

American Indian Addendum for the  
**Suicide Prevention**  
▶▶ **Toolkit for Primary** ◀◀  
**Care Practices**

WICHE  
Western Interstate Commission  
for Higher Education  
Behavioral Health Program

MONTANA  
**DPHHS**  
*Healthy People. Healthy Communities.*  
Department of Public Health & Human Services

## Preface

Rates of suicide among American Indians (AI) are higher than any other group in the country and continue to increase, posing a serious challenge to tribal communities. Tribal communities have many strengths and are masters of resilience but, at times, grief can overwhelm normal ability to cope and recover. When an AI community member is lost to suicide, that tragedy perpetuates a cycle of trauma and loss for that individual's family, friends, and other community members. Service providers in the community, including primary care providers, can provide critical support through the use of culturally responsive and respectful partnerships with local tribal communities, especially at times of heightened community pain.

Psychiatric hospitalizations do not lessen the long-term risk of suicide for a suicidal person; in fact, the first week post hospitalization is a high-risk time for death by suicide.<sup>1,2</sup> Communities must develop alternative, more effective strategies to address suicidal thoughts and behavior and primary care providers are perfectly positioned to be a part of the solution.

This addendum is designed to **accompany** the Suicide Prevention Toolkit for Primary Care Providers (SP Toolkit) created by the Western Interstate Commission for Higher Education's Behavioral Health Program and the National Suicide Prevention Resource Center (SPRC) in 2007 and revised in 2016. The addendum provides specific steps and best practices for primary care providers on engaging with tribal community members who are experiencing deep grief and other emotions and successfully intervening when a community member is struggling with suicidal feelings, thereby helping to prevent suicide among Native American patients and communities. A key reminder here to include community strengths into conversations about suicide, as reports on suicides in AI communities are often very negative and filled with stereotypes about Native populations, which they may then internalize.

This addendum follows the structure of the full SP Toolkit and is designed as a companion to the SP Toolkit released in 2016. Please refer to the full SP Toolkit for complete information on assessing for and intervening with suicide risk.

## Acknowledgements

This American Indian (AI) specific addendum to the Suicide Prevention Toolkit for Primary Care Practices was created by the Western Interstate Commission for Higher Education's Behavioral Health Program. Special thanks go out to the Addictive & Mental Disorders Division of the Montana Department of Public Health and Human Services for funding the toolkit addendum, and to Holly Echo-Hawk, Pawnee Nation member, of Echo-Hawk and Associates and Daniel Foster of Ft. Belknap Tribal Health for their thoughtful review and input. Your time and effort made this a much better product.

For questions about this AI specific SP toolkit addendum, please contact the primary author at [ltupa@wiche.edu](mailto:ltupa@wiche.edu).

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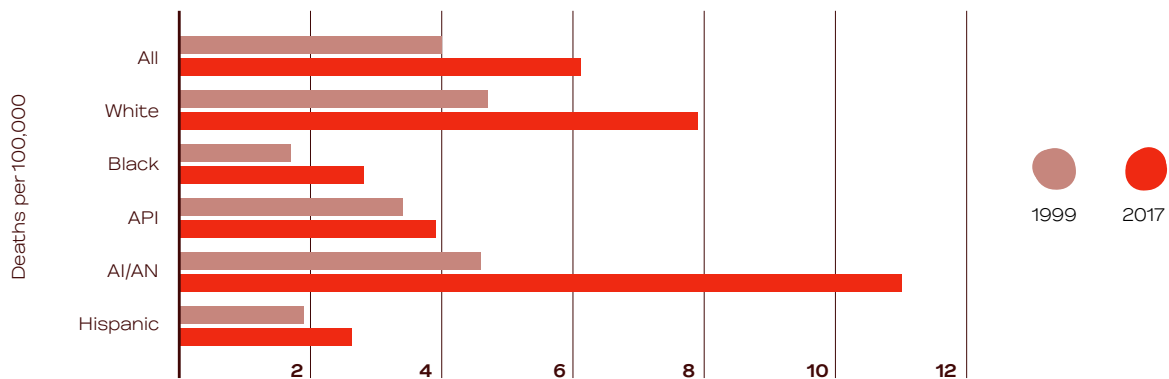
# MODULE 1

## PREVALENCE AND COMORBIDITY

### Prevalence

American Indian/Alaska Native (AI/AN) community members, overall, are at a higher risk of suicide in the United States than any other racial or ethnic group. Suicide rates among this group have been increasing since 2003, and AI community members continue to have the highest rates of suicide compared to all other documented racial or ethnic groups in the United States. Nationally, the rate of suicide in AI/AN community members in 2017 was 15.30 per 100,000 individuals compared to 13.06 per 100,000 for all races and ethnicities according to the Centers for Disease Control and Prevention's National Violent Death Reporting System, in 2016 AI/AN suicide rates were over 3.5 times higher than those of racial/ethnic groups with the lowest rates.<sup>3</sup>

Rates of AI/AN Loss to Suicide Compared to other Ethnic Groups 1999-2017<sup>4</sup>





## Comorbidity

Studies indicate that AI/AN community members who have been lost to suicide are less likely than their white peers to have been diagnosed with mental health problems, depressed mood, or to have been receiving mental health treatment prior to their passing.<sup>5</sup> However, rather than indicating that AI/AN individuals are less likely to have had comorbid depression or other mental health issues around the time of death by suicide than their white peers, this finding may illustrate that AI/AN individuals are not being evaluated, screened, or diagnosed adequately. Additionally, AI/AN suicide victims are roughly twice as likely (aOR = 1.8) to report an alcohol problem, almost three times (Adjusted Odds Ratio [aOR] = 2.7) as likely to have used alcohol in the hours prior to death, and over twice as likely (aOR = 2.1) to have a positive toxicology report compared to their white peers.<sup>6</sup>



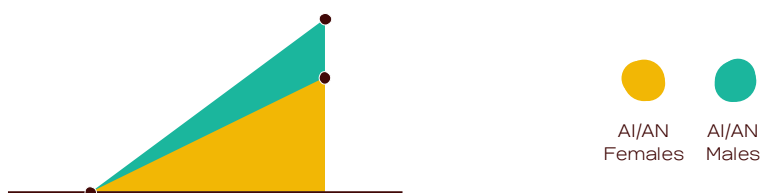


## MODULE 2 EPIDEMIOLOGY

### AI/AN Gender & Suicide

While AI/AN males are lost to suicide more frequently than females, between 1999 to 2017 the suicide rate increased 139% for AI/AN females and 71% for AI/AN males,<sup>7</sup> indicating that suicide among AI/AN females is also a critical concern.

AI/AN Suicide Rates by Gender, 1999 to 2017



## AI/AN Age & Suicide

While the numbers of youth suicide victims are growing at an alarming rate in the United States, they are especially alarming for AI/AN youth. Between 2003 to 2014, over one third (35.7%) of AI/AN community member losses to suicide occurred among youth between the ages of 10–24 compared to 11.1% of whites in the same age range.<sup>8</sup> More recently, AI/AN community members aged 25 to 29 have had the highest rates of suicide, at 29.21 per 100,000 individuals in 2017<sup>9</sup>.



## Geographic Location & Suicide

AI community members who live in rural or non-metropolitan areas are lost to suicide at a higher proportion than their white peers who live in similar settings. Data from the 2010 census indicates that 60% of AI community members in the United States and Puerto Rico live in urban areas<sup>10</sup>, yet almost 70% (69.4%) of AI community members who were lost to suicide resided in rural and nonmetropolitan areas, whereas 72.7% of white individuals who completed suicide resided in metropolitan areas<sup>11</sup> even though only 66% of white individuals live in urban areas<sup>12</sup>.

