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**SUICIDE INTERVENTION AND PREVENTION:
EVALUATION OF COMMUNITY-BASED PROGRAMS IN THREE
AMERICAN INDIAN COMMUNITIES**

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BACKGROUND

It was not until the late 1960s that suicide and suicidal behaviors among American Indians and Alaska Natives were recognized as a public health issue in need of serious attention. At that time patterns of suicide among American Indian/Alaska Natives were quite different from those of mainstream society. Young persons, those under 30 years of age, were dying at rates higher than the national average.

By the late 1980s national patterns were changing. Young persons in mainstream society were also dying at increasingly higher rates. However, the pattern delineated in the 1960s for American Indian/Alaska Natives has continued. Suicide is the second leading cause of death for the ages of 15-24 for the Native American population. American Indian/Alaska Native young people are more likely to attempt suicide, choose highly lethal means to do so (firearms or hanging), and more likely to complete suicide. In addition, although rates vary from tribe to tribe with the association of suicidal behavior and alcohol/substance abuse, they are usually very highly correlated.

In 1994 the National Center for Injury Control and Prevention, Centers for Disease Control and Prevention, the Mental Health/Social Services Programs Branch, Indian Health Service, and three geographically diverse American Indian tribes entered into a

cooperative agreement to evaluate the local community-based suicide intervention and prevention programs and document outcomes from the inception of the respective prevention program. In two tribes, suicide intervention efforts had been in place since 1989 and 1990, respectively; in the third, a suicide crisis in late 1992 precipitated community response. In this evaluation effort we sought to determine which types of suicide intervention and prevention strategies, or combination thereof, may offer the most promising practices to prevent adolescent suicide among American Indians.

In this report, we first list a synopsis of what is thought to underlie suicidal behavior in American Indian/Alaska Native populations from scientific studies, clinical observations, historical analyses, and reports by community health providers. A brief cultural history and history of suicide intervention efforts of each tribe are described, followed by a discussion of our methodology to carry out the study.

We describe our methodology, followed by results which include an analysis of suicide completions by tribe from a baseline of at least five years, including the study period, and discussion of the sensitivity of the surveillance mechanism(s) utilized. We describe the data from interviews with community stakeholders and client satisfaction surveys of suicide attempters who had utilized the respective community services.

In our discussion we address strengths and pitfalls in study design and implementation, make suggestions for future evaluation of American Indian and Alaska Native suicide prevention programs, and provide an outline for potentially effective suicide prevention programs in American Indian and Alaska Native communities.

METHODOLOGY

The methodology for this project included:

- a) development of a cultural historical background and history of suicide intervention for each tribe;
- b) an analysis of suicide activity from a baseline of at least five years, including the study period;
- c) analysis of the sensitivity of the suicide surveillance mechanisms used in each tribe;
- d) interviews with major community stakeholders by local Project Coordinators, each hired by the respective tribe to carry out the local evaluation activities of the project;
- e) interviews with persons who had attempted suicide during the first year of the study period regarding client satisfaction with the local suicide prevention program; and
- f) a project evaluation by an outside university-based evaluator of all project components.

The methodology of the project was designed utilizing a formative process. Since the conditions of the suicide prevention programs, the local reservations, and history of these problems varied from community to community, project personnel sought to develop common data gathering techniques which could be used across sites. The project was developed to be culturally sensitive yet provide consistent and specific information to evaluate each program comparatively as well as by itself. Surveillance included baseline

data for attempts, completions and, where possible, gestures and ideations. The actual method of surveillance varied slightly from site to site.

The project evaluation plan was developed jointly by the Indian Health Service, CDC personnel, and collaboration with an outside University-based evaluator. Previous suicide prevention programs within Indian country were used as guidelines for the program evaluation. Specifically, programs such as those carried out at Fort Hall, Idaho, Northern Ontario, and the previous Jicarilla Apache experience were used as reference to this particular plan.

The evaluation plan was developed to be minimally intrusive, carried out by local Project Evaluators hired for the project, and adapted to the specific programmatic and community needs. Therefore, it was a modest evaluation plan.

One of the areas addressed by the evaluation methodology was the diverse cultural and social history of each tribe. Further, the history of suicide intervention and types of programs being evaluated at each of the three sites varied tremendously. Hence, the minimum data set was not extensive but included both outcome and process measures.

Outcome measures, specifically, were developed using as extensive baseline information as was available for suicide attempts, completions, gestures, and ideation. At only two of the three sites were both completions and attempts well documented. Furthermore, one of the sites had only one year of baseline data from which to draw. Nevertheless, some outcome measures regarding the most important variable, attempts, are included in this analysis.

Both pre-program intervention and post-program implementation are covered in the

study period for all three sites. Even though the sensitivity of the surveillance mechanisms may vary from site to site, the combination of information contained in the report is indeed adequate to judge the effectiveness of suicide attempt prevention programs.

Process measures included two major approaches. First, stakeholder interviews were conducted by the local CDC funded project coordinators at each site. Each of these interviewers was hired by the respective tribe to carry out the local evaluation activities of the study. At least twelve (12) stakeholders in each community were asked about the effectiveness of the programs. Specifically addressed were the strengths and weaknesses of the program which can be used in further designing activities of this sort. Second, client satisfaction interviews were carried out in two of the three sites. People who were involved with the program as suicide attempters from the first year of study were asked by the local project coordinators what their experience was with the program. These client satisfaction surveys were done with 14 attempters and one family member at the Jicarilla Apache site and ten clients at the Southwest Athapascan site. Because of local political and administrator concerns at the Northern Woodlands site, no client satisfaction surveys were done.

No consistent time frame was followed in determining the period of follow-up after the attempt. In other words, attempters were interviewed as to their satisfaction at various times after the completion (e.g. one month, three months, or other time periods). As discussed below, this lack of consistency in client satisfaction follow-up is an issue to be addressed in future studies.

In all, the methodology was flexible which, in retrospect, led to a lack of consistency.

Some of the problems of this emergent methodology or formative methodology will be reviewed in the discussion section.

UNDERLYING ISSUES IN AMERICAN INDIAN/ALASKA NATIVE SUICIDE

It is important to note that suicide rates vary greatly from tribe to tribe. Many tribes have not experienced suicide and suicidal behaviors. Others, however, have extremely high rates well above those of other tribes, the states in which they reside, and national rates.

Suicidal behavior among American Indians/Alaska Natives is complex and multi-faceted. Some of the factors that have contributed to the suicide problem include:

1. Rapid and forced social and culture change;
2. The intergenerational effects of forced change on community and kinship roles;
3. The relatively violent milieu of United States society as a whole;
4. The modeling of suicide in communities, Indian and non-Indian alike, as a viable alternative to responding to environmental stressors;
5. Racism and oppression which create an “invisible” boundary around Indian communities;
6. Alcohol and substance abuse;
7. Family violence and child physical, sexual and emotional abuse and neglect;
8. Lack of non-violent strategies for coping with conflict in Indian communities;
9. Lack of economic and educational opportunities;
10. Depression and anxiety, often situational and related to combinations of factors listed above.

General characteristics of American Indian suicide are as follows. They are based on data from May (1987) with certain caveats that are noted:

1. American Indian suicide occurs largely among the young (under 30 years). This pattern has been consistent ever since social scientists began gathering consistent data on American Indian suicide. **Conversely**, the rate of suicide among older American Indians is lower than in the general population;
2. American Indian suicide is a predominantly male occurrence;
3. American Indian women have low suicide rates (but higher attempt rates) in most tribes;
4. Violent and highly lethal methods (guns, hanging) are used to commit suicide more often by American Indians than by the general population;
5. In the past, researchers have noted that tribes with loose social organization (which emphasizes a high degree of individuality) generally have higher suicide rates than tribes with tight integration (which emphasizes conformity). We are exploring the idea that conformity which is very restrictive may also give rise to suicidal behaviors, particularly when young persons are exposed to a general social milieu in United States society that emphasizes self-expression and "normlessness".
6. Tribes that are undergoing rapid change in their social and economic conditions have higher rates than those tribes that are not experiencing these changes. This is not to say that, historically, all tribes have not experienced rapid and forced culture change. However, many tribes are experiencing rapid economic and social

changes which could also be exacerbating suicidal behaviors.

7. As noted above, an association between alcohol and substance abuse have been implicated in American Indian suicide. Alcohol-related suicides occur more frequently among Indians than in non-Indian populations.

Regarding suicide attempters, a study by Zitzow and Desjarlait (1994) of suicide attempts on a Midwest reservation (**N=194**) found that adolescent attempters reported “relationship problems with family” as the highest **stressor** (63 per cent) and “relationship problems with a partner” as second (27 per cent). These two stressors were opposite for adult attempters (ages **20-60**): 54 per cent of adult attempters listed “relationship problems with a partner” as the greatest **stressor** and “relationship problems with family” as second (50 per cent). Single persons over the age of 20 tended to use more alcohol/drugs prior to the attempt and tended to have more previous attempts. Persons under the age of 19 and living with family tended to have family transport them more frequently to emergency services, appeared to be more impulsive in their attempt decisions, and tended to list more problems with their families. Single and divorced or separated persons tended to have the highest overall seriousness-of-intent score. Generally, persons using substances were less quiet, more agitated, less cooperative with emergency room personnel, and more likely to score higher on each of the seriousness-of-intent items.

Seriousness-of-intent items include: timing of the attempt so intervention by others would occur or not occur, precautions against discovery of attempt by others, actions patient took for self-preservation during/after the attempt, final acts in preparation for death, suicide note, lethality of method perceived by attempter, expressed intent of

attempter at the time of attempt, premeditation, post-attempt reaction 24 hours after attempt, and emergency room response after the attempt.

CULTURAL HISTORY AND HISTORY OF SUICIDE INTERVENTION AND PREVENTION IN THREE AMERICAN INDIAN TRIBES

The three tribes are described below as regards culture history, geography and demographics, and suicide intervention/prevention programming. Two tribe(s) chose to remain anonymous for this report. Out of respect for that choice, tribal name(s) have been made into geographically and culturally descriptive ones that do not identify any particular tribe. The tribes include the Jicarilla Apache Tribe, **Dulce**, New Mexico, a Western Athapaskan tribe, and a Northern Woodlands tribe in the Midwest. Data regarding suicide completions, attempts, comparisons with state rates, and use of the surveillance system are discussed in the Results section of this report.

Jicarilla Apache Tribe

Culture History

The Jicarilla Apache are one of the six groups of Southern Athapaskans who migrated into the southwest between about A.D. 1300 and 1500. The others include the Navajo, Western Apache (White Mountain and San Carlos Apache), Chiricuhua, and Mescalero. The Jicarilla separated from the Lipan Apache group about 1300. The Apachean-speaking bands settled in separate locations after migrating from the north, preserving much of their Athapaskan culture. Their ways of life were modified, influenced by the buffalo they encountered, the introduction of the horse, and their contact with other Indian groups such as the Pueblos and Plains tribes. Over the years these influences

blended into a combination of Plains traits and sedentary traits, one a group of migrants who followed the buffalo out on the plains but returned to Northern New Mexico to trade with and winter near the Pueblos of Taos, **Pecos**, and Picuris, and the other a semisettled agricultural people who lived in rancherías. At its base, however, Jicarilla culture is in fundamental agreement with a round of beliefs and traits which the Southern **Athapaskan**-speaking tribes share with one another.

There were two bands of Jicarilla that have been referred to in Spanish as Olleros (Potters) and Llaneros (Plainsmen). The Llaneros were composed of three groups which occupied the region east of the Rio Grande through southeastern Colorado and southwest Nebraska. These bands migrated south into Texas during the mid-1700s and returned to northern New Mexico by the 1800s at which time they merged with the Jicarilla. There are no cultural or linguistic differences between the two bands, membership simply being a matter of residence. When placed on reservations in 1880 and 1887, they lived in separate areas. During the late 1800s the two bands were politically aligned against each other over the location of their reservation. The two bands are the source for the two sides at the annual relay race and feast, Gojiya, that determines the relative abundance of meat or plant foods for the ensuing year.

Jicarilla social organization was like that of all other Southern Athapaskans. The extended family maintained matrilocal (the location of the mother) residence. The family was the basic social unit, consisting of parents, unmarried children, married daughters, their husbands and children. The next larger unit was the local group made up of a cluster of families. These groups moved around together, shared common territory, and were led

by elderly men and women, who were chosen for their wisdom, experience, powers of persuasion, and other leadership qualities. Members were free to come and go as they pleased. There was no formal political organization among the Jicarilla, but there was a hierarchy of leading religious leaders, warriors, and politicians, who dealt with other tribes and the Spaniards and Americans.

The Jicarilla Apache Reservation was established in 1887 after a long history of dealing with Spanish, Mexican and United States governments, Comanche raiders, and outright warfare with the United States government. In the same year the Jicarilla Apache Reservation was created, the Dawes Severalty Act of 1887 was passed. This outlined the specific procedures for allotment of Indian lands in 160-acre plots. The intent of the Act was to make Indians productive citizen-farmers and give up their tribal cultures to become assimilated into "mainstream" society. However, rugged mountainous terrain, the unfavorable climate, the presence of settlers within the boundaries of the reservation, and government indifference contributed to thwart implementation of the Act. As a consequence, the Jicarilla were denied a reliable means of support, their poverty worsened, and the stage was set for their near extinction in the first decades of the twentieth century. The next decades were fraught with government ineptitude, leaving the Jicarilla with no means of subsistence or livelihood, despite efforts by the tribe to rectify the situation.

The years between 1905 to 1920 were critical. The people were laboring to subsist on their unproductive allotments, employment opportunities were severely limited, and rations had been curtailed. Living conditions continued to deteriorate in the wake of

economic deprivation. Diseases of all types ravaged the population, but the most devastating was tuberculosis. Poor and insufficient nutrition contributed to the low resistance to diseases. Between 1905 and 1920 the Jicarilla population decreased largely due to deaths from tuberculosis.

By 1920 the government was forced to start a program of economic and health rehabilitation. A sanatorium for tubercular patients was established and sheep from the tribal herd (administered by the Bureau of Indian Affairs) were issued to each member of the tribe. Major and severe health problems with infectious disease were not brought under control until the late 1920s.

In 1903 a government boarding school with a capacity of 120 students was built in **Dulce**. English and vocational training were emphasized. The school was filled to capacity. Lack of adequate living quarters enhanced the spread of tuberculosis, which by 1907 was spreading rapidly among the school children as well as the adult population. The day schools were forced to close down due to high attrition rates caused by tuberculosis and other diseases. In 1917 the superintendent at the Jicarilla Agency reported that 90 percent of the students were afflicted with tuberculosis. A year later the boarding school was closed.

Recovery was slow. Traditional practices continued to flourish until the early 1950s. Christianizing efforts did not begin in earnest until 1910. Less than five major crimes were recorded among the Jicarillas between 1887 and 1935.

Under the Indian Reorganization Act of 1934 a new era for the Jicarilla began. The tribe organized its first formal government, adopting a constitution and by-laws on July 3,

1937. The livestock industry grew rapidly. The reservation also has other resources in gas, oil, and timber. Tribal income rose dramatically during the 1950s from several hundred thousand dollars to over one million dollars by 1960. The bulk of the income came from gas and oil revenues. This made it possible to diversify the economy, which was predominantly dependent on livestock raising.

By the 1960s the traditional kinship system was changing. Jicarilla religion and beliefs were still practiced by close to 70 percent of the Jicarilla tribe. However, a large number of Jicarilla had become Christians. As noted below, greater kinship and religious changes have occurred over the past 30 years, including increased rates of alcoholism and violent behaviors.

Geography and Demographics

The Jicarilla Apache tribe is located in north central New Mexico at the foot of the San Juan Mountains on the Colorado Plateau. Reservation land covers part of Rio Arriba County and **Sandoval** County in New Mexico and extends 65 miles southward from the Colorado border. It is 6 miles wide at its narrowest point and 25 miles wide at the broadest. The reservation encompasses 865,000 acres. However, ninety percent of the tribal members live in and around the town of Dulce, the seat of the Jicarilla tribal government. Dulce is located in the isolated northernmost portion of the reservation.

Tribal population in March 1994 was 3,044 registered (enrolled) members. The percentage of the enrolled tribal population who live in or near Dulce is very high. Less than 500 enrolled tribal members are estimated to live away from the reservation. **Fifty-four** percent (1,637) of the tribal population is under 25 years of age. School drop-out rates

are high, but published statistics are unavailable. By law, everyone under 18 is to be in school or working on a GED. However, this is not always the case. According to the 1990 census data, 9.1 percent of the population held a minimum of a bachelor's degree.

Unemployment rates are probably about 80 per cent with seasonal variation. More seasonal jobs are available during summer months. Average per capita income in 1990 was \$6,164, with a median household income of \$19,643. In 1989, poverty status was determined for 2,584 individuals of the total census population of 2,617 (98 percent of the reporting population). The largest employers on the reservation are the tribal government, the Bureau of Indian Affairs, and the public schools. Smaller employers include timber and gas and oil industries.

The tribal council is made up of a president and vice-president who are elected every four years. There are eight tribal council members who serve four year terms, and are elected on a staggered basis every two years. The Jicarilla Apache Tribe operates under a constitutional government formed under the Indian Reorganization Act, June 1934, which was revised in December of 1968. The tribal constitution is presently undergoing revision.

