In What Ways can Native American Communities Engage in Practices that Support Suicide Prevention?

Presented by Doreen Bird, M.P.H. and Laura Rombach, M.A.
University of New Mexico
Department of Psychiatry and Behavioral Sciences
Division of Community Behavioral Health
Disclaimer

• Doreen Bird and Laura Rombach have no financial relationship to this program
Suicide Prevention Webinar Series

The Suicide Prevention Webinar Series is presented through the National Strategy of Suicide Prevention in New Mexico grant

In collaboration with the University of New Mexico, State of New Mexico, Human Services Department, Behavioral Health Services Division and Indian Health Services
Learning Objectives

1. Recognize the uniqueness of suicide risk and protective factors specific to Native American Populations.

2. Identify approaches of incorporating strengths and protective factors in suicide prevention.

3. Identify two practices for suicide prevention in Native American communities.
Rates of Suicide in the United States

- Nearly 40,000 people in the United States die from suicide annually
- The suicide rate has been rising over the past decade
- Much of the increase is due to suicides in mid-life
- The highest number of suicides among both men and women occurred among those aged 45 to 54
- There are 3.6 male suicides for every female suicide
- From 1999 to 2010, the age-adjusted suicide rate for adults aged 35 to 64 in the United States increased significantly (28.4%). Half of these deaths occur by use of a firearm
- The highest rates of suicides (suicides per 100,000) occurred among men aged 75 and up and among women aged 45 to 54

Substance Abuse and Mental Health Services Administration 2014
# U.S.A. Suicide: 2011 Official Final Data

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Per Day</th>
<th>Rate</th>
<th>% of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nation</td>
<td>39,518</td>
<td>108.3</td>
<td>12.7</td>
<td>1.6</td>
</tr>
<tr>
<td>Males</td>
<td>31,003</td>
<td>84.9</td>
<td>20.2</td>
<td>2.5</td>
</tr>
<tr>
<td>Females</td>
<td>8,515</td>
<td>23.3</td>
<td>5.4</td>
<td>0.7</td>
</tr>
<tr>
<td>Whites</td>
<td>35,775</td>
<td>98.0</td>
<td>14.5</td>
<td>1.7</td>
</tr>
<tr>
<td>Nonwhites</td>
<td>3,743</td>
<td>10.3</td>
<td>5.8</td>
<td>1.0</td>
</tr>
<tr>
<td>Blacks</td>
<td>2,241</td>
<td>6.1</td>
<td>5.3</td>
<td>0.8</td>
</tr>
<tr>
<td>Elderly (65+ yrs.)</td>
<td>6,321</td>
<td>17.3</td>
<td>15.3</td>
<td>0.3</td>
</tr>
<tr>
<td>Young (15-24 yrs.)</td>
<td>4,822</td>
<td>13.2</td>
<td>11.0</td>
<td>16.3</td>
</tr>
<tr>
<td>Middle Aged (45-64 yrs.)</td>
<td>15,379</td>
<td>42.1</td>
<td>18.6</td>
<td>3.0</td>
</tr>
</tbody>
</table>

## Leading Cause of Death for U.S. 15-24 years old

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Causes</td>
<td>29,667</td>
<td>67.7</td>
</tr>
<tr>
<td>1. Accident</td>
<td>12,330</td>
<td>28.2</td>
</tr>
<tr>
<td><strong>2. Suicide</strong></td>
<td>4,822</td>
<td>11.0</td>
</tr>
<tr>
<td>3. Homicide</td>
<td>4,554</td>
<td>10.4</td>
</tr>
<tr>
<td>10-14</td>
<td>282</td>
<td>1.4</td>
</tr>
<tr>
<td>15-19</td>
<td>1,802</td>
<td>8.3</td>
</tr>
<tr>
<td>20-24</td>
<td>3,020</td>
<td>13.6</td>
</tr>
</tbody>
</table>
## Suicide by Race in the U.S. 2011

