American Indian/Alaska Native

SUICIDE PREVENTION REPORT

2010-2011

Division of Behavioral Health

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CONTENTS

PREFACE

This report describes the unprecedented efforts of the Indian Health Service (IHS), the Bureau of Indian Affairs (BIA), the Bureau of Indian Education (BIE), the Substance Abuse and Mental Health Services Administration (SAMHSA), and other federal agencies—all working in unison—to address the problem of suicide in Indian Country during 2010 and 2011. The report is divided into the following sections.

- The **Impact of Suicide and Its Causes** section details the trends in suicide among youth and other age groups and points to causes of suicide in Indian Country.
- The **Power of Collaboration** section explains the cooperative strategy for suicide prevention initiated by IHS, BIA, BIE, SAMHSA, and others during 2010 and 2011.
- The **Listening to Tribes and Villages** section shows how IHS, BIA, BIE, and SAMHSA have worked to gather input about the needs and priorities for suicide prevention and treatment in Indian Country. It describes the 10 tribal listening sessions held throughout Indian Country and the 2011 Senate oversight hearings in Montana and Alaska on Native youth suicide.
- The **Voices from the Listening Sessions** section shares selected stories and testimony from the listening sessions.
- The **Action Summits for Suicide Prevention** section reports on two national gatherings of recognized speakers, behavioral health providers, tribal leaders, health care providers, first responders, and many others.
- The **American Indian/Alaska Native National Suicide Prevention Strategic Plan** section introduces the IHS national strategic plan created in consultation with tribes and villages.
- **Appendix A: Regional Recommendations** summarizes regional recommendations from the listening sessions.
- **Appendix B: Discussion Questions from Tribal Listening Sessions** lists discussion questions from the listening sessions.

EXECUTIVE SUMMARY

Despite the strengths of American Indian and Alaska Native (AI/AN) families and communities, suicide remains a devastating and all too frequent event. Suicide among AI/AN youth ages 15 to 24 was 3.7 times the national average in 2002 through 2004, and it is the second leading cause of death.

Complex, interrelated factors contribute to an increased suicide risk among AI/AN populations. Risk factors include mental health disorders, substance abuse, intergenerational trauma, and community-wide issues. Research suggests that factors that protect AI/AN youth and young adults against suicidal behavior are a sense of belonging to their culture, a strong tribal/spiritual orientation, the opportunity to discuss problems with family or friends, a feeling of connection to their family, and positive emotional health.

Cooperation among tribal, federal, and other partners is imperative. At the federal level, the different agencies that address health, social services, education, and infrastructure for AI/AN communities recognize the need to work together to prevent suicide. The Department of Health and Human Services (HHS), the Department of Justice (DOJ), and the Department of the Interior (DOI) have agreed to improve coordination among the federal agencies that implement the Indian Alcohol and Substance Abuse Prevention and Treatment Act.

This interdepartmental agreement set up a framework for federal-tribal coordination, stated the roles and responsibilities of federal agencies, and created the foundation for implementing the Tribal Law and Order Act. The 2009 reauthorization of the Indian Health Care Improvement Act mandated other cooperative opportunities in substance abuse prevention and behavioral health.

Listening Sessions

In 2010 and 2011, the IHS, BIA, BIE, and SAMHSA joined together to begin new cooperative approaches in suicide prevention, beginning with hosting 10 tribal listening sessions around the country. The agencies sought input through facilitated discussions on how to work most effectively with AI/AN communities to prevent suicide. Individuals gave testimony about the impact of suicide on themselves and local communities, about the causes of suicide, and about the obstacles in trying to prevent suicide. “I believe that suicide is a bleeding wound in our community, as it is in almost every community in Indian Country,” one person remarked.

The listening sessions produced a wide range of recommendations and observations, which, in general, focused on five areas: contributing factors, reimbursement and funding, behavioral health staffing, improvement of services, and communication and coordination.

In addition to the IHS-BIA-BIE-SAMHSA listening sessions, the Senate Committee on Indian Affairs held two oversight hearings in Poplar, Montana, and Anchorage, Alaska, in 2011, on preventing suicide among Native youth. These hearings focused on contributing factors and the need for federal cooperation in addressing the problem.

Action Summits

One specific outcome of the listening sessions was the development of agendas for two Action Summits for Suicide Prevention in 2011: one in Scottsdale, Arizona, which attracted participants from the lower 48 states, and one in Anchorage, Alaska, which focused primarily on suicide and prevention efforts in Alaska. Sponsored

by the same four agencies that held the listening sessions, the Action Summits produced new research about suicide in Native communities, culturally relevant models for suicide prevention, national strategies for suicide prevention and behavioral health, and opportunities for collaboration.

IHS released the AI/AN National Suicide Prevention Strategic Plan, 2011–2015, and the AI/AN National Behavioral Health Strategic Plan, 2011–2015, at the Action Summit in Scottsdale. The suicide prevention strategic plan emphasizes culture as both prevention and treatment, and supports a holistic strategy for suicide prevention, while the behavioral health strategic plan advocates integrating mental health approaches with primary health care. Both documents were the products of extensive collaboration with three advisory groups: the IHS National Tribal Advisory Committee on Behavioral Health, the IHS Behavioral Health Work Group, and the IHS Suicide Prevention Committee.

HHS, DOI, and other departments launched the National Action Alliance for Suicide Prevention in 2010. This public-private partnership is advancing awareness, prevention, training, and research on suicide prevention at the highest levels. The Action Alliance focuses on high-risk populations through specialized task forces, and the AI/AN Task Force is led by Deputy Bureau Director, Office of Indian Services, BIA Hankie Ortiz; IHS Division of Behavioral Health Director, Dr. Beverly Cotton; and the National Indian Youth Leadership Project Executive Director, McClellan Hall.

IMPACT OF SUICIDE AND ITS CAUSES

Suicide rates have continued to rise in the AI/AN population, in spite of existing suicide awareness and prevention efforts. While the numbers are alarming, suicide, mental health disorders, and other behavioral health issues are still underreported and under researched in AI/AN communities. More health data is greatly needed to support suicide awareness and prevention efforts in Indian Country.

Suicide Rates

Suicide mortality is 74.3% greater in AI/AN populations compared to the U.S. all-races rate of 10.9% for 2005-2007.[1] Suicide mortality is growing; it increased from 15.2 per 100,000 in 1999–2001 to 19.8 per 100,000 in 2004–2006.[2]

During 2005–2007, the suicide rate for AI/ANs was 1.7 times greater than the U.S. all-races rate for 2006 (19.0 vs. 10.9 per 100,000).[1]

During 2006–2008, the percentage of all AI/AN deaths from suicide were 100 % higher than the percentage of U.S. all-races deaths from suicide; 2.8% of all AI/AN deaths in that period were by suicide, compared to 1.4% of all-races deaths.[3]

In 2004–2006, unadjusted suicide rates for Alaska Native males of all ages was 4 times the rate for U.S. all-races population.[1]

Youth Suicide

Suicide among AI/AN 15- to 24-year-olds makes up 64% of all suicides in Indian Country,[4] and it is the second leading cause of death for AI/AN 15- to 24-year-olds.[5]

While AI/AN males ages 15 to 24 are at highest risk for suicide completion, the group at the highest risk for suicide attempts is females of the same ages, indicating the prevalence of the same risk factors in the lives of young women.[6]

Suicide among AI/AN 15- to 24-year-olds was 3.7 times the national average in 2002–2004. Among AI/AN 15- to 24-year-olds, mortality rates increased from 28.5 per 100,000 in 1999–2001 to 39.1 per 100,000 in 2004–2006 (Table 1).