Family organization and household structure are complicated, influenced by the chronic housing shortage in **Dulce**. Although numbers are not available, service providers have observed that many homes include extended family members. Children will often live with parents into their 20s and 30s. Couples from their 40s down to younger ages often live together without being married. There are at least 100 persons on lists waiting for housing. Sometimes housing priorities go to persons who have children which, along with

per capita increases when one has children, may be an incentive to have children.

Five churches serve the reservation: two Baptist denominations, the Assembly of God, Catholic, and Reformed Church. Traditional practices exist but are waning. There is a strong effort to bring back traditional practices, particularly speaking the language that has almost been lost.

History of Suicide Prevention Activities

The Jicarilla Apache Tribe has had a history of suicidal behavior that came to serious public attention in the late 1980s. At that time, personnel from the IHS Mental Health departments in Albuquerque and Santa Fe gathered data on suicide attempts that demonstrated an extremely high attempt rate for young Jicarilla Apaches, probably at least 22 times the national average based on national attempt estimates.

Efforts were made by the tribal attorneys to bring this issue to the attention of IHS, Congress and other officials who could potentially allocate funds to address these serious suicidal behaviors. In 1989 the Mental Health/Social Services Programs Branch learned that \$75,000 was available from the **Office** of Policy Analysis and Evaluation (OPEL), IHS, and made concerted efforts to fund a suicide prevention program with the Jicarilla Apache Tribe. In 1990 the National Adolescent Suicide Prevention Project was initiated. Since that time the funding level increased substantially through outstanding proposals to OPEL outlining the success of the project and through other funded projects which have rounded out the services including those for domestic violence, child abuse, and community awareness on family violence prevention. OPEL funding ceased in 1994. The tribe currently contracts with the Indian Health Service for its mental health and social services

programs and continues the multifaceted effort begun by the National Adolescent Suicide Prevention Project.

The National Adolescent Suicide Prevention Project is described as a comprehensive, multifaceted program providing prevention services at primary, secondary and tertiary levels to lower the incidence of suicide and suicide attempts on the Jicarilla Apache Reservation. Implementing a community and family systems approach, the project utilizes cultural values and traditions to positively impact the community and decrease suicidal behaviors.

One of the goals of the National Adolescent Suicide Prevention Project is to determine the specific risk factors for suicide in the Jicarilla Tribe. Staff are exploring the characteristics noted above as outlined by May (1987) with particular emphasis on alcohol/substance abuse and the physical, sexual, and emotional abuse and neglect of young children as risk factors. In 1993, for example, according to Indian Health Service Records, 58 percent of all deaths were alcohol-related. From October 1992 to September 1993, there were sixty-five reported cases of child abuse to the Bureau of Indian Affairs. From 1989-1991, the average age of death for the Jicarilla Apache Tribe was 42.4 for males and 40.7 for females.

Stakeholders in the suicide prevention effort have included the tribal council, many community members and service providers. The tribal council initially pursued efforts to create a suicide prevention program and has been supportive throughout the program's functioning. The Tribal Health Director has been Project Director since the project's inception, and has been an advocate for the effort within the community and throughout

the country on health boards and other national committees.

A community mobilization project was initiated at the same time the suicide prevention project was begun. Since then, a Community Resource Action Group (CRAG), comprised of service providers and community members, has met monthly to address social issues in the community. The National Adolescent Suicide Prevention program team has been an integral part of the CRAG committee and has usually taken the lead to continue CRAG's functioning. Education and training has been provided on a regular basis regarding suicide prevention, family violence and child abuse prevention, as well as other health and behavioral health concerns. A peer counseling program was developed which involves young people from the community. These young people have traveled to different parts of the country, have presented programs to the community, and provide peer counseling in the schools. Through additional program development for the suicide prevention project, victims' advocates for women and children have become integral to program functioning and a batterer treatment group has also been formed.

The Indian Health Service operated an outpatient clinic in **Dulce** which, in 1996, was made into a separate service unit. The National Adolescent Suicide Prevention staff provide 24 hour, on call emergency services. Those in need of psychiatric hospitalization usually utilize more local hospitals through IHS Contract Health Service monies since the nearest IHS hospital is in Santa Fe, at least two and one half hours away in good weather.

Western Athapaskan Tribe

Culture History

The Southwestern Athabaskan tribe includes two Athabaskan groups The term

Athabaskan refers to a linguistic family. Dialectical differences existed among the two groups, but they were minor and did not interfere with effective verbal communication.

It seems probable that by 1525 Athabaskan-speaking peoples who had earlier migrated southward from points in northern Canada were established on the plains of Texas and New Mexico. In the centuries that followed, some of these latecomers to the Southwest increased in population and, for reasons that remain obscure, moved to occupy territories west of the Rio Grande river. Some Athapaskan groups pressed on into the heart of what is now Arizona and there, responding to a new set of environmental conditions, including the presence of other human populations, began to develop the linguistic, social, and cultural characteristics that were eventually to distinguish them Western Athapaskans. Agriculture was added to a hunting and gathering subsistence repertoire from the Western Pueblos or Navajo, whereby the Western Athapaskans were able to cultivate limited quantities of maize, beans and squash.

It has been suggested that the practice of agriculture fostered the development of unilineal descent groups (matrilineal, where descent is reckoned through one's mother) among the Western Athabaskans. Western Athabaskan social organization included a system of matrilineal clans. Whereas bands, local groups, and family clusters were spatially distinct (that is, residence groups), clans were not. Members of the same clan were scattered throughout Western Athapaskan territory, thus creating an extensive and intricate network of relationships that cut across bands and local groups, but at the same time served to link them together. The members of a clan considered themselves related

through the maternal line, the descendants of a group of women who, according to mythology, established farms at the clan's place of origin. These locations provided the names for clans (for example, 'juniper standing alone people') and were held to be sacred. Altogether there were 60 clans.

Marriage between members of the same clan was not allowed, although marriage into the clan of one's father was permissible. Persons belonging to the same clan were expected to aid one another in a variety of ways, and if it was deemed necessary, the entire clan might be called upon to avenge a wrong done to one of its members. Most of the 60 Western Athapaskan clans claimed ultimate descent from one of three archaic clans, and on this basis were grouped into phratries. Through the phratry system, members of 'closely related' clans were not permitted to marry and were bound by reciprocal obligations only slightly less demanding than those between persons belonging to the same clan. This network of relationships across local groups bound people together and helped keep in check the divisive tendencies inherent in local group isolation.

The introduction of the horse (introduced into the Southwest by Coronado, the Spanish conquistador) enabled the Western Athapaskan to greatly increase their geographic range and exploit economic resources far beyond the boundaries of their own territories. By the middle of the eighteenth century, the Western Athapaskan had established an intricate network of trading and raiding relationships that involved at least a dozen other cultural groups and reached all the way from the Hopi villages in northern Arizona to Spanish settlements in central Sonora.

The Western Athapaskan responded to the Spanish regime with vigorous raiding

and warfare. The Western Athapaskan did not organize raids for the purpose of increasing their already vast territory or to drive away or destroy Europeans. To the contrary, the European settlements were viewed as valuable economic resources that could be counted on throughout the year to produce substantial amounts of cereal grain and livestock. It was to the Athapaskans' distinct advantage that such resources remain viable, and this may help explain why mass killing and the wide-scale destruction of enemy property never figured prominently in the raiding complex. The Western Athapaskan drew a sharp distinction between raiding (literally 'to search out enemy property') and warfare ('to take death from an enemy'). Raiding expeditions were organized for the primary purpose of stealing livestock. War parties, on the other hand, had as their main objective to avenge the death of a kinsmen who had lost his life in battle.

Western Athapaskan drew a sharp distinction between persons who possessed a supernatural power and those who did not. Members of the former category were partitioned into two subclasses labeled by the terms diyin 'shaman/medicine person' and 'inlaashn 'witch, sorcerer'. Medicine persons admitted to the possession of power and some of them used it publicly in the context of ceremonials. Witches, on the other hand, kept their powers hidden, manipulating them in private to cause sickness, certain forms of insanity, and 'accidents' that resulted in death, bodily injury, or the destruction of personal property. On those rare occasions when it was absolutely certain that one person had used witchcraft against another, the victim's kinsmen were entitled to retaliate with murder. Normally the suspects guilt was uncertain and he was given a trial. If the suspect could not defend himself or he refused to confess, he was strung up by the wrists from the limb

of a tree so that his toes barely touched the ground. Commonly, the suspect was released on the condition that they leave the local group and never attempt to return.

The knowledge necessary to perform ceremonials was detailed and extensive. It could be acquired only through specialized instruction from an established medicine person. This instruction required payment, usually in the form of large quantities of food, and lasted several years. During the period of instruction, student and teacher lived together, alone, and at a distance from other people that allowed them to work undisturbed. It was a fundamental postulate of Western Athapaskan culture that serious forms of physical and mental illness could result from behaving “without respect” toward things that were ‘sacred’.

A Spanish policy to subdue the Western Athapaskan was to provide them with alcoholic beverages and inferior firearms. For nearly 25 years the new policy worked with moderate success. After 1821, when Mexican independence was achieved, the Mexican government could not continue to subsidize the rationing system. In 1831 the Western Athapaskans resumed intensive raiding, and the Mexican government retaliated by pursuing a policy of extermination. From the mid-1830s until Anglo-Americans assumed control of Arizona in 1853, the population of Sonora declined from raids and sieges.

When the **Gadsden Purchase** was finally ratified in 1853 all of Arizona came under the control of the United States, and shortly thereafter Anglo settlers and prospectors, lured by hopes of taking wealth from the land, began to intrude upon the domain of the Western Athapaskan. At first the Indians were wary but peaceful, thinking that the Anglos, like themselves, would continue to fight the Mexicans. As soon as it became apparent

that the Anglos wished to put an end to Athapaskan raiding and would stop at nothing to continue mining for minerals, mistrust flared into open hostility. The result was a harsh, tragic, and bitterly immoral war that lasted nearly 40 years and ended with the irreversible defeat of the Western Athapaskan and their consignment to reservations.

With the fighting finally over, the United States government turned its attention to the modification of Western Athapaskan culture in an attempt to prepare them for eventual assimilation into Anglo society. Three objectives were primary: first, the economic development of reservations; second, education to “civilize” Athapaskan children and persuade them to relinquish their native language and customs; and third, the establishment of churches and the eventual conversion of all Athapaskans to belief in Christianity.

Long before Whites set foot in Western Athapaskan territory, the Indians produced an intoxicating beverage called Mlapai (‘gray water’) or n, it was quite mild and, unless consumed quickly and in large quantities, had only the slightest inebriating effects. For the most part, drinking was restricted to social occasions, including ceremonials, when groups of people came together to participate in collective enterprises. Placed in the reservations, the Athapaskans continued to make tulapai but, deprived and confused, they frequently drank to excess. Tulapai functioned as an anesthetic against uncertainty and anxiety. Other forms of alcohol became available and the native brew was replaced with beer, wine, and whiskey. Subsequently, alcoholism has developed into a major problem that permeated virtually every aspect of Athapaskan life.

As part of the program to assimilate the Western Athapaskan into Anglo-American

society, several government and mission schools were founded between 1895 and 1922.

Athapaskan children were taught to speak the English language, to read and write, and to farm, make clothes, and prepare “proper foods.” At the same time, the children were subject to excessively harsh discipline. Classroom regimes involved strict separation of the sexes, the exclusive use of English, and forms of punishment that included whipping, shackling to a ball and chain, and periods of solitary confinement with only bread and water to eat. Runaways were common.

Christian missionaries have been present on all Western Athapaskan reservations since about 1900. Early on, the Athapaskans ignored them. As is noted below, this pattern had changed considerably by 1994.

Geography and Demographics

The Western Athapaskan Reservation encompasses 2,600 square miles, topography and climate vary from desert foothills (elevation approximately 2,600 feet) in the southern section of the reservation to evergreen forest in the eastern and northern sections (elevations to over 11,000 feet). There are five major population centers, the largest accounting for approximately 85 percent of the reservation population as well as being the center of tribal government. The next largest population center is located 53 miles west and accounts for approximately 10 percent of the reservation population. The remaining three areas comprise the remainder of the population.

There is a total population of about 14,000 residing on the reservation with approximately 12,000 enrolled tribal members. The remainder are members of other tribes or non-Indian residents. Half of the reservation population is 16 years of age or younger.

Of those tribal members aged 25 and older, 43 percent have completed high school, and 1.3 percent have completed college.

Unemployment is about 60 percent, or roughly ten times the rate for the state in which the reservation is located. Median income for males is \$4,400 per year and \$2,800 a year for females. Median family income is \$9,200. Over 50 percent of the households fall below the U.S. poverty line. The major industry is the tribally operated Western Athapaskan Timber Company which employs approximately 500 people. The next major employers are the tribally operated ski resort which employs about 200 people seasonally and the newly opened casino which employs close to 120 people. The federal government also employs between 400 to 600 individuals (some seasonally) for various federal programs and agencies.

The political structure of the Western Athapaskan tribe includes a tribal constitution and an elected tribal council. Eleven representatives for the various districts on the reservation are elected by popular vote to the tribal council for four year terms. A tribal chairman and vice chairman are also elected by popular vote in four year cycles. The tribal judiciary is a separate operating branch, but there is no completely distinct or independent executive branch.

Family organization and household structure are mixed, probably based on a migratory pattern that now, unfortunately, has much to do with alcohol abuse, limited housing, and "children having children." Much of the traditional family structure based on matrilineality and matrilocality has changed. Children go back and forth to grandparents, uncles and aunts. Increasingly, marriage and long-term relationships are not the norm.

Households often hold three generations that shift and change regularly.

Of great concern is increasing gang activity and inter-gang violence. Service providers see the emerging gangs as “surrogate families,” where children and youth find more stability than at home. A comment was made that young people are not now killing themselves as they were only a few years ago, but are now being violent with each other. No young person has died from homicide at the hands of another youth as yet, but the fear is that this kind of behavior could be the next wave of interpersonal violence on the reservation.

There are **30-plus** churches on the reservation representing approximately 12 religious **affiliations**, all of whom identify as being Christian. Approximately 50 percent of the population is affiliated with a church. Traditional spiritual practices have declined, but there remains a small and active minority who continue to follow traditional ways. There is a significant conflict between Christian churches and traditional practices, as well as conflicts among the various Christian denominations. Such conflicts have separated families, strained cultural identities, and exacerbated political agendas.

History of Suicide Prevention Activities

From December 1992 through February 1994, 15 people committed suicide on the Western Athabaskan reservation (3 in 1994). Over 100 persons made what were considered “serious attempts.” Combined data from the Indian Health Service, tribal police, and the tribally-administered Behavioral Health Services program indicated 543 calls/referrals were recorded involving suicidal acts and/or ideations in calendar year 1993. In 1993 alcohol was involved in approximately 68 percent of all attempts and 63

percent of all completions. Approximately 91 percent of all completions were 25 years of age and younger; one was 13, another was 12. Of the suicides, 10 were by hanging, 4 by firearms, and one was self immolation by gasoline. There were 12 male and 3 female victims. Among the Western Athabaskan tribe for this time period, suicide has been the leading cause of death for young people 25 and younger.

The tribal chairman was instrumental in supporting suicide intervention and prevention efforts. He made public service announcements over the radio about suicide and how to ask for help and supported local service providers' efforts to develop suicide intervention and prevention strategies.

The present suicide intervention team was formed by the Chief of police in March 1993. Administration and supervision of the program is shared by the police department and the Behavioral Health Program. The Team consists of five tribal members who are available 24 hours a day for suicide crisis response and intervention, training, and education. The suicide intervention team members are primarily field service personnel. They respond to potential suicidal persons and situations anywhere on the reservation and work directly with the mental health professional on-call, either in the field or at the hospital.

From March 1993 through January 1994 the Team had over 250 calls. The Team provided follow-up on over 200 attempters identified by the police over the previous two years. Utilizing the local newspaper, radio station, and tribal agencies, the Team provides training in the identification of people at risk as well as how to seek help. These training efforts are all conducted in the local Athabaskan language. The Behavioral Health Services program also offers suicide intervention and prevention training, but in English.

In one year service providers gave 31 training events in the community which addressed suicide, alcohol abuse, and parenting skills. Approximately 500 people attended these trainings.

During the course of the “suicide epidemic”, it was imperative that the suicide prevention team was a part of and understood the cultural underpinnings of a very basic Athabaskan belief system having to do with seeing spirits in human form. Numerous persons who were suicidal reported seeing such a spirit who talked to them about killing themselves. Regardless of an individual’s spiritual beliefs, Christian, traditional, or both, these sightings were noted by suicidal young people and were more easily reported to persons they knew would understand.

In December 1993 a suicide pact among at least 23 young people, mostly middle and high school students, was discovered. The young people had planned a mass suicide on Christmas Eve as “a Christmas gift to our parents.” One of the more recent completions was a member of this group. It was through the subsequent investigation that the suicide pact group became known to behavioral health and school personnel. Interventions were implemented before Christmas Eve. Whether a mass suicide would have occurred without the interventions will never be known. Many members of the group have remained resistant to intervention and/or treatment. However, other group members have responded actively.