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of Suicides</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Male</td>
<td>28,103</td>
<td>23.0</td>
</tr>
<tr>
<td>White Female</td>
<td>7,672</td>
<td>6.2</td>
</tr>
<tr>
<td>Non White Male</td>
<td>2,900</td>
<td>9.4</td>
</tr>
<tr>
<td>Non White Female</td>
<td>843</td>
<td>2.5</td>
</tr>
<tr>
<td>Black Male</td>
<td>1,828</td>
<td>9.0</td>
</tr>
<tr>
<td>Black Female</td>
<td>413</td>
<td>1.9</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2,720</td>
<td>5.2</td>
</tr>
<tr>
<td>Native American</td>
<td>459</td>
<td>10.6</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1,043</td>
<td>5.9</td>
</tr>
</tbody>
</table>
Data from National Violent Death Reporting System

Based on data about suicides in 16 **National Violent Death Reporting System** states in 2009:

- Death certificates;
- Coroner/medical examiner reports;
- Law enforcement reports; and
- Crime laboratories.

- 33.3% of suicide decedents tested positive for alcohol,
- 23% for antidepressants,
- and 20.8% for opiates, including heroin and prescription pain killers.

Precipitating Circumstances of Suicide Among Youth Aged 10–17 Years by Sex: Data From the National Violent Death Reporting system 16 States 2005-2008

• **Relationship problems, recent crises, mental health problems, intimate partner and school problems** were the most common precipitating factors and many differed by sex.

• School problems were reported for 25% of decedents,
  • of which 30.3% were a drop in grades
  • and 12.4% were bullying related.
  • those who died in a house or an apartment (82.5%).
• Over the past 30 years, New Mexico has consistently had among the highest alcohol-related death rates, and the highest drug-induced death rate in the nation (SAMHSA, 2013).

• New Mexico also has the highest prescription drug overdose death rate in the nation.

• Mental illness increases the risk for both attempted suicide and suicide completion

• Approximately 90% of suicide victims in New Mexico had a diagnosable behavioral health condition, most commonly a mood or substance use disorder (IBIS, 2012).
Tribal Epidemiology Centers

AASTEC established in 2007
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nanibé</td>
<td>0.0</td>
<td>90.4</td>
<td>82.9</td>
<td>56.6</td>
</tr>
<tr>
<td>Jicarilla</td>
<td>17.2</td>
<td>105.8</td>
<td>46.0</td>
<td>54.2</td>
</tr>
<tr>
<td>Cochiti</td>
<td>23.7</td>
<td>68.0</td>
<td>58.2</td>
<td>47.4</td>
</tr>
<tr>
<td>Laguna</td>
<td>27.7</td>
<td>60.5</td>
<td>55.7</td>
<td>45.2</td>
</tr>
<tr>
<td>Isleta</td>
<td>24.0</td>
<td>57.6</td>
<td>44.8</td>
<td>41.3</td>
</tr>
<tr>
<td>Placitas</td>
<td>0.0</td>
<td>0.0</td>
<td>122.4</td>
<td>37.2</td>
</tr>
<tr>
<td>Santa Ana</td>
<td>0.0</td>
<td>42.7</td>
<td>68.1</td>
<td>35.9</td>
</tr>
<tr>
<td>Taos</td>
<td>36.0</td>
<td>37.8</td>
<td>52.0</td>
<td>33.6</td>
</tr>
<tr>
<td>Mescalero</td>
<td>24.6</td>
<td>0.0</td>
<td>71.4</td>
<td>32.1</td>
</tr>
<tr>
<td>Canoncito</td>
<td>40.0</td>
<td>0.0</td>
<td>68.5</td>
<td>31.7</td>
</tr>
<tr>
<td>Zuni</td>
<td>5.6</td>
<td>30.3</td>
<td>39.7</td>
<td>31.4</td>
</tr>
<tr>
<td>Zia</td>
<td>30.2</td>
<td>34.7</td>
<td>26.8</td>
<td>30.2</td>
</tr>
<tr>
<td>San Juan</td>
<td>31.0</td>
<td>21.5</td>
<td>96.0</td>
<td>30.0</td>
</tr>
<tr>
<td>San Felipe</td>
<td>0.0</td>
<td>48.1</td>
<td>19.3</td>
<td>21.3</td>
</tr>
<tr>
<td>Acosta</td>
<td>5.5</td>
<td>6.9</td>
<td>33.3</td>
<td>13.8</td>
</tr>
<tr>
<td>Ramah</td>
<td>0.0</td>
<td>38.1</td>
<td>10.8</td>
<td>13.9</td>
</tr>
<tr>
<td>San Ildefonso</td>
<td>41.7</td>
<td>0.0</td>
<td>0.0</td>
<td>13.9</td>
</tr>
<tr>
<td>Jemez</td>
<td>18.5</td>
<td>11.7</td>
<td>5.2</td>
<td>13.2</td>
</tr>
<tr>
<td>Santa Clara</td>
<td>0.0</td>
<td>22.0</td>
<td>18.3</td>
<td>12.4</td>
</tr>
<tr>
<td>Alamo</td>
<td>21.0</td>
<td>0.0</td>
<td>0.0</td>
<td>6.2</td>
</tr>
<tr>
<td>Santo Domingo</td>
<td>0.0</td>
<td>0.0</td>
<td>6.7</td>
<td>2.4</td>
</tr>
<tr>
<td>Pojoaque</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Tesuque</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Sandia</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
Adverse Childhood Experiences Data from NM