In 2004 to 2006, Alaska had the highest suicide mortality rate among AI/AN 15- to 24-year-olds (107.8 per 100,000), followed by the IHS Aberdeen Area (74.6 per 100,000) and the IHS Tucson Area (59.3 per 100,000). Although the IHS Navajo Area had the fourth highest suicide rate for 15- to 24-year-olds in 2004 to 2006 (42.9 per 100,000), this rate was still more than 4 times greater than the U.S. all-races rate for this age group (10.0 per 100,000). Table 1 shows the suicide rate per 100,000 population for each IHS Area from 1999 to 2006, as well as the rate for all IHS Areas and the U.S. all-races rate for the same years.

Table 1: CY Suicide Rates in IHS Areas and Entire Country (per 100,000): *Ages 15–24*

Area Name	1999–2001	2000–2002	2001–2003	2002–2004	2003–2005	2004–2006
Aberdeen	42.0	42.1	46.7	61.8	67.6	74.6
Alaska	99.7	112.9	102.8	119.4	106.0	107.8
Albuquerque	36.1	26.0	11.0	14.3	17.4	15.2
Bemidji	21.1	30.2	30.5	37.1	40.6	38.2
Billings	43.1	20.8	17.0	21.6	39.0	35.4
California	6.8	7.5	10.3	17.0	19.5	23.8
Nashville	6.4	2.0	5.6	5.4	8.9	6.9
Navajo	28.4	27.3	33.0	34.5	38.0	42.9
Oklahoma	14.9	20.6	20.0	25.3	27.4	34.0
Phoenix	32.3	39.5	40.6	34.8	31.2	29.4
Portland	27.3	23.1	21.1	25.3	22.7	30.2
Tucson	26.7	20.9	25.8	30.5	60.2	59.3
All IHS Areas	28.5	29.6	29.6	34.3	36.2	39.1
U.S. All Races	10.2	9.9	9.9	9.7	10.3	10.0

Of great public health concern are the alarming rates of suicide mortality among AI/ANs at the extremely young ages of 5 to 14: 15.3 per 100,000 for the IHS Tucson Area; 12.2 per 100,000 for the IHS Aberdeen Area; 5.8 per 100,000 for the IHS Alaska Area; and 5.6 per 100,000 for the IHS Navajo Area. In comparison, the U.S. all-races rate was 0.7 per 100,000 for this age group over the same time period. Suicide rates per 100,000 population for ages 5 to 14 are shown in Table 2 for each IHS Area, plus combined IHS Areas rate and the U.S. all-races rate.

Table 2: CY Suicide Rates in IHS Areas and Entire Country (per 100,000): *Ages 5–14*

Area Name	1999–2001	2000–2002	2001–2003	2002–2004	2003–2005	2004–2006
Aberdeen	5.2	5.3	4.0	4.0	9.5	12.2
Alaska	2.7	1.3	0.0	2.7	2.8	5.8
Albuquerque	5.1	5.1	3.4	1.7	1.8	1.8
Bemidji	0.0	0.0	0.0	0.0	1.5	1.6
Billings	0.0	0.0	2.6	2.6	2.7	2.7
California	0.0	0.0	0.0	0.0	0.0	0.0
Nashville	0.0	0.0	0.0	0.0	0.0	0.0
Navajo	3.8	5.7	5.2	5.3	5.5	5.6
Oklahoma	0.0	0.0	2.1	2.1	2.1	2.1
Phoenix	1.1	1.8	2.6	0.9	1.8	2.7
Portland	1.0	1.0	0.0	1.0	1.0	2.0
Tucson	4.9	9.8	14.8	9.9	15.0	15.3
All IHS Areas	1.8	2.1	2.3	2.2	2.9	3.6
U.S. All Races	0.7	0.7	0.6	0.6	0.7	0.7

Given the data, current suicide prevention efforts should be expanded to include age-appropriate prevention, intervention, and postvention for an increasingly younger AI/AN population at risk for suicide and suicide-related behaviors.

Suicide Clusters and Suicide Contagion

Some communities face outbreaks of suicide and suicide attempts that take on a frightening and seemingly contagious form, where communities affected by suicide deaths report dozens of additional deaths and attempts that sometimes reach into the hundreds, according to tribal leadership testimony before the U.S. Senate Committee on Indian Affairs.

Suicide contagion occurs when exposure to suicide, suicidal behaviors, or other unexpected deaths influences others to attempt or complete suicide. Teenagers and young adults are at highest risk for suicide contagion, and experimentation with drugs or alcohol can increase their vulnerability.

Suicide clusters are the occurrence of more suicide attempts or deaths by suicide in a given time period than would be expected for a community.[7] Suicide clusters can be sparked by unintentional deaths due to accidents or violence, and deaths by suicide.

Contributing Factors and Related Issues

In the discussion of suicide as a behavioral health problem, it is important to recognize risk factors at all ages and the need for comprehensive, integrated solutions across communities and generations, even as strategies for suicide prevention and appropriate treatment may also be specially adapted for relevance to certain groups, such as AI/AN teenagers and young adult men.

Risk factors for increased suicide among Native populations can include mental health disorders, substance abuse, intergenerational trauma, and community-wide issues, such as health provider shortages.

Mental Health Disorders

The HHS Office of Minority Health reports that AI/ANs experience higher rates than all races generally in the following areas: serious psychological distress; feelings of sadness, hopelessness, and worthlessness; feelings of nervousness or restlessness; and suicide.[7]

AI/ANs are overrepresented among high-need populations requiring mental health services (e.g., people who are homeless or incarcerated, drug and alcohol abusers, persons exposed to trauma, and children who are in foster care).[8]

In more than 120 studies of a series of completed suicides, at least 90% of the individuals involved were suffering from a mental illness at the time of their deaths,[9] demonstrating the important role that mental health disorders and mental health care can play in reducing suicide risk.

Substance Abuse

AI/AN adults have a 30.6% rate of past-month binge drinking, compared to the national average of 24.5%.[10] According to 2007 data from the National Survey on Drug Use and Health, 12.6% of AI/ANs ages 12 and older have had an illicit drug use disorder in the past year—more than any other race or ethnicity.[11]

Community-Wide Solutions

Because of the wide range of risk factors, suicide prevention must include a public health approach with community-wide solutions. In addition, virtually all aspects of a community are touched by a suicide attempt or death: parents, first responders, health care providers and emergency room workers, law enforcement, schools, and the community at large. Effective suicide prevention, intervention, and postvention must, therefore, involve a broad range of community stakeholders.

