, other tribal agencies/departments, tribal organizations, and external partners (non-profit organizations, referral sites, and universities).
STAFF TRAINING	At least one project staff member attended at least one training, conference or workshop during the reporting period. Common training topics listed as successes included: AI Life Skills, ASIST, Mental Health First Aid, Sources of Strength, CONNECT, safeTALK, MATRIX, QPR, CISM, Project Venture, Trauma Incident Reduction Training, etc.
SYSTEM CHANGE	Project has identified at least one new or expanded/improved service that it offers as a success during the reporting period. Examples include: support groups, traditional ceremonies/practices (talking circles), extended hours, aftercare/follow-up, group treatment, new/expanded counselling and case management services, equine therapy, expanded number of facilities offering services, classes (self-defense, parenting, self-care, stress management, mindfulness, art therapy), etc.
PLANNING	Project focused on planning for future program opportunities. Staff researched new strategies, engaged in networking opportunities, furthered program preparation, etc.

SMALL MEDIA	Project has developed one or more small media products or implemented a media-related activity during the reporting period and identified it as a success. Examples include: billboards, radio or television public service announcements (PSAs), radio shows, documentary development, newsletter/newspaper, brochures, posters, digital stories, and social media (e.g. Facebook).
PRESENTATIONS	Program presented on project information at local/national level.
SUCCESSFUL PROGRAMMING	Project described supporting participant progress through program activities and/or successful progression through/completion of project objectives.
HIRED NEW STAFF	Project has identified at least one new staff person (part-time, full-time or contractual) joining its MSPI project during the reporting period.
INCREASED PARTICIPATION	Project has noted an increase in community participation in MSPI sponsored activities and/or an increase in referrals to its services during the reporting period.
NEW POLICY or PROTOCOL	Project identified the development/implementation of at least one new, updated, or enhanced policy or protocol related to MSPI project aims during the reporting period. Examples include: new patient screening tools (ER and clinic), tribal suicide response protocols, new referral policies and procedures, new enforcement laws, and enhanced wrap-around and post-treatment protocols.
DATA IMPROVEMENTS	Project has identified improvements in data access or data systems related to MSPI project aims. Examples include: new electronic reporting systems, new data management system, completed needs assessment, audit of existing suicide surveillance systems, improved coding, database development, data reports, and development of a suicide surveillance initiative.
OTHER	The other category included unique successes reported by five or fewer MSPI projects during the reporting period. These included: leveraged for additional funding; successful program delivery; successful completion of program by participants.

PROJECT BARRIERS

Figure 39. Types of Barriers Reported among MSPI Purpose Area 3 Projects, 2016-2017

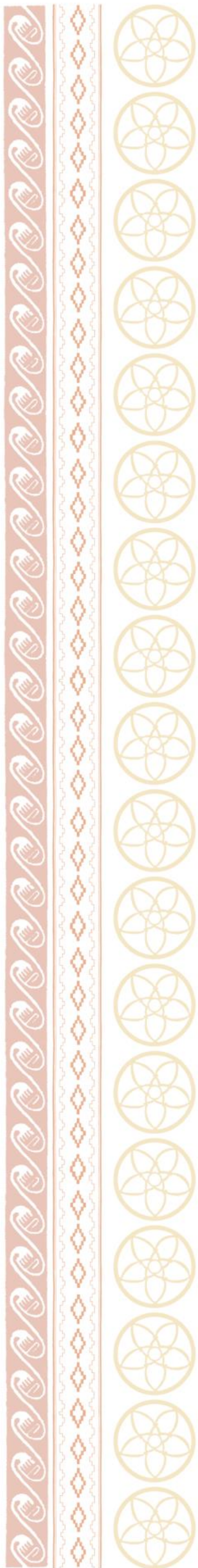


As evidenced in Figure 39, the most commonly reported MSPI Purpose Area 3 project barriers included insufficient resources (32%) and insufficient staffing (26%). Definitions and examples for each barrier category are provided on the following pages of this report.

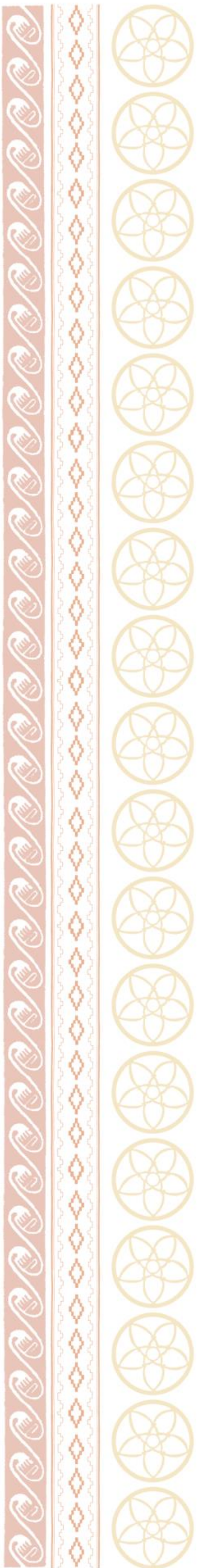
Note: These data were gathered through project narratives. There were no limits on the number or type of barriers that each project could report.

Table 9: MSPI Purpose Area 3 Project Barrier Definitions

BARRIER	DEFINITION
INSUFFICIENT STAFFING	Project identified a lack of staff within its MSPI project as a barrier during this reporting period. This barrier category included staff turnover, difficulty recruiting for vacant positions, lack of qualified applicants (education, certifications, AI/AN), and understaffing, where existing staff are burdened with excessive job duties due to insufficient staffing.
INSUFFICIENT RESOURCES	Project cited a lack of funding or poor infrastructure as barriers to meet high local demand for services and activities.
LACK OF PARTICIPATION	Project cited insufficient community participation/support in project services and/or activities as a significant challenge.
TRANSPORTATION/ DISTANCE	Project identified rurality, insufficient transportation, large geographic service areas, and/or excessive travel times as major challenges to the delivery of project services and patient access to these services.
POOR COLLABORATION	Project identified gaps or challenges in collaboration and/or coordination with other agencies/departments as a significant barrier during this reporting period. The most commonly cited entities included schools, law enforcement, clinics/hospitals (including IHS), and other tribal agencies/departments.
GRANTS MANAGEMENT	Project noted challenges with grants management including local bureaucracies, new directives from tribal administration, long delays in securing procurement and contract approval, poor record keeping, and challenges in procuring needed equipment and training.
HIGH DEMANDS	Project identified high demands (staff and partners) as a barrier to optimal service delivery and routine meeting/coalition participation. High demands encompass competing priorities, busy schedules, excessive workload, difficulties coordinating schedules with partners, and situations where the need for services exceeded local capacity.
STIGMA	Program cited the ongoing stigmatization of mental health concerns among community members as a program barrier. In some instances, programs noted that stigma limits open discussion about these topics in community settings.