Current services and stakeholders include the tribal council, service providers, including the suicide intervention team, the local radio station and newspaper, and community members. As noted above, the radio station and local newspaper have been

critical vehicles for broadcasting/publishing information about suicide and where and how to seek help.

Current Behavioral Health Services include 26 full and part-time employees who provide mental health and alcohol services for the reservation. Ten employees work for the residential alcohol treatment program, a ten bed facility with 24 hour coverage. The remaining 16 employees are mental health service providers. Services are provided in three separate locations as well as school, community, jail and home visits. There are Behavioral Health personnel at the Indian Health Service Hospital and in two tribally operated locations in the largest and second largest communities on the reservation.

Each school on the reservation has a school counselor. The IHS Hospital has 42 beds and a full outpatient clinic. It operates a 24 hour emergency room with a physician on premises. Behavioral Health Services provides 24 hour on call to the emergency room. Psychiatric hospitalization off-reservation is arranged through IHS using Contract Health Services (CHS) monies. In the past year, psychiatric hospitalization has been the largest expenditure of CHS dollars for the Western Athabaskan IHS Hospital at \$500,000.

An eastern university-based Center for American Indian Studies has had a long affiliation with the Western Athabaskan Tribe. Representatives from the university have been invaluable in assisting the tribe to delineate suicide behavior patterns by reviewing hospital, police department and other agency records, and computerizing the surveillance intake form on EPI INFO.

In March 1994 the Western Athabaskan tribe testified before Congress to ask for Congressionally mandated monies to address the suicide problem on the Western

Athabaskan **reservation**. To date, monies have not been mandated to address the issue. Congress did ask for a report from the Indian Health Service Mental Health/Social Services Programs Branch on the need for and cost of suicide intervention programs in Indian Country. The Congressional request was the direct result of the plea by the Western Athabaskan tribe and a Northwest tribe for monetary assistance with suicide intervention and prevention.

Northern Woodlands Tribe

Culture History

The Chippewa or Ojibwa (Anishinabe) lived over an extensive area, mainly north of Lakes Superior and Huron. Since the seventeenth century they have expanded into western Saskatchewan, and south into what are now the states of Michigan, Wisconsin, Minnesota, and North Dakota, as well as into southern Ontario. The Chippewa-Ojibwa were the largest tribe north of Mexico in 1972. The first historical mention of the Chippewa-Ojibwa was in a listing of the bands in the Upper Great Lakes area in 1640. The bulk of the Chippewa-Ojibwa population at the time of European contact was in the present province of Ontario, and the same was true in 1972.

An Algonquian speaking tribe, their closest relatives are the Cree, to the north, and the Potawatomi and Ottawa, to the south. The aboriginal Chippewa-Ojibwa had a classless, egalitarian society. However, there were people of importance and prestige who achieved positions earned as the result of outstanding abilities as warriors, civil leaders, religious leaders, or medicine persons. Often the medicine person was the most respected and feared member of the band. The smallest unit was the nuclear family: parents and

their unmarried children. A number of families living together formed a band. These bands had from 20 to 50 members. A leader's political, religious and economic roles were based on ties of kinship. In addition to family affiliations, every individual was a member of a clan named after an animal, bird, or fish. Clans were patrilineal (descent reckoned through the father), and one could not marry into one's clan. The dual division, or moiety system, found among other Central Algonquian tribes was not used by the Chippewa. However, there were linked clans, or phratries.

Children were desired, and a warm relationship existed between parents and children. Parents were responsible for the care, education and discipline of the children, who were expected to help their parents to the extent of their own abilities. Upon puberty, brother and sister acted with shyness and considerable avoidance, which continued until one of them married. Chippewa society was kin-oriented and kinship ties were its chief binding force. Nearly everyone was related to another in the band.

Older people were treated with respect and cared for, if necessary. For some, old age was the time when their spiritual power reached its height. It was a common pattern that a man, in his vision quest, was told that he had the power to cure, but it must not be used until he had "white hair."

The religious life of the Chippewa was rich, deep, personal, and of daily concern. The supernatural world held a host of spirits that inhabited trees, rocks, birds, animals, the sky, earth, underground, and water. Of major importance were the sun, moon, the four winds, thunder, lightning, and thunderbirds. Of great personal concern to the individual was his guardian spirit, acquired in his vision quest, which could be called upon for

guidance, help, and protection. Dreams, in general, were regarded as revelations of utmost importance, and each dream was reviewed for possible significance. Besides the benign spirits, there were also fearsome, malevolent ones. The spirits were placated or honored through prayers and offerings of tobacco and food through traditional healers paid for their services, usually with food. The initial rite of all religious and ceremonial occasions was the smoking of tobacco accompanied by a prayer.

The settlement pattern in early historic times was that of numerous, widely scattered, small autonomous bands. Thus the term "tribe" is applicable to the Chippewa-Ojibwa in terms of a common language and culture, but not in the political sense that an overall authority or unity was present.

The Chippewa-Ojibwa were intricately involved in the fur trade, especially during the eighteenth century, and were deeply affected by it in both economic subsistence and resultant westward movement as the French extended the outlying geographic boundaries of their posts. There was a tendency toward concentration of population as Chippewa groups sometimes clustered near, or at, a trading post in order to attain the necessary items for trapping and other elements of the fur trade.

The fur trade also brought alcohol to the Chippewa-Ojibwa, where drinking behavior was learned from French trappers. In 1832 the United States government passed the Indian Nonintercourse Act which prohibited the further sale of alcohol to Indians.

There was considerable intermarriage between Indian women and the French and other traders, as is attested by the many French surnames among the Chippewa today. The more positive relationship between the Chippewa-Ojibwa and the French was in sharp

contrast to the relationship between the Indians and the British. The Chippewa-Ojibwa supplied warriors to the French in an attempt to maintain their forts along the northern frontier at Quebec, Montreal, Niagara and Detroit. It was with deep regret that they saw the surrender of French Canada to the British in 1760.

During this period the Southwestern Chippewa moved into Wisconsin's northern rim and the northern half of Minnesota extending up to the Lake of the Woods on the Ontario-Manitoba border. There they found a rich supply of wild rice which became an important part of their economy. They also collected maple sugar and did gardening in addition to their important mainstays of hunting, trapping, and fishing.

One impetus to greater organization was their involvement in war. After continuing intermittently for more than 100 years, hostilities between the Southwestern Chippewa and their hereditary enemies, the Dakota, reached their peak during the first half of the nineteenth century. It should also be remembered that much pressure to move westward was occurring in the east with European settlement pushing the Eastern Tribes to the west. The more visible cause was the use of hunting and trapping territory and the wild-rice fields.

The culminating clash between the Chippewa and the Dakota took place in what is now Minnesota, near Battle Lake, named for the conflict. Ordinarily, warfare was small-scale, one village against another, while other villages on either side might be at truce. While only small numbers were involved in the battle, the loss of life was relatively high. Ultimately, the Chippewa were successful in driving the Dakota across the Mississippi River. Hostilities continued and did not cease until the reservation period became

established.

As a result of treaties made during the 1850s and 1860s, the various bands were allocated 11 reservations, 7 of which were Chippewa. The effect of the reservation system on the Southwestern Chippewa was considerable. It restricted movement to only within their locales with reduced lands. Besides stemming further expansion, reservations were a blow to the traditional economic system that required substantial territory for hunting. In addition, by the mid-nineteenth century the fur trade had declined. Hence, the reservation period began with the Chippewa in serious economic plight. With the Allotment Act of 1887, which parceled out reservation lands to the individual, the Indians could, and did, sell their timber rights, a source of income that left them with cut-over lands. The Allotment Act resulted in a sharp reduction of Indian-held land throughout the United States until it was reversed by the Indian Reorganization Act in 1934.

In 1924 citizenship status was conferred upon Indians, allowing them to vote for the first time. While Chippewas, along with other Indians, had fought as volunteers in World War I, the citizenship act made them eligible for the draft. Many served in World War II, as in subsequent wars (American Indians have served in all wars, including those prior to the founding of the United States: the Revolutionary War, Civil War, etc.).

Many children from the Chippewa reservations attended government and mission boarding schools, experiencing similar treatment noted above for the Western Athabaskan. In the 1960s Robert F. Kennedy asked for a report on Indian education. Completed in 1969, the report found boarding schools run by the federal government as seriously inadequate. This report reflected the Meriam Report of 1928 which found similar atrocities

in government boarding schools for Indian children.

After World War II, the lack of economic opportunity on the reservation resulted in a considerable movement to large cities in search of work. This movement was stimulated by the Volunteer Relocation Program begun by the Bureau of Indian Affairs in 1954. Although unsuccessful in its goals, by 1972 nearly half the Chippewa were living in urban centers, particularly Minneapolis, Milwaukee, Chicago, and Duluth. Close ties were and continue to be maintained between urban Indians and their home reservations. People go back and forth constantly.

The next section describes the Northern Woodlands Tribe in the Midwest, specifically, and outlines geography and demographics pertinent to 1994.

Geography and Demographics

The Northern Woodlands tribe in the Midwest encompasses all of one county and portions of two. The reservation covers over 1300 square miles, contains 36 townships, 5 incorporated cities, with populations ranging from 110 to 1200, and several isolated communities. An estimated 59 percent of the Native American population reside within the five isolated communities located on the reservation. The seat of tribal government is at one of the reservation communities.

Tribal enrollment includes an excess of 20,000 members with 25 percent of the tribal membership living within or near the reservation boundaries. The total population residing on the reservation is 8,727, of which 2,759 are American Indian, according to the 1990 U.S. census report. The Northern Woodlands Reservation is “checkerboard”, meaning that tribal land is scattered throughout the reservation boundaries, interspersed

with land belonging to non-Indians. Forty-eight percent of the enrolled tribal membership is under 18.

Annual per capita income for adults (1991) is \$9,530, while household income is \$16,500. Twenty-three percent of the population has incomes below poverty level. Forty percent of the adult population has a high school diploma or GED equivalent. Forty-seven percent of tribal membership households have married couples, while others are single parent families or couples living together.

Latest labor force statistics available were gathered before the opening of a casino/hotel complex which opened in the spring of 1992. At that time, the unemployment rate was 73 percent. With the opening of the casino/hotel, the Northern Woodlands tribal council has become the largest employer in the area, with about 1,700 employees in the gaming/hospitality industry and over 300 persons employed through tribal government services. The Indian Health Service is also a major employer on the reservation. The tribe has a sewing factory which employs 12 people, and a mail order wild rice business which employs five people.

Unemployment rates are suspect because they are taken from the U.S. Census by county. Counties included in the reservation are very mixed with non-Indian and Indian populations. Employment also varies seasonally, with 65 percent employment in winter and 85 percent employment in summer. Seasonal employment includes forestry, trapping, fishing bait business, and home and road construction.

Among the communities on the reservation there are 19 churches, most of which are Catholic and Episcopalian, or Lutheran. Others include Assembly of God, Church of

Christ, and a traditional Indian church.

In reference to themselves, some tribal members prefer to be called Indian, others call themselves Ojibwa (of French origin), Chippewa (of English origin) or Anishinabe (which means “human beings” in the indigenous Algonquian language and is now likely to refer to a political movement where persons are conscious of traditional American Indian roots).

The Northern Woodlands tribe is one of six Chippewa reservations in the state that are organized to form the entire tribe. The tribal council was established by treaty on March 19, 1867, and is governed under a constitution (under Section 16 of the Indian Reorganization Act of June 18, 1934). Each reservation has a local reservation tribal council of five members elected on a staggered basis to four year terms. The chairman and secretary of the local reservation tribal councils form the 12 member Tribal Executive Committee of the tribe.

Suicide Prevention Activities

In 1990 the Northern Woodlands tribe experienced an extreme upsurge in its number of suicides and suicide attempts. There were 4 suicide completions in 1990 as compared to a previous five year average of less than one suicide completion per year. In 1990 there were 53 suicide attempts (more than one per week) that required medical attention as compared to a previous decade high of 26 for a single year. Half of all attempts were by individuals age 19 or younger. After a period of disbelief, shock, and fear that a cluster suicide epidemic might take hold, followed by frustration and feelings of inadequacy, a grass roots community effort began.

The tribal council sponsored open forums, providing opportunities for parents, teenagers, and adults to speak on issues relating to suicide concerns. Helping professionals, medical personnel, educators and clergy volunteered their thoughts and time. All these efforts led to the formation of a suicide intervention team. Outside consultants were hired to train the suicide intervention team volunteers who, in turn, made themselves available on a call list, with 24 hour coverage.

The Team evaluated and addressed a variety of system response problems which included:

1. Nearly 60 per cent of all attempters were allowed to return to their families within hours after admission to emergency rooms without a follow-up plan for therapeutic intervention or referrals to appropriate resources.
2. Law enforcement personnel from all the counties on the reservation were often unwilling to transport suicide attempters.
3. Inpatient psychiatric facilities frequently refused to accept suicide attempters because: a) patients often had inadequate medical insurance to cover expenses; b) if patients appeared to be under the influence of alcohol, the problem was considered "chemical dependency" rather than a psychological problem; c) confusion concerning state statutes on involuntary admission was a problem. Less than 15 per cent of all attempters were placed under mandatory holds for observation. Six attempters re-attempted within 24 hours after initial admission and release from the emergency room. Less than 17 per cent of attempters ever followed up with their referral appointment to psychologists/psychiatrists.

The Team responded to the above issues in a variety of ways. First, they agreed to be called for assistance from a 24 hour call list of volunteers to assist suicidal persons after an attempt. Second, the Team provided support for emergency room personnel and the attempter's family with referral alternatives. Third, the Team encouraged 72 hour voluntary placement for attempter protection whenever possible. Fourth, the Team provided a more informal, non-judgmental and attractive listener resource to attempters for at least three contact periods. Fifth, the Team provided case management of attempter progress and referral to psychiatric services. Sixth, the Team provided contact during the crisis to establish a more lasting rapport with attempters, negotiate a no-suicide contract, and create an opportunity to discuss suicide as a non-solution to any problem. Seventh, the Team developed continuing education for intervention volunteers and suicide intervention and prevention activities. And finally, the Team assisted in the clarification of roles and responsibilities with emergency room, law enforcement, emergency medical assistance and inpatient psychiatric personnel regarding suicidal individuals.

The suicide intervention team continues to be active, attracting an increasing number of new volunteers on a regular basis. In 1991 the suicide rate fell by 75 percent from the previous year; the suicide attempt rate fell by 30 per cent. In 1990, 14 persons, or 26 per cent of the total population of attempters, re-attempted within the year. In 1991 there were two re-attempters, making up 5 per cent of the total attempt population.

The Team's greatest impact appears to be most significant in reducing the numbers of re-attempters. Little has been done to reduce the frequency of first-time attempts. However, it is difficult to measure what does not happen, and there may be an

unmeasurable impact in the potential first attempt population, as well. The Team continues to revise its efforts and objectives in response to the changing demands and needs of early suicide intervention.

RESULTS

The results section includes background on tribal surveillance efforts as initiated by the Indian Health Service, the suicide completion data since 1990 and description of the surveillance mechanisms utilized by each of the three tribes, the stakeholder interview results, and the client satisfaction survey responses.

Description of Surveillance Mechanisms by Tribe

Since the 1970s, the Indian Health Service has recommended that all of its general medical service units maintain a suicide register. In 1986, the Indian Health Service inaugurated its Special Initiatives Team (SIT) in response to a growing concern for and national media attention towards suicide epidemics and clusters in American Indian/Alaska Native (AI/AN) communities (DeBruyn, Hymbaugh and Valdez 1988; DeBruyn, et. al., 1994). As part of its agency-wide plan to aid AI/AN communities in responding to and preventing suicide clusters, the SIT developed general guidelines for the recommended suicide register. The original purposes of the register are listed below:

- | |
|---|
| a. To provide a list of high risk persons who need referral and follow-up; |
| b. To provide a mechanism for identifying at-risk families; |
| c. To provide epidemiological data for prevention and intervention program planning and development; |

d. To provide a data base for analysis of local suicide rates and trends;
e. To provide a data base for the development of proposals to secure outside funding for prevention/intervention programs;
f. To provide a basis for reporting national data to secure increased IHS funding for mental health and suicide prevention services.

The Special Initiatives Team proposed minimum data requirements and encouraged communities to expand the register to collect additional information relevant to their local circumstances. The SIT also recommended the following case definitions for the events under surveillance. These definitions are consistently used by two of the sites described in this study; the third site uses the more conventional term, ideation, instead of gesture.

Gesture: A self-destructive act where the primary motive is not death, but an attempt to cause someone or something to change. The **self-destructive** act is often not life-threatening.

Attempt: A genuine life-threatening effort to kill oneself by self-inflicted means which would lead to death if no intervention occurred; not an accident or manipulation.

Completion: Death caused by a self-destructive act.

Ordinarily, an evaluation of a surveillance system would include examination of records from law enforcement, emergency rooms, medical providers and the local

medical examiner. These records would be compared with data in the suicide register in order to evaluate the representativeness, sensitivity, and predictive value of the surveillance system. However, concern for tribal confidentiality by the respective programs within tribes as well as limited funds for travel made it impossible to obtain the necessary access to these records.