Protective Factors

To reduce suicidal risk, increasing protective factors is equally or more effective than decreasing risk factors. Research suggests the factors that protect AI/AN youth and young adults against suicidal behavior are their sense of belonging to their culture, a strong tribal/spiritual orientation, the opportunity to discuss problems with family or friends, their feeling of connection to their family, and positive emotional health.

THE POWER OF COLLABORATION

At the federal level, different agencies address health, social services, education, and infrastructure for AI/AN communities. Tribes have requested that federal agencies work together more holistically and effectively to improve access and enhance implementation of these programs at the community level. Federal agencies also recognize the need to collaborate with each other on interconnected issues. Cooperation among tribal, federal, and other partners is imperative to maximize the effectiveness of services.

Working with tribes, villages, and each other, the IHS, BIA, BIE, and SAMHSA plan to weave a safety net of interconnected programming to address health, education, law enforcement, public health and safety, economic development, and physical and behavioral health including substance abuse. These are facets of community life that can play a part in protecting individuals against suicide risk.

Agency collaboration maximizes the impact of existing groups, such as the IHS Suicide Prevention Committee, the U.S.-Canada Suicide Prevention Working Group, and the Federal Partners for Suicide Prevention Workgroup. Federal partnership also creates new frameworks, such as the National Action Alliance for Suicide Prevention.

Recent legislation has mandated federal cooperation as well. The Tribal Law and Order Act of 2010 (TLOA) called for a memorandum of agreement between HHS, DOJ, and DOI to improve coordination among the federal agencies in carrying out the Indian Alcohol and Substance Abuse Prevention and Treatment Act. The memorandum of agreement creates a framework for interagency and tribal coordination; it establishes the roles and responsibilities of the federal agencies and sets the foundation for further implementation of the TLOA. The 2009 reauthorization of the Indian Health Care Improvement Act mandated other cooperative opportunities in substance abuse prevention and behavioral health.

The spirit of interagency-tribal collaboration in 2010 to 2011 led to wide-ranging listening sessions, action-oriented conferences, and national strategies that are now being implemented by all partners.

LISTENING TO TRIBES AND VILLAGES

Federal cooperation on suicide prevention has its roots in listening and responding to requests from AI/AN communities for programs and services that work together. The mission of each agency is grounded in: (1) consultation, (2) a commitment to listening to tribes, (3) working in partnership with tribes and villages to support them in improving health status, (4) acknowledging sovereignty, and (5) promoting self-determination. The first step was to seek first-hand knowledge from AI/AN communities to identify the specific needs expressed by tribal and village community leaders, clinicians, practitioners, and youth.

10 Tribal Listening Sessions

Following the launch of the National Action Alliance for Suicide Prevention in September 2010, the IHS, BIA, BIE, and SAMHSA announced they would jointly hold 10 tribal listening sessions on suicide and suicide prevention across Indian Country. The overall goal of the listening sessions was to seek input on how these federal agencies can most effectively work in partnership with AI/AN communities to prevent suicide. One specific outcome planned for the listening sessions was to receive input on the development of a national conference on suicide awareness and prevention to be held in 2011 (which resulted in the **Action Summits for Suicide Prevention**).

Logistics of the Listening Sessions

Listening session dates and locations were announced in mid-November 2010. The sessions were open to the public and held in 10 BIA administrative regions. (IHS and BIA use different regional configurations to administer their programs and services. Refer to the map in Figure 1 to see the BIA regions and the locations of the listening sessions.)

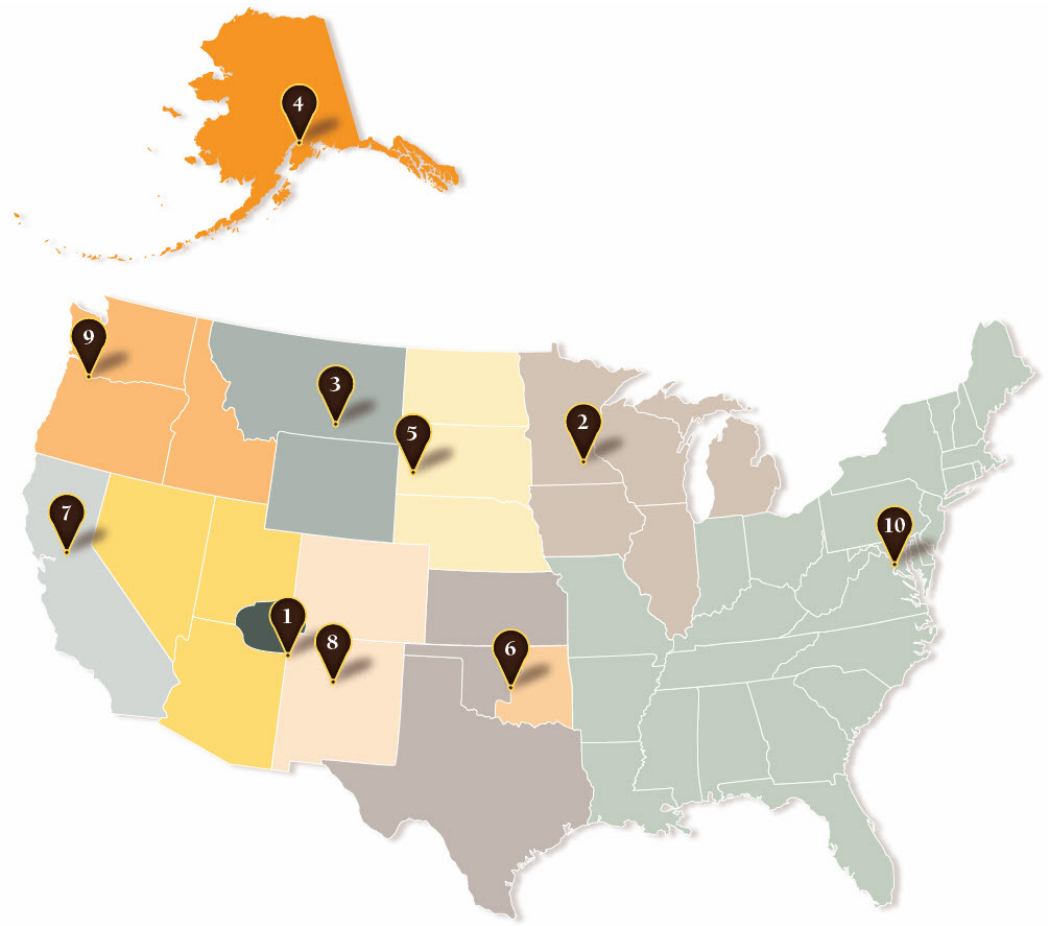
Each listening session had a broad representation from each community. Attendees included federal and state officials, local stakeholders, tribal leaders, parents, health care workers, education professionals, and law enforcement officials. Representatives from IHS, BIA, BIE, and SAMHSA listened directly to all comments and testimony offered. Many of the listening sessions were also attended by representatives from the Department of Veterans Affairs.

Overall, the listening sessions were well attended, with the Alaska listening session drawing 200 attendees, the most of any session.