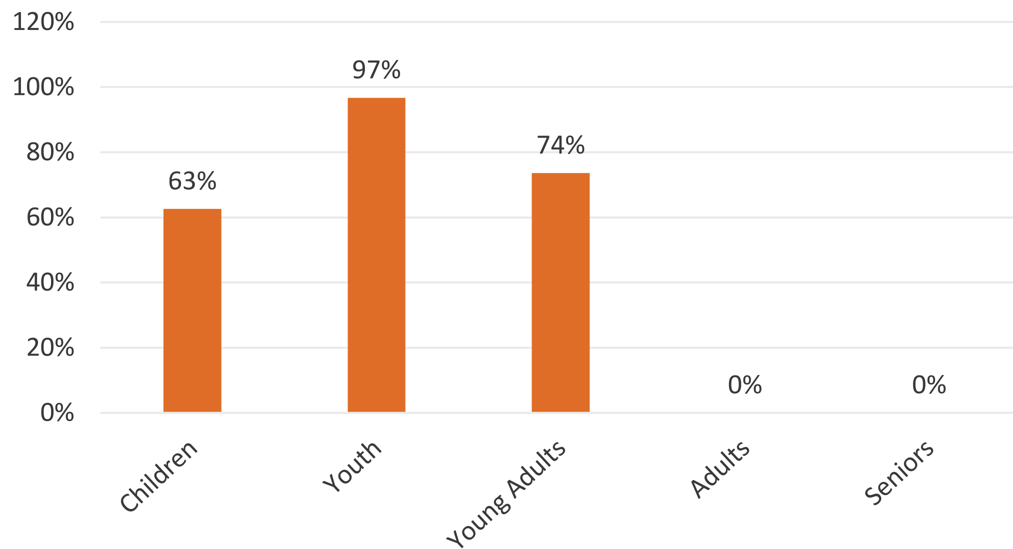
OTHER	The other category included unique challenges reported by five or fewer MSPI projects during the reporting period. These included: difficulty establishing policy/protocols; external requirements/infrastructure; lack of trust; local requirements/infrastructure; restriction in purchasing food; and weather.



SECTION 7: MSPI PURPOSE AREA 4 ONLY

TARGET POPULATION

Figure 40. Target Population Served by MSPI Purpose Area 4 Projects, 2016-2017*



**Projects were able to select multiple target populations.*

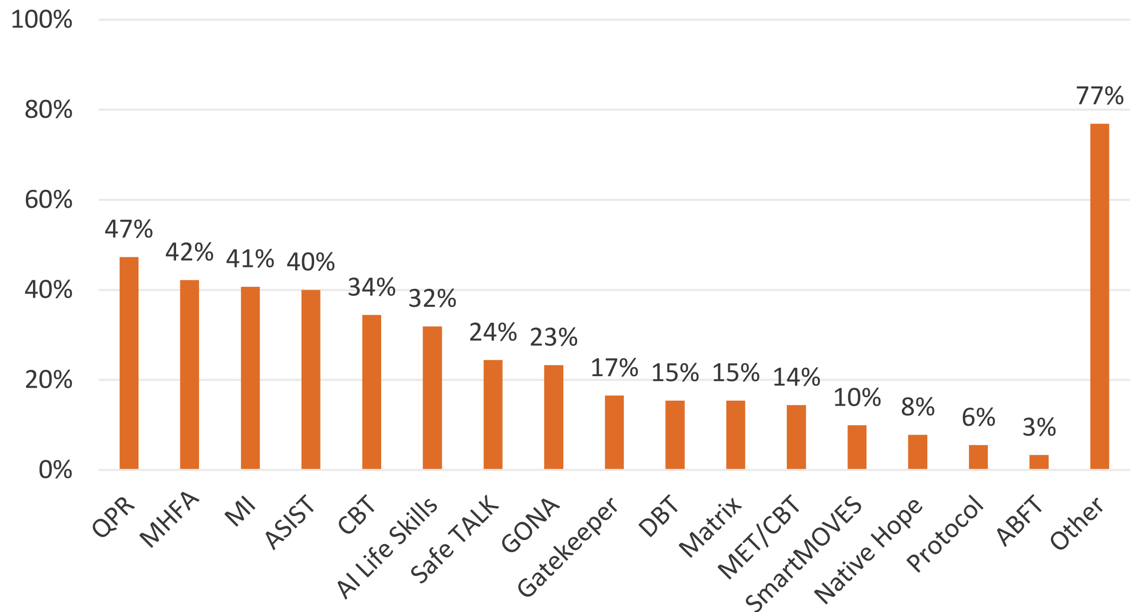
A total of 91 MSPI Purpose Area 4 projects reported on their progress
intervention strategies and implement positive youth programming aimed at reducing risk factors for suicidal behavior and substance abuse. As shown in Figure 40, MSPI Purpose Area 4 projects focused their services largely on younger age groups.

TARGET POPULATION DEFINITIONS
Children (up to age 11)
Youth (age 12-17)
Young Adults (age 18-24)
Adults (age 25-54)
Seniors (age 55+)

SERVICE TYPES

EVIDENCE-BASED PRACTICES

Figure 41. Type of Evidence-Based Practices and/or Practice-Based Models Currently Being Used for Suicide Prevention – MSPI Purpose Area 4 Only, 2016-2017.*



**Projects were able to select multiple types.*

As demonstrated in Figure 41, the most common Evidence-Based Practices and/or Practice-Based Models utilized among MSPI Purpose Area 4 projects for prevention were Question, Persuade, Refer (47%), Mental Health First Aid (42%), Motivational Interviewing (41%), and Applied Suicide Intervention Skills Training (40%). Most programs also utilized an approach which fell into the "other" category (77%).

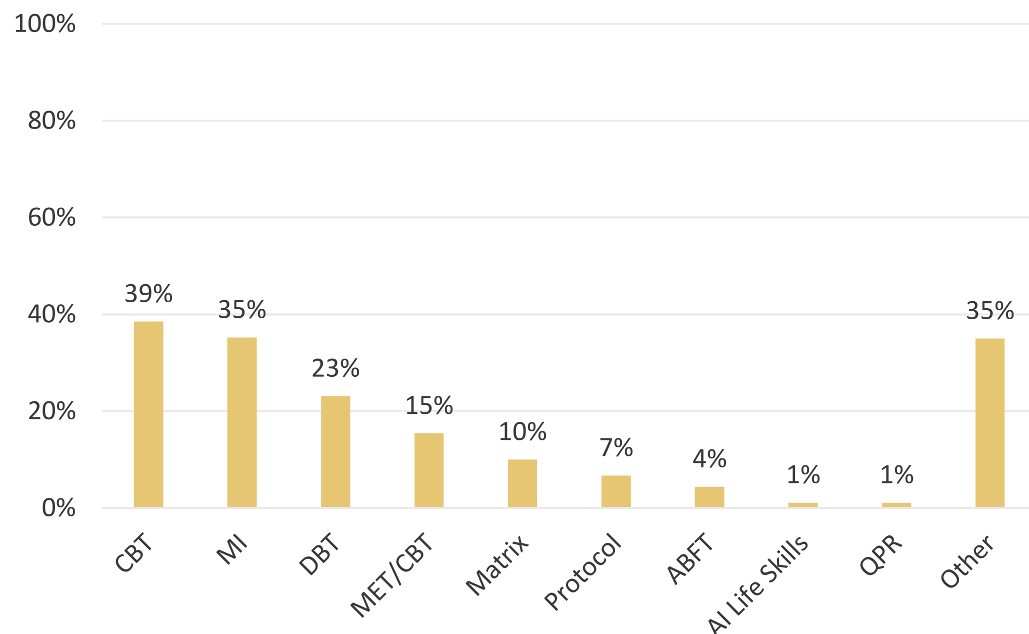
"Other" types reported included: 12 Step Program; 12 Teachings for Native Youth; 40 Developmental Assets; ACEs Model; Adolescent Community Reinforcement Approach (ACRA); Active Parenting; Alcohol True Stories; An Apple A Day; Art Therapy; Beginning Awareness Basic Educational Studies (BABES); Boy's Running Program; Boys and Girls Club of America; BrainWise; Building Communities of Hope; Bullying Prevention Program; C2: Character Challenge; Canoe Journey; Casey Life Skills; CAST curriculum; Community Resilience Model; Community/Cultural Prevention; Crisis Response; CSACs; Cultural Practices and Revitalization; Culture Camp; Daughters and Sons of Tradition; Eye Movement Desensitization and Reprocessing (EMDR); Equine Therapy; First Thunderbeing House; Friendship House; Gottman Couple's Therapy; Healing of the Canoe; Indigenous Way of

