

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

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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

U.S.A. SUICIDE: 2011 OFFICIAL FINAL DATA

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

Source: McIntosh, J. L., & Drapeau, C. W. (for the American Association of Suicidology). (2014). *U.S.A. suicide 2011: Official final data*. Washington, DC: American Association of Suicidology, dated June 19, 2014, downloaded from <http://www.suicidology.org>.

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

Cause	Number	Rate
All Causes	29,667	67.7
1. Accident	12,330	28.2
<u>2. Suicide</u>	4,822	11.0
3. Homicide	4,554	10.4
10-14	282	1.4
15-19	1,802	8.3
20-24	3,020	13.6

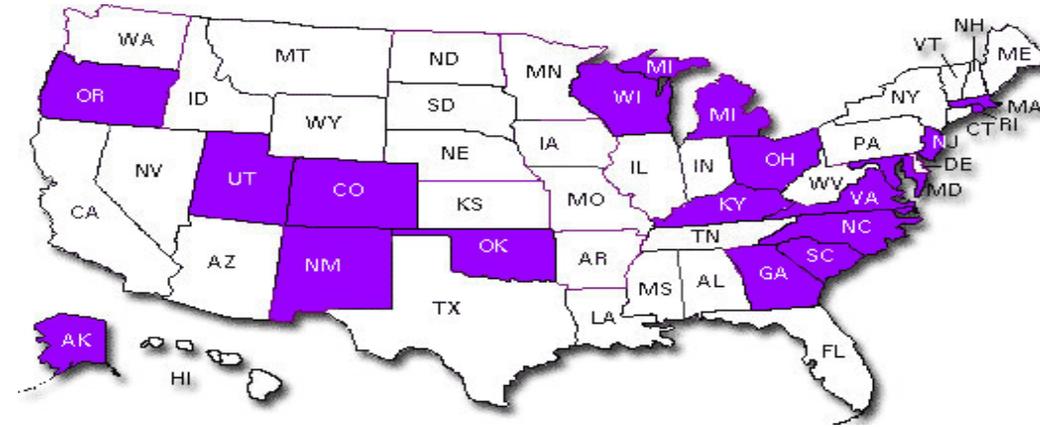
Suicide by Race in the U.S. 2011

Group	Number of Suicides	Rate
White Male	28,103	23.0
White Female	7,672	6.2
Non White Male	2,900	9.4
Non White Female	843	2.5
Black Male	1,828	9.0
Black Female	413	1.9
Hispanic	2,720	5.2
Native American	459	10.6
Asian/Pacific Islander	1,043	5.9