The format of the listening sessions was a facilitated discussion, and participants were given a list of questions to begin the discussion. The questions were intentionally broad to elicit a wide range of input on suicide and related issues, while remaining consistent with a holistic view of health. The discussion questions were also designed to gain specific recommendations on how federal partners can best support the programs and resources that tribes and villages need as well as how to increase federal cooperation with tribal, state, and local authorities. Many participants provided comments, personal stories, testimony, and recommendations. (**Voices from the Listening Sessions** includes representative highlights from the comments and testimony. See **Appendix B: Discussion Questions from Tribal Listening Sessions** for a list of the discussion questions.)

Summaries were created from session notes and transcripts and then synthesized into general and common recommendations. These recommendations will guide the ongoing joint suicide prevention activities of IHS, BIA, BIE, and SAMHSA, and will shape the agenda and objectives of national AI/AN suicide prevention efforts.

Figure 1: Tribal Listening Sessions on Suicide and Suicide Prevention in Indian Country



1 NAVAJO REGION
Window Rock, AZ
November 15, 2010

2 MIDWEST REGION
Prior Lake, MN
November 19, 2010

3 ROCKY MOUNTAIN REGION
Billings, MT
November 23, 2010

4 ALASKA REGION
Anchorage, AK
November 30, 2010

5 GREAT PLAINS REGION
Rapid City, SD
December 2, 2010

6 SOUTHERN PLAINS/ EASTERN OKLAHOMA REGION
Oklahoma City, OK
December 13, 2010

7 PACIFIC REGION
Sacramento, CA
December 21, 2010

8 SOUTHWEST REGION
Albuquerque, NM
January 10, 2011

9 NORTHWEST REGION
Portland, OR
January 12, 2011

10 EASTERN REGION
Arlington, VA
February 10, 2011

VOICES FROM THE LISTENING SESSIONS

The statements below, gathered from the listening sessions, tell the story of suicide and its contributing factors in the words of attendees.

I believe that suicide is a bleeding wound in our community, as it is in almost every community in Indian Country.

I met a young man who said that he'd lost 13 friends to suicide. This young man was 15 years of age—that's a friend for almost every year of his life.

We average one to two suicide deaths per month on my reservation on a pretty regular basis. One of them was as young as six years of age. Six years old. What in life could be so bad at the age of six that you want to depart this world?

I know that many of our young people are troubled by suicide, but it hurt my ears when I heard that those of the older generation are contemplating the same problem.

When our children are removed from the home and put in non-Indian homes, the kids lose their culture and their traditions. They lose all of their family, not just … the ones who are being bad. Families are torn apart, and no one cares enough to find an appropriate place for the kids to go, like to relatives. Some people whose children are taken end up taking their lives because they can't deal with the pain

Being taken away from your family stays with you forever. It's like PTSD from Vietnam; it's like when I was taken away to boarding school, and that pain gets carried on down through the family.

When we focus on veterans in our health programs, we know we must focus on the kids and spouses, too, because when a veteran comes home from war, they carry a lot of this with them, and sometimes they can be really hard on their children and their mates.

Both of these young men who had made suicide attempts were students at our tribal school, but they weren't successful there, and consequently, they went away feeling that they didn't have any value. Both of them excelled in cultural activities, in art, in the things they could do with their hands. They didn't read well. Math was boring to them, the way it was presented, as were European history, State of Washington history, all those subjects they were failing in. That sense of failure, of hopelessness and uselessness is such a deep thing. The more people tell you that you can't, the more you come to believe it, until you come to the place where you say "What's the use? I can't do it anyway."

Some of our tribal enterprises are selling things that are detrimental to our health. We make a fortune on the fireworks, but look at the damage we get from our children getting burned, tourists coming and shooting up our cattle and our resources. The products in our smoke shops are high-fructose corn syrup products, the junk food and energy drinks that are causing health problems for our kids. Instead of Native arts and crafts, we sell low-cost, made-in-China products that are easy to purchase, but they really represent a lack of self-identity for our people.

The biggest thing on our reservation is that there are no jobs. There's a lot of hopelessness out there because of the economy, and that leads to suicide.

We're carrying all this historical grief with us today—to this day. Our children are going to inherit it from us unless we deal with it.

I believe we need to address all the healing aspects of the medicine wheel philosophy. Only this will encompass a whole being. Oftentimes, only a portion of our lives are looked at in existing tribal programs—only mental health, or physical health, instead of our whole selves

I see the positive effects of cultural activities; when we come out of the sweat lodge, I see how calm those kids are

We need help to get back to the basics of being an Indian person again. The young people on my reservation, especially—they need that help.

I want our young people to have the fortitude and the mind to protect those things that my forefathers believed were important 155 years ago because they're still important today; they're important to me. I want them to be important to my children and my grandchildren.

How do you make talking about suicide a conversation that people aren't afraid to have? How do you open the dialogue and express that, yes, people do think about hurting themselves, but that's not the only option there is?

Outcomes from the Listening Sessions

Testimony given at the listening sessions was summarized into regional and general recommendations.

General Recommendations

Five fundamental concerns emerged about current suicide prevention efforts: contributing factors, reimbursement and funding, behavioral health staffing, service improvement, and communication and coordination.

1. CONTRIBUTING FACTORS

Recommendations

- Disseminate information on the factors known to contribute to the risk of suicide, and address these factors in overall suicide prevention planning.
- Provide additional funding to address problems, such as substance abuse and domestic violence, which can contribute to suicide.
- Increase mentor-type programs to broadly address contributing factors and provide support for youth.
- Provide training on addiction and mental health resources that incorporate cultural influences, such as constant communication with elders, attending and participating in ceremonies, and the teaching of Native languages.

Rationale

- Suicide is a public health issue with many different contributing factors, including alcoholism and substance abuse of all types. Effective suicide prevention takes into account these contributing factors and addresses them in a holistic and culturally relevant manner.

2. REIMBURSEMENT AND FUNDING

Recommendations

- Provide or leverage sustained funding to address prevention, intervention, treatment, and postvention needs for suicide.
- Recognize and reimburse traditional healing practices and practice- or culture-based treatment in existing funding sources.
- Streamline funding application processes so that less funding goes to administration and more funding goes to local programs for services

Rationale

- Many prevention services, especially those that are culture or tradition based, are not currently billable or reimbursable. Therefore, supplemental funding is needed to develop programs for prevention, intervention, and postvention. While some tribes and villages receive grant funding targeted toward these needs, many do not have the technical and human resources to continue programs beyond the grant period. Many funders require evidence-based practices, but these practices have rarely been based in AI/AN communities, and they do not measure or represent the efficacy of traditional cultural practices.

3. BEHAVIORAL HEALTH STAFFING

Recommendations

- Increase the availability of behavioral health staff trained in suicide and suicide-related prevention and intervention in Indian Country.
- Provide suicide prevention, intervention, and postvention training for health care providers, school and law enforcement staff, elders, and tribal leaders.
- Incorporate traditional healing practices in services provided.

Rationale

- There is a lack of culturally competent behavioral health professionals trained in suicide-related treatment modalities. The behavioral health staff currently available is not equipped or trained to respond to suicide epidemics in Indian Country.