Knowing; Integrated Behavioral Health; Keepin' It REAL; Kognito; Learning Prevention Using Local Values (Adapted); Life is Sacred; Lifeline; Living in Balance; Look, Listen, Link, and HELP; Medicine Wheel Model; Mending Broken Hearts for Youth and the Community; Meth 360 program; Mindfulness; modified Native Wellness Institute Curriculum; Moral Reconation Therapy; Music/Emotions Coping Skills group; National Institute of Drug Abuse's 16 Principles; Native American Substance Use Prevention Curricula; Native American Values Summer School; Native STAND; NCAI Meth in Tribal Communities; NIAAA Screening and Brief Intervention for Youth; Partners in Parenting; Promoting Alternative THinking Strategies (PATHS); Peer-to-Peer Helpers; Positive Community Norms; Positive Culture Framework Model; Positive Youth Leadership; Prime for Life; Professional Roles to Facilitate Care; Project Alcohol Free; Project Venture; Protecting You Protecting Me; Rational Emotional Behavioral Therapy; Red Road to Wellbriety; Relapse Prevention Therapy; Relationship Workshops; Resiliency Training; Riding the Waves; SAMHSA Treatment Plans; Screening, Brief Intervention, and Referral to Treatment (SBIRT); SBQR tool; Screening/Evaluation/Referral; ScreenDOX Screening Technology; SEARCH Institute Framework for Young People and Engaging Families; Seeking Safety; SMART Kinds; Smart Moves/Meth Smart; Social Marketing; Sons of Tradition; Sources of Strength; Structured Family Therapy; Student Assistant Program; Supportive Education for Children of Addicted Parents; The Good Road of Life: Native Families; Therapeutic Behavioral Health Services; Too Good for Drugs; Tribal Suicide Prevention; Tribal Wellness Model; Walking the Red Road Medicine Way; We R Native; White Bison; Wellness Recovery Action Plan (WRAP); Wraparound Systems of Care; Young Warriors; and Zero Suicide.

KEY:

ABFT = Attachment-Based Family Therapy
ASIST = Applied Suicide Intervention Skills Training
CBT = Cognitive Behavioral Therapy
DBT = Dialectical Behavioral Therapy
GONA = Gathering of Native Americans
MET/CBT = Motivational Enhancement Therapy/Cognitive Behavioral Therapy
MHFA = Mental Health First Aid
MI = Motivational Interviewing
QPR = Question Persuade Refer

Figure 42. Type of Evidence-Based Practices and/or Practice-Based Models Currently Being Used for Intervention/Treatment - MSPI Purpose Area 4 Only, 2016-2017*



Projects were able to select multiple types.

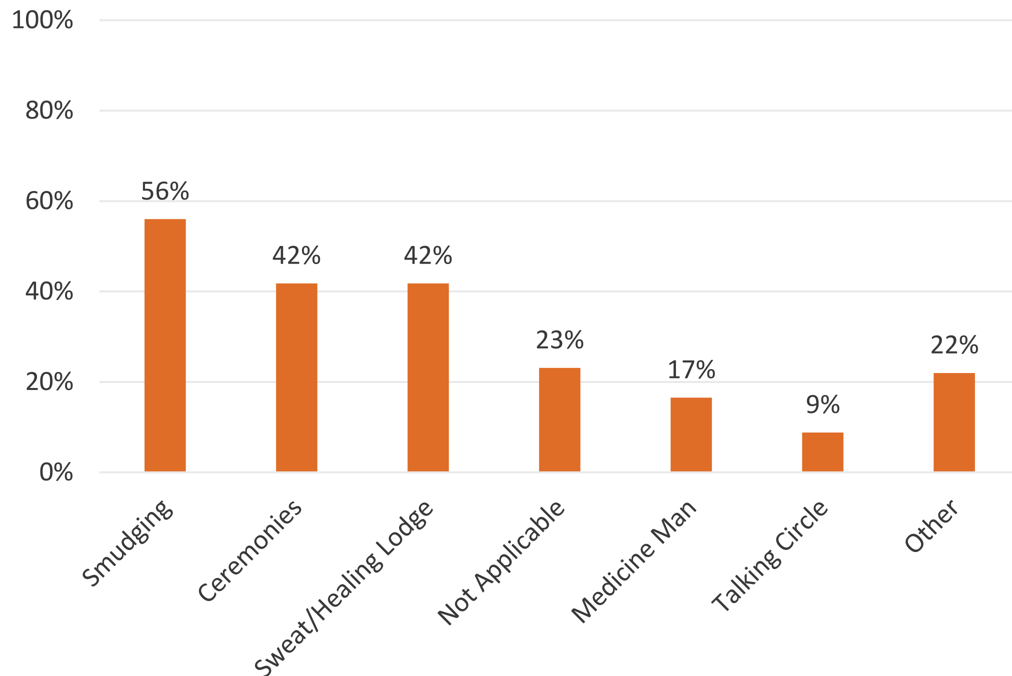
As demonstrated in Figure 42, Cognitive Behavioral Therapy (39%) and Motivational Interviewing (35%) were the most commonly utilized evidenced-based practice types in intervention/treatment among MSPI Purpose Area 4 Projects. Many programs (35%) also utilized a practice which fell into the "other" category.

"Other" types reported included: Adolescent Community Reinforcement Approach (ACRA); Art Therapy; Boys and Girls Club of America; Cognitive Energy Work; Community Resiliency Model; Creator's Game Family Healing Camp; Crisis Support Planning; Equine Therapy (ELI); Evaluations and Medication Management; Eye Movement Desensitization Processing (EDMR); Friendship House; Grief Recovery Model; Mending Broken Hearts for Youth; Nurturing Parenting; Patient Safety Planning; Project Venture; Relationship Workshops; SBIRT; Smart Moves/Meth Smart; Structured Family Therapy; Suicidal Crisis Response Protocol; Suicide Postvention Training; Suicide Screenings; Tribal Youth Council; Wellness Recovery Action Plan (WRAP); and Youth Mental Health First Aid.