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

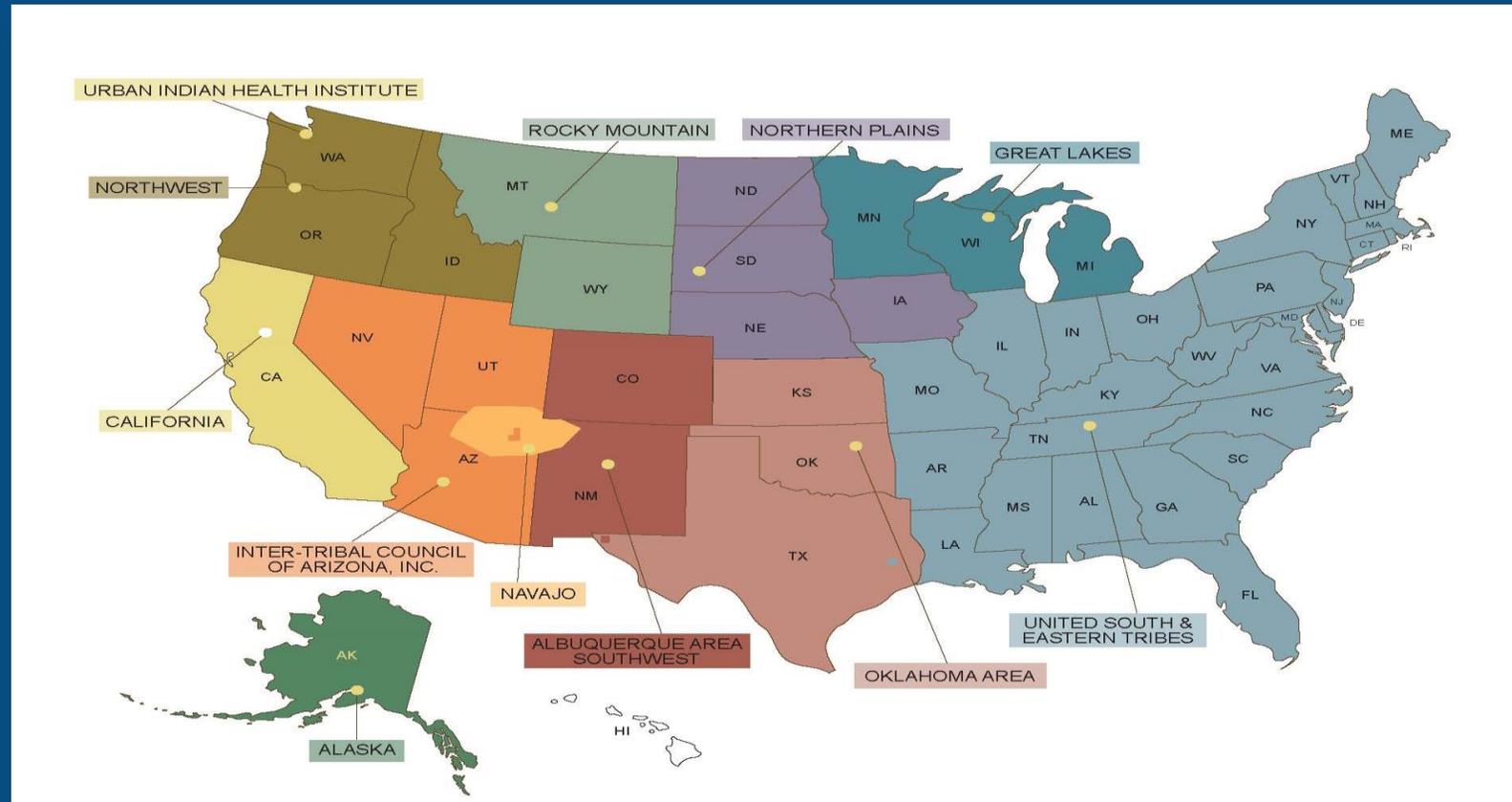
- Relationship problems, recent crises, mental health problems, intimate partner and school problems were the most common precipitating factors and many differed by sex.
- School problems were reported for 25% of decedents,
- of which 30.3% were a drop in grades
- and 12.4% were bullying related.
- those who died in a house or an apartment (82.5%).

New Mexico

- 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



Albuquerque Area Southwest Tribal Epidemiology Center

ALBUQUERQUE AREA SOUTHWEST



TRIBAL EPIDEMIOLOGY CENTER

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Westlake Van Winkle & May, 1986- NM Suicide Rates (per 100,000) by Reservation

Reservation	1957-1965	1966-1972	1973-1979	1957-1979
Nambe	0.0	99.4	82.9	56.6
Jicarilla	17.2	105.8	46.0	54.2
Cochiti	23.7	69.0	58.2	47.4
Laguna	27.7	60.5	55.7	45.2
Isleta	24.0	57.6	44.8	41.3
Picuris	0.0	0.0	122.4	37.2
Santa Ana	0.0	42.7	68.1	35.9
Taos	19.0	37.8	52.0	35.6
Mescalero	24.6	0.0	71.4	32.1
Canoncito	40.0	0.0	49.5	31.7
Zuni	5.6	30.3	53.7	31.4
Zia	30.2	34.7	26.8	30.2
San Juan	31.0	21.5	36.0	30.0
San Felipe	0.0	48.1	19.3	21.3
Acoma	5.5	6.9	33.3	15.8
Ramah	0.0	38.1	10.8	13.9
San Ildefonso	41.7	0.0	0.0	13.9
Jemez	18.5	11.7	9.2	13.2
Santa Clara	0.0	22.0	18.3	12.4
Alamo	21.0	0.0	0.0	6.2
Santo Domingo	0.0	0.0	6.7	2.4
Pojoaque	0.0	0.0	0.0	0.0
Tesuque	0.0	0.0	0.0	0.0
Sandia	0.0	0.0	0.0	0.0