Jicarilla National Model Adolescent Suicide Prevention Project

The goals of the Jicarilla Model Adolescent Suicide Prevention project were to reduce the incidence of adolescent suicides and suicide attempts and to increase community awareness through education. Objectives for the intervention project include:

- a. Identify suicide risk factors specific to the Jicarilla Apache Tribe, which may be generalized to other American Indian communities;
- b. Identify high risk individuals and families;
- c. Identify and implement prevention activities to target high-risk individuals, groups, and families;
- d. Provide direct mental health services to high-risk individuals, families, and groups; and
- e. Implement a community systems approach to increase community awareness.

The National Model Adolescent Suicide Prevention Project provides services to members of the Jicarilla Apache Tribe, their family members, and members of

the Dulce community.

Project staff include a project director, clinical psychologist, a counselor-aide, and clerical assistant. The project director, a social worker, is responsible for the continuous direction and administration of the project; coordination of community training and prevention activities and coordination of activities with those of the Tribal Council, the Bureau of Indian Affairs, the Indian Health Service, the local school system, and the State. The project director also provides some clinical services. The staff psychologist provides clinical services, follow-up, and crisis response for attempters, participates in community education activities, and documents variables associated with gestures, attempts and completions. Most clients receive services on a voluntary basis, but many are referred to the system through other individuals, school, Tribal programs, Tribal Council members, or by court order for psychological evaluation or treatment.

In addition to direct services and crisis intervention, the National Model Adolescent Suicide Prevention Project provides a comprehensive approach to community problems through education on domestic violence, child abuse, economics, teen pregnancy and sexuality, substance abuse and parent education. Suicide risk assessment training is also provided for teachers and school personnel, peer counselors, emergency medical transportation staff, and law enforcement **officers**. The project maintains a suicide register, and is part of a Community Resource Action Group (CRAG), consisting of community leaders and service

providers, that helps mobilize political and legal changes that impact social problems on the reservation.

The suicide data form with 32 items was adapted for the local suicide register from the one-page format developed by the IHS Special Initiatives Team for use in the Phoenix Area Suicide Surveillance System. Data points include:

First and Last Name	Community & Community Code	Marital Status
SSN	# of Previous Attempts	Employment History
Tribe & Tribal Code	Significant family History	Natal Complications
Medical Chart number	Location of act	Education
Method	Substance-Abuse related	Possible stressors
Date of Birth	Trauma History	Clinic visits prior to act
Birth Order	Person completing report	Date of referral
Sex	MH treatment recommended	Date of follow-up
Disposition	Self Destructive Act	Previous MH hospitalization
Date of Episode	Living arrangement/Domicile	Age

Initially the program focused on collecting data on suicide gestures, attempts, and completions for youth between the ages of 12-19. Realizing the need to include the entire population, staff quickly expanded the database to include all members of the Jicarilla Apache Tribe, family members, and members of the Dulce community.

An intake form was later developed to collect similar information on all

patients seen by the Dulce IHS Mental Health Center, in order to identify high-risk youth and families. The suicide register database includes archival information from Dulce health Clinic records, Emergency Medical Services, and the Indian Health Service, Santa Fe Service Unit Hospital, for years 1980-1 989. Data are not complete for years prior to 1985.

Since 1980, any staff with the National Model Adolescent Suicide Prevention Project who has client contact fills out the suicide registration form when a suicide incident occurs. The following community agencies have been trained to participate in the suicide register, and report fairly consistent data on a voluntary basis: Dulce IHS Health Clinic, Emergency Medical Services, Dulce police department, and the San Juan Regional Medical Center in Farmington, New Mexico. The community reports serve as ancillary information to the data collected by the mental health program.

The patient intake form is filled out by the counselor-aide, who reviews the data on the suicide register form. The Aide enters data from both forms into the computer, using the Epi Info software package. There is a central system where paper reports for the intake and suicide register forms are kept in locked files. The computer database requires a password and is accessible only to the counselor-aide and the psychologist.

Mid-year review of data is performed by the psychologist, who examines the data for frequencies of attempts/gestures/completions by age and sex. The

relationship between the incident and alcohol/substance use, method, and previous attempt history is evaluated. An annual report on program activities and end-of-year summary are sent to the Tribal Council and the Indian Health Service (the funding agency). The data are used locally for program planning and to determine where gaps in community training may exist. For example, a review of recent incidents showed that young adult males were most in need of intervention. Individually, the strongest risk factors included child abuse, family violence, and family history of suicide.

Increases in suicide activity and ‘hot spots’ are generally first identified through informal communication rather than formal analysis of register data. Through discussions that emerge from regular staff meetings or ad-hoc during a crisis, high-risk families are identified and strategies are devised to respond to the crisis. While planning the mental health team response, staff also contact the BIA and other multiple services to coordinate support efforts.

Characteristics of the Suicide Register:

1. Simplicity The length of time required to fill out the form depends on the clinician who responds. The suicide register form takes 10 minutes for the mental health staff to complete; the patient intake form requires about 45 minutes. Forms are usually filled out the same day the incident occurs. Staff are well trained in the definitions used on the form, and are consistent in applying them. The mental health staff work cooperatively and communicate well to coordinate their efforts.

Weekly staff meetings, where case management assignments are made and individual cases are discussed, are often a time when improvements to the surveillance system are suggested.

2. Flexibility The data form for the suicide register has been reviewed and updated once, while the patient intake form has been modified three times. Items which seem to be redundant on the register include: trauma history, previous mental health hospitalization, clinic visit prior to act, and birth order. These items often need to be looked up on the medical chart, and it would probably be more expedient to include them on the patient intake form. Prior visit and birth order have not been useful predictors of suicidal behavior. Useful data elements include: nature of the self-destructive act, cause; and patient disposition. Because the patient register is time consuming to complete, the mental health staff is experimenting with entering suicide register data directly into the computer.

3. Acceptability At first, clinicians warned that patients would not answer questions on the register form due to their intrusive nature. Clients *did* initially appear to be guarded. They were concerned about the eventual use of the data and in protecting their own privacy. Following explanation that the data would be used to help the mental health staff function more effectively and the assurance of patient confidentiality, patients were more comfortable in answering the questions. Over time, as the program as operated, the Mental Health staff have established a reputation for trustworthiness that has increased the willingness of the community

to share private information (May and DeVecchio, 1995).

As the program has continued, the community has become open to new information about problematic family and social issues. Systematic community education efforts have broken the myth that talking about mental health problems will only increase their occurrence or severity.

6. Timeliness The surveillance system is designed to be self-contained for the **Dulce** community. Data are not routed through the an IHS Area Office; therefore, the data are available for use as soon as they are entered and analyzed.

7. Resources Simple resources are used to run the surveillance system: copy costs for the suicide register and patient intake forms, personal computer system staff time for intake, data entry and analysis. Epi Info software is provided by CDC for a low one-time charge to cover printing costs.

Western Athabaskan Tribe's Suicide Intervention Program

The Western Athabaskan tribe's suicide prevention effort is part of a larger system of mental health services on the reservation. These include two behavioral health centers, funded by a **PL93-638** contract to the tribe. One is the alcohol treatment center, a coed facility for substance abuse detoxification and treatment. The other is the tribal Guidance Center, a mental health facility that coordinates suicide prevention efforts on the reservation. The Guidance Center also provides substance abuse aftercare for adolescents with off-reservation placement; a tribal demonstration project for patients with serious mental illness; art therapy for

children, and advocacy for crime victims. The Guidance Center is staffed by three Ph.D. psychologists, one of whom is the director.

In addition to these tribal behavioral health centers, the IHS operates both a satellite clinic with two mental health workers and the IHS hospital, with a mental health staff of a psychiatric technician and one psychologist. As noted above, the Western Athabaskan police department and the Guidance Center collaborated to form a 24-hour on-call community suicide intervention outreach team. The team consists of tribal members, four females and one male, who call the Guidance Center in response to police calls involving a suicide attempt. It should be noted that, in 1997, as this report was being prepared, the tribe elected to phase out the suicide intervention outreach team.

A recent Tribal Resolution was passed to support a response protocol that directed authorities to transport persons who are suicidal and intoxicated to jail. Once in jail, the police notify the Guidance Center's on-call staff, who then arrange for a mental health evaluation or admission to an inpatient facility, usually the IHS hospital.

The Western Athabaskan suicide intervention program provides services to those living on the reservation. Fourteen thousand (14,000) persons live on the reservation, 12,000 (85.7 %) of whom are enrolled tribal members. Of these, about half are under the age of 16; 25% are between the ages of 17 and 44; and 25% are 45 or older.

The Western Athabaskan suicide intervention program participates in an Area-wide surveillance program under the coordination of the respective IHS Area Mental health program. The reporting form, used at all sites, was adapted from that developed by the IHS Special Initiatives Team, and consists of a single-page, 28 item data sheet. Data points include:

Name	Method	Marital Status
SSN	# of Previous Attempts	Employment History
Tribal Code	Significant family History	Natal Complications
Medical Chart number	Location of act	Education
Community Code	Substance-Abuse related	Possible stressors
Data of Birth	Trauma History	Clinic visits prior to act
Birth Order	Person completing report	Date of referral
Sex	MH treatment recommended	Date of follow-up
Date of action	Living arrangement	Previous MH hospitalization

The suicide surveillance plan implemented at the IHS Area Mental Health Program Office provides for the collection of data by community practitioners, primary care clinicians, mental health workers and/or hospital emergency staff at the local level. In the Western Athabaskan program, forms are completed by any of the 6 staffers at the Guidance Center: 3 Ph.D. psychologists, 1 M.A.-level therapist, 1 B.S.-level therapist, and the substance abuse aftercare coordinator. The five-member suicide intervention outreach team also files reports. The IHS psychologist at the hospital reviews all reports for completeness before sending a

hard copy to the IHS Area Office. Photostatic copies are kept in locked files in the IHS psychologist's office. Original forms sent to the IHS Area Office have the client's name deleted to ensure anonymity.

The IHS Area Office is responsible for collecting, coding, and entering information into the suicide surveillance database using the Epi Info software package. The IHS Area Mental Health Programs Office produces quarterly and annual aggregate reports on the cumulative frequency of suicide gestures, attempts and completions, and also prepares site-specific reports for each IHS hospital/service unit in the Area on a quarterly and annual basis.

The director of the Western Athabaskan Guidance Center receives copies of the annual statistical summaries from the IHS Area Office, and uses them to clarify staff and community perceptions concerning trends in suicide attempts, gestures, and completions. Aggregate data are used primarily for grant writing and comparison with other sites. For follow-up of attempters or surviving relatives of suicide completions, the suicide prevention program relies on case histories rather than information from the register. Potential clusters are initially identified mostly through word-of-mouth among Guidance Center staff, the alcohol treatment center, IHS hospital, the police, and the suicide intervention outreach team members.

During a visit in June of 1994, behavioral scientists from the university which has had long affiliation with the tribe evaluated the sensitivity of the Western Athabaskan suicide surveillance system. They entered data from records of those

who had completed suicide into a database for subsequent analysis, evaluated the completeness of the register by comparing it with ICD-9 codes from the IHS hospital and with police reports, and offered suggestions for improving the local usefulness of the register. Findings from this separate study are integrated into this report, as noted.

U s e f u l n e s s

1. Simplicity The suicide reporting form takes 15 to 20 minutes to complete. There is some overlap with data collected in the medical record at the hospital, though most of the data pertinent to suicide gestures, attempts, and completions are contained on the suicide surveillance form only. The suicide reporting form contains important data on contributing socioeconomic factors not found in the medical or law enforcement data systems. In the experience of the Western Athabaskan suicide intervention program staff, many suicide attempts are under reported by the hospital and hospital emergency room. Many injuries that are classified as motor vehicle crashes are felt, in actuality, to be suicide attempts. The majority of completions involve persons who have not been seen at the Guidance Center, so they have no mental health medical chart.

2. Flexibility According to the project director, the field most frequently left blank is the educational level of the patient. The Western Athabaskan suicide intervention program staff agree that information on family history, date and type of previous attempts would be useful additions to the register. Modification of the alcohol and

drug use section are under consideration, primarily the addition of items to include history of alcohol and drug overdose and blood alcohol level confirmed by laboratory analysis. Program staff have also discussed the possibility of incorporating a suicide autopsy into the surveillance process.

3. Acceptability The Western Athabaskan suicide intervention program staff have embarked on a strong public information campaign to inform the public of the nature of suicide and community helping resources. There has been a good response to the reporting questionnaire from patients and family members, who feel it serves as an opportunity to share feelings and concerns with mental health professionals. Similarly, clinical professionals and paraprofessionals alike have responded to the surveillance program in a cooperative fashion.

4. Sensitivity A 1992 Centers for Disease Control and Prevention (CDC) study of the IHS Area Suicide surveillance system found that the Western Athabaskan register likely captured 100% of the suicides that occurred between 1989 and 1991 (Katchur 1992). However, the 1994 comparison of Western Athabaskan registry records by university behavioral scientists to IHS Hospital ICD-9 codes indicated that some incidents were not included in the register. Between January, 1990 and December, 1993, 283 encounters for 243 individuals were recorded in the suicide register. Hospital medical records for September, 1990 - June, 1994 show 476 encounters (303 individuals) for "suicidal acts and thoughts" (ICD-9 code 300.9). The names of only 126 patients are common to both lists. At this time, it is

unknown to what degree the discrepancy is caused by miscoding on the medical record, different reporting periods, or incompleteness of the suicide register.

5. Representativeness A review of death certificates from 1983 until the present is underway in order to identify potential suicides that were coded otherwise on the death certificate. The results of that review are not available at the time of the completion of this report.

6. Timeliness

Paper register forms are forwarded directly to the IHS Area Office for entry into a database and subsequent analysis on a yearly basis. The annual report is used for grant writing and for some planning purposes. Since data are not entered into an on-site computer data base, local staff have no control over the frequency and timeliness of monitoring events on their reservation. Without access to the database and local analysis expertise, staff are unable to tailor queries to meet specific local needs or investigate relationships between events and predisposing factors. The Western Athabaskan suicide prevention program relies more heavily on case descriptions and discussions at staff meetings to gain a general sense of community needs. However, staff intend to begin entering and analyzing local data so that program activities may be more directed by epidemiological data and analysis.

7. Resources The suicide register uses few resources. The IHS Area Office provides forms and manpower for data entry, analysis, and dissemination.

Professional staff time is provided by the local service unit to complete register forms and send them to the Area Office.

Northern Woodlands Tribe's Suicide Intervention Program

The Northern Woodlands Tribal Voluntary Family Protection and Suicide Intervention team came into being after a dramatic increase in the incidence of suicide attempts and completions. There were four suicides in 1990, compared to an average of one per year in the previous five years. In addition, there were 53 attempts in 1990, approximately double the average annual frequency in the previous decade.

The intervention team was formed as an outgrowth of community forums sponsored by the Northern Woodlands Tribal Council. A coalition of helping professionals, medical personnel, educators and clergy donated their time and expertise to identify gaps in the current mental health/medical/law enforcement system, and sought strategies to fill these gaps. For example, prior to 1990, few attempters had immediate care or observation following a suicide attempt. Sixty percent of attempts were allowed to return home to their families after release from the emergency room without a written plan for follow-up. Coordination between law enforcement emergency rooms, and psychiatric care facilities was poor or non-existent. Law enforcement representatives were sometimes unwilling to transport attempters, and in-patient facilities refused to admit attempters due to a lack of clear admission guidelines regarding involuntary admission. Attempters were sometimes

refused admission because their medical assistance reimbursed providers at a rate lower than the existing charge rate. Others were refused because they were intoxicated, and medical staff considered this a substance abuse problem rather than an acute psychological problem warranting hospitalization.

In order to respond to the need for suicide intervention and prevention, a 24-hour on-call volunteer community crisis response team was formed. A psychologist with the local Indian Health Service mental health program is responsible for coordination and oversight of the suicide intervention program. Outside consultants were hired to train volunteers in suicide prevention and post-attempt intervention. A protocol was developed, delineating use of emergency services, 72-hour holds, and referral strategies. Efforts were made to increase cooperation and coordination of medical, law enforcement, and psychological services personnel in response to suicide attempts.

The intention of the Northern Woodlands Tribal Family Protection and Suicide Intervention team is to provide each client with a minimum of three contacts as soon as possible following a gesture or attempt. The team plans future suicide prevention and education activities on an individual or group basis. Project objectives include:

- a. To provide a 24-hour on-call list of volunteers to assist suicide attempters post-facto;
- b. To provide information to emergency room staff and to supply referral

alternatives to the attempter's family;

- c. To encourage 72-hour voluntary placement for attempter protection, whenever possible;
- d. To provide a resource of informal, non-judgmental listening to attempters for a minimum of three contacts;
- e. To coordinate case management and referral for psychiatric services;
- f. To provide support and intervention during a crisis such that there will be a lasting rapport between attempter and intervention team member; to obtain a no-suicide contract; and to establish agreement that suicide is not a solution;
- g. To continue to train volunteers;
- h. To develop community suicide education and prevention activities as appropriate;
- i. To clarify roles and responsibilities of emergency room staff, law enforcement personnel, emergency medical transport, and in-patient psychiatric personnel.