Source: AASTEC.net
ACE Risk Factors among a Sample of American Indian Adults in New Mexico

<table>
<thead>
<tr>
<th>ACE Risk Factors Reported During Childhood</th>
<th>Percent</th>
<th>NM Statewide/US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem drinker/drug user in home</td>
<td>51%</td>
<td>25.7% / 26.9</td>
</tr>
<tr>
<td>Adult in home swear/insult respondent</td>
<td>31%</td>
<td>37.9% / 10.6</td>
</tr>
<tr>
<td>Parents ever separated or divorced</td>
<td>30%</td>
<td>24.0% / 23.2</td>
</tr>
<tr>
<td>Physical violence among adults in home</td>
<td>28%</td>
<td>18.1%</td>
</tr>
<tr>
<td>Physical violence involving respondent in home</td>
<td>23%</td>
<td>19.2%</td>
</tr>
<tr>
<td>Depressed or suicidal person in home</td>
<td>12%</td>
<td>19.9% / 19.4</td>
</tr>
<tr>
<td>Someone in household went to jail or prison</td>
<td>9%</td>
<td>6.8% / 4.7</td>
</tr>
<tr>
<td>Sexual contact by adult in home</td>
<td>7%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

*Childhood refers to when respondent was age 18 years or less

http://www.cdc.gov/violenceprevention/acestudy/prevalence.html
Number of ACEs among Sample of American Indians in New Mexico
Sadness & Suicide Ideation (*Past 12 Months*)
American Indian High School Students  NM 2013 – By Gender

<table>
<thead>
<tr>
<th>Event</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistent Sadness</td>
<td>21%</td>
<td>40%</td>
</tr>
<tr>
<td>Considered Suicide</td>
<td>14%</td>
<td>23%</td>
</tr>
<tr>
<td>Made Plan</td>
<td>9%</td>
<td>14%</td>
</tr>
<tr>
<td>Attempted Suicide</td>
<td>11%</td>
<td>17%</td>
</tr>
</tbody>
</table>
ACE & Depression in Adulthood

- 0 ACE: 1
- 1 ACE: 1.9
- 2 ACEs: 2.5
- 3 ACEs: 2.3
- 4+ ACEs: 3.4
ACE & Suicide Attempt in Adulthood

- 0 ACE: 1
- 1 ACE: 0.9
- 2 ACEs: 2.2
- 3 ACEs: 2
- 4+ ACEs: 3.6

The bar chart shows the number of suicide attempts in adulthood based on the number of ACEs (Adverse Childhood Experiences) experienced.
## Suicide Risk/Protective Factors