Adverse Childhood Experiences Data from NM

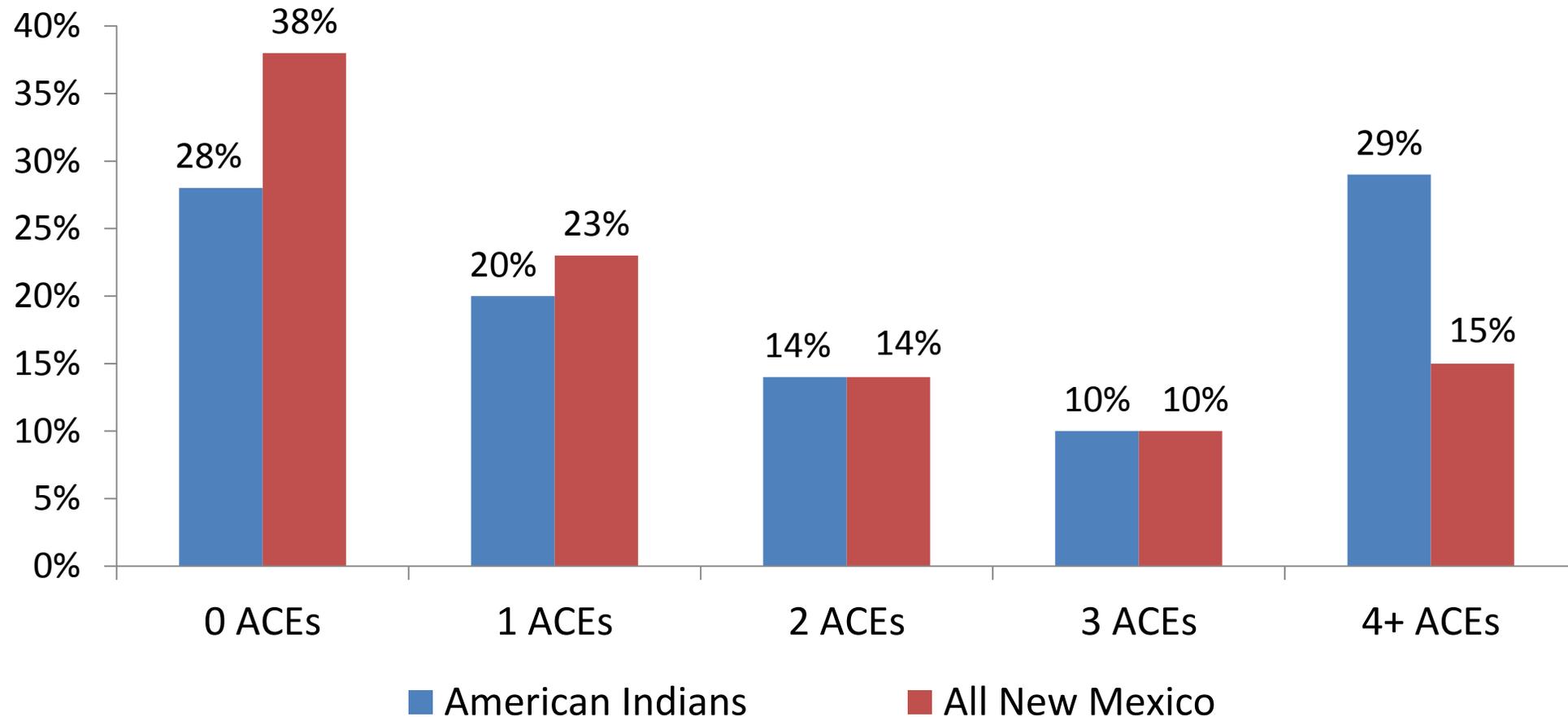
Source: AASTEC.net

ACE Risk Factors among a Sample of American Indian Adults in New Mexico