## Type and Circumstances of Suicide among AI/AN Community Members

AI/AN community members who are lost to suicide most often die by firearm (42.1%) followed by hanging, strangulation, or suffocation (39.7%).<sup>13,14</sup> Compared to whites, AI/AN community members who complete suicide tend to have more frequent instances of the following challenges<sup>15</sup>:

- experiencing problems with an intimate partner (1.2 times more likely)
- experiencing the suicide of a family member or friend (2.4 times more likely)
- and experiencing a nonsuicide death of a family member or friend (1.7 times more likely)

Awareness of these risk factors can alert providers and other community members to potentially vulnerable community members in the effort to prevent suicide.





## MODULE 3 EFFECTIVE PREVENTION STRATEGIES



The full SP Toolkit contains information and guidance for each of the five effective suicide prevention strategies listed below. This toolkit addendum provides additional information about warning signs, risk factors, and protective factors for AI community members to aid in risk assessment and safety planning.

- Train staff to recognize and respond to the warning signs of suicide
- Screen for and manage depression
- Screen all patients for suicide risk
- Educate patients about warning signs for suicide
- Safety Plan/Temporarily restrict means for lethal self harm







*“I cannot understate the importance of providers getting to know community members by mingling and mixing at community events, shopping local, and finding other ways to interact informally. Forming these relationships will facilitate valid assessments later.”*

*(Dan Foster, personal communication, May 2020)*

## MODULE 4 SUICIDE RISK ASSESSMENT

The tragedy of suicide among AI community members, as well as individual suicidal ideation, is most accurately understood within the complex socio-cultural factors, including hopelessness and isolation, associated with suicide risk in AI individuals. As you read through the information in the **Suicide Risk Assessment** and **Intervention** sections of this Addendum and in the full SP Toolkit, please refer also to the Community Response section below, as suicide risk in the individual AI patient should include an assessment of and appreciation for their community and socio-cultural context. Understanding these dynamics will provide clinicians with more accurate risk assessments and potentially effective safety planning interventions.

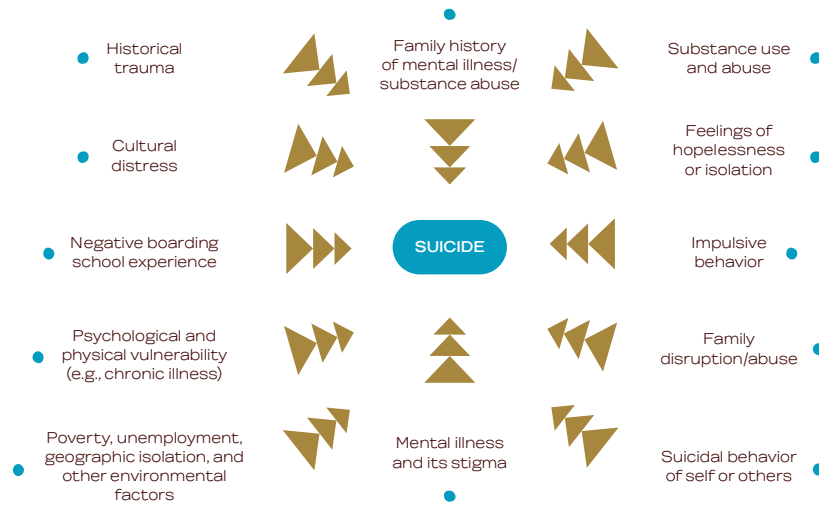
When assessing for risk of suicide with an AI patient using your own thoughtful questions or those provided in this SP Toolkit Addendum and the full SP Toolkit, providers are encouraged to pause and appreciate that AI community members may be more comfortable with reflective silence during a clinic visit. Tribal youth in particular may often be silent for long periods. Many providers are uncomfortable with silence and will talk/chatter to “fill the void” of conversation; appreciating the silence is an important skill to be mastered and can help elicit more information from AI patients (Echo-Hawk, personal communication, May 2020).

### 1. Assess Warning Signs and Risk Factors

In addition to the warning signs and risk factors addressed in the full SP Toolkit, there are several warning signs and risk factors specific to AI/AN communities, and culture and community provide extremely relevant context for these factors. The figure below lists many of the individual, social/environmental, and societal risk factors that are found to be applicable to community members, including:



Exhibit 1. Interrelated Risk Factors for Suicide Among American Indians and Alaska Natives\*<sup>16</sup>



\*Adapted from Walker, D., Walker, P.S., & Bigelow, D. (2006) *Native Adolescent Suicide Cofactors: Prevention and Treatment Best Practices*. PowerPoint presentation available from One Sky Center, at <http://www.oneskycenter.org/education/presentations.cfm>.

## SUBSTANCE USE

One risk factor for all individuals and for AI/AN individuals in particular is substance use. AI/AN youth have the highest overall rate of alcohol use of all racial/ethnic groups, and their marijuana use is more than double that of other racial groups.<sup>10</sup> Furthermore, research indicates that AI/AN youth tend to view substance use as less risky or harmful, which may decrease their inclination to seek help for substance use issues. Mental health challenges often co-occur with substance use for all racial groups. For individuals being treated for mental health concerns, 20 to 50% also have a substance use disorder, and for those being treated for a substance use disorder, 50 to 75% also have a mental illness. Best practice indicates that patients should be screened for both substance use and mental health issues regardless of the presenting issue(s). The SAMHSA Zero Suicide framework urges providers to screen all patients for thoughts of suicide. Please refer to the full SP Toolkit for information and tips on screening tools and their use in a clinic setting.



## HERE ARE SOME WAYS YOU CAN ASK AI COMMUNITY MEMBERS ABOUT SUBSTANCE USE:

- I know that it can be an uncomfortable topic but in order to help you best it's important for me to know about whether you've been using any drugs or alcohol; can I ask you a few questions?
- Have you had four or more (if female) or five or more (if male) drinks on one occasion, or at one time in the past month?
- Have you used drugs or medication for nonmedical reasons in the past month? Have you used any drugs or medication without your own prescription?
- Has drinking or drug use been a problem for you? Has it caused any problems with your friends, school, your family, your job, or legal trouble?
- During the past three months, how often have you not been able to do what was normally expected of you because of your use of any substances?
- Has a friend or relative or anyone else ever expressed concern about your use of substances?
- Have you ever tried and been unable to control, cut down or stop using substances?





## TRAUMA

A history of trauma is an all-too-prevalent life challenge for many tribal community members. It is critical to assess for trauma exposure and depth of unresolved trauma when providing treatment for AI patients. Trauma exposure and symptoms of unresolved trauma exposure can interfere with a patient's ability to follow prescribed instructions or to actively participate in treatment or other interventions.