**AMERICAN INDIAN HIGH SCHOOL STUDENTS IN NM**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Odds Ratio</th>
<th>95% CI</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistent Sadness</td>
<td>13.8</td>
<td>(9.5-20.1)</td>
<td>p &lt; 0.00</td>
</tr>
<tr>
<td>Bullied past 12 months (any)</td>
<td>5.1</td>
<td>(3.3-8.0)</td>
<td>p &lt; 0.00</td>
</tr>
<tr>
<td>Parent/adult in home believes student will be a success</td>
<td>0.41</td>
<td>(0.29-0.59)</td>
<td>p &lt; 0.00</td>
</tr>
<tr>
<td>Extracurricular activities outside of home/school</td>
<td>0.47</td>
<td>(0.35-0.63)</td>
<td>p &lt;0.00</td>
</tr>
<tr>
<td>An adult outside of home/school really cares about student</td>
<td>0.60</td>
<td>(0.39-0.91)</td>
<td>p &lt;0.00</td>
</tr>
<tr>
<td>Have a friend same age who really cares about student</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
</tbody>
</table>
Risk Factors - Alcohol and Drug Abuse and Suicide

• Alcohol and drug abuse are second only to depression and other mood disorders as the most frequent risk factors for suicide

• In 2008, alcohol was a factor in approximately one-third of suicides reported in 16 states

• In 2011, there was a 51% increase in drug-related suicide attempt visits to hospital emergency departments among people aged 12 and older (SAMHSA)
Risk Factors - Comorbidity

- More than 90% of people who dies by suicide have a mental health disorder or substance abuse disorder or both
- More than 50% of suicides are associated with a major depressive disorder
- Approximately 25% of suicides are associated with a substance abuse disorder
- Ten percent of suicides are associated with psychotic disorders

Suicide Prevention Toolkit for Rural Primary Care 2015
# Suicide Risk/Protective Factors

**AMERICAN INDIAN HIGH SCHOOL STUDENTS**

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</tr>
</tbody>
</table>

Source: Albuquerque Area Southwest Tribal Epidemiology Center, 2015
Protective Factors

“AI/AN youth had higher thresholds of risk before making a suicide attempt. Protective factors buffered the impact of risk, particularly for higher risk youth.”

What Protects Native Youth from Suicide?

- Social support - peers, family, community, leaders
- Life skills and coping skills
- Traditional culture and involvement in ceremony
- Positive religious influences
- Having good mental health
Suicide Prevention Practices
In Native America

• http://sparktalks.sprc.org/
A Prevention Paradigm for Native Americans

https://www.youtube.com/watch?feature=player_embedded&v=ZRpJaap-En0
Innovative messaging in tribal suicide prevention

- **Native H.O.P.E.** (Helping Our People Endure)
- **Honor Your Life:** Mescalero Apache School- Social networking
- **Zuni Life Skills Development Curriculum**
- **San Felipe GLS:**
  - Native language to de-stigmatize mental illness
- **Natural Helpers- Dine specific example**
- **WeRNative website:**
  - [http://www.wernative.org/](http://www.wernative.org/)
- **Strengths Based Approach**
  - “We are Resilient Walk” vs. “Suicide Prevention Walk”
- **Digital Storytelling- gives people a voice for selected audience**
Community Readiness

Manual on Suicide Prevention in Native Communities

Assessing community readiness for change and increasing community capacity for suicide prevention. Creating a climate that makes healthy community change possible.

Barbara A. Harrell
Remita J. Beeman-Champion
Ruth H. Edwards

SAMHSA
Community Readiness Model

• Initially developed through the Tri-Ethnic Center in the College of Natural Sciences, Department of Psychology at Colorado State University as a method to “meet research needs, (e.g., matching treatment and control communities for an experimental intervention) as well as to provide a practical tool to help communities mobilize for change.”

• Was also initially developed for use with alcohol and drug abuse programs.
  • (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000)
Community Readiness Model

• The community readiness theoretical model is based on several underlying premises:
  1. that communities are at different stages of readiness for dealing with a specific problem,
  2. that the stage of readiness can be accurately assessed,
  3. that communities can be moved through a series of stages to develop, implement, maintain, and improve effective programs
  4. that it is critical to identify the stage of readiness because interventions to move communities to the next stage differ for each stage of readiness.