4. IMPROVEMENT OF SERVICES

Recommendations

- Provide transportation services for clients to access behavioral health services.
- Increase telepsychiatry services to extend the reach of behavioral health care into geographically remote communities.
- Supply psychiatric inpatient services to provide dual-diagnosis treatment that addresses both a mental health and substance use disorder at the same time.
- Provide services that offer a strong commitment to families and promote resilience through culture.
- Provide positive parenting classes, education, and other parenting support programs.
- Provide safe houses in communities.
- Provide a 24-hour, 7-day-a-week crisis team in every community.
- Provide an AI/AN-specific 24-hour hotline to offer early response for youth in crisis.

Rationale

- Many specific suicide prevention services are needed in AI/AN communities across the nation.

5. COMMUNICATION AND COORDINATION

Recommendations

- Assist AI/AN communities and other stakeholders in communicating and enhancing collaboration for suicide prevention.
- Launch a national media campaign on AI/AN suicide prevention using more social media.

- Hold an AI/AN suicide prevention summit at the national level and in Alaska to focus on sharing best or promising practices, including Project Venture, Wellness Warriors, Healing Circles, White Bison Wellbriety, Youth Ambassadors, Suicide Task Force, SEEDS (Suicide Ends through Education and Socialization), American Indian Life Skills, and Native Youth Council.

Rationale

- Communication and coordination of activities and resources among federal, state, private sector, county, and community-based programs need to improve to provide needed services in partnership with tribes and villages.

Regional Recommendations

Recommendations specific to particular regions are summarized in **Appendix A: Regional Recommendations**. Differing geography, cultures, and history between regions may influence factors related to suicide.

2011 Senate Oversight Field Hearings

Congress also listened to tribes and villages. In 2011, the Senate Committee on Indian Affairs (SCIA) held two field hearings on suicide prevention and Native youth. The first SCIA field hearing was held August 9 in Poplar, Montana, on the Fort Peck Reservation. The second was on October 22 in Anchorage, AK.

Committee members heard testimony from experts, government officials, tribal leaders, and regional organizations about suicide, the wide range of contributing risk factors, and suicide prevention and intervention needs. The goal of the hearings was to share information with lawmakers to help them design effective, informed policy to comprehensively address the causes and outcomes of suicide in AI/AN communities. The hearings represented a commitment on the part of Congress to learn from the program experience of executive agencies and from the expertise of AI/AN communities themselves about what national policies will best support suicide prevention in Indian Country.

Testimony in both hearings focused on comprehensively addressing the wide range of risk factors contributing to suicide among AI/AN youth, such as sexual abuse, poverty, substance abuse, and colonization. Panel members emphasized the need for cooperation among federal programs to address suicide in AI/AN communities, especially given the history of fragmentation among these programs, resulting in difficulty accessing care. University of Montana staff testified at the Fort Peck hearing that one of the lessons learned in suicide prevention work among Fort Peck youth was that "showing up matters." In that spirit, panelists thanked the Indian Affairs committee for "showing up here" for field hearings and shared that the community viewed the hearing as a positive development and an indication of the Committee's sincere concern for the problems faced in Indian Country.

ACTION SUMMITS FOR SUICIDE PREVENTION

IHS, BIA, BIE, and SAMHSA sponsored two Action Summits for Suicide Prevention in 2011—one in Scottsdale, AZ, and the other in Anchorage, AK—to develop a strong, unified approach to suicide and substance abuse prevention. About 1,200 attendees, including behavioral health providers, tribal leaders, health care providers, law enforcement, first responders, and school personnel, were able to network with nationally recognized experts in suicide prevention and treatment. The Action Summits created a national forum to promote suicide awareness and to share information on the latest research, best practices, and promising practices in suicide and substance abuse prevention, intervention, and aftercare throughout Indian Country. The conferences were named "Action Summits" to highlight the intention to take meaningful, coordinated action for suicide prevention at the federal, state, tribal, and village levels.

Objectives and Collaboration

The idea of a national, collaborative suicide awareness conference germinated from the 10 tribal listening sessions. In the context of discussion of tribal promising practices, program needs, recommendations for collaboration, and other concerns, the following objectives for a national conference took shape:

1. Strengthen tribal, federal, state, and community partnerships;
2. Advance the AI/AN National Behavioral Health Strategic Plan, the AI/AN National Suicide Prevention Strategic Plan, and the National Strategy for Suicide Prevention;
3. Create an opportunity to collaborate, network, and share effective strategies on topics in suicide and substance abuse prevention in AI/AN communities;
4. Provide the most up-to-date information regarding best and promising practices to address suicide and substance abuse prevention, intervention, postvention, and aftercare;
5. Provide the most up-to-date research related to suicide and substance abuse;
6. Increase awareness and understanding of current and emerging suicide and substance abuse prevention programs; and
7. Provide professional development opportunities.

Another outcome of the listening sessions was the decision to add a second Action Summit in Alaska to focus on the particularly acute suicide problem facing Alaska Natives. (See **Table 1: Suicide Rates in IHS Areas and Entire Country (per 100,000): Ages 15–24.**)

While Summit sponsors IHS, BIA, BIE, and SAMHSA played a lead role, planning for the Summits also relied on representatives from tribal behavioral health programs to add the perspective of different tribes and regions across the country. The National Indian Health Board and the National Council of Urban Indian Health played important roles, along with HHS, DOJ, DOI, VA, the Centers for Disease Control and Prevention, the National Institute of Mental Health, and Health Canada, the Canadian national health department.

First Action Summit

Under the banner of "partnering with tribes to protect the circle of life," the first Action Summit for Suicide Prevention on August 1 through 4 emphasized the importance of collaboration among tribal, federal, state, and community programs for the advancement of AI/AN behavioral health. The 4-day event in Scottsdale, Arizona, drew approximately 1,000 people.

August 1: Pre-Summit

The August 1 agenda was filled with pre-Summit meetings and skill-building seminars. Practitioners learned about QPR (Question, IHS /BIA /BIE/SAMHSA Persuade, and Refer), Native HOPE (Helping Our People Endure), and other prevention and risk assessment tools. The National Tribal Advisory Committee on Behavioral Health, the Youth Regional Treatment Center Directors, the IHS Suicide Prevention Committee, the AI/AN Task Force of the National Action Alliance for Suicide Prevention, and other national committees met on August 1.

August 2-4: Awareness, Prevention, and Aftercare

The Action Summit in Scottsdale was divided into three main areas of suicide and substance abuse awareness and response: prevention and screening on August 2, intervention and treatment on August 3, and aftercare and postvention on August 4. In addition to the main focus areas, the Summit featured 12 topical workshop tracks that focused on youth, at-risk populations, clinical aspects, incident response, methamphetamine, general substance abuse, program sustainability, public health communications, and more. Participants could attend one workshop track through all 3 days or attend workshops on any topic. Workshop tracks followed the overall focus for each day, examining issues of prevention, intervention, and aftercare from the perspective of each track's topic.

Moving presentations from youth suicide prevention programs and youth-specific panels, the presentation of suicide prevention achievement awards, and informative poster sessions on local projects were some of the Action Summit's highlights. On the morning of the final day, attendees participated in a Walk for Life to remember loved ones lost to suicide and to support suicide awareness.