Trauma can be categorized in four ways, according to Dolores Subia BigFoot, PhD. (Caddo Nation of Oklahoma/Affiliation with Northern Cheyenne Tribe of Montana in which her children are enrolled), Director of the Indian Country Child Trauma Center at the University of Oklahoma Health Sciences Center:



- **Cultural trauma:** An attack on the “fabric of society,” which affects the “essence” of the community. This is of relevance for AI individuals, because of experience of discrimination and racism, possible limitations of reservation life, as well as associated stress.
- **Historical trauma:** The cumulative effect of traumatic historical events on an individual or community that affects subsequent generations. Historical trauma often leads to intergenerational trauma.
- **Intergenerational trauma:** When trauma is transferred from the first generation or survivors to subsequent generations. If the trauma is not resolved, it is subsequently internalized and passed down to the next generation.
- **Present trauma:** Current traumatic events being experienced by AI community members in present or recent time (this includes experiencing abuse or neglect, witnessing violence, or other negatively overwhelming events).

As a provider it is important to determine if your AI patient has experienced any of the levels of trauma described. Providers must remain alert to the generational nature of cultural and historical trauma. Many AI children “suffered deprivations beyond description and those who did survive became the wounded guardians of the culture and tentative parents to the next generation of children.”<sup>18</sup> Understanding the contribution of various types of trauma to individual suicide risk can help providers refer the individual to potentially helpful types of treatment, services, and community supports.

## HERE ARE SOME WAYS YOU CAN ASK AI COMMUNITY MEMBERS ABOUT TRAUMA:

- **Have you ever had a stressful or scary experience that you really struggled to cope with or make sense of the situation?**
- **Have you had disturbing memories, thoughts, or images of the experience?**
- **Have you ever had physical reactions like heart pounding, trouble breathing, or sweating when something reminded you of the experience?**
- **Have you ever avoided thinking about or talking about the experience or tried to avoid your feelings about it?**
- **Have you ever avoided places or situations because they remind you of the stressful experience?**
- **Do you feel like you are emotionally numb?**
- **Do you feel as if you won't have a long life?**
- **Do you feel jumpy or easily startled?**

## LACK OF CULTURAL CONNECTEDNESS - FEELING ISOLATED OR DISCONNECTED

The need to feel connected is of critical importance to people, and a lack of belonging can affect physical and emotional health. Feelings of isolation and disconnection from family and peers can occur in anyone, and should be routinely assessed, especially among AI youth. This may also have relevance for AI veterans, who may feel even more isolated because of their combat experience, possible trauma, and sometimes repeated re-entry into their tribal communities after time spent in varying cultures and settings. Providers should routinely outreach to their military veterans and communities should engage their military veterans, who may be at elevated risk but can also be local assets in any community suicide prevention planning efforts. For example, The New Mexico Veterans Affairs (VA) Health Care System in Albuquerque, NM, created a Talking Circle Group for veterans as an adjunct to western primary and behavioral healthcare. Talking Circles are traditional way of bringing people together for the purposes



of teaching, listening, learning and sharing. The intent of the Talking Circle at the VA is to help group members feel like they are part of a larger community and thus assist with healing.

### **HERE ARE SOME WAYS YOU CAN ASK AI COMMUNITY MEMBERS ABOUT CULTURAL CONNECTEDNESS AND FEELINGS OF ISOLATION AND DETACHMENT:**

- **Do you feel a strong attachment to your community or nation?**
- **Do you have a traditional person, Elder or Clan Mother who you can talk to?**
  - » **These first two questions are taken from the Cultural Connectedness Scale- Short version.<sup>19</sup>**
- **How often are you involved in school or community or other tribal activities?**
- **How often do you get together to talk with friends?**
- **Do you feel useful to your family and friends?**
- **Do you feel connected to your family?**
- **Do you feel like you have at least one satisfying interaction with others per day?<sup>20</sup>**

### **FEELINGS OF DEPRESSION OR DESPERATION**

Another key risk factor for AI community members contributing to a struggle to find reasons to live is feelings of depression and desperation.<sup>21</sup> For many tribal community members who contemplate suicide, there are one or more factors contributing to a feeling of desperation. For adults these factors may include unresolved trauma/pain and substance use. For tribal young people it can be ongoing abuse they can't escape from; desperation to escape watching violence between family members; addiction and/or that of a parent (including substances and gambling) a beloved supportive teacher or other mentor leaving a rotation, recent romantic breakup, or a deep grief and desire to join a friend who was recently lost to suicide. For all age groups and issues, being heard is key to being inclined and able to accept help. Furthermore, asking about and including the patient's views on any solution may be an important way for someone who feels least valuable to feel that their opinion is heard. In AI communities, it may be helpful to bring in a traditional lens of the need to honor one's Elders, contribute to the community, and consider how actions may affect subsequent generations.

### **HERE ARE SOME WAYS THAT YOU CAN ASSESS AI COMMUNITY MEMBERS FOR FEELINGS OF DEPRESSION OR DESPERATION:**

- **Have you been worried that there is no way to escape some of the stressors in your life?**
- **Do you need some help working through your challenges right now?**
- **Have you been feeling sad or down a lot lately?**

### **SHAME, OR STIGMA**

Cultural values and beliefs can have profound effects on whether or not an individual who is struggling will seek help. Many AI community members feel shame about needing mental health help, especially if it involves seeking that help from non-native providers. Concern about confidentiality in small communities can also be a barrier to help-seeking. Risky behaviors can be normalized in some tribal communities which means that help-seeking may not even be a consideration for some. Many religious beliefs consider suicide a "sin" or otherwise taboo and this stigma or shame has filtered throughout the general population and AI communities. In fact, many AI communities avoid discussing death by suicide, and providers using the phrase "committed suicide" may increase this sense of shame as it is reminiscent of "committing



a crime.” Similarly, there can be stigma around seeking help from Western mental health practitioners. When individuals perceive that they may be judged negatively for seeking mental health help, they may avoid seeking some types of treatment. The full SP Toolkit contains tips on how providers can help reduce the general stigma of seeking help for mental or emotional issues. But the tribal perspective may be different. In the provider office setting, tribal tips include learning to recognize silent pain; being empathetic and respectful; allowing the patient time to tell their story; ability to talk freely and non-judgmentally about mental and emotional pain and ways to recover; and the impact of grief on physical health. Some tribal clinics use video stories of recovery that play in waiting rooms, have tribal youth poster contests about suicide prevention that are placed in the clinic, and other types of messaging around the clinic that normalize and encourage seeking help. Clinic providers should also have ample mutual referral resources encouraging and providing access to traditional forms of healing in the community. Some AI community members will seek and have success using traditional practices and don’t need to seek mental health or substance use help from clinics, and some will have success with using a combination of tribal traditional practices and clinic support (Echo-Hawk, personal communication, May 2020). The important concept for providers to remember is to listen to the patient, ask about what supports typically work for them, and facilitate access to those supports.





## ADDITIONAL RISK FACTORS FOR AI YOUTH

There are some additional individual, social and generational risk factors to consider for AI reservation youth as they attempt to navigate the challenges posed in their environments, which may be marked by discrimination, economic disadvantage, and other stressors. Research has shown that the following challenges and adverse childhood experiences can affect suicide risk in AI youth:

- Discrimination and racism, and the related stress and anger, even rage that these oppressive conditions bring.<sup>22</sup>
- Anger and Depression
- Family history of drug abuse
- An arrest history
- Diagnosis of Conduct Disorder
- Being a victim of physical and sexual abuse
- Rejection by family members due to LGBTQ/ Two Spirit orientation

For urban youth, research has identified additional risk factors correlated with suicidal behavior, although these factors may be found among rural and reservation youth as well:

- Less social support
- Diagnosis of conduct disorder



When assessing AI youth (particularly teens and younger) for risk of suicide, Dr. Dan Foster, Consulting Psychologist at Fort Belknap Integrated Behavioral Health, advises providers to remain polite, but to take charge in a gentle manner. Tell patients, “I am going to ask you a few questions” rather than asking “may I ask you a few questions?”. This subtle difference communicates that you are an adult that cares, you already know they are ambivalent and confused, and you want to gently help them (Foster, personal communication, May 2020).