  (Edwards, Jumper-Thurman, Pleston, Oetting, & Swanson, 2000)
Six Dimensions of Community

A. **Community efforts**: To what extent are there efforts, programs, and policies that address SUICIDE PREVENTION?

B. **Community knowledge of the efforts**: To what extent do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?

C. **Leadership**: To what extent are appointed leaders and influential community members supportive of SUICIDE PREVENTION?

D. **Community climate**: What is the prevailing attitude of the community toward SUICIDE PREVENTION? Is it one of helplessness or one of responsibility and empowerment?

E. **Community knowledge about the issue**: To what extent do community members know about or have access to information on SUICIDE PREVENTION, consequences, and understand how it impacts your community?

F. **Resources related to the issue**: To what extent are local resources (people, time, money, space) available to support the prevention efforts?
Training in Suicide Prevention, Intervention and Postvention

Much more than an off-the-shelf manual, on-line seminar or toolkit, Connect provides customized training and interaction with experts in the field of suicide prevention and postvention.

Benefits of Connect

- Nationally Designated Best Practice Program
- Public health approach
- Best practice protocols
- Can be customized to meet training needs of audience
- Culturally competent
- Cross-training that includes collaboration between service providers

Training by Audience

- American Indian / Alaska Native
- Education
- Law Enforcement
- Military
- Mental Health / Substance Abuse
- Social Services
- Suicide Prevention Coalition
- Youth

Connect Training

- Prevention/Intervention
- Postvention (promoting healing and reducing risk after a suicide)
- Specialized Training/Consultation
- SurvivorVoices: Sharing the Story of Suicide Loss
- Train-the-Trainer

Connect News

- Connect Training Takes Off in Guam
- Exeter, NH - The story of how one community responded to youth suicide

Best-Practice News for Saving Lives from Suicide

> View More Audiences
CONNECT MODEL

• Developed out of National Alliance on Mental Illness-New Hampshire

• Nationally designated Best Practice program through the Suicide Prevention Resource Center

• Is a community centered approach to suicide prevention, and assists in the development of community based approaches to intervention as well as postvention and crisis response.

• Includes an Evaluation component with both pre and post tests for both basic community training efforts as well as Train the Trainer components.
CONNECT: and the Socio-Ecological Approach

• CONNECT: Recognizes Suicide as a public health issue, one that is preventable.

• CONNECT: Suicide prevention is not limited just to a single system, such as a Behavioral Health program, Prevention Program, Law Enforcement or Social Services.

• Acknowledges that Suicide occurs within the context of an individual’s relationships, family, community, society and culture.

• CONNECT strives to work within the multiple systems simultaneously through community based implementation efforts
  – Again Community Readiness is a helpful and natural lead in to the training and focus areas of CONNECT
Suicide Prevention/Intervention

Suicide Prevention

Survivor/Voices: Sharing the Story of Suicide Loss

Specialized Training/Consultation

Connect Train-the-Trainer: Suicide Prevention/Intervention and Postvention

Evaluation

Click Here to Sign Up for our eNewsletter

It takes a community to prevent suicide

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Suicide Response, Prevention, Intervention and Postvention Training

Connect is designated as a National Best Practice Program™ that trains professionals and community members to prevent and respond effectively to suicide across the lifespan. Our public health, socio-ecological model emphasizes collaboration between service providers. Best practice protocols are provided for each service provider discipline. The training can be customized to meet the needs of a community or organization.

We offer the following training programs:

**SUICIDE PREVENTION/INTERVENTION** - education about early recognition and skills for responding to attempts thoughts or threats of suicide. Read more.

**SURVIVOR/VOICES: SHARING STORIES OF SUICIDE LOSS**
Survivors of suicide loss play an important role in reducing the shame, isolation and guilt felt by loved ones after a suicide death. Speaking privately and publicly about one’s own loss provides insight that goes beyond traditional suicide prevention training. Read more.