The AI/AN National Strategic Plans on Behavioral Health and Suicide Prevention and the AI/AN Behavioral Health Briefing Book were introduced at the Action Summit. See the **American Indian/Alaska Native National Suicide Prevention Strategic Plan** section for more information.

Action Summit sponsors showcased their programs and initiatives. SAMHSA offered workshops on emerging models of suicide prevention in AI/AN communities, the SAMHSA suicide prevention toolkit for school- based programs, and the Gathering of Native Americans/Gathering of Alaska Natives (GONA/GOAN) model and its role in the Native Aspirations program.

Second Annual Methamphetamine and Suicide Prevention Initiative Conference

The Action Summit incorporated the Second Annual Methamphetamine and Suicide Prevention Initiative (MSPI) Conference, and IHS reported on the progress of the MSPI program at the end of the program's first year. MSPI awardees and grantees networked with one another and shared experiences, successes, concerns, and promising practices. Action Summit planners carefully designed MSPI-related tracks, workshops, and presenters that would benefit MSPI awardees and grantees. Suicide and methamphetamine prevention learning labs that had been presented across the country were offered at the Scottsdale Summit. See the **Methamphetamine and Suicide Prevention Initiative** section for more.

Second Action Summit

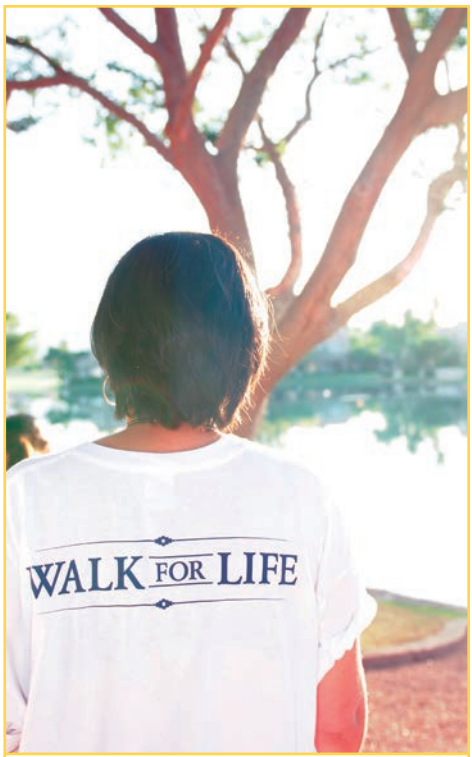
The second Action Summit for Suicide Prevention on October 25 through 27, 2011, in Anchorage continued the conversation that began in Scottsdale. Under the banner of "partnering with Alaska Native people to protect the circle of life," the second Action Summit focused on addressing suicide in an Alaska Native context, as well as the ways the IHS, BIA, BIE, and SAMHSA could cooperate effectively to support these activities. More than 230 people attended.

The Anchorage Summit covered the same concepts of suicide and substance abuse awareness and response as the Scottsdale Summit, moving sequentially from prevention to intervention to aftercare. During the first 2 days, participants had a choice of seven workshop tracks focusing on clinical issues, traditional healing, youth, data and research, and other topics.

IHS/BIA/BIE/SAMHSA
ALASKA AREA ACTION SUMMIT FOR SUICIDE PREVENTION

October 27, 2011, was a day of training and meetings. Meetings included the MSPI programs and the Action Alliance AI/AN Task Force while trainings were offered on a variety of topics, including suicide intervention, assessing and managing suicide risk, Gathering of Alaska Natives (GOAN), survivor support, and strengthening Alaska families.

While some presenters at the Anchorage Summit had appeared in Scottsdale, many presenters were unique to the Anchorage event. They specifically discussed Alaska organizations and partnerships and Alaska Native



WALK FOR LIFE

At 6:00 a.m. on August 4, 2011, nearly 200 Action Summit attendees participated in a remembrance and awareness Walk for Life. Participants were invited to walk in remembrance of a loved one, to show support for individuals and families, and to raise awareness about mental health and suicide.

models of healing and community intervention. Rural health care delivery and access, which plays a unique role in suicide prevention services for Alaska Native communities, was also discussed.

Other highlights of the Anchorage Summit included a poster session that presented information from program representatives on Alaska youth regional treatment centers, best practices for prevention and treatment among Alaska Native populations, and data-driven service improvements.

The Anchorage Summit also featured a remembrance wall, where participants could write notes of remembrance, hang pictures of loved ones, and place flameless candles in memory of friends or relatives whose lives were lost to suicide.

Outcomes from the Action Summits

To ensure that all participants left the summits with concrete tools to assist their work in their home communities, each attendee received a toolkit binder at registration. The binders offered a place to store and catalog action-oriented materials received during the summit presentations. The toolkit binders show the commitment of the Action Summit sponsors IHS, BIA, BIE, and SAMHSA to take action, to identify concrete steps to increase suicide and substance abuse prevention, and to share as widely as possible the tools that will assist in these efforts.

The Action Summits proved that collaboration does, in fact, exist among federal agencies; among AI/AN communities, states, and local organizations; and across a broad range of community organizations, including law enforcement, schools, and social services programs. However, there are opportunities to increase partnerships.

APPENDIX A: REGIONAL RECOMMENDATIONS

Recommendations were gathered and summarized for each listening session. Because BIA Regions and IHS Areas do not share the same geographic boundaries, differences exist in demographic and tribal composition. For example, the BIA's Western Region includes all of the Tucson IHS Area and much of the Phoenix Area. The listening sessions in each region were open to the public from anywhere in the country; therefore, recommendations listed below from a given BIA Region's listening session are not necessarily confined to that region.

Alaska Region Recommendations

Contributing Factors

Historical trauma and generational grief need to be addressed in the context of suicide prevention and treatment. All communities need to take more aggressive action on substance abuse prevention, domestic violence prevention, and suicide prevention.

Reimbursement and Funding

Funding is needed for programs that address domestic violence, substance abuse, and injury prevention. Funding should not be accompanied with increased reporting requirements to federal agencies. "Hard money," not grants, is needed with the concept that tribes know best how to apply funds that will emphasize culturally relevant approaches. Funding provided directly to tribes should be increased specifically to develop traditional ways to address these issues. Federal funding from multiple agencies should be readily blended or combined to fully fund programs. Sustainable funding for initiatives and facilities is needed.

Behavioral Health Staffing

More behavioral health professionals are needed in our communities. First responders need support and relief.

Improvement of Services

Prevention and intervention takes a whole-village approach. Communities need support and action on suicide prevention immediately and do not want to wait when their kids are vulnerable. Teachers should have mandatory suicide prevention training, and schools should be used for counseling opportunities. School curricula should be redeveloped and adapted to the local community environment. Increased involvement is needed from parents, adults in general, and elders. Parenting education and parenting support programs are needed.