## SUICIDE CONTAGION OR CLUSTER SUICIDE

A critical risk factor is personal experience of recent losses, including losses to suicide. Individuals within a community where one suicide has taken place may be more likely to attempt suicide themselves, especially if they were particularly close

to the person who took their life. Youth and family members appear to be especially vulnerable to this dynamic. This “suicide contagion” (one suicide seeming correlated with other suicides) may be decreased by involving Elders and youth in decision making, the presence of adult role models, and traditional healing practices.<sup>23</sup> As mentioned previously, the death of a family member, loved one, friend, or acquaintance should prompt assessment for thoughts of suicide in patients. Please see the Community Response





section of this toolkit for more information on crucial community response to suicide contagion, but providers must be aware of the increased risk associated with recent losses to suicide in the community.

## **HERE ARE SOME WAYS THAT YOU CAN ASSESS AI COMMUNITY MEMBERS ABOUT RECENT LOSSES INCLUDING LOSSES TO SUICIDE:**

- **Have you lost anyone close to you recently? Have you lost anyone to suicide? Can you tell me about that?**
- **When applicable- I've heard that the community suffered a tragic loss to suicide recently; have you been affected by that loss?**

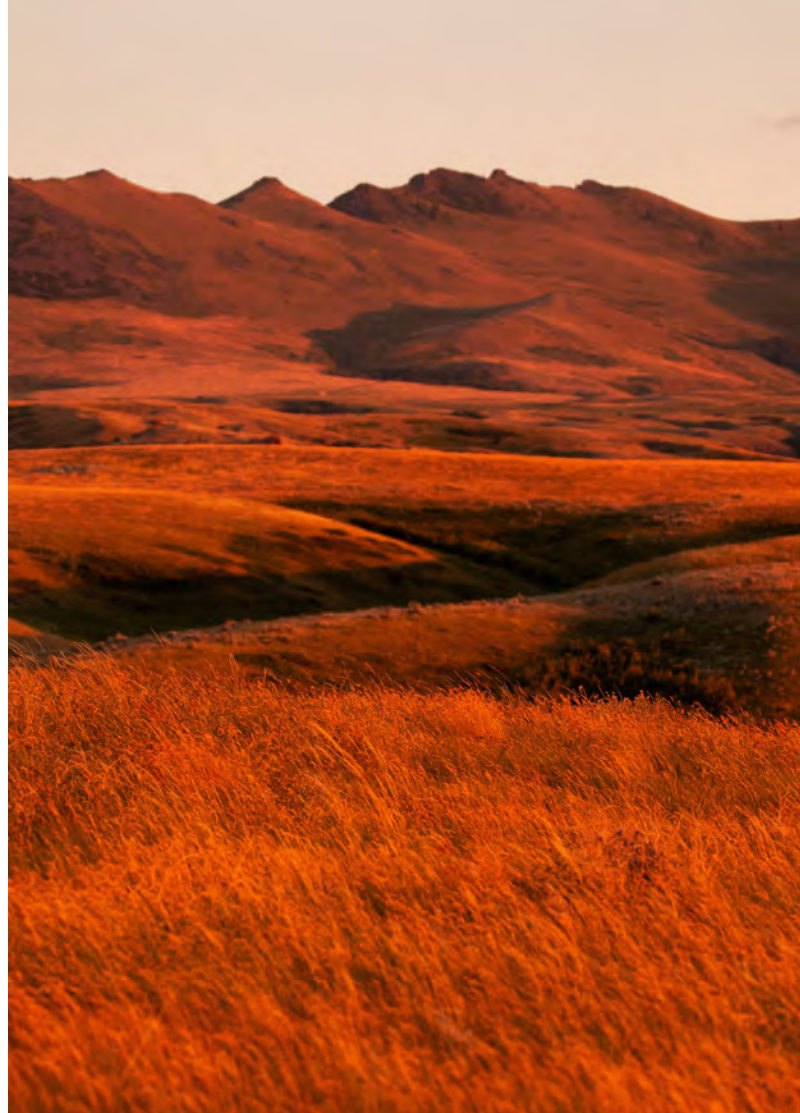




## 2. Assess Protective Factors

Protective factors have been found to mitigate the longer-term risk for suicide and can serve as the foundations when engaging in safety planning with a patient. Providers should understand the value of the strengths as mitigation, and build crisis plans that highlight or boost the protective factors for patients as risk for suicidal behavior. Understanding the community's strengths are as important as understanding the patient's strengths. Protective factors include:

- Community and family support
- Positive peer support
- Cultural beliefs that emphasize reasons for living and future roles as tribal leaders
- Access to a variety of clinical interventions mental, physical, and substance abuse disorders, along with ongoing support from medical and mental health professionals, although many tribal communities lack some or all of these resources.
- Coping skills and conflict resolution skills
- Restricted access to lethal means of suicide
- Strong tribal spiritual and religious beliefs - A study of AI community members living on reservations found that individuals with a strong tribal spiritual orientation were half as likely to report a suicide attempt in their lifetimes.<sup>24</sup> Previous research shows that religion is a protective factor in the general population, and tribal spiritual and religious beliefs are protective factors.
- Social Connectedness - Research shows that one of the most significant protective factors against suicide attempts in AI individuals is feeling connected to family, feeling able to discuss problems with family or friends, and general positive emotional health.



***“Embedded in Native American culture are many protective factors to weather adversity and ward off the potential development of mental illness.”<sup>25</sup>***



## CULTURAL CONNECTEDNESS AND CULTURAL CONTINUITY

Similarly, research with First Nations in Canada has found that Cultural Connectedness, the level of awareness and engagement an AI/AN individual has to their identity, tribal traditions and spirituality, plays a role in positive mental health, especially among youth.<sup>26</sup> Tribal communities have long believed in the power of cultural continuity and cultural practices as part of wellness and healing. In addition, re-

*Asking about suicide and suicidal thoughts can be very uncomfortable for some providers – it is important for providers to assess their own level of comfort with suicide inquiry and rehearse or role-play to increase their level of comfort.*



searchers have found a connection between “cultural continuity” and reduced suicidal behavior. In communities that actively work to preserve their heritage, individuals are more protected from suicide.<sup>27</sup> As tribal people have long known, researchers believe that when individuals have a secure sense of the past, present, and future of their culture, it is easier to maintain a sense of connectedness of own’s own future, or self continuity. For tribal communities, self-continuity also means tribal community continuity (Echo-Hawk, personal communication, May 2020). Aspects of culture that reduce risk of suicide, such as spiritual beliefs, traditional values and healing methods, and spiritual and cultural continuity can be enquired about and encouraged. Since culture is the foundation of personal identity, if culture is devalued or thrown into disorder, then individuals have confusing grounds to form a coherent sense of self and could become indifferent to reasons for living.