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

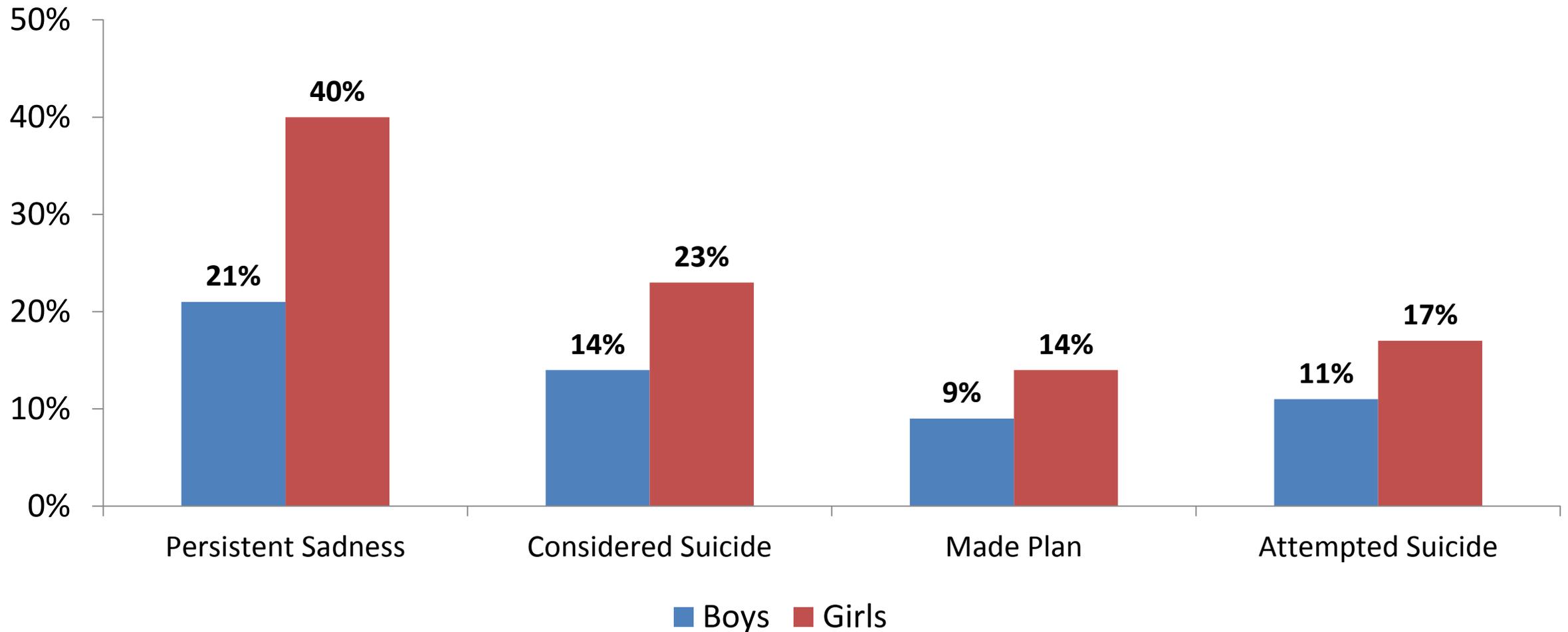
** Childhood refers to when respondent was age 18 years or less*