KEY:
ABFT = Attachment-Based Family Therapy
CBT = Cognitive Behavioral Therapy
DBT = Dialectical Behavioral Therapy
MET/CBT = Motivational Enhancement Therapy/Cognitive Behavioral Therapy
MI = Motivational Interviewing
QPR = Question Persuade Refer

HOLISTIC APPROACHES TO SERVICES

Figure 43. Percentage of MSPI Purpose Area 4 Projects Integrating Traditional Healing into Project Services, by Practice Type, 2016-2017*

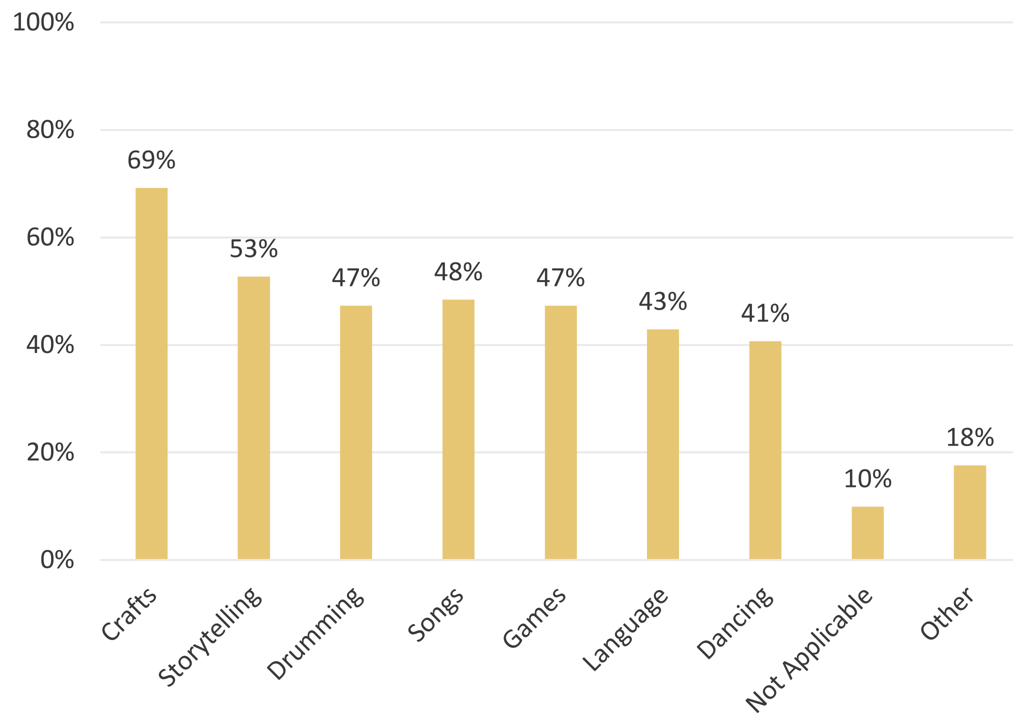


**Projects were able to select multiple types.*

Figure 43 demonstrates that a range of traditional healing related practices have been incorporated into MSPI Purpose Area 4 project activities included smudging (56%), ceremonies (42%) , and sweats/healing lodges (42%). The majority of MSPI Purpose Area 4 projects reported integrating at least one of these traditional healing practices into their project services (68%).

“Other” traditional healing practices reported included: Art Therapy; Building Longhouses; Canoe Journey; Circle of Life Healing Methods; Clan System; Community Cultural Celebrations; Creating Family Trees; Cultural Identification; Cultural Presentations; Cultural Revitalization; Evenings with Elders; Grief Healing Circle; Healing Circles; Integrative Care; Naming Ceremonies; Nature Walks; Potlucks; Powwow; Red Road; Round Dance; Seat Fasting; Tipi Teachings; Traditional Positive Parenting; Traditional Tobacco; Wheel of Health; Young Warriors Groups.

Figure 44. Cultural Practices Offered in MSPI Purpose Area 4 Project Services, 2016-2017*



**Projects were able to select multiple types.*

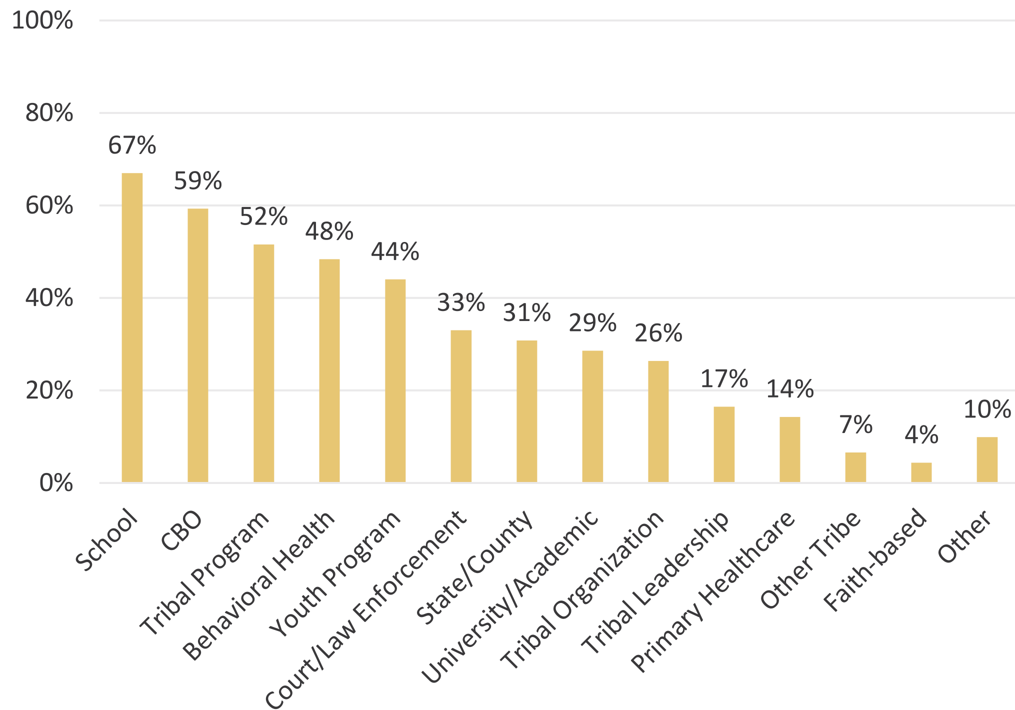
As evidenced in Figure 44, the most common cultural services included in MSPI Purpose Area 4 projects were crafts (69%) and storytelling (53%). The majority of MSPI Purpose Area 4 projects reported integrating at least one of these cultural practices into their project services (87%).

“Other” cultural practices reported included: 7 Grandfather Teachings; Archery; Community Traditional Gardening; Community Tribal Circle; Culturally-based Reflective Discussions; Fatherhood/Motherhood is Sacred; Flute Circles; Honoring of Our Elders; Horsemanship; Hunting; Journey to Healing; Native Plant Recognition and Gathering; Teepee/Camp setup; Traditional Foods Cooking Classes; Traditional Tobacco; and Village Wellness Team.

PROJECT OPERATIONS

PARTNERSHIPS

Figure 45. Most Common Types of Partners Enlisted among MSPI Purpose Area 4 Projects, 2016-2017*



**Projects were able to select multiple types.*

Common "other" partner types included: cultural entities/instructors.