## HERE ARE SOME WAYS YOU CAN ASK AI COMMUNITY MEMBERS ABOUT CULTURAL CONNECTEDNESS AND CULTURAL CONTINUITY:

- **How do Elders in your community help community members overcome past traumas and maintain culture identity?**
- **What traditional beliefs taught you self-discipline, coping and problem-solving skills? Can you use these now?**
- **What or who could help you feel stronger and have greater hope?**



### 3. Suicide Inquiry

When a screening is positive or when warning signs and risk factors are present, be sure to ask directly about thoughts of suicide, and to sensitively communicate that frank and honest discussion is necessary even if it is uncomfortable and creates anxiety. Please see the full SP Toolkit for complete information on the suicide inquiry. How you ask the questions affects the likelihood of getting a truthful response. Use a non-judgmental, non-condescending, matter-of-fact approach. Suicide Inquiry always involves asking about the following components, and getting information about each of these components is essential to effective safety planning:

- **Thoughts of Suicide** - What kinds of thoughts is the patient having? How often? You can ask:
- **Plans for Suicide** - Does the patient have a concrete plan? What does it entail? Does the patient have a timeline?
- **Intent of Suicide** - What is the individual's motivation, what are they hoping to resolve or avoid? Understanding intent can help you assist the patient with safety planning and problem solving.
- **Access to Lethal means** - How accessible is the means the patient intends to use?

NEVER ask leading questions like: "You're not thinking of suicide, are you?" or "I hope that you aren't thinking about hurting yourself."

An AI community member's thoughts of suicide are best understood through a cultural lens. For example, in some cultures suicide may be viewed as honorable when an individual's death is an atonement for shame, a protest against injustice, or a form of martyrdom in service of a cause, religion or for others. AI community members may be reticent to report symptoms to physicians, especially regarding substance use.<sup>28</sup> Providers should be prepared to ask about symptoms in various ways to maximize the accuracy of reporting.

Individuals contemplating suicide may also communicate unclear warning signs that are difficult to recognize. Researchers posit that some AI individuals may avoid directly discussing their thoughts of suicide in order to avoid an "unpleasant" conversation that they fear may lead to embarrassment on both sides, and not wanting to be a burden to others. In some ways, being vague or indirect with a call for help is protective for an individual, as they can avoid embarrassment if the listener does not respond appropriately. The vagueness allows both sides to "save face" during a potentially difficult situation.<sup>29</sup> Furthermore, it is a myth that asking about suicidal thoughts will cause someone to consider suicide. These factors point to the importance observing carefully and of inquiring gently, empathically, but directly, about thoughts of suicide in a culturally sensitive way.

The use of active listening is particularly helpful at this time. Active listening involves the listener patiently concentrating on, understanding, and responding to what is being said, in a way that communicates that understanding to the speaker.

#### HERE ARE SOME WAYS TO ASK AI COMMUNITY MEMBERS ABOUT SUICIDAL THOUGHTS:

Consider prefacing questions with, "I know that this can feel awkward to talk about, but I really want to help you today..."

- **Have you been struggling to find reasons to live? (Thoughts)**
- **Many people in our community have been facing so much pressure and stress, and**



sometimes they might think about killing themselves. Have you had thoughts about killing yourself/ending your life? (Thoughts)

- “Have you ever thought things would be better if you were not alive?”

If patient does report thoughts of suicide-

- “How often do you have thoughts of ending your life? How long do they last? How strong are they?” “What is the worst they have ever been?” (suicidal thoughts)
- “What do you do when you have suicidal thoughts? Do you find that you have them more frequently or more intensely at different times of the day or of the week?” (suicidal thoughts)
- Can you tell me why you’ve been thinking about killing yourself? Do you have feelings or a problem that you are trying to escape? (Intent)
- Have you thought about how you would end your life? Have you made a plan? Have you thought about when you might do this? (Plan)
- Do you have the [gun, medication, rope or cord, other means] that you are thinking of using to end your life? (Access to lethal means)
- Do you feel like you can talk to your family/friends about the feelings you’ve been having about ending your life? If not, could I help you talk with them?

Look for any disagreement between what you see (objective findings) and what the patient tells you about their suicidal state (subjective findings). When possible, and always with youth, seek to confirm the patient’s reports with information from a family member, spouse, or close friend. Patients are more likely to tell a family member than a PCP that they are suicidal.

Determine the extent to which the patient expects to carry out the plan and believes the plan or act to be lethal vs. self-injurious. Also explore the patient’s reasons to die vs. reasons to live. Many patients are very ambivalent about suicide – see Module 5: Intervention – of the SP Toolkit to learn more about ways to capitalize on this ambivalence and get them focused on reasons for living.

**“Silence is dangerous when we pretend the problem is not there ... communication is a healer to break the silence.”<sup>30</sup>**

*Canadian First Nations Elder*



## 4. Clinical Judgement of Suicide Risk

Assessing suicide risk in primary care is complex when patients have medical illnesses, mental health and substance abuse problems, and myriad family, contextual and environmental risk and protective factors. At the low end of the risk spectrum are patients without thoughts of death or wanting to die, and without intent or a plan. Those with highly specific suicide plans, preparatory acts or suicide rehearsals, and clearly articulated intent are at the high end of the risk spectrum. Impaired judgment (intoxication, psychosis, TBI, impulsiveness) further exacerbates that heightened risk. There is no screening tool or questionnaire that can predict with complete accuracy which patients from among the many with suicidal risk will go on to make a suicide attempt, either fatal or non-fatal. The pocket guide developed by the WICHE Mental Health Program and Suicide Prevention Resource Center in the SP Toolkit provides a decision tree for use by primary care professionals in assessing suicide risk and determining appropriate interventions.



Please refer to the full SP Toolkit for detailed information on all components of Intervention. The first steps to getting help for AI community members may not be in the primary care setting. It may instead be a traditional healer or ceremony, Native American Church ceremony, or talking to an AA sponsor or close friend (Echo-Hawk, personal communication, May 2020). Primary Care Intervention always involves the following components:

1. Primary Care Treatment
2. Collaborative Safety Planning
3. Referral to Evidenced Based and Culturally Appropriate Treatment
4. Documentation and Follow-Up Care

## **1. Primary Care Treatment**

Many primary care providers can medically treat depression and anxiety, which reduces the risk of suicide, without referral to a psychiatrist. Again, please refer to the full SP Toolkit for detailed information on and additional resources for this step.

## **2. Collaborative Safety Planning**

Working together with a patient, and ideally a supportive person in the patient's life, to create a Safety Plan is critical to preventing suicide. The Safety Plan is an individualized physical document that provides structure, resources and coping strategies for a patient struggling with suicidal thoughts. Please see the full SP Toolkit for complete information on collaborative safety planning and see Appendix A in this addendum for a Safety Plan template that you can use with your American Indian patients.

### **LETHAL MEANS RESTRICTION**

A critical step in collaborative safety planning is engaging AI community members and their loved ones in concrete steps to restrict lethal means. Providers work with the patient, their loved ones, and other involved helpers to restrict these means. In AI communities, the most common means of dying by suicide involve firearms or hanging or suffocation. Restricting access to firearms, including with patients who are veterans, is already well documented in the toolkit. Briefly, providers will want to help their patients engage with loved ones about who might be able and willing to temporarily but securely store a suicidal patient's firearms, so they are not immediately available to the patient. Another option is to help patients obtain a gun lock and have a loved one temporarily take possession of the key. Click here for information about obtaining free gun locks: <https://projectchildsafe.org/safety/safety-kit/>.

Lethal means restriction is even more challenging when the method of suicide is more difficult to restrict, such as by hanging<sup>31</sup> or suffocation. This method is used almost as frequently as firearms by AI youth and overall is increasing in frequency among most ethnic groups across the United States.