The Voluntary Family Protection and Suicide Intervention Team provides service to members of a Northern Woodlands Tribal band of Indians and their family members. Because the Northern Woodlands reservation is "checkerboard", its total population is 8,727, of whom 2,759 are American Indian (1990 census.)

Data on suicide completions and attempts have been collected since 1990,

and consist of the following data points:

First, Last, & Maiden Name	Current living arrangements	Previous MH treatment history
Marital Status	Family members & history	Sex
Tribe	Significant family history	Date of Birth & Age
Medical Chart number	Education	Psychotropic Medications used
Purpose of MH Visit	Employment	Date report completed
Severity of Psychosocial Stressors	Trauma History (childhood abuse)	Psychiatric (Medical) Diagnosis
Referral name & source	Treatment Plan	Date of referral
Presenting MH Problem & assessment of mental status	Substance-Abuse current use and previous history	Name of person completing report

Each member of the voluntary suicide intervention team is trained to fill out the form using consistent definitions. Data are collected during the response to an acute incident; much of the data are transcribed to the medical record when a patient is admitted for 72-hour hold at the psychiatric facility. Paper records are stored in a central location under lock and key, until such time as data are entered into the computer by the psychologist, who is responsible for maintaining the data files and for performing the analysis. The community crisis intervention team reviews current statistics during its monthly staff meetings in order to identify trouble spots. An annual report compiled by the psychologist compares current statistics to those of previous years. The report is used locally by the psychologist, the intervention team, and the Tribe to identify trends, gauge the effectiveness of

prevention strategies, and to measure the consistency and quality of intervention efforts. The Tribe releases information only sparingly in the application for grant funds in an effort to protect its privacy. The chief of the Indian Health Service Area Office also receives a copy of the annual report with aggregate statistics.

Usefulness of the Suicide Reaister:

1. Simplicity Approximately 80% of the intervention team complete the form immediately on-site when conducting the intervention. Another 15% fill in basic time-person-place data fields and provide more detailed response within 24 hours. The data points most **often** left blank include: preceding stressors, name of family members, and telephone number (although some people living on the reservation do not have telephones). Many urban Indians have returned home to work at the new casino on the reservation. Much of the background information is difficult to obtain on transient people who migrate into the community. Training workshops are held periodically to orient new team members to the definitions and methods for completing the form. Reporting inconsistencies are noted at monthly staff meetings to clarify of terms and give direction on how to improve reliability of the data.

2. Flexibility The focus of the intervention team activities is to provide support for the patient and the family during and immediately after the crisis, and escort the patient through the medical and law enforcement system. Therefore, team members concentrate on those data points that are most essential: demographics, patient disposition (to best plan how to keep the patient from harm) and treatment

plan. Diagnosis of the patient's psychiatric condition was dropped from the form, on the advice of the Tribal Attorney, in order to avoid legal problems associated with a missed diagnosis resulting in a completed suicide.

3. Acceptability The team has found it best to maintain a low profile in order to maintain the community acceptance of the surveillance system and intervention program. Though the team works directly with law enforcement and medical facilities to educate them concerning suicide etiology and facilitate a coordinated response, the team feels that mass broadcast of information to the community is likely to produce anxiety and reluctance to participate in surveillance activities. Team members do grief counseling with families and school classes on an individual, case-by-case basis.

4. Timeliness Information from the suicide surveillance system is used to direct the day-to-day operations of the suicide intervention program, perform quality assurance for the intervention program, and provide annual status reports to the Tribe. As the data are reported, analyzed, and used locally, turn-around time is short, allowing the team to respond rapidly to an increase in activity.

5. Resources Simple resources are required for suicide surveillance, such as copying costs for paper forms, the personal computer system for data storage and analysis, and the services of the psychologist to monitor the program and handle data storage and analysis.

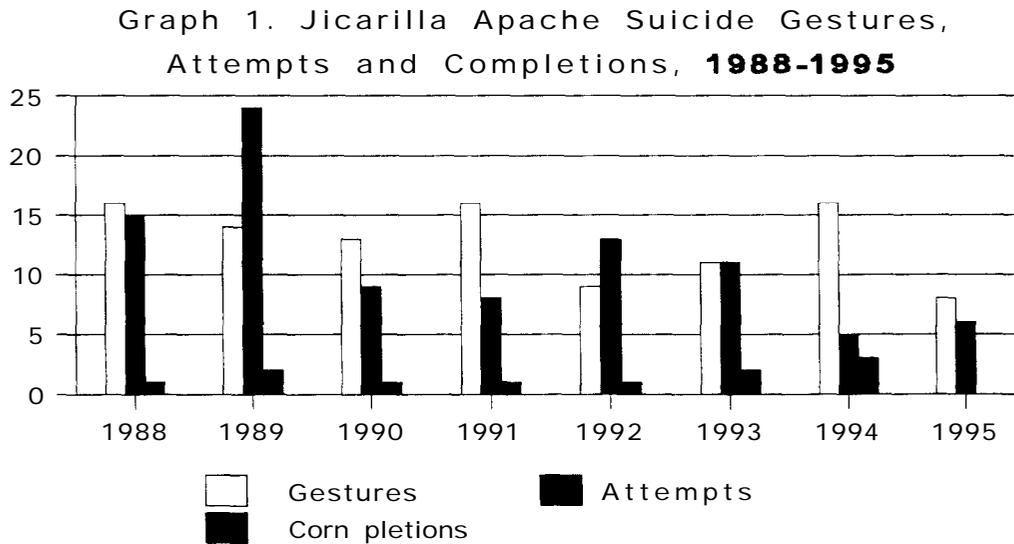
Description and Internal Comparison of Suicide Rates by Tribe from Baseline through Project Evaluation Period

Jicarilla Apache Tribe. The Jicarilla Apache database includes data on 205 cases of suicide attempts, gestures and completions from 1988-1995. Of these incidents, 10 (5%) were completions. The most frequently used method for suicide gestures and attempts was drug overdose (66%) followed by hanging (11%) and firearms (6%). Males tended to use the more lethal methods of hanging and firearms (89%), while females were more likely to use overdose (67%). Over half the records in the database have a history of previous attempt (53.7%), some as many as 7 or 8. Most episodes involve alcohol use (85.7%), highlighting the need to address alcohol and substance abuse in suicide prevention efforts. Most attempts and completions occurred in the home (68.3%) followed by a public place (18.%) or jail (13.7%). It is hoped that current efforts to educate jail officials about suicide prevention will reduce the incidence of attempts in jail.

Table 1 compares the number of gestures, attempts and completions by gender for 1988 to 1995. Gestures and attempts outnumbered completions 19:1. Between 1988 and 1995, females were slightly more likely to make suicide gestures (57 for females compared to 46 for males) but males were more likely than females to make suicide attempts (51 for males compared to 40 for females). All 10 suicide completions during the study period were by males.

Table 1. Jicarilla Apache Suicide Gestures, Attempts and Completions, 1988-1995									
Year	Gestures			Attempts			Completions		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
1988	4	12	16	6	9	15	1	0	1
1989	6	8	14	13	11	24	2	0	2
1990	4	9	13	5	4	9	1	0	1
1991	9	7	16	7	1	8	1	0	1
1992	5	4	9	5	8	13	1	0	1
1993	4	7	11	9	2	11	2	0	2
1994	10	6	16	3	2	5	3	0	2
1995	4	4	8	3	3	6	0	0	0
Total	46	57	103	51	40	91	11	0	11

Graph 1 represents Table 1 in graphic form to compare suicide attempts/gestures to completions among the Jicarilla Apache Tribe for the years specified.



Prior to implementation of suicide prevention program, the average number of attempts and gestures was 34.5 per year. After implementation of the program, the average attempts/gestures per year was 20, representing a 42% decrease overall. After a high rate of attempts in 1988-1989, the number of gestures, attempts and completions dropped by a third in 1990, and remained stable until 1995, when they dropped to half their initial frequency.

Data in Table 2 show that this decrease is due to a decline in attempts among ages 11-18 in 1990, and a decline in attempts by young adults in 1992. The over-25 year age group comprised the largest number of suicide attempts.

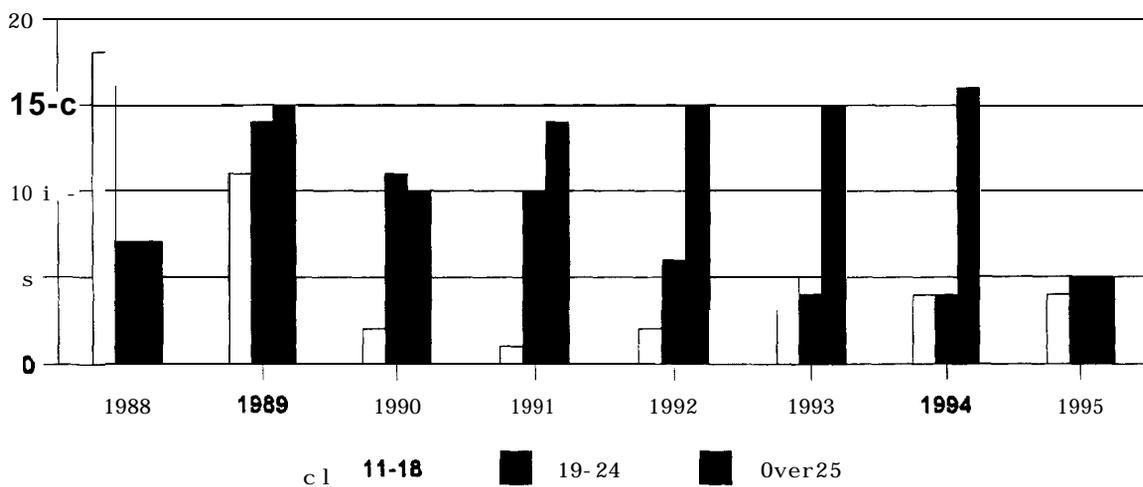
Before the program was implemented, the average number of suicidal acts occurring among youth aged 11-18 years was 14.5 per year (1988-1989). After the program was developed and put in place, the average dropped by 79% to 3 per year, a significant and meaningful decrease. Furthermore, a 23.8% drop occurred in the 19-24 year age group. The average number of suicidal acts pre-program was 10.5 per year (1988-1989), dropping to 8 per year early in the program (1991-1992), and 4.3 per year most recently (1993-1995).

This trend in the reduction of suicide attempt and gesture rates among the age-specific target populations indicates that the educational and follow-up elements of the program were having a lasting effect on the community, as youths who aged beyond the target group carried with them a lower suicidal risk.

Table 2. Jicarilla Apache Suicide Gestures, Attempts and Completions by Age Group, 1988-1995.			
Year	11-18	19-24	25+
1988	18	7	7
1989	11	14	15
1990	2	11	10
1991	1	10	14
1992	2	6	15
1993	5	4	15
1994	4	4	16
1995	4	5	5
Total	47	61	97

Graph 2 depicts Table 2 graphically, Jicarilla Apache suicide gestures, attempts, and completions by age group for the years specified.

Graph 2. Jicarilla Apache Suicide Gestures, Attempts and Completions by Age Group, 1988-1995



In further support of the impact of the program, the number of suicidal gestures, attempts and completions in the untargeted cohort (25+) changed little during this period.

Western Athabaskan Tribe. The Western Athabaskan data set contains 352 cases of suicide attempts, gestures and completions that occurred between 1990 and 1994. Of these incidents, 18 (5.1%) were completions. The median age for register cases is 23-24, with cases ranging in age from 13 to 54. Data were missing for some variables of interest: 3 of the female cases and 6 of the male cases are missing substance abuse data. It should be noted that, according to the IHS Area Mental Health Director, where suicide surveillance data are sent from the Western Athabaskan Tribe for analysis, the numbers for 1995 may not be as accurate or complete as they were in prior years during the "suicide epidemic."

Prescription medication overdose was the most frequent method, used in 33% of all attempt/completions. Overdose of alcohol or non-prescription drugs was involved in 22% of attempts and completions; hanging was involved in 21%. Males tended to use the more lethal method of hanging, while females preferred prescription medication overdose. Gestures, attempts and completions occurred most frequently in the home (70%). Seven per cent of all episodes occurred in jail. In 1991 and 1993, completed suicides often happened in pairs; at least one was a boyfriend/girlfriend couple. Nine of the completed suicides had a record of a previous attempt.

Table 3 provides a comparison of the number of gestures, attempts, and completions between 1990-1995. The average ratio of attempts to completions was 18:6:1. Females were twice as likely as males to make suicide gestures, while attempts were evenly distributed between males and females. The number of suicide completions by males outnumbered completions by females 5:1.

Prior to full implementation of the program in 1994, the average number of gestures was 28.3 (1990-1993). Gestures dropped by 71% in 1994-1995, to an average of 8 per year. Attempts, however, increased by nearly 50%, from 26.5 per year in 1990-1993 to 40 per year in 1994-1995, mainly due to an increase in attempts among males. Suicide completions decreased from 3.5 per year pre-program to 2.0 per year in the years following full implementation.

Table 3. Western Athabaskan Suicide Gestures, Attempts and Completions, 1990-1995									
	Gestures			Attempts			Completions		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
1990	11	14	25	3	4	7	2	0	2
1991	5	33	38	11	27	38	3	1	4
1992	3	23	26	17	18	35	1	0	1
1993	21	23	44	12	14	26	6	1	7
1994	4	7	11	15	5	20	1	1	2
1995	5	0	5	37	23	60	2	0	2
Total	49	100	149	95	91	186	15	3	18

Graph 3 depicts Table 3 graphically for Western Athabaskan suicide gestures and attempts compared to completions for the years specified.

Graph 3. Western Athabaskan Suicide Gestures, Attempts and Completions, 1990-1995

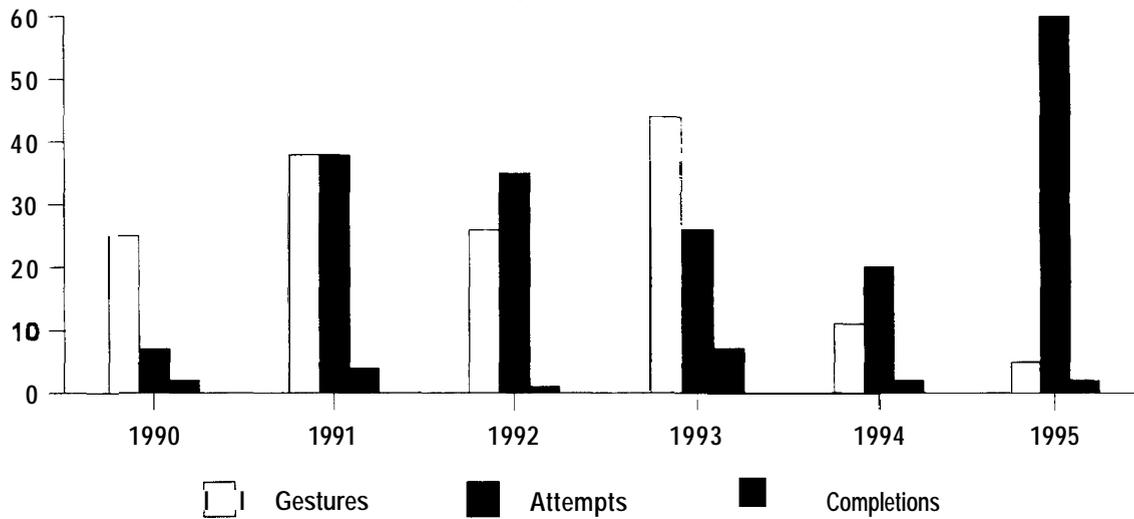


Table 4¹ compares trends in suicide attempts and completions among four age groups between 1990-1995. More than half of all attempts and completions during this period occurred in the 15-24 year old age group (58.6%). The number of attempts and completions in this age group peaked in 1991-1992, dropped by a third in 1993-1994, and returned to a higher level in 1995.

Attempts and completions decreased for the 5-14 year age group and the 25-34 year age group in the years following full implementation of the intervention program. The average number of attempts and gestures among ages 5-14 dropped by 66%, from an average of 9 episodes per year in 1990-1993 to 3 per year in 1994-1995. The 15-24 year age group showed a more moderate effect,

¹ Row totals for Table 4 may be greater than row totals for Table 3, due to some records having data missing for age groups and not being included in Table 3.

decreasing by 26.8 % overall from an average 35.5 episodes per year in 1990-1993 to 26 per year in 1994-1995. The 25-34 age group average of suicidal acts decreased from 10.75 per year pre-program 8 per year post-intervention, for an overall decrease of 25.6 percent. The over 35 age group showed a reverse trend pre- and post-program, increasing 11.4 percent from 5.75 per year to 7.5 per year.