Number of ACEs among Sample of American Indians in New Mexico

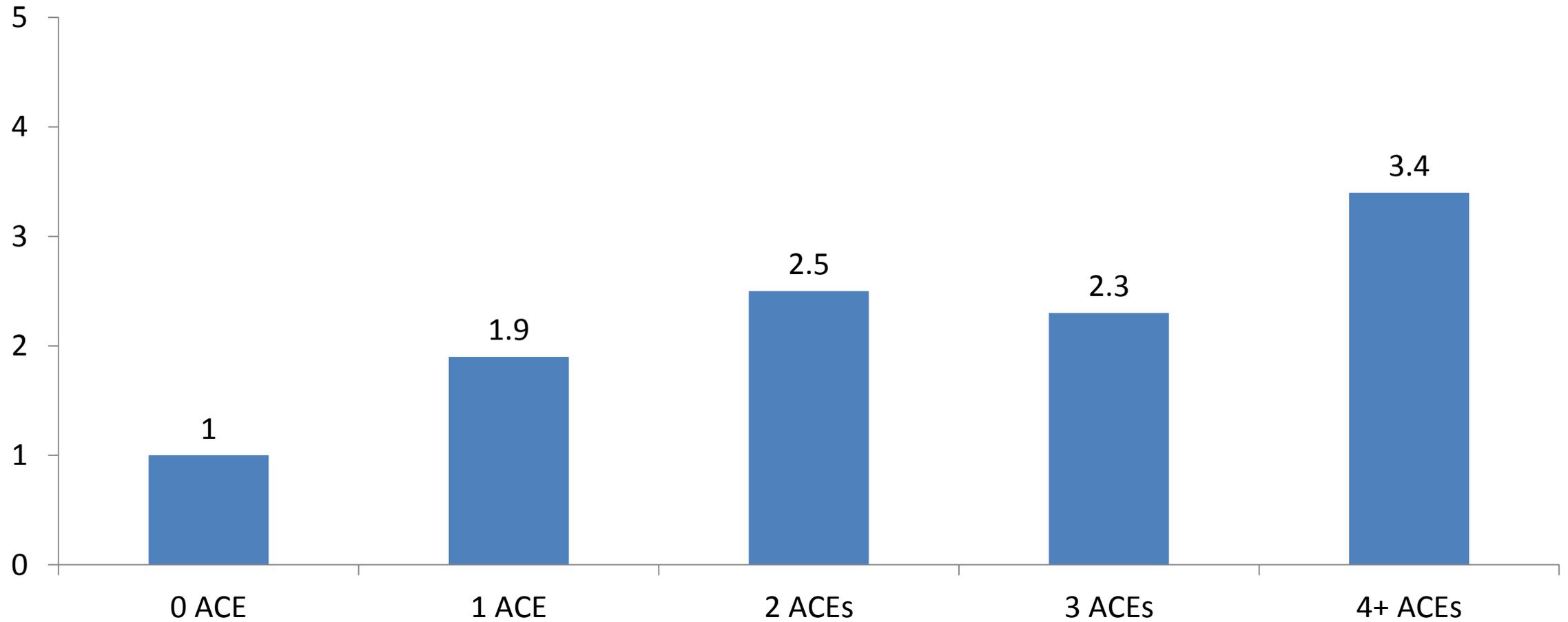


Sadness & Suicide Ideation (*Past 12 Months*)

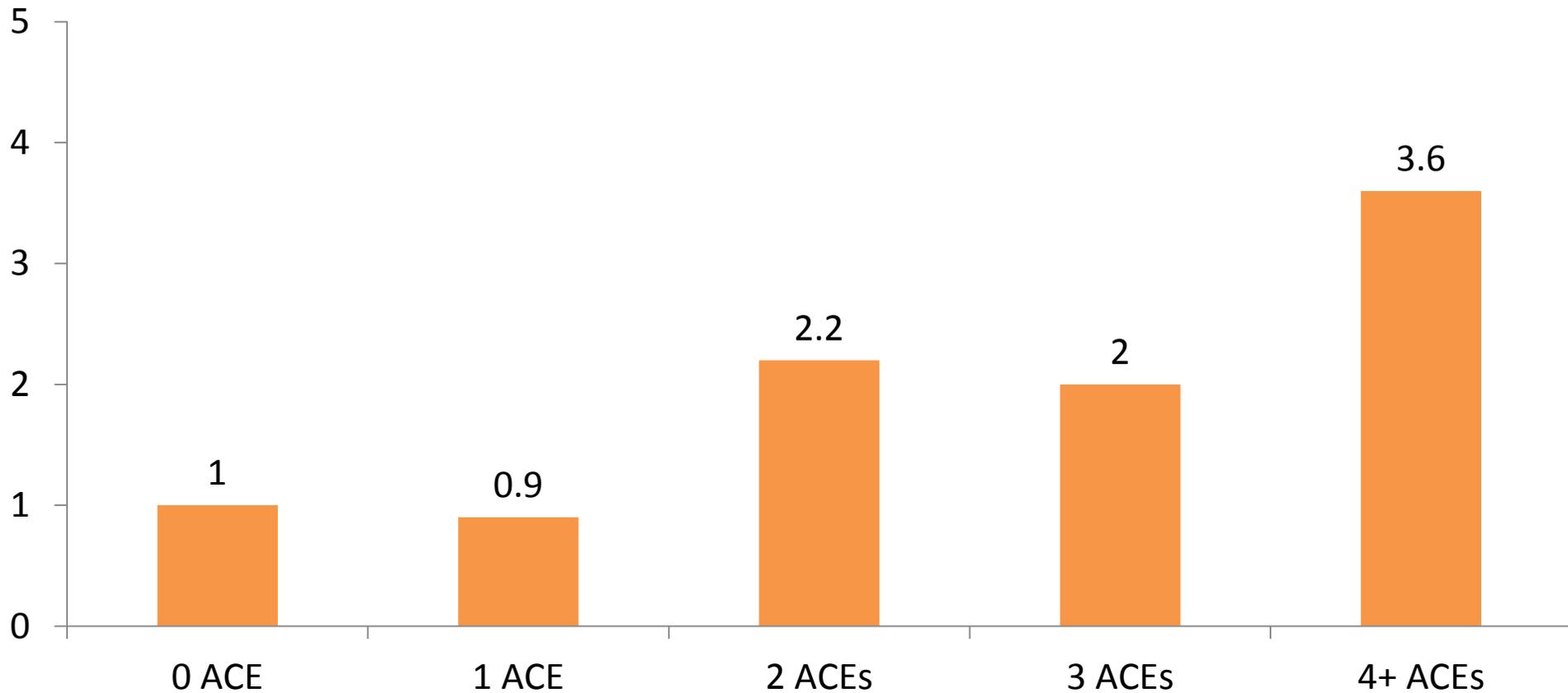
American Indian High School Students NM 2013 – By Gender