Restricting access to means such as hanging takes multiple approaches. First, providers can work with loved ones to do what they can to make it more difficult to die by suicide using hanging, such as gathering up ropes and cords, and asking the patient to give up their belts to a family member. For example, researchers discussed an indigenous community that removed closet rods and bedroom door locks.<sup>32</sup> Finally, providers should counsel family members and even friends (with the proper permissions) about ensuring that someone is always with a patient who is thinking about suicide.

For means that are difficult to restrict, such as hanging, the CDC also recommends that AI/AN communities to consider other “modifiable” factors. Examples include identifying trends in bullying that would benefit from school prevention efforts, day of the week or seasonal patterns that could inform additional programs or supports for youth, monitoring when alcohol or other substance use may be higher than normal (such as community celebrations) or even economic changes (industry closings) that may lead to higher risk.<sup>33</sup>





### 3. Referral to Evidence Based Treatment

Primary care providers should use an integrated care approach for suicidal patients including, when available, referral and close coordination with behavioral health treatment providers. When behavioral health treatment providers are not accessible, primary care staff can follow all of the intervention steps in the full SP Toolkit to help keep their patients safe.

Before providing a referral, assess your patient's level of comfort and likelihood of complying with a referral for mental health treatment or other helpful interventions; ask about any barriers to compliance and help provide solutions for those barriers. All patients likely have additional barriers to treatment discussed below. Using a "warm handoff" to a behavioral healthcare provider is crucial for patient compliance with such a referral, for example, offer clinic staff assistance to set the original appointment and set the appointment together with the patient and answer any questions the patient has about the new provider. When a provider assesses that a patient most likely will not follow through with a referral to behavioral health treatment, the provider should make repeated and supported efforts for a successful referral over time, but should also use the information and processes in the Suicide Prevention Toolkit for Primary Care Practices to address and impact suicide risk themselves.

***“Empirically-based science leaves no room for the cultural context that is crucial to the success of a treatment approach within tribal communities.”***

*Holly Echo-Hawk, Echo-Hawk and Associates & Pawnee Nation*





## CULTURAL CONSIDERATIONS

Historical trauma may impact tribal interest in professional services. Some AI individuals may (correctly) believe that non-native professional providers represent a white majority system and may not understand their culture, or they may be apprehensive what to expect from mainstream health care. Often, AI individuals may choose to use traditional healers instead of physicians and value advice from the traditional healer over that of a physician. Effective treatment for AI will encourage the use of both traditional and mainstream therapies and interventions, meeting each client where they are in terms of trust and use of various treatment systems.

*Behavioral health providers should note that the standard 50-minute psychotherapy model may not be the best approach for AI clients. There is a dearth of research on evidence-based practices with AI individuals, but promising practices include meeting clients at a physical location where they are comfortable (at home, etc.), or using “cruise therapy”—providing counseling while driving individuals around the reservation or to other appointments or errands. Both are non-traditional forms of therapy that respect clients need for confidentiality and help build therapeutic rapport<sup>34</sup>*





#### ***4. Documentation and Follow-Up Care***

Please review the full SP Toolkit for guidance about documentation and follow-up care. Briefly, providers should be sure to assign a staffperson to follow -up with a suicidal patient within 24 hours of a visit or other contact and assessment. If a patient experienced a psychiatric hospitalization (and remember, this should be the treatment of last resort due to the spike in suicide risk post-hospital discharge), follow-up must occur within the first 24 hours of discharge, and thereafter as needed.



## COMMUNITY RESPONSE

### Suicide Prevention at the Community Level

While the Suicide Prevention Toolkit for Primary Care Practices is focused on assessment and treatment of suicidal thoughts and feelings at the individual level in the primary care setting, the social and cultural factors associated with suicide in AI communities must be considered and addressed to effectively prevent suicide overall.<sup>35,36</sup> Thus, community level suicide prevention is briefly addressed here. Mainstream programs need to be adapted to be effective for AI communities. According to Bird (2016), it is especially important to understand a community's culture, including its strengths and taboos related to suicide.<sup>37</sup> Bird recommends engaging in a **“community-based participatory prevention”** approach, which invites community members to participate in the process of developing a suicide prevention program that fits within their community's particular culture and belief system. One of the most helpful actions a primary care clinic can take for their patients is to devote some staff time to being involved with any community suicide prevention initiatives. Community members are aware of their community's taboos related to suicide and may be able to facilitate discussion about these topics, and lead community discussion to determine the best ways to address issues that are not typically discussed. For instance, some AI cultures believe that talking about death can cause it to happen or that talking about a deceased person may hinder the deceased's ability to move on from the physical world. These beliefs are not universal among AI groups, however, which makes it essential to understand how a community thinks and talks about suicide in order to effectively reframe suicide prevention messages.

Bird also notes that AI communities may be hesitant to collect or share data on suicide because many have seen this information used to perpetuate stereotypes. If this has been the experience within a community, community members can be helped to understand how data on suicide can be used to reduce suicide.<sup>38</sup> In 2001, the White Mountain Apache Tribe (WMAT) created the WMAT Suicide Surveillance System to collect data on suicidal behavior from community and clinical settings and saw decreased in deaths by suicide in their community.<sup>39</sup> Through a tribal mandate, WMAT collects data from all medical, social service, and school personnel working within the tribal area. These personnel report all observed cases of suicide ideation, attempts, and deaths. In this way, community health providers were alerted to issues even before a tragic death and then successfully strategized with their community partners to intervene most effectively. Primary care providers can play an important role in contributing to the development of similar systems in their areas to better understand and track suicide in their communities.



When working on a community level, it is critical to assess how the community views mental health, substance use, and seeking help. Once there is an understanding of any community or cultural stigma around these issues, more effective messaging can be developed to combat the stigma.

Finally, include community strengths into conversations about suicide. Reports on suicides in AI communities are often very negative and filled with stereotypes about Native populations, which Native people may then internalize. Highlighting the strengths of AI communities, such as strong family connections, respect for elders, and so on brings these protective factors to the forefront of intervention and prevention efforts.<sup>40</sup> Providers should discuss these strengths with consumers and include them in the risk inquiry and safety planning processes.

## Avoiding Suicide Clusters/Contagion

A suicide within a community or tribe is a tragedy that can greatly impact the lives of others within that group. Individuals touched by the suicide will need additional support from their community as they process their grief and try to make sense of their loss. When one person completes suicide there is also a risk of suicide contagion, meaning that survivors may be at increased risk of also completing suicide. Therefore, it is ideal for communities to develop their own response to suicide to prevent further tragedy. The more the community is involved in suicide prevention efforts, the more successful the efforts will be. Find resources for addressing and suicide contagion and community prevention strategies under **Postvention**, below, and in the **Additional Resources** section of this Toolkit Addendum.

### Involving Elders and Community Members

Including community members and Elders in suicide prevention/containment plans is essential for the success of the effort. The Centers for Disease Control (CDC, 2014) recommends that AI/AN communities (1) use culturally competent practices, (2) create a shared community-vision of wellness through the connection of resources, and (3) talk to community Elders to gain an understanding of suicide within the specific community/tribe. Some questions outlined by the CDC (2014) for talking with Elders about difficult issues in their community include:

- How have community members traditionally come together to address challenges and issues?
- What are the stories that can motivate members to address an issue as important as suicide prevention and guide them in their efforts to join together in action?
- What are some examples of how the people have overcome difficult barriers in the past?