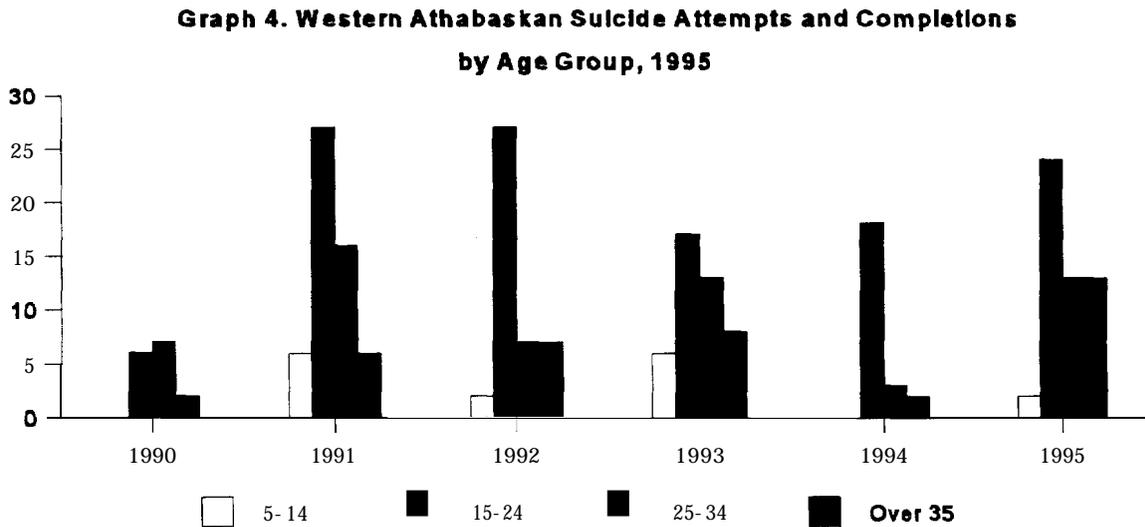
The number of gestures, attempts, and completions in both the 25-34 and over 35 year age groups fluctuated sporadically both before and after program implementation. The high number of attempts occurring in 1995 among those over age 35 was nearly twice as many episodes in this year alone than in the previous five years combined. The cyclical and sporadic nature of attempts in these two age groups highlights the unpredictability of this behavior among Western Athabaskan tribes in general (Van Winkle and May, 1986; 1994).

These age-specific data suggest that suicide prevention efforts among American Indians have their biggest impact on the very young, impressionable individuals in adolescence or pre-adolescence.

Table 4. Western Athabaskan Suicide Gestures, Attempts and Completions by Age Group, 1990-1995.

Year	5-14	15-24	25-34	Over 35
1990	0	6	7	2
1991	6	27	16	6
1992	2	27	7	7
1993	6	17	13	8
1994	0	18	3	2
1995	2	24	13	13
Total	42 (12.6%)	194 (58.3%)	59 (17.7%)	38 (11.4%)

Graph 4 depicts Table 4 graphically comparing Western Athabaskan suicide attempts and completions by age group for the years specified.



Northern Woodlands Tribe. The Northern Woodlands Tribal Suicide Intervention Team has collected data on 219 suicide attempts and completions between 1990 and 1995. The Northern Woodlands Tribe suicide intervention team characterizes non-fatal episodes as either ideations (verbalization of intent to inflict harm to self) or attempts (which includes self-harm events which are serious enough to warrant medical attention and those which do not). Hence, the term “gesture” as used in this report is combined with attempts for the Northern Woodlands suicide activity definitions and data are presented under attempts only.

Table 5² provides a comparison between the number of attempts, ideations and completions by gender for this time period. The average ratio of attempts to completions was 21 :1. Overall, females were 1.6 times as likely to attempt as males, though all completions were by males. The attempt to completion ratio for males was 8:1. The most frequently used method in suicide attempts between 1990 and 1995 was an overdose of pills (62.5%) followed by cutting (13%), firearms (7.7%) and hanging (6.3%).

Seventy-five of the cases (36.1%) seen by the suicide intervention team between 1990 and 1995 reported no prior attempts; 20 (9.6%) reported two or more attempts. Thirty-five persons who attempted suicide went on to repeat the attempt within the year. Ninety-six episodes involved alcohol (46.2%) and 45 involved a combination of pills, alcohol and inhalants (21.6%). Attempts and completions occurred primarily in the home (68.3%), followed by a public place (18.%) or jail (13.7%). Current efforts to educate jail officials about suicide prevention should reduce the incidence of attempts in jail.

After a high number of attempts and completions in baseline year 1990, the total number of ideations, attempts and completions dropped by 30% and remained fairly stable between 1991 and 1993. In 1994 and 1995, however, the total number of ideations, attempts, and completions rose to the 1990 level,

² Attempts also include gestures as defined in this report throughout the tables and graphs for the Northern Woodlands Tribe.

mainly due to an increase in reported incidents of suicide ideations.

No cases of suicide ideations were reported in 1990, but an increasing number were reported between 1991-1995. Though the average number of attempts per year dropped by 41.5% overall in the years after program implementation, attempts began increasing again in 1994-1995. However, the number of attempts in 1995 remained less than baseline year levels for males and females. Suicide completions also dropped during this time to a fourth of the initial frequency and remained fairly stable through 1995.

One argument might suggest that the 1995 increase in ideations and attempts could be due to increased sensitivity in reporting more “minor” suicidal events because of the “institutionalization” of the suicide intervention team in the community and attention paid to surveillance during the CDC program evaluation. Further, an increase in the incidence of ideations might be more than compensated by a decrease in more serious events--attempts and completions.

Conversely, however, the data may indicate that the effectiveness of this program is dampened by the challenges presented by a decentralized community coupled with the confidential nature of the existence of the team in outlying communities on the reservation. In addition, we do not know about cyclical patterns of suicidal behaviors in Northern Woodlands tribes as we do in Western Athabaskan populations.

Table 5. Northern Woodlands Tribe Suicide Ideations and Attempts Compared to Completions, 1990-1995

Year	Ideation	Attempts		Completions			
	Total	Male	Female	Total	Male	Female	Total
1990	0	23	30	53	4	0	4
1991	6	14	19	33	1	0	1
1992	10	9	15	24	1	0	1
1993	7	10	16	26	1	0	1
1994	17	10	27	37	2	0	2
1995	22	13	22	35	1	0	1
Total	62	79	129	208	10	0	10

Graph 5 depicts Table 5 graphically, Northern Woodlands Tribe suicide ideations, attempts (includes gestures) by completions for the years specified.

Graph 6. Northern Woodlands Tribe Ideations, Attempts and Completions, 1990-1995

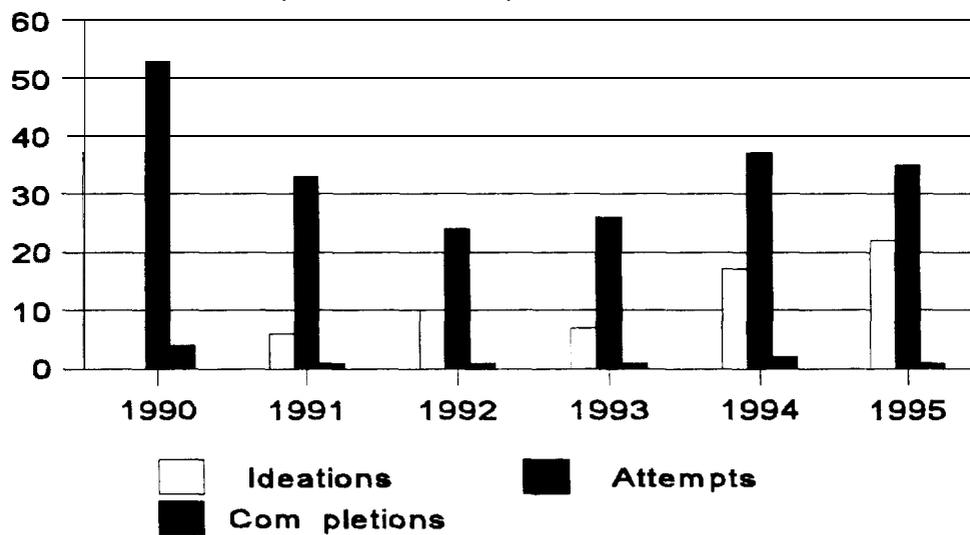


Table 6 depicts Northern Woodlands suicide attempts (includes gestures) and completions by age. Between 1990 and 1995, 29.8% of all suicide attempts occurred in the 15-19 year age group. Attempts in age groups 20-26, 27-35 and over 36 each comprised slightly less than 20% of all episodes. The youngest age group, 0-14, had the lowest number of attempts for the period.

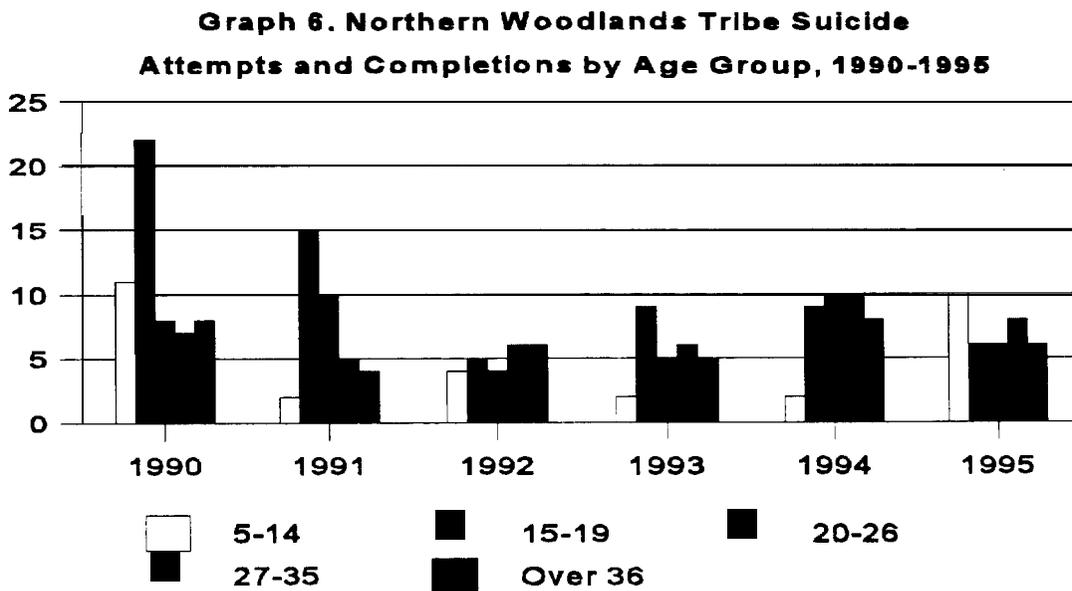
Implementation of the intervention program seemed to have the greatest effect in reducing the number of suicide attempts by people under 20 years of age. Attempts in ages 0-14 dropped by 63.6%, from 11 in 1990 to an average of 4 attempts per year in 1991-1995. Similarly, attempts in the 15-19 year old age groups dropped by 60%, from 22 to an average of 8.8 per year during this period. The intervention program seemed less effective in the 27-35 age group who experienced no change overall. In the 36 year and over age group, there was a 27.5% decrease in suicidal activity, decreasing from 8 per in 1990 to 5.8 per year in the post-intervention years. Numbers in all categories are small, however, a factor which must be considered when analyzing change over time in reduction of attempts in the Northern Woodlands Tribe.

For all age groups, the impact of the program seemed to be greater in the early years of the program, with all age groups showing an upswing in the number of attempts during 1994-1995. Because gestures and attempts are not differentiated in the attempt category because of how data are collected, it is unclear whether the upswing of suicidal activities reflects an increase in life

threatening actions or heightened surveillance which captures more minor suicidal activity.

Table 6. Northern Woodlands Tribe Suicide Attempts and Completions by Age Group, 1990-1995.					
Age Group	5-14	15-19	20-26	27-35	Over 36
1990	11	22	8	7	8
1991	2	15	10	5	4
1992	4	5	4	6	6
1993	2	9	5	6	5
1994	2	9	10	10	8
1995	10	6	6	8	6
Total	31 (14.1%)	66 (30.1%)	43 (19.6%)	42 (19.2%)	37 (16.9%)

Graph 6 depicts Table 6 graphically, Northern Woodland Tribe suicide attempts and completions by age groups for the years specified.



The Northern Woodlands Tribal crisis intervention team has improved the handling of suicide attempts by increasing the percentage of attempters who are not released to their own custody immediately following an attempt. In 1990, 77% of attempters were allowed to return to their home following an episode. Only 15% were placed on involuntary 72 hour hold. By the end of the period, only 6% of attempters were released to their own custody following an incident, and 69% were protected by an involuntary 72-hour hold.

Stakeholder Interviews by Tribe

Stakeholders from each of the tribes were asked four questions regarding the quality and utilization of suicide intervention and prevention services in each respective community. Questions were asked by the Project Coordinator hired by the tribe for this project. These questions were fashioned after those used for the final evaluation of the **National Model Adolescent Suicide Prevention Project** conducted by the Jicarilla Apache Tribe, 1989-1994 (May and DeIvecchio, 1995). One tribe asked an additional two questions to the core of four.

The four core questions are:

1. Describe in your own words the services provided by the suicide intervention and/or prevention project/program.
2. Have you worked with the personnel who make up the suicide intervention and/or prevention project? If so, in what capacity?

3. Please comment on the quality of the services provided by project personnel.
4. Has your agency/program consulted with or requested information from the suicide intervention and/or prevention project personnel? If so, please comment on the services and materials provided.

The results are presented for each tribe, listing types of stakeholders and their composite responses.

Jicarilla Apache Tribe

Nine stakeholders were interviewed by the Project Coordinator. They included representatives from the Tribal Court, Tribal Police, Employee Assistance Program, Decade of Hope (Center for Substance Abuse Prevention coalition-building project), Tribal Youth Department, **Dulce** Health Center, Tribal Multi-Service Program, Tribal Council/Tribal Community Development Program, and Jicarilla Mental Health and Social Services.

Question one, **Describe the work or service provided to the community by the Jicarilla Mental Health and Social Services Program,** produced the following responses: The program provides mental health services, individual, couples and family counseling, crisis intervention, educational classes and workshops, such as domestic violence prevention, victim and perpetrator therapy groups, workshops on depression, alcohol information and alcohol abuse prevention (Alcoholics Anonymous meetings, educational information on

alcohol issues). Social Services needs are provided, such as assistance in applying for Aid to Families with Dependent Children, Medicaid, SSI, Natural Helpers Program for the youth, FAS/FAE information/intervention, advocacy, case management services, support services, involvement with youth activities such as youth conferences, child abuse prevention, elder abuse prevention, sexual abuse prevention, technical assistance-grant writing, provide twenty-four hour on call services, and educational services and training for employees.

Question **two, How have you used the services of the Jicarilla Mental Health and Social Service Program?**, indicates that, of the nine stakeholders, only five had used the services provided by the program. One had received information on behalf of a relative, three indicated they had not personally received services but had sought assistance for clients or other family members.

Responses to Question three, **Please comment on the quality of the services provided by the Jicarilla Mental Health and Social Services program**, indicated satisfaction with the services provided, including professionalism, immediate follow-up, helpful to respective programs represented as well as in the stakeholders' personal lives, confidentiality, immediate response to information requested during consultations when needed, friendly and helpful staff, confidence in the program providers, outstanding quality of service, and "enlightening" compared to other community programs.

Question four, **Has your agency/program received technical assistance from the staff at the Jicarilla Mental Health and Social Services program? If yes, what form did the technical assistance take? Comment on the usefulness of the technical assistance,** reflected the following answers: the program provides psychological and alcohol evaluations for our program, they attend staffings, provide information on alcohol and substance abuse issues, assisted in helping establish a women's support group, provided materials on **FAS/FAE** for the prenatal clinic, assisted in grant writing, provide crisis intervention and training for employees or other service providers, provide domestic violence training, wrote the tribal domestic violence code [for judicial and law enforcement], provide consultations for the judges and other court personnel, assist community members who are moving out of the community to access other resource agencies, provided assistance in writing a proposal to establish a tribal employee assistance program, provided statistical information for another program, established a Community Resource Action Group (CRAG) which has helped identify and address prevention needs in the community, provide training for other program's employees, and assist and collaborate with other programs in different activities in the community.

Suggestions for program improvement and other responses were: keep the Community Resource Action Group going, more tribal members need to be recruited to work for the program, need more immediate response to crises [not

defined what kind], and need more educational training for community members and service providers. It was noted particularly that the program needs a new building to reflect the kinds of services provided and for a “professional look and atmosphere.” The current building causes some confidentiality issues with thin walls and shared offices. A bigger and better parking area for their clientele is needed, clarification on the domestic violence code, program needs a designated person to attend all **staffings**, and there need to be more training on “professionalism and boundaries” for different programs.

All of the stakeholders felt positive about the program, noting that services are provided in a professional manner. Finally, all stakeholders stated that the program is useful and much needed in addressing the needs of the community.

It must be noted, for purposes of this report, that the Project Coordinator made no direct reference to the suicide prevention project by name when asking the questions or in any of the stakeholder responses. Consequently, the questions and responses are not consistent with reports from the previous evaluation done by the outside university evaluator. The present tribal program was referred to as the Suicide Prevention Project in that report.

Western Athabaskan Tribe

Twelve stakeholders were interviewed by the Project Coordinator. They included members from the health and human services agencies and programs in the community (Indian Health Service and Tribal Health programs), teachers,

school counselors, tribal council members, high school students, police officers and tribal court representatives, clergy, parents and community members.

In response to question one, **Describe in your own words the services provided by the Western Athabaskan Tribe Behavioral Health Services to prevent and intervene with suicide**, all stakeholders, with one exception, were able to identify and describe the basic services provided by the tribe. The stakeholders described those providing the services, such as a psychologist on-call 24 hours, the Suicide Prevention Outreach Team, as well as programs including community based prevention and education, public service announcements, and individual and group counseling.