KEY
CBO = Community Based Organizations

Table 10. Number of Partners and Memorandum of Agreements (MOAs) Reported among MSPI Purpose Area 4 Projects, 2016-2017

	N
Total Partners (All Projects)	744
Average per project	8.4
Range	1 – 47
Total Memorandum of Agreements (MOAs)	73

STAFFING

Figure 46. Percentage of MSPI Purpose Area 4 Projects that Experienced Staff Turnover, 2016-2017

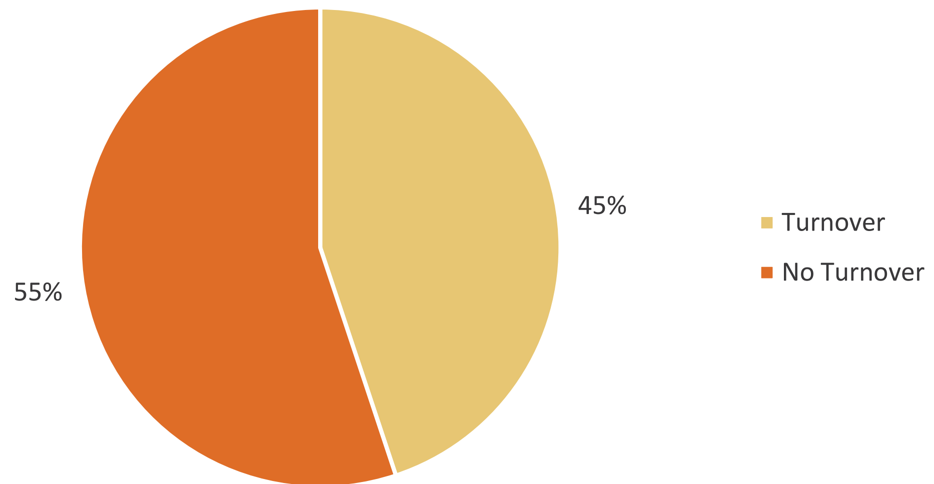


Figure 47. Percentage of MSPI Purpose Area 4 Projects that Have Been Able to Recruit, Hire, and Onboard Staff, 2016-2017

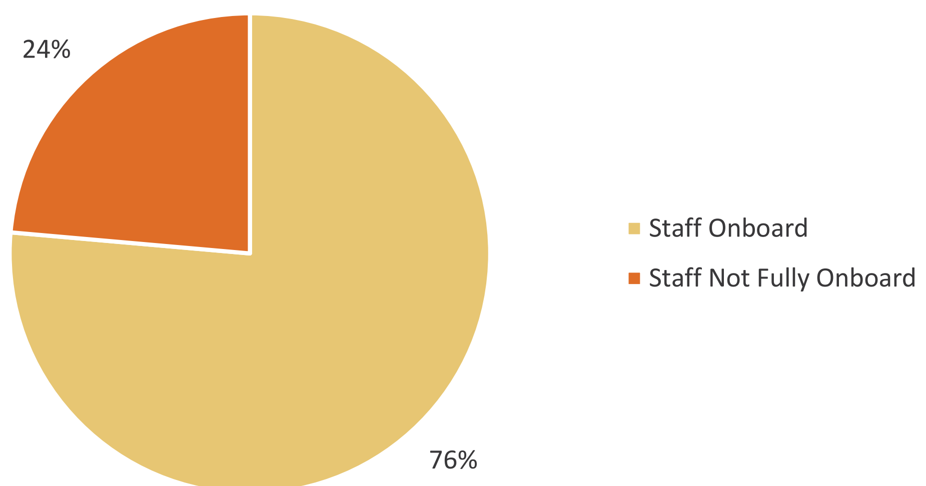
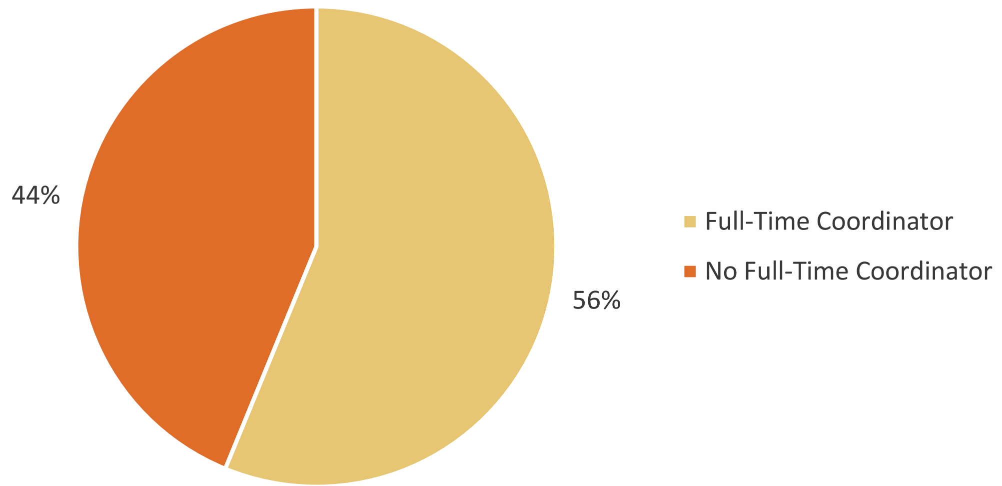


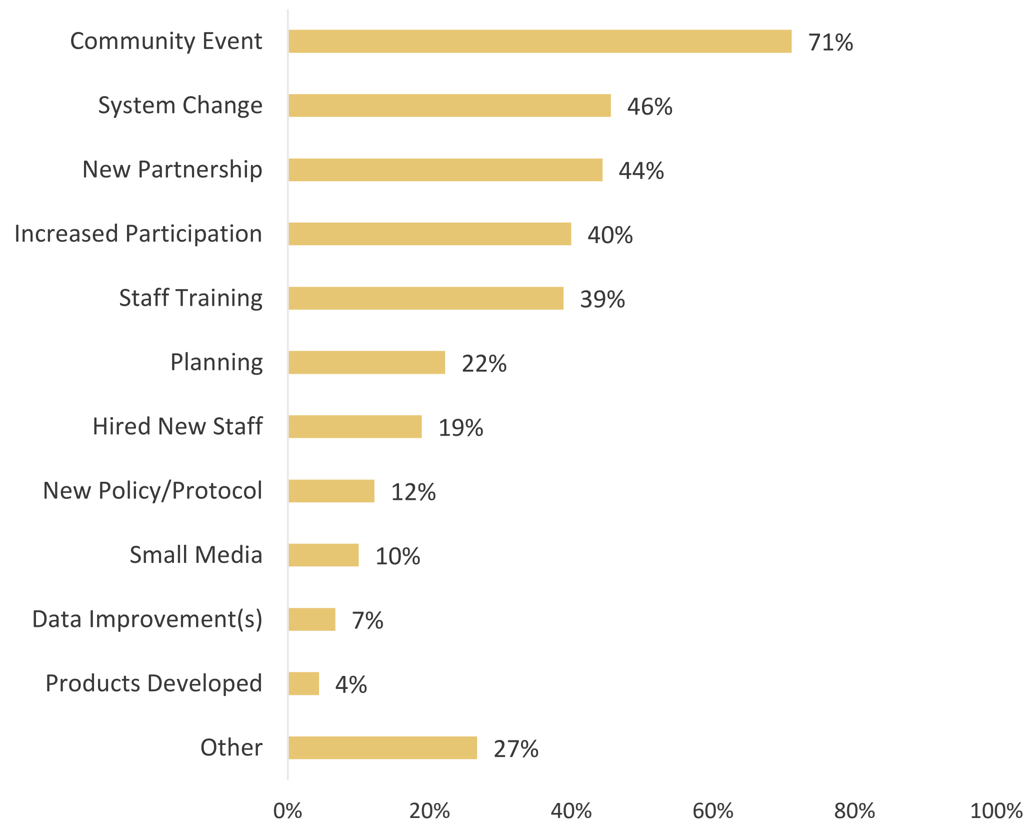
Figure 48. Percentage of MSPI Purpose Area 4 Projects with a Full-Time Project Coordinator, 2016-2017



PROJECT ACCOMPLISHMENTS AND BARRIERS

PROJECT ACCOMPLISHMENTS

Figure 49. Type of Accomplishments Reported among MSPI Purpose Area 4 Projects, 2016-2017



As evidenced in Figure 49, the most commonly reported accomplishments among MSPI Purpose Area 4 Projects in project year 2 included implementing successful community events (71%), producing system change (46%), and establishing one or more new partnerships (44%). Definitions and examples for each accomplishment category are provided on the following pages of this report.