**CONSULTATION**
Consultation can be provided in the following areas:

- assessing community readiness for suicide prevention programming
- identifying and strengthening community risk and protective factors
- bringing community members and resources together to build a safety net and promote healing
- implementation of program activities and best practices in prevention and postvention
- sustainability of suicide prevention efforts

**POSTVENTION** - a proactive planning tool to help service providers promote healing and reduce risk after a suicide. Read more.

**SPECIALIZED TRAINING**
Specialized training in the following areas:

- Clinicians as Survivors
- Cultural Factors
- Developing a Community Suicide Postvention Plan
- Ethical Concerns: Working with At-Risk Individuals
- Healing Words: speaking safely about suicide
- Media, Safe Messaging and Suicide Prevention
- Social Media
- Reporting/Journalism Students
CONNECT IN TRIBAL COMMUNITIES

• Training that can be customized to meet the needs of your community or organization.
  – For tribal communities this is key in that creating programming to address issues such as suicide, we need to always consider our cultural context.
  – CONNECT allows communities to work from a cultural perspective and base while integrating model approaches.
  – Recognizes that the strengths and answers lie within the community itself.
  – CONNECT helps in providing a framework and language for use to begin to incorporate those into prevention and intervention efforts.
CONNECT IN TRIBAL COMMUNITIES

• Allows tribal communities the ability to map steps, protocols and linkages with all relevant systems:
  – Including traditional cultural systems where appropriate, spiritual leadership where appropriate, tribal administrators, direct service providers, elders, youth, etc.

• Helps COMMUNITIES TO CREATE AND LINK PROTOCOLS/POLICY from system to system and acknowledges there are ways to interface and ways to work through challenges
  – Examples: I.H.S. to tribal programs
  – Educational programs (FERPA) to Healthcare programs (HIPAA)
Resources

• Action Alliance for Suicide Prevention- http://zerosuicide.actionallianceforsuicideprevention.org/
• Indian Health Service
  – Information about Indian Health Service - http://www.ihs.gov
  – Location of an Indian Health Service facility in your area - http://www.ihs.gov/findhealthcare/
• CONNECT: www.theconnectprogram.org
• Community Readiness: http://triethniccenter.colostate.edu/communityReadiness_home.htm
• SAMHSA – Substance Abuse and Mental Health Services Administration
• Suicide Prevention Life Line  1-800-273-TALK (8255)
• Suicide Prevention Resource Center - http://www.sprc.org/
  – American Indian and Alaska Native Suicide Prevention Programs
  – Garrett Lee Smith State/Tribal Suicide Prevention Program
Resources

• Mental Health First Aid http://www.mentalhealthfirstaid.org/cs/

• ASIST – Applied Suicide Intervention Skills - https://www.livingworks.net/programs/asist/

• QPR – Question, Persuade and Refer - https://www.qprinstitute.com/gatekeeper.html

• CALM-Counseling on Access to Lethal Means  
  http://www.sprc.org/library_resources/items/calm-counseling-access-lethal-means

• safe TALK https://www.livingworks.net/programs/safetalk/

• Honoring Native Life: www.honoringnativelife.org
Resources

• Suicide Prevention Resource Center - [http://www.sprc.org/](http://www.sprc.org/)
  – American Indian and Alaska Native Suicide Prevention Programs
  – Garrett Lee Smith State/Tribal Suicide Prevention Program
• Action Alliance for Suicide Prevention- [http://zerosuicide.actionallianceforsuicideprevention.org/](http://zerosuicide.actionallianceforsuicideprevention.org/)
• Suicide Prevention Life Line  1-800-273-TALK (8255)
• SAMHSA – Substance Abuse and Mental Health Services Administration
• Military One Source  [http://www.militaryonesource.mil/](http://www.militaryonesource.mil/)
• Columbia-Suicide Severity Rating Scale Training [http://www.cssrs.columbia.edu/](http://www.cssrs.columbia.edu/)
• CONNECT: [www.theconnectprogram.org](http://www.theconnectprogram.org)
• Community Readiness: [http://triethniccenter.colostate.edu/communityReadiness_home.htm](http://triethniccenter.colostate.edu/communityReadiness_home.htm)