Responses to question **two, Have you worked with either the mental health therapists or the members of the suicide prevention outreach team? If so, in what capacity?**, depended greatly on the stakeholder position and role in the community. Five (41.7%) stakeholders responded “no” who were program administrators and/or not associated with a human service agency. Those stakeholders representing the schools responded that they had “only referred students.” Three stakeholders (25%), two of whom included an Indian Health Service physician and the local Catholic priest, noted that they had participated in a number of events, including local education sessions and community awareness walks, and had sought help from the psychologist on call and the Suicide Prevention Outreach Team personnel for suicide-related emergencies.

For question three, **Please comment on the quality of the services provided by these individuals**, with the exception of two, all stakeholders expressed high regard for the quality of services provided. The Suicide Prevention Outreach Team was recognized for its “cultural, traditional and spiritual (as well as Christian) approach.” Stakeholders noted that “...it seems community members love these people. **I’ve** heard only good stuff about them.”

Services provided by the psychologists were described as excellent and professional. The two stakeholders that did not respond to the question were a tribal council member who had not had firsthand experience with the program and a school counselor relatively new to the reservation. The latter was chosen specifically to evaluate the marketing and public relations efforts of the suicide prevention program over the last year.

In response to question four, **Has your agency/program/office ever consulted with or requested information from the Suicide Prevention Outreach Team or Western Athabaskan Behavioral Health Services?**, all of the human service providers and others, with the exception of the two same stakeholders, said the agency or organization with which they were affiliated had received some form of information/consultation from both the team and the tribal program, including in-service trainings, workshops, conferences, and case consultations. Stakeholders noted that representatives from the Western Athabaskan Behavioral Health Services sit on numerous boards, committees,

associations and task forces in the community and that they keep these respective groups informed on suicide prevention issues affecting the community. In addition, suicide prevention staff from the Behavioral Health Services program have made countless informal presentations and consultations with many members of the community.

Question **five, What do you see as the strengths of the Western Athabaskan suicide prevention approach**, with the exception of the two already noted, stakeholders commented that the Suicide Prevention Outreach Team was made up of community members, all Western Athabaskan, who were knowledgeable of Athabaskan culture and communicate in Athabaskan. Their availability 24 hours a day was of exceptional note. The team is aware of the “negativity” involved in suicide ideation and how to address that negativity. According to the majority of stakeholders, through the efforts of the Suicide Prevention Outreach Team, many young people in the community have realized how important they are to the tribe, their families, and themselves.

Other comments also centered around the Suicide Prevention Outreach Team such as: “they sacrifice their time and get involved;” “there is somewhere and someone to turn to who cares;” “they mix cultural values and traditions with modern approaches;” “they are available to the community, they are out driving about all hours of the day.”

Of special merit to the majority of stakeholders was that the entire suicide

prevention program “relies on the natural gifts and talents of the local Athabaskan people.” Special comment noted that the Suicide Prevention Outreach Team incorporated the appeal of the Christian religious leaders and emphasized unity and cooperation among Christian and traditional spiritual leaders.

As noted, the primary focus of this response was on the Suicide Prevention Outreach Team made up of local spiritual leaders who represented different traditions, including traditional spirituality and Christian denominations, sometimes both.

Question six, **What suggestions for improvement do you have?**, mainly focused on other community needs regarding young people and programming. For example, additional office space for confidential one-to-one consultation was noted, additional leadership in efforts to coordinate with Healthy Nations (another program on the reservation), the need for local residential treatment facilities for problem youth, and a call for a 24 hour hotline other than “911” or the hospital switchboard. Programmatic issues included the suggestion to add youth members to the Suicide Prevention Outreach Team and other prevention services for youth and that the outreach team needed to advertise themselves as a suicide prevention team and identify those individuals publicly who are members of the team. Other suggestions included the need for parent and staff education/information workshops, high school activities, youth suicide

prevention teams, counselors, suicide prevention literature and better public relations among services for youth.

Northern Woodlands Tribe

Nine stakeholders were interviewed by the Project Coordinator out of an identified 50 potential persons to interview. They included team members, tribal officials, mental health workers, social workers, medical personnel, clergy, tribal dispatch personnel and law enforcement officials.

In response to question one, **Describe in your own words the services provided by the Suicide Intervention Team**, everyone interviewed had a general knowledge of the services provided. Persons who volunteer time on the team and those who have had direct contact with the intervention process had a better understanding of the details of how the team works. Several stakeholders commented that, five years before such a program existed, there was a definite absence of support for suicide attempters and family members. Now suicide attempters and family members are in touch immediately with support and a referral system that has significantly helped everyone involved. Stakeholders perceive that the coordinated response has been instrumental in lowering the number of re-attempts.

All stakeholders understood that the Team is made up of volunteers in the local area who have received training to offer immediate response when a suicide is attempted or completed. Once a call is received at dispatch, two team

members are called or notified. The Team members go either to the client's home or to the hospital. They make contact with the client and family members offering support and information. They do not go to offer therapy but, rather, practical support, empathy, and active listening. They gather important background information about the client. They assist law enforcement officials and medical professionals in attaining a 72-hour hold order, if needed. They assist in referrals for counseling or placement for treatment. If a hold order is not obtained, they negotiate a "no-suicide contract" with the client. Most stakeholders mentioned that the responding team member makes several follow-up visits with the client. Many persons felt that the follow-up visits were extremely important and significant. The stakeholders generally expressed appreciation for such a program and the dedicated volunteers who make it happen.

Responding to question **two, Have you worked with the Suicide Intervention Team? If so, in what capacity?**, two interviewees said they had worked with the Team indirectly, by way of administrative help. They support the team by encouraging their staff participation within the scope of their work. Both of these persons have helped the team in securing and funding liability insurance through the Tribe. They both also provide administrative support for the CDC Suicide Evaluation grant project.

Seven (77.7%) stakeholders had worked directly with the Suicide

Intervention Team in responding to a suicide attempt or completion. Two were medical professionals, two law enforcement officials, a dispatcher, a clergy/team member, and a mental health worker/team member. Each of these stakeholders expressed gratitude and appreciation for the assistance and practical help that the Team provides in this type of crisis situation.

For question three, **Please comment on the quality of the services provided by the Suicide Intervention Team**, seven of the stakeholders described the quality of services provided by the team with positive affirmations such as excellent, very good, very professional, and very helpful. Two stakeholders could not comment from direct experience but had heard that the quality was quite good. One of the stakeholders commented that, upon inquiry, they were informed of the highly confidential nature of the program. The manner in which the Team respects the confidentiality of everyone involved in a crisis intervention was expressed as a real strength of the program.

Seven stakeholders commented on the diversity of the Team as a asset. Team members are both Indian and non-Indian volunteers. They also represent a wide range of helping professions such as: mental health workers, psychologist, social workers, child welfare workers, medical professionals, domestic violence workers, clergy, and others. The diversity was particularly commented upon in relation to networking in the community.

The stakeholders felt that the excellent quality was due to the commitment

level and dedication of the volunteers on the Team. Many commented on how the Team members deeply care about people, desire to do good and are willing to go into very difficult and sometimes frightening situations. It was mentioned all of the Team members have skills in talking with people and, in many situations, the client and family are more comfortable talking with a Team member than they are with the medical or law enforcement personnel.

The ongoing and extensive training of the Team members contributes greatly to the success of the program. One stakeholder commented that the leadership and training provided by the IHS psychologist since the beginning of the program has been of great value and enabled its success.

The only area of weakness expressed by stakeholders is that inherent in any volunteer organization. Sometimes the Team suffers from a lack of on-call volunteers and recruitment is an ongoing concern. Two people mentioned that communication difficulties existed in the early days of the program, but most of these have been worked out.

According to the stakeholders, the contributions of the Suicide Intervention Team are to be commended. This service has been successful on a variety of fronts. It is a service to other professionals who respond to suicide calls. It is a support and comfort to clients and families. It provides a service of referral and important information about the appropriate treatment for the client.

In response to question four, **Has your agency/program consulted with**

or requested information from the Suicide Intervention Team? If so, please comment on the helpfulness of the consultation, seven (77.7%) stakeholders had received information by way of inservice presentations or by attending training meetings. They found this consultation very helpful and educational.

It is important to note that the Suicide Intervention Team focuses its energy on intervention and does not provide a prevention program. However, stakeholders generally felt that prevention is provided due to the one-on-one relationship formed between Team members and clients.

Information is given to agencies regarding the services provided by the Team. The membership of the Team is of a confidential nature. Therefore, as a group, the Team keeps a relatively low public profile. Those who had received information found the presentations to be very professional.

Two stakeholders had not received a formal presentation of information by the Team. However, both expressed interest in and intention to take part in such. They had received some informal consultation by way of interaction during a crisis intervention, or by way of association with **an** individual Team member.

Those stakeholders who serve as volunteers on the Tern have received extensive training and information sessions provided by the Team. Since 1990, when the Team was formed, some 45 workshops, inservice training and information sharing opportunities have been available.

Client Satisfaction Interviews

Two tribal suicide intervention and/or prevention programs completed this section. The team of one tribe felt that their ethics dictated not going back to an attempter to fulfill this part of the project due to the volunteer nature of the Team and the concern about their credibility after client contacts were over.

This part of the evaluation study was the most difficult to do, since it involved going back to clients who might be reluctant to talk about their attempts. The Project Coordinators, too, experienced reluctance in carrying out this part of the project. Initially, a psychological autopsy was to be conducted only on suicide completions in each community, but all three Project Coordinators felt it would be difficult to pursue this particular type of evaluation research. Representatives from each of the communities felt in future studies/research, the initial contact with the client/attempter be informed that they will be contacted at three or six months increments after treatment to follow up on the success of the treatment/intervention, noting that the “window of opportunity” for client response was only about 2-4 months post-attempt or post-completion for families of deceased persons. The “psychological autopsy” was changed to “follow back study” to lessen the negative impact of this terminology. The consensus was to do a follow back on the 1995 and not the 1996 suicide attempts in the communities to ensure a more complete study of a calendar year. In addition, a follow back study of completions only wouldn't work for the Jicarilla community

since there were no completions in 1995. It was determined that the follow back study be completed on all attempters in 1995 for Jicarilla (n=14), and that a random sample of 14 attempters be interviewed in the other two sites if attempts for one year exceeded 14. The term follow back study was changed later to the term “client satisfaction survey” to fit **IRB** requirements. Each local Project Coordinator was to interview the sample of those who had attempted in 1995 and one family member to complete this project activity.

Jicarilla Aoache Tribe

The Project Coordinator notes that this part of the evaluation project got off to a slow start due to time constraints and other problems associated with the sensitivity of conducting psychological autopsies on suicide completions in each community without over-stepping tribal beliefs and customs. In Athabaskan communities, generally, of which the Jicarilla Apache Tribe is one, traditional persons are reluctant to say the name of the deceased for fear of reprisal from the deceased person’s spirit. At all times project staff supported the need for and practiced cultural sensitivity in this regard. The Jicarilla Apache suicide prevention staff asked four core questions and developed another on their own to complete the follow back study.

Of the fourteen suicide attempts in 1995, one moved out of state, two persons did not respond, five refused to participate, one completed suicide in 1996, but the mother agreed to do the interview, and five agreed to participate in

the client satisfaction interview. The Project Officer also notes that these interviews were done not only very late in the year but also very reluctantly by the local Project Coordinator.

In response to question one, **Describe the work or service provided to you/client by the Jicarilla Mental Health and Social Services Program**, the responses by attempters focused largely on counseling efforts of the staff. Four noted the immediacy of the counseling and crisis intervention: “I was provided with counseling and crisis intervention quickly, the responder was open and listened to what I had to say about my problems;” “I was provided with counseling, transportation, and crisis intervention;” “individual counseling...;” and “I got a lot of benefit out of the counseling. It was good, I got a lot of help when sent to the psychiatric hospital and how to deal with it - depression. The medication helped with my depression and cut down on my cravings for alcohol. When I had a problem, my counselor was there.” The fifth noted that “no contact was made with me because I was in another town, but my mother must have been contacted.”

The family member, whether it be a mother, sister, or grandmother, the responses focused on the immediate treatment following the attempt of the family member. One noted, that, “when he was sick from alcohol, we asked him what was wrong, but he wouldn’t talk to us, so we called the psychologist to talk to him.” Two family members briefly stated that “counseling” was utilized. A

mother noted, “the response time for the crisis intervention was excellent when my son made the attempt, the intervention was helpful but there was some dissatisfaction after my son came back from the psychiatric hospital when I felt the counseling didn’t seem to help.” A sister stated local services weren’t offered to her brother right after a serious attempt because he was flown out immediately to the hospital. However, she notes her brother was court-ordered into counseling after his suicide attempt. Another mother notes that she called the program for assistance to locate an [alcohol] treatment center for her daughter. She found a place and assistance with financial support.

Regarding question **two, How have you/client used the services of the Jicarilla Mental Health and Social Services Program?**, all except one response was positive or neutral. One person stated she received individual counseling after her attempt which she feels didn’t help her. Others, however, noted that counseling had been well received and, in more instances than not, was helpful.

One person noted that individual counseling gave him the ability to think out problems rather than be impulsive and helped increase his self-esteem. One commented that he came for counseling before his attempt and the therapist provided him with good therapy and that he could converse well with the counselor. He does not comment, however, on what occurred after he attempted suicide. Another client stated the counseling helped her overcome

her shyness, and that the mediation given her for the voices she was hearing really helped her. Finally, the fifth client stated he received good ideas about how to handle feelings and anger, received help with court and court papers, medicine and refills, and, when he went for counseling, his counselor listened to his problems.

Family members noted the following: A grandmother stated she had called the psychologist to check on her grandchild, the psychologist helped with family meetings and transferred information to the family when her grandchild was in the psychiatric hospital or at alcohol treatment. A mother noted that individual counseling was provided for her and her son, but family therapy was not provided which had been court ordered. A sister of one of the clients stated her own immediate family was provided with family counseling which really helped at the time. She thought the individual counseling provided by the program, although court ordered, really helped her brother. Another mother briefly commented that her son received a psychological evaluation and individual counseling. Finally, another mother stated she received individual counseling for herself and her daughter.

For question three, **Please comment on the quality of the services provided by the Jicarilla Mental Health and Social Services Program**, the responses were mixed, but more positive than not. Only one client stated she didn't think the counseling provided was any good: "it didn't do her any good in

terms of solving her problems because her counselor had too high expectations of her, and there was not enough time for the sessions.” Another client stated the services provided were good, he felt comfortable talking to a counselor that he knew and was from the community, and the counselor “understood him.” A third client stated he was happy with the services provided and that the therapist was empathic, listened to his problems and helped him to cope. The fourth client stated that sometimes the services provided were against her will, such as hospitalization, but that she understands “it is because she needed help.” Otherwise, she was satisfied with the services provided. Finally, the fifth client stated, when his counselor wasn’t around, other counselors were there to listen to him and he could talk to them. “There was always somebody around to contact and that was good. I got a lot of benefit from it [counseling].”

Family members’ responses were also mixed, leaning more toward the positive. One relative noted that her family member who attempted suicide seeing the therapist twice a week was helping. She noted the therapy was required by court and that “his counselor checks on him once a week - it is helping him.” One mother stated the crisis intervention that was provided when her child made the attempt was all right and she was satisfied with it, but she felt the aftercare was not effective because no family therapy took place. She stated that her child was “not too verbal about his problems” and because of this characteristic thought the counseling was not effective. She suggested that

having a young adult male counselor would be helpful to counsel young men in the community. A sister stated she felt the services provided to her were good, her confidentiality was kept, and she felt safe talking about family issues with someone who was not from the community. In reference to her sibling's counseling, she commented she saw positive change in his behavior. A mother stated the serves were good, but there are not enough personnel to meet the needs of clients. Finally, another mother stated the services were "so-so," didn't appear to help her child as far as counseling was concerned, but the program was a good resource for other services.

Question four, **What kind of support system do you think is available to you/client in the community?**, evoked the following very mixed responses. The focus of "support" in the community centered more around program staff than family members and the community at large.

One client stated there is no support system for her in the community. She states she does other things around her home and writes to "cope and stay busy." Another client felt there was a great deal of support for hm in the community such as his employer, sisters, friends, and the Jicarilla Mental Health and Social Services program. One client noted he received support from his high school principal, grandparents, and the Jicarilla Mental Health and Social Services program. Another stated "there's really nothing or nobody in the community besides Mental Health and the IHS clinic who's there for me or who

understands my problems besides my family.” The fifth client stated she had no other support system but from Alcoholics Anonymous meetings, the tribal Multiservice programs, and the Jicarilla Mental Health and Social Services program.

Family members also focused primarily on program supports for their family members. One grandmother commented that ‘I think he can get a job after the feast and that will help him, the family is keeping him busy and staying with him all the time, and he is happier when he can spend time with his daughters.’