We need to increase person-to-person activities to counter the increasing depersonalization and isolation encouraged by modern media (e.g., music with ear buds, cell phones, digital gaming, TV, and internet communication). Emphasis on exercising faith, prayer, and spiritual protection of young people is also recommended. Culturally focused, locally available healing camps should be developed. Southeast Alaska Regional Health Consortium's Youth Ambassador Program has been a successful program to provide significant training, growth, and increased positive interactions for youth at school and between youth and the community.

Communication and Coordination

Collaboration between federal and state agencies and tribes is needed. While it is okay for the federal staff to "hear us," they should not dictate local formats or solutions. Agencies need to travel to each community to see that one village's circumstances are not necessarily like another village, and one program design does not fit all. Tribal leaders need to take the lead and be responsible for addressing customary values and the education of our youth.

Suicide prevention efforts should emphasize the involvement of resources from across the community. Any follow-up activities on initiative or program results need to be communicated back to communities. A local suicide prevention council should be established to include multiple community resources, such as state, schools, and safety and health agencies. A tribal suicide prevention summit should be held in Anchorage, in addition to the summit planned for the lower 48 states. The summit focus should be on suicide prevention and not just signs and symptoms. Communication and collaboration is needed among state, tribes, and federal agencies at the Alaska Summit.

Eastern Region Recommendations

Contributing Factors

There should be greater attention to opportunities to address the issue of historical trauma at the community level.

Reimbursement and Funding

Increased funding is needed to sustain suicide prevention programs past the end of grant periods.

Improvement of Services

Suicide prevention efforts need to be increased, with greater attention given to providing a community-wide safety net for people at risk. Tribal leaders and providers should encourage creative ideas when designing and developing suicide prevention and intervention programs. More credible prevention and intervention efforts for youth are urgently needed. Suicide prevention and intervention programs should be developed for schools and delivered to students there. The involvement of youth in decision making at the community level should be increased. Gatekeeper training (including basic suicide awareness and intervention skills) should be expanded for the entire community. Mental health awareness training should be provided for multiple disciplines and paraprofessionals. Parenting classes should be developed and offered at the junior high school level and above. Social marketing should be used to help change community members' thinking about suicide and suicide prevention and to reduce stigma. Integrated care and continuity of care should be emphasized in planning for individual and community health needs.

Communication and Coordination

We should all increase our willingness to share ideas about suicide prevention.

Great Plains Region Recommendations

Contributing Factors

Suicide is a symptom. Prevention should address contributing factors, such as alcoholism, poverty, unemployment, and trauma.

Reimbursement and Funding

Increased funding for, and reimbursement of, services is needed. Many of the services needed in our communities are not billable. Tribes do not have the resources needed to support projects past the grant period. Funding sources, such as grants and other awards, need to be available in the field in their entirety, instead of being used for administrative purposes. Awards should be based on the need and priorities of the Area, rather than having one tribe compete against another for these funds. There are regulations prohibiting the use of funds for food, but having food available is a part of the culture and should be respected as such.

Improvement of Services

Native culture and spirituality can build resilience in youth and effectively combat suicide in Indian Country. Programs and interventions need to come from within the community. Many mainstream, evidence-based practices may not be appropriate for tribal communities. The focus should be on practice-based evidence, instead of evidence-based practices. There is a strong need for cultural competency and cultural sensitivity training for providers. Programs are needed that offer a strong commitment to families and promote resilience through culture. The focus should be on our children and being actively involved with them, because the youth and young adults are hit the hardest with suicide completions. Youth are our future leaders, so the youth and young adults need to be included in developing plans for addressing suicide in Indian Country. We need to address youth in many different ways, which includes using their modes of communication, such as music, texting, and social networking. Safe houses and activities for youth in the evenings and on weekends are needed. Suicides happen at night; therefore, services need to be available at all times, not just 8 a.m. to 4:30 p.m.

Communication and Coordination

Strong collaboration and increased sharing of resources and information are needed. The collaboration needs to come from all levels of the agencies and organizations involved. Systems need to work together to make it easier to obtain funding. Currently, different agencies have different requirements, making it difficult to work with several agencies. Data collection and evaluation are also hindered when every organization involved has its own data system. Collaborations need to be sustainable and ongoing. The focus on suicide prevention occurs for a short time after a suicide happens, and then people forget about it until the next one. Collaboration with the community, mental health program, alcoholism treatment program, law enforcement, schools, and other agencies is needed. Youth need to be included in communications about suicide prevention efforts.

Midwest Region Recommendations

Contributing Factors

All IHS, Tribal, and Urban Indian (ITU) health programs should participate in state prescription drug monitoring programs. There should be increased communication between IHS and community and private providers on prescription drug and narcotics abuse issues. Bullying should be addressed as a factor that contributes to suicide risk.

Reimbursement and Funding

Increased funding and research are needed in suicide prevention. The relationship between tribes and the U.S. government should bypass states and counties. Federal funds should be sent directly to tribes to create a pipeline.

Behavioral Health Staffing

More mental health professionals are needed in AI/AN communities. A Native behavioral health provider network should be created. Support is needed to help "heal the healer" to prevent professional burnout. The IHS American Indians into Psychology program should be expanded to recruit and support more psychologists of AI/AN descent.

Improvement of Services

Community ownership is critical for suicide prevention efforts, as well as elder support and decision making. Traditional healing practices need to be a reimbursable service. Youth need a greater sense of belonging. Youth service programs should be increased. Creative community activities focused on healing and resiliency should be developed. Suicide prevention posters should be displayed around health clinics, schools, and the community. An AI/AN suicide prevention national media campaign is needed. An effective, local suicide prevention hotline established in tribal communities is needed—not someone hundreds, or even thousands, of miles away. A crisis team with 24-hour staffing should be established in every AI/AN community. The team must have the ability and resources to provide a consistent response in emergencies. ITU health facilities should emphasize data sharing and modernize their information technology. A database to link local emergency medical services, police, and IHS is needed to improve communication. Telepsychiatry services are needed. A behavioral health inpatient hospital or other facility is needed to address dual-diagnosis patients of all ages in the state.

Communication and Coordination

Communication and collaboration is needed from everyone in the community, Native and non-Native. Collaboration is needed among all community groups (e.g., law enforcement, IHS, BIA, BIE, schools, and families). Federal agencies need to partner with tribes and to value tribal practices and culture. The leadership in Washington, DC, needs to visit our reservations for an onsite view. Other agencies should be given cultural competency training on how to work with AI/AN communities. Tribal leaders need to be included at the table as decision makers in developing health and prevention programs for a community. The Action Summit for Suicide Prevention should focus on working sessions and tangible products. In addition, communities should be supported to send teams to attend the Action Summit.

Navajo Region Recommendations

Reimbursement and Funding

Adequate and flexible funding is needed for suicide prevention and public health activities, so that tribes can have flexibility to adapt their own solutions. Grant programs should be sustainable, not competitive. Funding opportunities among the federal partners and tribes are needed.

Communication and Coordination

Cultural sensitivity is needed in funding and services. Healing of the people will be possible only through relying on culture and strongly incorporating a cultural perspective in health and prevention activities.

Northwest Region Recommendations

Contributing Factors

Training is needed to address the needs of dual-diagnosis patients (people with addictions plus mental health disorders). The competitive processes for funding among tribes needs to be discontinued so that tribes do not compete against one another for funds. There should also be reduced reporting requirements for the funding that tribes do receive.