Note: These data were gathered through project narratives. There were no limits on the number or type of accomplishments that each project could report.

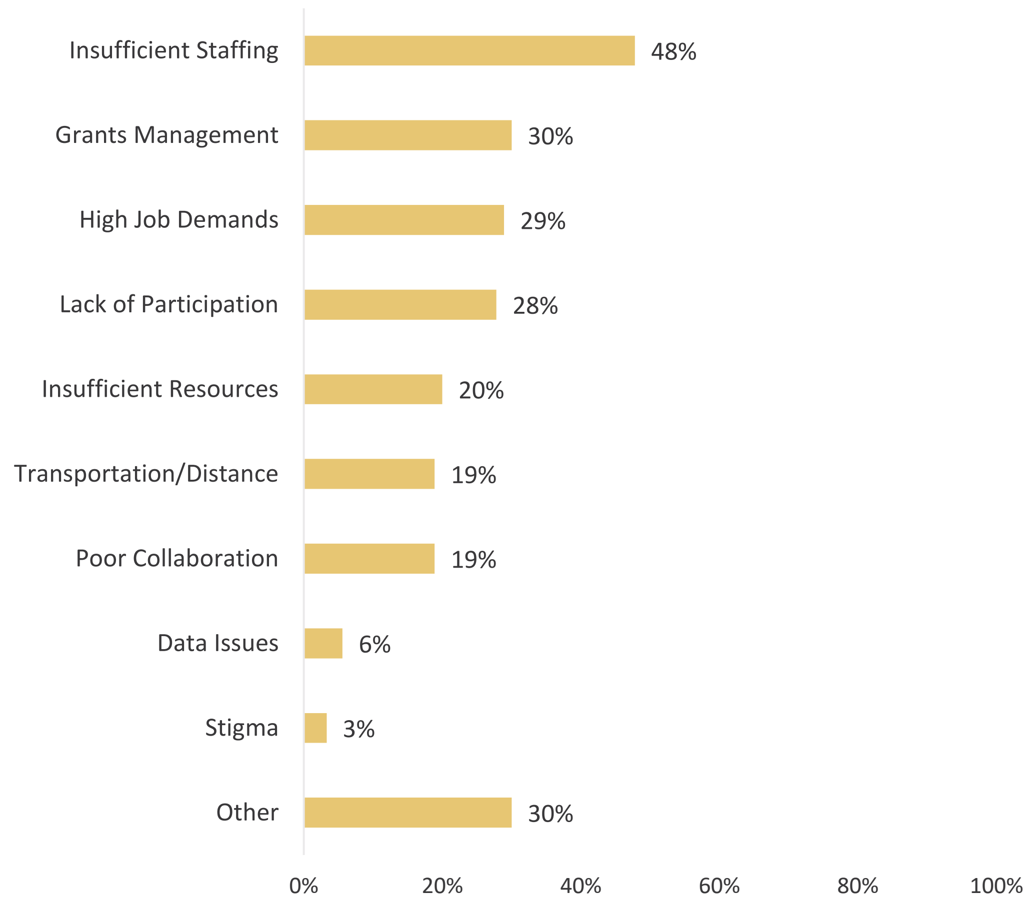
Table 11. MSPI Purpose Area 4 Project Accomplishment Definitions

ACCOMPLISHMENT	DEFINITION
COMMUNITY EVENT	Project has identified at least one community event or activity sponsored by the MSPI project as a success during the reporting period. Common community event types included: school education events, health fairs, camps, run/walk, community presentations/workshops, contests, photovoice/art galleries, movie nights, and cultural activities (e.g., arts and crafts, archery, drumming, traditional games, storytelling, etc.).
NEW PARTNERSHIPS	Project has identified at least one new/enhanced partnership during the reporting period as a measure of success. These partnerships may be formal (as evidenced through MOUs or MOAs) or informal. Common new/enhanced partner categories included: schools, law enforcement, courts, hospitals/clinics, social services, correctional facilities, other tribal agencies/departments, tribal organizations, and external partners (non-profit organizations, referral sites, and universities).
STAFF TRAINING	At least one project staff member attended at least one training, conference or workshop during the reporting period. Common training topics listed as successes included: AI Life Skills, ASIST, Mental Health First Aid, Sources of Strength, CONNECT, safeTALK, MATRIX, QPR, CISM, Project Venture, Trauma Incident Reduction Training, etc.
SYSTEM CHANGE	Project has identified at least one new or expanded/improved service that it offers as a success during the reporting period. Examples include: support groups, traditional ceremonies/practices (talking circles), extended hours, aftercare/follow-up, group treatment, new/expanded counselling and case management services, equine therapy, expanded number of facilities offering services, classes (self-defense, parenting, self-care, stress management, mindfulness, art therapy), etc.
PLANNING	Project focused on planning for future program opportunities. Staff researched new strategies, engaged in networking opportunities, furthered program preparation, etc.

SMALL MEDIA	Project has developed one or more small media products or implemented a media-related activity during the reporting period and identified it as a success. Examples include: billboards, radio or television public service announcements (PSAs), radio shows, documentary development, newsletter/newspaper, brochures, posters, digital stories, and social media (e.g. Facebook).
SUCCESSFUL PROGRAMMING	Project described supporting participant progress through program activities and/or successful progression through/completion of project objectives.
HIRED NEW STAFF	Project has identified at least one new staff person (part-time, full-time or contractual) joining its MSPI project during the reporting period.
INCREASED PARTICIPATION	Project has noted an increase in community participation in MSPI sponsored activities and/or an increase in referrals to its services during the reporting period.
NEW POLICY or PROTOCOL	Project identified the development/implementation of at least one new, updated, or enhanced policy or protocol related to MSPI project aims during the reporting period. Examples include: new patient screening tools (ER and clinic), tribal suicide response protocols, new referral policies and procedures, new enforcement laws, and enhanced wrap-around and post-treatment protocols.
DATA IMPROVEMENTS	Project has identified improvements in data access or data systems related to MSPI project aims. Examples include: new electronic reporting systems, new data management system, completed needs assessment, audit of existing suicide surveillance systems, improved coding, database development, data reports, and development of a suicide surveillance initiative.
OTHER	The “other” category included unique successes reported by five or fewer MSPI projects during the reporting period. These included: enhanced opportunities for youth in community; enhanced ability to provide transportation; external presentation; good location; increased community awareness; increased local language use; leveraged for additional funding; program recognition/award; positive community response; reduction in/no completed suicides; successful programming; and supportive parents.