### Indian Health Services (IHS)

In addition to community efforts to prevent and recover from suicide, IHS has created an emergency response system uniquely designed for assisting AI communities dealing with suicide. Through this model, IHS and the U.S. Public Health Service (USPHS) provide emergency mental health and community outreach services for up to 90 days to help decrease the burden and immediate impact of the suicide on community members. The process for AI communities to request this assistance at various levels (e.g., Tribal, IHS Area, IHS Headquarters, and Local Community-level responses) is located here:

<https://www.ihs.gov/suicideprevention/communityguidelines/>

### Media Coverage

Consider how suicide is reported in the media to avoid suicide contagion. For instance, suicide should not be presented in a manner that romanticizes or glamorizes the event. Information on crisis intervention re-



sources, suicide hotlines, and treatment should be emphasized often. The Suicide Prevention Resource Center has created a guide for Safe Reporting on Suicide for community reporters and editors. The complete guide can be accessed here: <https://health.cornell.edu/sites/health/files/docs/Safe-reporting-on-suicide.pdf>

### **Postvention**

Community response following one or more deaths by suicide is also known as “postvention”. Along with prevention, postvention is critical to avoiding additional deaths by suicide when tragedy does strike a community in this way. There is not enough room in this addendum to cover all the information regarding community response to suicide, but some resources are provided below:

The Center for Disease Control (1988) provides recommendations for community plans for the prevention and containment of suicide clusters. In addition to reviewing the CDC suggestions, the CDC recommends that communities review their recommendations and develop their own response plan before a suicide occurs. A good suicide prevention/containment plan will include all members of the community who could like to be involved, it should identify community resources, and create a coordination committee who can respond to crises. To see all the CDC’s recommendations, visit: <https://www.cdc.gov/mmwr/preview/mmwrhtml/00001755.htm>

### **Here are several excellent, culturally appropriate toolkits for community prevention of suicide in AI communities:**

- **Indian Health Service’s Methamphetamine and Suicide Prevention Initiative**  
This is a national pilot program, which focuses on providing methamphetamine and suicide prevention and intervention resources to communities in Indian Country. For more information on this program visit the website at: <https://www.ihs.gov/mspi/>.
- **The American Indian Life Skills Curriculum**  
This curriculum was created by Dr. Teresa LaFromboise in collaboration with the Zuni Pueblo and Cherokee Nation of Oklahoma. This culturally tailored curriculum addresses social and life skills, increases awareness about suicide, and provides methods for students to help a peer turn away from suicidal thinking and seek help. For more information, see: <http://uwpress.wisc.edu/books/0129.htm> and LaFromboise, T., & Howard-Pitney, B. (1995). The Zuni life skills development curriculum: Description and evaluation of a suicide prevention program. *Journal of Counseling Psychology*, 42(4), 479-486.
- **The White Mountain Apache Suicide Surveillance and Prevention System**  
The White Mountain Apache tribe, along with their partners at Johns Hopkins University, developed a suicide surveillance and mandated reporting system, which has been effective in decreasing suicide rates. For more information on this project, see: <https://www.sprc.org/news/white-mountain-apache-tribe-decreases-suicide-deaths-attempts>, <http://www.sprc.org/sites/default/files/resource-program/WMA%20SSS.pdf>, or Cwik, M. F., Tingey, L., Maschino, A., Goklish, N., Larzelere-Hinton, F., Walkup, J., & Barlow, A. (2016). Decreases in suicide deaths and attempts linked to the White Mountain Apache suicide surveillance and prevention system, 2001-2012. *American Journal of Public Health*, 106(12), 2183-2189.
- **The Gathering of Native Americans (GONA) Responding to Suicide Training**  
The GONA Responding to Suicide training is based on a model used for the past 40 years which helps native communities heal from the lasting effects of colonization, including high suicide rates.

This is a three-day, interactive event for staff members in tribal communities working in prevention, social services, behavioral health, and tribal leaders. For more information, visit: <https://www.nativewellness.com/gathering-of-native-americans-gona---responding-to-suicide.html>

- **Qungasvik Toolbox (Toolbox for Living)**

This toolkit focuses on youth substance use and suicide prevention and has many cultural and bicultural activities designed to build protection these challenges in AI communities, families and youth. The Toolkit includes community case examples and can be found here:

<https://www.sprc.org/resources-programs/qungasvik-toolbox-toolbox-promoting-youth-sobriety-reasons-living-yup%E2%80%99ik-cup%E2%80%99ik>

- **The Substance Abuse and Mental Health Services Administration's (SAMHSA) 2017 "Suicide Clusters within American Indian and Alaska Native Communities: A Review of the Literature and Recommendations"** is a helpful compendium of information and recommendations for clusters of death by suicide in AI communities. This report can be found here:

<https://store.samhsa.gov/system/files/sma17-5050.pdf>

- **Native P.R.I.D.E. (Prevention, Research, Intervention, Development, and Education)**

Native P.R.I.D.E. offers a variety of programs for Indian Country, including Native H.O.P.E. (Helping Our People Endure). Native H.O.P.E. creates a safe space for Native youth to discuss suicide, substance abuse, and mental health. Native H.O.P.E. uses a peer-counseling approach to help Native youth help their peers through times of crisis. For more information, see:

<http://www.nativeprideus.org/programs.html>

- **The Warrior Movement**

The Warrior Movement is in Montana and provides free activities for youth and communities to promote a sense of belonging and to bring awareness about suicide to those who may be able to support others in times of crisis. For more information, visit: <https://www.jointhewarriormovement.com/?fbclid=IwAR3jxkAL7O74Oj9vO3VeK7OT2MDX97zW1pRJJa8wC2e2vY9W60szWunGn7Ys>

- **Northwest Suicide Prevention Tribal Action Plan: A Five-Year Strategic Plan for the Tribes of Idaho, Oregon, and Washington 2009-2013**

The Tribal Action Plan was initiated by the Northwest Portland Area Indian Health Board in collaboration with other tribal health organizations. The mission of the Tribal Action Plan is to decrease suicide rates among AI in the Pacific Northwest through increasing capacity and collaboration. To view to strategic plan, see: [http://www.npaihb.org/images/healthissues\\_docs/suicide/NW%20Tribal%20Suicide%20Action%20Plan%202009.pdf](http://www.npaihb.org/images/healthissues_docs/suicide/NW%20Tribal%20Suicide%20Action%20Plan%202009.pdf).

- **To Live to See the Great Day that Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults**

This suicide prevention manual provides a foundation for community-based suicide prevention for AI youth and youth adults. It provides information on suicide risks and protective factors, as well as prevention models. To view the manual, visit: [https://www.sprc.org/sites/default/files/migrate/library/Suicide\\_Prevention\\_Guide.pdf](https://www.sprc.org/sites/default/files/migrate/library/Suicide_Prevention_Guide.pdf) or see U.S. Department of Health and Human Services. To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults. DHHS Publication SMA (10)-4480, CMHS-NSPL-0196, Printed 2010. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2010.