Reimbursement and Funding

Increased funding for reservation and urban communities is needed to serve many special populations: veterans, homeless, youth, young adults, parents, and those suffering with addiction and mental health issues. Increased funding for behavioral health treatment and aftercare, law enforcement, education, and health care services is needed.

Behavioral Health Staffing

Trainers used in any IHS suicide prevention or response initiative should be people who work in the field with their communities and not outside experts.

Improvement of Services

More treatment and prevention programs that incorporate the entire family and community in a safe, healthy environment are needed. Transportation to services is also needed.

Communication and Coordination

Increased collaboration to improve the partnership with the Centers for Medicare and Medicaid Services is needed.

Pacific Region Recommendations

Reimbursement and Funding

Funding is needed for prevention and for programs that will strengthen families at risk (e.g., the Indian Child Welfare Act). Increased funding is needed for programs that will connect with youth, families, and communities. Coordinated access to Proposition 63 California State funds is recommended.

Improvement of Services

Tribal leaders need to address the problem of suicide proactively. Suicide prevention, intervention, and postvention training is needed in communities, along with general capacity building and support to develop community-based crisis response plans. Tribal community based interventions and prevention programs based on traditional Indian beliefs and customs are recommended. The focus on enhancing cultural identity for Indian people needs to be respected and honored. A peer and community-member counseling network should be created. Job training programs and youth leadership skills are needed. Outreach to AI/AN veterans through collaboration with the VA is recommended.

Improved technology, such as telepsychiatry, is recommended to ensure access to services in remote locations. A suicide hotline should be created for Indian Country, similar to what the VA created for veterans. Data collection for suicidal behavior and risk conditions should be enhanced in IHS, Tribal, and Urban Indian health facilities. Educational materials (e.g., DVDs and other media) should be developed that focus on the recognition of suicide risk. These educational materials should have an understanding of risk factors—such as historical trauma and, especially, California Indian-specific history—and information on prevention and wellness. Mental health first-aid training and aftercare services available in the community are recommended. Cultural sensitivity training is needed for all providers.

Communication and Coordination

Collaboration between agencies at all levels of government, including tribal, county, municipal, state, and federal agencies, should be increased. Non-Indian agencies need to be educated about Indian history, historical trauma issues, and community strengths.

Rocky Mountain Region Recommendations

Reimbursement and Funding

Legislation is needed to support suicide prevention the way legislation has addressed other health issues, such as diabetes.

Behavioral Health Staffing

Increased support is needed for providers in rural areas that lack resources. These isolated providers are at risk for burnout.

Improvement of Services

A paradigm shift and a new framework are needed to handle suicides in Indian Country. Suicide awareness, prevention, and intervention training is needed in every community. Law enforcement and dispatchers need to be trained on suicide intervention. Schools need to be involved in the community to reach out to parents and youth. More parent education is needed. To increase the involvement of youth, social networking, such as Facebook, should be used in outreach and prevention programs. Elder involvement in schools is needed for cultural education. Tribally specific programs, such as the equestrian therapy model that the Crow Tribe is exploring, should be developed and used to support and increase cultural identity. Safe houses or crisis centers for youth and adults should be developed in communities.

Communication and Coordination

Increased collaboration and communication are needed among national agencies, such as IHS and BIA and local entities, such as tribal programs and law enforcement.

Southern Plains/Eastern Oklahoma Region Recommendations

Contributing Factors

Historical trauma needs to be addressed as a contributing factor to suicide risk.

Behavioral Health Staffing

A professional network is needed to support behavioral health caregivers. Training for health care professionals in suicide prevention, intervention, and postvention should be developed. A resource list of trainings and best practices for suicide prevention should be developed and distributed.

Improvement of Services

A resource list for communities and crisis response teams should be developed. Training is needed in prevention programs, such as Question, Persuade, and Refer (QPR) and Applied Suicide Intervention Skills Training (ASIST). Training is also needed in assessments like Patient Health Questionnaire (PHQ) and other screening tools. Access to care should be improved through the integration of mental health into all other health care services.

Cultural sensitivity training is needed for behavioral health workers, schools, law enforcement, and all community partners who are part of suicide awareness and prevention. We recommend partnering with the Jason Foundation, Inc. to develop and increase cultural competency in the Foundation's teen suicide awareness and prevention materials by providing information to the Foundation on AI/AN-specific issues. Peer support programs and alcohol and substance abuse prevention education should be developed and provided.

At the Action Summit for Suicide Prevention, cultural ceremonies should be included, along with creating different tracks of learning for youth and elders. Counseling should be made available for conference attendees.

Southwest Region Recommendations

Contributing Factors

The image, self-identity, and sense of community of Native tribes and communities need to be improved.

Behavioral Health Staffing

Programs and providers need to address and offer training in cultural competency. Training will require qualified professionals and adequate response teams.

Improvement of Services

Holistic prevention, intervention, and postvention models for suicide prevention for all families, extended families, and communities are needed. The preservation of culture, traditions, and language is vitally important. Tribes each need their own best-practice models based on community values, traditions, and culture. The protective and risk factors within individual communities should be recognized. Service delivery has to focus on, and be consistent with, the culture of the community; culture and traditions need to be taught to our youth. Community task forces should be developed that include youth.

Programs that offer client care need more resources and more development. Care models are needed, including improved interventions, improved services, laws, and inpatient access for psychotic patients. Improved data collection should include improving electronic template forms and standardizing service plans. Access needs to be improved for activities for youth and families who struggle due to poverty, lack of housing, and unemployment. Tele-behavioral health services are needed to ensure access to care in remote areas.

We need to recognize the gay and lesbian population and reach out to it. They are in our communities and have been with us since our beginning. We should not isolate them.

Communication and Coordination

Communication between programs and agencies should be improved. A national website should be created where all tribes can post successes and needs. This could be modeled as a clearinghouse for tribes.

APPENDIX B: DISCUSSION QUESTIONS FROM TRIBAL LISTENING SESSIONS

- What can federal agencies do together to help communities reduce suicide and suicide-related problems in Indian Country?
- What is the best way for federal agencies to coordinate suicide prevention activities with tribal groups?
- In what way can we assist in addressing the problem?
- What are some ways that we can improve community understanding of suicide as a public health issue?
- Are there ways technology can be used to address gaps in services or community education?
- In what ways can federal agencies better support and help sustain local programs?
- What technical assistance and program evaluation support is needed to illustrate program success and extend successful programs?
- How is success measured?
- What programs were successful but short lived?
- What can we do to extend the life cycles of successful programs?
- How is success measured with these programs (e.g., reduction in suicide, change in behaviors)?
- How can the various disciplines work collaboratively to address suicide within your communities?
- What are some of the specific challenges to addressing suicide in your region?
- What are some community strategies that have worked to prevent suicide? What can we learn from successful tribal prevention and intervention models?
- How can federal agencies work collaboratively to promote youth success, wellness, and resilience?
- What steps need to be taken to develop a comprehensive strategy that addresses suicide in your community?

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American Indian/Alaska Native

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