PROJECT BARRIERS

Figure 12. Types of Barriers Reported among MSPI Purpose Area 4 Projects, 2016-2017

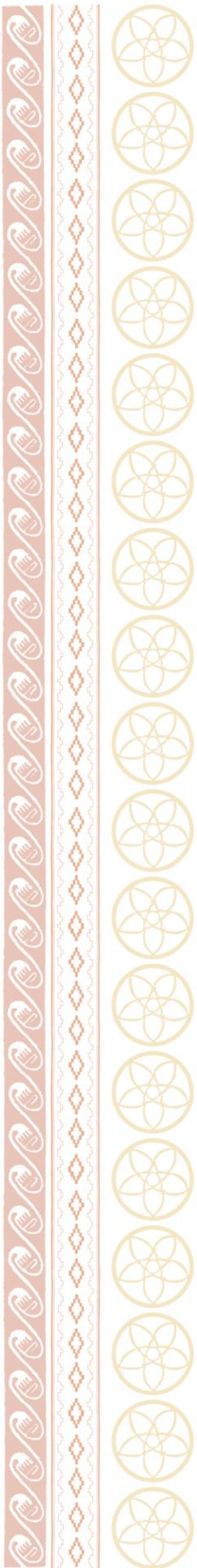


As evidenced in Figure 50, the most commonly reported MSPI Purpose Area 4 project barriers included insufficient staffing (48%), grants management (30%), high job demands (29%), and lack of participation (28%). Definitions and examples for each barrier category are provided on the following pages of this report.

Note: These data were gathered through project narratives. There were no limits on the number or type of barriers that each project could report.

Table 3: MSPI Purpose Area 4 Project Barrier Definitions	
BARRIER	**DEFINITION**
INSUFFICIENT STAFFING	Project identified a lack of staff within its MSPI project as a barrier during this reporting period. This barrier category included staff turnover, difficulty recruiting for vacant positions, lack of qualified applicants (education, certifications, AI/AN), and understaffing, where existing staff are burdened with excessive job duties due to insufficient staffing.
INSUFFICIENT RESOURCES	Project cited a lack of funding or poor infrastructure as barriers to meet high local demand for services and activities.
LACK OF PARTICIPATION	Project cited insufficient community participation/support in project services and/or activities as a significant challenge.
TRANSPORTATION/ DISTANCE	Project identified rurality, insufficient transportation, large geographic service areas, and/or excessive travel times as major challenges to the delivery of project services and patient access to these services.
POOR COLLABORATION	Project identified gaps or challenges in collaboration and/or coordination with other agencies/departments as a significant barrier during this reporting period. The most commonly cited entities included schools, law enforcement, clinics/hospitals (including IHS), and other tribal agencies/departments.
GRANTS MANAGEMENT	Project noted challenges with grants management including local bureaucracies, new directives from tribal administration, long delays in securing procurement and contract approval, poor record keeping, and challenges in procuring needed equipment and training.
HIGH DEMANDS	Project identified high demands (staff and partners) as a barrier to optimal service delivery and routine meeting/coalition participation. High demands encompass competing priorities, busy schedules, excessive workload, difficulties coordinating schedules with partners, and situations where the need for services exceeded local capacity.
DATA CHALLENGES	Program noted poor access to relevant/reliable data or insufficient local data management systems/IT capacity as significant challenges.

STIGMA	Program cited the ongoing stigmatization of mental health concerns among community members as a program barrier. In some instances, programs noted that stigma limits open discussion about these topics in community settings.
OTHER	The "other" category included unique challenges reported by five or fewer MSPI projects during the reporting period. These included: completed suicide/suicide cluster; difficulties inherent to target population; external requirements/infrastructure; insufficient matched pairs for evaluation; restriction in purchasing food; limited uptake of program information; lack of family/social support; limited space/capacity; local requirements/infrastructure; and weather.

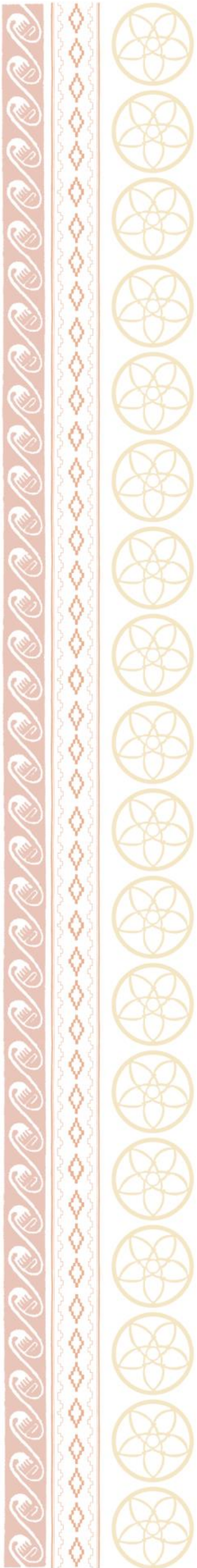


SECTION 8: MSPI PURPOSE AREA 1 ONLY

MSPI PURPOSE AREA 1: BRIEF PROGRESS REPORT 2016-2017

Due to the small number of MSPI Purpose Area 1 projects (n=3), there was not sufficient power to complete a separate analysis of progress report data for this purpose area. General trends reported included the following:

- The average number of partners identified among projects was 6, with a range of n=2-10.
- Common partner types included behavioral health programs, schools, courts, law enforcement, other tribes, other tribal organizations and programs, and churches.
- No formal MOUs were established between MSPI Purpose Area 1 projects and these partners during this reporting period.
- Two projects experienced some staff turnover during the reporting period, and two projects were able to hire new staff.
- Key accomplishments identified included:
    - Community events
    - Staff training
    - Partnerships
    - Data improvements
    - Development of products
    - Successful plan development
- Key barriers identified included:
    - Staff turnover
    - Data challenges
    - Busy schedules impacting project meeting attendance among partners
    - Grants management concerns



APPENDIX: PROJECTS REPORTING

MSPI PROJECTS REPORTING 2016-2017

Purpose Area 1

Catawba Service Unit

Mashpee Wampanoag Tribe

Otoe - Missouria Tribe

Purpose Area 2

Alaska Native Tribal Health ConsortiumA5:A22

Aleutian Pribilof Islands Association, Inc.

American Indian Health Service of Chicago, Inc.

Blackfeet Tribal Health Department

Bristol Bay Area Health Corporation

California Rural Indian Health Board, Inc.

Cass Lake Hospital

Cheyenne River Sioux Tribe

Chickasaw Nation

Chinle Comprehensive Health Care Facility

Choctaw Nation of Oklahoma

Chugachmiut

Confederated Salish & Kootenai Tribes

Confederated Tribes of Warm Springs

Council of Athabascan Tribal Governments

Eastern Aleutian Tribes

Feather River Tribal Health, Inc.