- **American Indian and Alaska Native National Suicide Prevention Strategic Plan (Indian Health Services)**

This strategic suicide prevention plan fosters collaborations across Tribes, Tribal/Indian organizations,





and Indian Health Services. The website offers suicide prevention resources, including how to discuss suicide, warning signs, patient and provider resources, and AI Community Crisis Response Guidelines. For more information, visit the website at: <https://www.ihs.gov/suicideprevention/about/>

## Additional AI Suicide Prevention Resources

### AI LGBTQ and Two-Spirit Resources

- **NativeOUT**

NativeOUT is a nonprofit that provides news, information, and events to support LGBTQ and two-spirit people. For more information, visit: <https://www.facebook.com/nativeout/>

- **Ensuring the Seventh Generation:**

#### **A Youth Suicide Prevention Toolkit for Tribal Child Welfare Programs**

This toolkit was developed by the National Indian Child Welfare Associate to help educate child welfare workers on issues related to child suicide, including risk factors and warning signs, as well as prevention and intervention strategies. To access the toolkit, see: <http://www.icctc.org/August2013/PMM%20Handouts/Youth%20Suicide%20Prevention%20Toolkit.pdf>

- **Suicide Prevention and Two-Spirit People Report**



This report describes how AI communities can support two-spirited people and reduce their risk of suicide. To view the report, go to: [https://ruor.uottawa.ca/bitstream/10393/30544/1/Suicide\\_Prevention\\_2Spirited\\_People\\_Guide\\_2012.pdf](https://ruor.uottawa.ca/bitstream/10393/30544/1/Suicide_Prevention_2Spirited_People_Guide_2012.pdf)

## Historical Trauma and Trauma-Informed Resources

### Indian Country Child Trauma Center (ICCTC)

The ICCTC was originally funded by the Substance Abuse Mental Health Services Administration (SAMHSA) to develop trauma-related treatment, training, resources, and technical assistance designed for AI children and families. Their website offers information on treatment models, resources, demographics, and publications. To visit their website, go to: <http://www.icctc.org/index.asp>

### Indian Health Services

A list of resources from IHS: <https://www.ihs.gov/suicideprevention/providerresources/>

### National Native Children's Trauma Center (NNCTC)

The University of Montana's NNCTC is part of the National Child Traumatic Stress Network and provides trainings on AI childhood trauma. For more information, visit their website at: <https://www.nnctc.org/>

### SAMHSA's Tribal Training and Technical Assistance Center (TTAC)

The Tribal TTAC offers training and technical assistance on suicide prevention, mental health, and substance use for AI. To learn more, visit: <https://www.samhsa.gov/tribal-ttac>

### Suicide Prevention Resource Center (SPRC), American Indian/Alaska Native Settings

SPRC has a variety of information and resources for understanding and preventing AI suicide. To see their resources, visit the website at: <https://www.sprc.org/settings/aian>

### Telehealth

*Tele-behavioral health may be a useful tool for communities in suicide prevention, particularly for rural or small communities that have limited behavioral health services*

Tele-mental health guide: <http://www.tmhguide.org>.

Tele-health projects with AI communities being conducted at the University of Colorado: [http://aianp.uchsc.edu/cnatt/cnatt\\_index.htm](http://aianp.uchsc.edu/cnatt/cnatt_index.htm).

### We R Native

We R Native was created by Native youth for Native youth, and offers various health resources on their website, including information on suicide. They have articles on various mental health topics, address how to talk to loved ones about suicide, resources for support, as well as videos and shared stories. To learn more, visit their website at: <https://www.wernative.org/my-life/my-mind/suicide>

### Walking Softly to Heal: The Importance of Community Readiness

Walking Softly to Heal offers a manual and a three-part webinar to assess Native community readiness for suicide prevention. A list of links to these resources are here: [https://www.sprc.org/sites/default/files/CRM\\_Resources-%20Final%2011.29.2016.pdf](https://www.sprc.org/sites/default/files/CRM_Resources-%20Final%2011.29.2016.pdf)





## My Safety Plan – How I Stay Strong & Keep Myself Safe

What are my warning signs that things are getting worse for me? (thoughts, images, mood, situation, behavior) That a crisis may be developing?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What are my internal coping strategies – things I can do to take my mind off my problems, ways I can calm and center myself? (relaxation technique, physical activity, distractions)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Who can I reach out to or where can I go that provides healthy distractions?

1. Name \_\_\_\_\_ Phone \_\_\_\_\_
2. Name \_\_\_\_\_ Phone \_\_\_\_\_
3. Place \_\_\_\_\_
4. Place \_\_\_\_\_

Who can I reach out to for help?:

1. Name \_\_\_\_\_ Phone \_\_\_\_\_
2. Name \_\_\_\_\_ Phone \_\_\_\_\_
3. Name \_\_\_\_\_ Phone \_\_\_\_\_

Other professionals or agencies I can contact during a crisis:

1. Clinician Name \_\_\_\_\_ Phone \_\_\_\_\_  
Clinician pager or emergency contact # \_\_\_\_\_
2. Clinician Name \_\_\_\_\_ Phone \_\_\_\_\_  
Clinician pager or emergency contact # \_\_\_\_\_
3. Local Urgent Care services  
Urgent Care services address \_\_\_\_\_  
Urgent Care services phone \_\_\_\_\_
4. **Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)**

How do I make my environment safe? Who can temporarily keep my guns, medications, or other things I might use hurt myself?

1. \_\_\_\_\_
2. \_\_\_\_\_



## My Safety Plan – How I Stay Strong & Keep Myself Safe (continued)

These are my reasons for living:

These are the ways my culture and community keep me safe:

These are the ways my culture and community keep me safe:

These are the things I am still looking forward to doing one day:

These are the things I am still looking forward to doing one day:



<sup>1</sup>Crawford, M. (2004). Suicide following discharge from in-patient psychiatric care. *Advances in Psychiatric Treatment*, 10(6), 434-438. doi:10.1192/apt.10.6.434

<sup>2</sup>Qin P, Nordentoft M. Suicide Risk in Relation to Psychiatric Hospitalization: Evidence Based on Longitudinal Registers. *Arch Gen Psychiatry*. 2005;62(4):427-432. doi:10.1001/archpsyc.62.4.427

<sup>3</sup>Leavitt, R.A., Ertl, A., Sheats, K., Petrosky, E., Ivey-Stephenson, A., Fowler, K.A. (2018). Suicides Among American Indian/Alaska Natives – National Violent Death Reporting System, 18 States, 2003–2014. *MMWR Morbidity and Mortality Weekly Rep*, 67:237–242. DOI: <http://dx.doi.org/10.15585/mmwr.mm6708a1external icon>.

<sup>4</sup> NCHS, National Vital Statistics System, Mortality

<sup>5</sup> Leavitt et al, 2018.

<sup>6</sup> Leavitt et al, 2018.

<sup>7</sup> Curtin, S.C. & Hedegaard, H. (2019). Suicide rates for females and males by race and ethnicity: United States, 1999 and 2017. NCHS Health E-Stat.

<sup>8</sup> Leavitt et al, 2018.

<sup>9</sup> <https://wisqars.cdc.gov:8443/nvdrs/nvdrsDisplay.jsp> CDC National Violent Deqat5h reporting system



- <sup>10</sup> <https://youth.gov/youth-topics/american-indian-alaska-native-youth>
- <sup>11</sup> Leavitt et al., 2018.
- <sup>12</sup> Pew Research Center, May 2018, "What Unites and Divides Urban, Suburban and Rural Communities"
- <sup>13</sup> Leavitt et al., 2018.
- <sup>14</sup> Centers for Disease Control and Prevention. (2014). Fatal injury reports, national and regional, 1999–2014. Retrieved from [http://webappa.cdc.gov/sasweb/ncipc/mortrate10\\_us.html](http://webappa.cdc.gov/sasweb/ncipc/mortrate10_us.html)
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