ACE & Depression in Adulthood



ACE & Suicide Attempt in Adulthood



Suicide Risk/Protective Factors

AMERICAN INDIAN HIGH SCHOOL STUDENTS IN NM

Factor	Odds Ratio	95% CI	P value
Persistent Sadness	13.8	(9.5-20.1)	p < 0.00
Bullied past 12 months (any)	5.1	(3.3-8.0)	p < 0.00
Parent/adult in home believes student will be a success	0.41	(0.29-0.59)	p < 0.00
Extracurricular activities outside of home/school	0.47	(0.35-0.63)	p < 0.00
An adult outside of home/school really cares about student	0.60	(0.39-0.91)	p < 0.00
Have a friend same age who really cares about student	NS	NS	NS

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

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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.”

Mackin, Perkins, & Furrer, (2012).

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/>

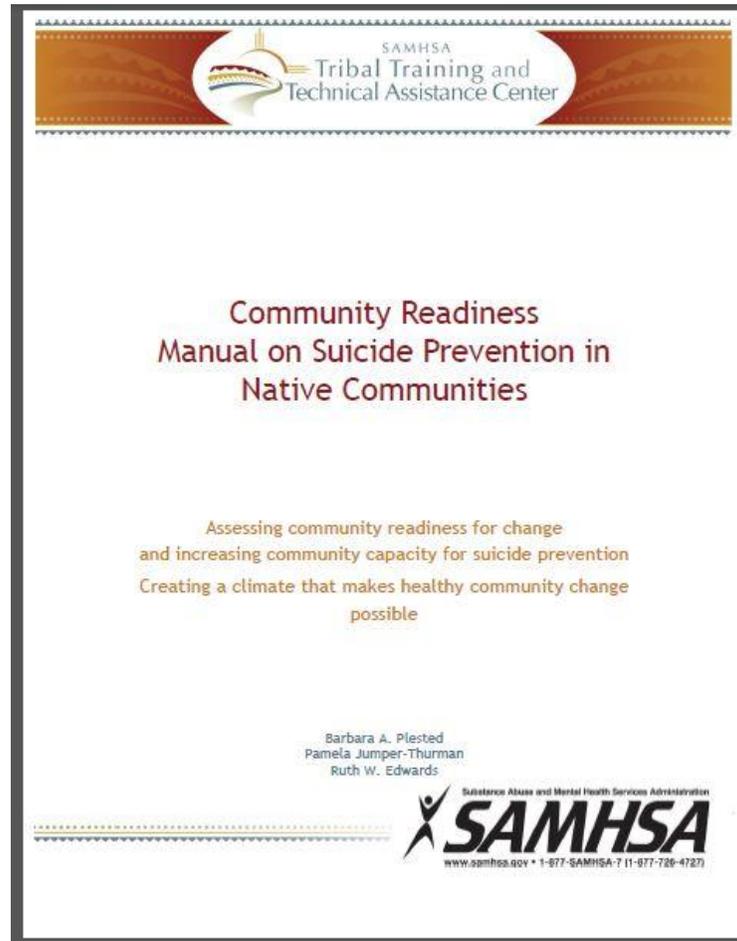
Video

- 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/>
- ❖ Strengths Based Approach
 - “We are Resilient Walk” vs. “Suicide Prevention Walk”
- ❖ Digital Storytelling- gives people a voice for selected audience

Community Readiness



Community Readiness Model

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, Plested, 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?

Search



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](#)

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 Coalitions](#)
- [Youth](#)

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Best-Practice News for Saving Lives from Suicide

Connect News

[Connect Training Takes Off in Guam](#)

[Exeter, NH - The story of how one community responded to youth suicide](#)

[View All](#)

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



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It takes
a community
to prevent
suicide

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.](#)

SurvivorVoices: 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](#)
- [Reporters/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/>
- American Indian Life Skills Development Curriculum
<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=81>
- 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

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- Suicide Prevention Life Line 1-800-273-TALK (8255)
- SAMHSA – Substance Abuse and Mental Health Services Administration
- Military One Source <http://www.militaryonesource.mil/>
- Columbia-Suicide Severity Rating Scale Training <http://www.cssrs.columbia.edu/>
- CALM-Counseling on Access to Lethal Means
http://www.sprc.org/library_resources/items/calm-counseling-access-lethal-means
- CONNECT: www.theconnectprogram.org
- Community Readiness:
http://triethniccenter.colostate.edu/communityReadiness_home.htm