First Nations Community Health Source

Fort Thompson Service Unit

Gila River Health Care

Hualapai Indian Tribe

Kickapoo Tribe of Oklahoma

Little Traverse Bay Bands of Odawa Indians

Marimn Health

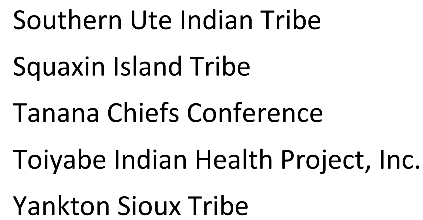
Mississippi Band of Choctaw Indians

Muscogee Creek Nation

Native American Rehabilitation Association of the Northwest, Inc.
Northern Arapaho Tribe
Northwest Portland Area Indian Health Board
Norton Sound Health Corporation
Oklahoma City Area Office
Phoenix Indian Medical Center
Ponca Tribe of Indians of Oklahoma
Pueblo of Sandia
Puyallup Tribe of the Puyallup Reservation
Reno-Sparks Indian Colony
Rosebud Sioux Tribe
Salt River Pima-Maricopa Indian Community
Shoshone-Bannock Tribes
South Dakota Urban Indian Health, Inc.
Southcentral Foundation
Tulalip Tribes of Washington
Utah Navajo Health System
Ute Mountain Ute Tribe
Yukon-Kuskokwim Health Corporation

Purpose Area 3

Bad River Band of Lake Superior Tribe of Chippewa Indians
Bemidji Area Office
Cherokee Nation
Crow Tribe of Indians
Indian Health Council, Inc.
Kodiak Area Native Association, Inc.
Muscogee Creek Nation
Oklahoma City Indian Clinic
Pascua Yaqui Tribe
Pyramid Lake Paiute Tribe
Rocky Boy Band of Chippewa Indians
Salt River Pima-Maricopa Indian Community
San Diego American Indian Health Center
Sisseton Wahpeton Oyate



Southern Ute Indian Tribe

Squaxin Island Tribe

Tanana Chiefs Conference

Toiyabe Indian Health Project, Inc.

Yankton Sioux Tribe

Purpose Area 4

Amercian Indian Association of Tucson, Inc.

American Indian Health and Family Services of SE Michigan, Inc.

Aroostook Band of Micmacs

Bakersfield American Indian Health Project

Bay Mills Indian Community

Chinle Comprehensive Health Care Facility

Choctaw Nation of Oklahoma

Citizen Potawatomi Nation

Confederated Salish & Kootenai Tribes

Confederated Tribes of Grand Ronde

Cook Inlet Tribal Council

Copper River Native Association

Cow Creek Band of Umpqua Tribe of Indians

Crow Tribe of Indians

Crownpoint Health Care Facility

Delaware Tribe of Indians

Eastern Shawnee Tribe of Oklahoma

Eight Northern Indian Pueblos, Inc.

Elko Service Unit - Southern Bands Health Clinic

Fairbanks Native Association

Five Sandoval Indian Pueblos, Inc.

Fort Defiance Indian Hospital

Fort Peck Assiniboine & Sioux Tribes

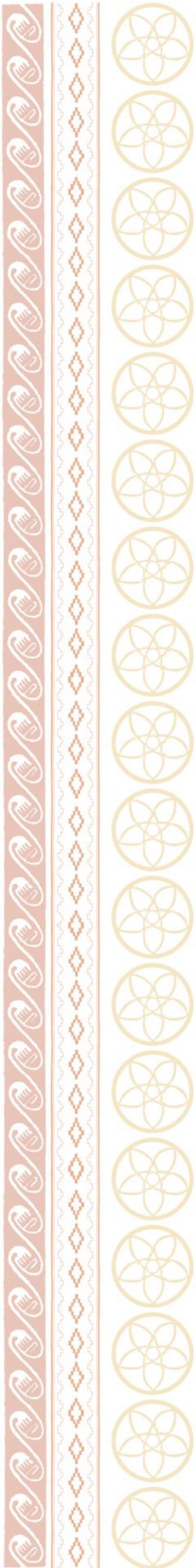
Fresno American Indian Health Project

Friendship House Association of American Indians

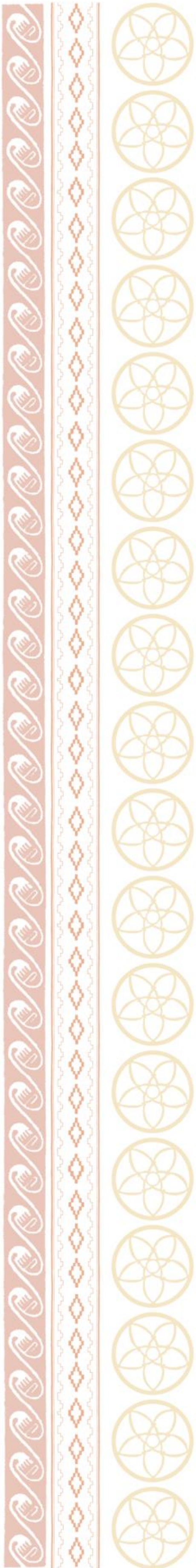
Gallup Indian Medical Center

Gerald L. Ignace Indian Health Center, Inc.

Grand Traverse Band of Ottawa & Chippewa Indians



Hoh Indian Tribe
Hualapai Indian Tribe
Indian Health Board of Minneapolis
Indian Health Care Resource Center - Tulsa
Indian Health Center, Inc. (Lincoln, NE)
Iowa Tribe of Kansas and Nebraska
Kenaitze Indian Tribe
Keweenaw Bay Indian Community
Kiowa Tribe of Oklahoma
Kodiak Area Native Association, Inc.
Lac Courte Oreilles Band of Lake Superior Chippewa
Makah Indian Tribe
Maniilaq Association
Native Americans for Community Action, Inc.
Navajo Nation Department of Behavioral Health Services
Navajo Nation Department of Social Services
Nebraska Urban Indian Health Coalition
Nevada Urban Indians, Inc.
Northeastern Tribal Health System
Northern Cheyenne Tribe
Northwest Portland Area Indian Health Board
Oglala Sioux Tribe
Ohkay Owingeh Tribal Council
Oklahoma City Indian Clinic
Omaha Tribe of Nebraska
Osage Nation
Paiute Indian Tribe of Utah
Passamaquoddy Indian Township
Pawnee Tribe of Oklahoma
Pinoleville Pomo Nation
Ponca Tribe of Nebraska
Pribilof Islands Aleut Community of St. Paul Island
Pueblo of Acoma
Pueblo of Isleta
Pyramid Lake Paiute Tribe



Quileute Tribal Council
Ramah Navajo School Board, Inc.
Red Lake Band of Chippewa Indians
Riverside-San Bernardino County Indian Health, Inc.
Rocky Boy Health Board
Saint Regis Mohawk Tribe
San Pasqual Band of Mission Indians
Santee Sioux Nation
Santo Domingo Tribe
Seattle Indian Health Board
Sherman Indian School Clinic
Sisseton Wahpeton Oyate
SouthEast Alaska Regional Health Consortium
Southern Indian Health Council, Inc.
Southern Ute Indian Tribe
Spirit Lake Tribe
Taos Pueblo Central Management System
Tohono O'odham Nation
Tonkawa Tribe of Indians of Oklahoma
Tuba City Regional Health Care Corporation
Tulalip Tribes of Washington
Turtle Mountain Band of Chippewa Indians
United American Indian Involvement, Inc. (Los Angeles)
Western Oregon Service Unit - Chemawa Indian Health Center
White Earth Band of Chippewa Indians
Winnebago Tribe of Nebraska
Winslow Indian Health Care Center
Wyandotte Nation