A mother’s response included the school counselor, juvenile officer, Jicarilla Mental Health and Social Services program, and the tribal Multiservice programs. However, she noted that the counselor wasn’t helpful for her child. A sibling listed different support systems in the community such as Jicarilla Mental Health and Social Services, the IHS clinic and Bureau of Indian Affairs social services. Another mother listed the AA group, women’s group, men’s group, churches, Alanon and family. One mother was vague, stating, “I know there is a lot of support for all kinds of mental and behavioral problems.”

Finally, in response to question five, **What, if anything, could be different in your environment/community that will give you the support you need to effectively deal with problems?**, the responses elicited were more descriptive than those to previous questions. One client responded, “someone

to talk to, someone my own age to talk to, parents who are more open and understanding, and we need a youth counselor or youth-oriented counselor.”

Another indicated if his childhood and adolescent years were better, including family support and love, “things could’ve been different.” He notes that his father was very abusive, the community environment depicts drinking, and parents are not supportive of family: “ this [is what] causes problems.” A third client stated that “non-drinking/non-drugging friends would help”, having a lot of activities at school and at home, family life would be better if his mother didn’t drink, marital problems between his step-father and mother needed to improve for the better, and he wished father were still alive because he was very close to his father and they used to do a lot of things together. Another client’s response was “there need to be more tribal members trained in counseling to be available 24 hours a day, seven days a week.” The final client’s comment was “to have a close-knit family” and that she “doesn’t follow through with suicide because her family will be sad and feel bad” if she should complete.

Family member responses were as follows. The grandmother commented, “I’ve been trying to tell the other family members not to get mad at him or say things to him that will get him upset, to not be critical of him. If his friends or brother would not come around and tempt him to drink...” One mother’s response was, “if more parents were involved with the school system, academically, and with the teachers;” She noted that she herself needed to be

more involved with her children, admitting she was not involved with her son and his education as much as she should because of her employment and having other children in the home. "If her son's father was still alive," she said, "it would have been different, because he was very involved with his sons." She also noted that the environment would be more helpful if there was more positive peer pressure from his friends instead of negative pressures. Another mother suggested an **Alateen** program for youth would be good and noted the need for adequate qualified counseling personnel to meet the needs of individuals and be on call after hours. Finally, a mother commented that "easing the stigma for people who are ashamed of being associated with mental problems" is needed, along with a youth counselor, and **Alateen** meetings.

In summary, feedback on the program was largely positive from both clients and family members interviewed. Youths and young adults alike emphasized that a youth counselor on staff would be able to identify with them and understand their issues much better. They also felt that more activities at school and in the community would be helpful regarding community support for local young people's needs.

Many of the attempters who were interviewed had made significant changes in their lives. The Project Coordinator was surprised that one attempter agreed to be interviewed, since he was hostile prior to his attempt. This young man is now able to talk about his feelings and problems, which was noticed by

family members and the program staff.

A number of those who had attempted suicide refusing to participate in the client satisfaction survey were reluctant to do so because of embarrassment and shame surrounding the attempt. Others stated that they were drunk at the time and did not remember attempting suicide or that they “just wanted to forget about it.” Those who did not remember attempting suicide wanted to know where the local Project Coordinator got the information that they had attempted suicide and they had to be reminded of the program’s intervention with them.

Western Athabaskan Tribe

Ten interviews were conducted with persons who had attempted suicide in 1995 in the Western Athabaskan tribe. It must be noted that the local Project Coordinator left his position before completing the entire set of interviews with all attempters. No family members were interviewed. Western Athabaskan Behavioral Health Services staff were not able to complete the entire set of interviews, and had to search for the following data. The data are thin and incomplete, gathered through June 1996. However, they do indicate a range of responses to the questions that are useful for evaluating the utility of the suicide prevention programs on the reservation. Since the answers are so short, all answers for each question are presented by each client interviewed.

The core questions asked were to be identical across sites. The fifth question was similar to that asked in the Jicarilla Apache community. The

questions included:

1. **Describe services provided to you by the Western Athabaskan Behavioral Health Services.**
2. **How have you used the program's services?**
3. **How was the quality of the services?**
4. **What kind of support system is available to you in the community?**
5. **What could be different in your community to better address your problems?**

The first client's responses to all five questions included the Behavioral Health Service program's help in getting alcohol treatment, assistance with "my kids' problems," using counseling for the children, and that personnel in the program were "nice and helped me a lot." The support system in the community was the Behavioral Health Services program and the client's church. Support needs included "more help from the Tribal Council and more jobs and housing for the homeless."

The second client interviewed responses to each question were very short: counseling, reference to one of the counselors who is helpful, seeing this same counselor "when I need help," support came from "my family," and community support needs were described as the need for "more things for kids to do" and "do something about everybody drinking all the time."

The third, as did most of, the clients, had similar responses: "the program

helped me with my family, provided family counseling and medicines, the Behavioral Health Services people were great but I didn't like the pharmacy people." Support systems included "my aunt and grandma and my brothers and sisters." In response to the last question the person replied that "families should stay together."

The fourth clients's responses all focused on keeping his job and drinking: the program "helped me with my job and my boss so I wouldn't get fired," "I had to go see them [Behavioral Health Services] after I had a problem with drinking and then tried to overdose. They got me to the hospital and helped me get my job back. I thought they were real good. I wouldn't have a job now [if it were not for Behavioral Health Services]." Support included friends and family that "help a lot." Support need included "more Alcoholics Anonymous and to stop the bootlegging [of liquor onto the reservation]."

The fifth client noted that she worked with one of the psychologists who 'helped a lot ' with her problems and her children. She stated that this psychologist "was the best" and that her church, this particular psychologist and her family were her support system in the community. In response to the fifth question, she noted, "there is too much violence and drugs. Drinking is also very bad."

The sixth client noted that she gets counseling, his counselor is "nice," support includes her boyfriend and family, and that she wants to go to school

and get a job [to take care of] her children.

The seventh client noted that Behavioral Health Services staff “helped me in the emergency room and sent me to Charter [for alcohol treatment]. Services were “okay, I guess,” friends were the support system, and the community needed “more things to do” because “it’s boring.”

The eighth client noted that the Suicide Outreach Intervention Team helped him when he had a fight with his girlfriend, members of the team come by and see him sometimes to “make sure I’m okay,” the client “likes them [the Team] and they help me. They’re like my grandma’s or something.” This client responded “I don’t know” when asked about his support in the community. Situations that needed to change included ‘drinking and gangs and drugs. They are all very bad.”

The ninth client noted that ‘they [Behavioral Health Services] put me in jail when I was drunk and tried to kill myself.” The client went to the local tribal alcohol rehabilitative center and notes that he has been sober for three months. Support includes Alcoholics Anonymous and Narcotics Anonymous meetings and family. Problems in the community include “too many drugs and drinking. Too much anger and violence.”

Finally, the tenth client noted that ‘I became very depressed after my husband left me for this other lady. I tried to do it on my own, but his family was very mean to me and they bothered me all the time. One of his sisters even tried

to have me arrested. I didn't know what to do. I had his children and he was messing around and didn't care about any of us. I just got real bad somehow. I took some pills." She notes that one of the psychologists from the Behavioral Health Services program "saved me." The psychologist "took care of me and my kids while I was away and he counseled me when I came back." For support, she noted that "I have my children and my side of the family. I kind of have a boyfriend now, too." Problems in the community include "too much drinking and messing around. We need to make our families stronger."

Northern Woodlands Tribe

The Project Coordinator offered this report regarding the Suicide Intervention Team's decision to not do the client satisfaction interviews:

When the Northern Woodlands Tribe Suicide Intervention Team began the preliminary work on developing the questions and plans for interviewing clients who had attempted suicide, two significant issues arose. As the group deliberated issues of confidentiality and a perceived "window of opportunity," it eventually became apparent to the Team that they could not, in good conscience, proceed with the process. Team members remembered that, in 1990, when the tribal people decided to begin a grassroots response program for suicide attempters, the only way a volunteer response in such sensitive situations could succeed was if confidentiality was guaranteed to every client and family. It was also felt that a reputation of confidentiality would have to be

built among all the people of the reservation. This continues to be the consensus among Team members today. Without the assurance of confidentiality, a volunteer response would have failed from the outset. The Team has been successful in the past 6 years in establishing a reputation of professionalism and complete confidentiality, not only within the community, but also among fellow team members. Names of clients are never used even within the team itself.

The only conceivable way to interview previous clients without breaching confidentiality would be if the responding team member conducted the interview. This would involve 25 volunteers interviewing clients. It was felt that the reliability of a Team responder interviewing one's own client in relation to quality assurance would be seriously questionable.

In addition, it was unanimously acknowledged that clients would not be comfortable or open to an evaluative interview reminiscent of the suicide attempt incident. After several years of experience, team members have found that, after a 2 month period, attempters no longer want to talk about or remember their suicide attempt. Therefore, it is believed that a "window of opportunity" exists, where suicide attempters are able to talk about their attempt and associated events. Follow-up visits after this time period have been unsuccessful. Team members attribute this finding to the immensity of shame their clients experience about the attempt. Also, Team members have found

that their clients reach a point where they want to move on with their lives, leaving this memory behind them.

The Team members unanimously agree that, while information about quality assurance from their clients is desired and would be valuable to the program, given our unusual circumstances, this kind of retrospective interview would jeopardize the program and be perceived as insensitive to the needs of clients. With regret and much deliberation a decision was reached by the Team to forego the client satisfaction interviews in the interest of the clients and the program.

Because the Team program incorporates three follow up visits with clients after the initial visit, the Project Coordinator recommended that evaluative questions be given to clients at that time, if such a study is done in the future. While reliability still may be questionable, perhaps an evaluation form for the client to fill out would lessen the reliability risk and remain within the time frame of the 2 month "window of opportunity." Team members are seriously considering implementing this suggestion into future studies and for their own information as to the quality of their services.

Overall, the evaluation process as carried out under this project has strengthened the Suicide Intervention Team program and initiated important changes. The positive changes the evaluation study has and is bringing about are as follows:

1. An openness to a higher public/community profile as service providers.
2. Recognition that ongoing evaluation is necessary for effective service.
3. Interest in networking with other reservation suicide intervention and prevention programs.
4. The Team developed a manual of a volunteer suicide intervention model that was presented at the National Suicide Prevention Conference, sponsored by the Indian Health Service, in the summer of 1996.
5. Clarification of policy and procedures.
6. Recognition of and interest in developing more suicide prevention tactics.
7. Recognition of needed improvements in risk and liability management of the Team.
8. Interest in seeking funds to hire administrative help.

While the Team members feel they could not do the client satisfaction survey (follow back study) on past clients, they feel the CDC project evaluation process has been a success, having provided important information and opening doors for improvements to the Team's operation.

DISCUSSION

This project sought to evaluate ongoing suicide intervention and/or prevention efforts in three diverse American Indian communities. Developing the evaluation plan in conjunction with the various constituencies involved, the Centers for Disease Control and Prevention, the Indian Health Service, a

university consultant, and the three communities was a challenge in this particular project. In the attempt to make the evaluation culturally and programmatically sensitive, some consistency was lost in the data collection process. For example, data were gathered differently at each site, analyzed across differing age groups, and were not presented in raw form to the project epidemiologist for comparative analyses.

For a number of reasons, the local program coordinators seemed to experience difficulty carrying out the detailed evaluations necessary for the project. In general, it seemed that the local program coordinators did not have time to do the process evaluation, for it took time away from their actual prevention duties. Staff turnover was a problem at two of the sites which adversely affected the process evaluation as well. All three local project coordinators were not actually community tribal members; only one had an ongoing role in the community suicide prevention program prior to being hired on this project. Further, each project coordinator was supervised by the very persons and program he or she had to help evaluate. In each community, local politics or personal issues became paramount, getting in the way of the process evaluation itself.

In sum, the local nature of the process opened itself to problems of diffuse authority and lack of focus on the evaluation process. Suicide prevention issues, tribal identity issues, and staffing issues took precedent over the actual

evaluation activities.

Therefore, a major recommendation to come out of this study is to have process evaluation activities conducted by an external (non-community member) evaluator not supervised by local staff. Local staff may have too many other conflicting demands on their time and loyalties to spearhead the process, but would be vital in assisting and guiding an outside evaluator in gathering appropriate information.

Surveillance data gathering techniques were structured differently at each site. The Jicarilla Apache program maintained its own surveillance data system, while the Western Athabaskan and Northern Woodlands tribes relied more heavily on IHS systems at the Area level. In all three cases, the attempt data seem to be reliable and consistent. However, it would be valuable to have extensive program surveillance capabilities at both the local and Area levels to serve as measure of reliability and encourage active surveillance useful to program planning and efficiency.

In general, three very valuable pictures have been drawn of three different types of programs in Indian country. First, the Jicarilla Apache program represents a suicide prevention program in a very small, cohesive, and well coordinated community response which depends on a staff model. The Jicarilla Apache program has adequate mental health and social service staff able to coordinate with a suicide prevention team employed to look after the particular

problem of self destruction. At the Jicarilla Apache site a number of different activities which led to primary, secondary, and tertiary prevention initiatives were instituted.

At the Western Athabaskan reservation, the prevention program utilized several special initiatives which were coordinated, in some cases loosely, with the existing well-staffed Behavioral Health Services program. This reservation had the largest staff in behavior and mental health services. The community education outreach programs, on-site counseling and investigation, and case management were overseen and coordinated with this system.

The Western Athabaskan initiative, therefore, is also a staff model where many of the mental health services are performed by full-time staff. However, other special volunteer and coordinated efforts were created to address suicide prevention, specifically. The client satisfaction interviews for the Western Athabaskan, although lacking in detail, clearly indicate that people recognized the importance of the activities and all aspects of the coordinated community programs. Particularly, the interviews indicate the importance of counseling and mental health services.

The Western Athabaskan community has been fraught with politics and changing views of the tribal counsel, which has been a challenge to the health care infrastructure. Because so many staff are full time employed staff, however, the infrastructure has held. It must be noted, however, in 1997, during

the writing of this report, the Suicide Outreach Intervention Team was disbanded, showing the vulnerability of a program component structured around the activities of one issue - suicide - which fluctuates over time.

The experience in the Northern Woodlands encountered special challenges. Working on a reservation characterized by interspersed White and Indian lands and populations, less centralization of services and people, and fewer mental health resources, a different type of program was set up. The volunteer network did seem to suffer from lack of full-time paid staff to oversee all aspects of the program. That is, surveillance, referral, follow-up, and overall program duties probably need more resources and full-time staff to carry out its mission. The lack of on-site full-time program staff seemed to make the program more vulnerable to political issues which proved to be somewhat frustrating and disruptive for the intervention team at certain times.

A major accomplishment which was stimulated by the CDC suicide evaluation efforts, however, was the development of an excellent manual describing how a volunteer suicide prevention system can and should work. The manual, entitled "Wiidookadaadiwin" ("people helping each other"), was prepared by the Northern Woodlands suicide intervention team. It describes a grassroots community approach to suicide intervention using a variety of volunteer coordinated activities. The manual is a valuable contribution to the suicide prevention literature and may be useful in other communities where

resources are scarce, population is dispersed, and the public health and mental health systems are a challenge to coordinate.

The indicators of programmatic success in reducing suicidal activity in the three communities are highlighted in this section. Among the Jicarilla Apache, the data clearly showed how suicide attempts and completions in the target group (ages 15-19) declined with the creation and implementation of the comprehensive program. With the older age groups, the success was not quite as dramatic, but shows evidence that the program had an impact. In the 19 to 24 year age groups ("graduates" of the 15 to 19 year age group impacted by the program) the affects of suicide attempt reduction showed a two to three year lag, indicating the program had an impact on the target group as they aged. Furthermore, the pattern of attempts showed that those who were never in the targeted age groups (25+) were not affected to any great degree. Therefore, the Jicarilla Apache program seems to be indicative of one which worked well.

Another indicator of program impact is in the suicide completions in the Jicarilla Apache community. There were no completed suicides in the targeted age groups from the time the program was instituted until the seventh year of operation (1996). There were several suicides at Jicarilla, but they were all older suicides, well outside the target age groups.

In 1996, when two young people killed themselves, project staff conjectured that the deaths may have been related to the fact that the "natural

helpers” program had not been allowed into the schools that year. Staff suggested that they lost their “network” and “information grapevine” of young people in the schools who could keep staff informed about who was suicidal and had plans to kill themselves. The program is being reinstated in 1997.

The evaluation outcomes suggest the Jicarilla Apache Tribe’s suicide prevention program benefited from a number of special conditions which may be necessary for any effective program in Indian country. First of all, the Jicarilla Apache program had consistent and well trained staff. They were with the program from its inception to end and worked in a community with a small centralized population. Not only is 90% of the population in the small town of **Dulce**, but the services are clustered there, as well. Although the mental health and social services are not extensive in this community, they are adequate and were well coordinated between the Indian Health Service, the tribe and the special suicide program initiative. The program was active in maintaining surveillance data and evaluated their program on a yearly basis. Evaluation findings were “folded into” continued program development, intervention efforts, and prevention planning on a regular basis. This multifaceted program which utilized a variety of preventive techniques (primary, secondary, tertiary) was by all surveillance indicators, successful, and supports **CDC’s** suggestions to develop numerous coordinated program efforts to address suicide (1988). The program evaluation of client and stakeholder interviews validated these findings.

The Western Athabaskan reservation also demonstrated success. The data showed that, after program implementation in 1994, following a major epidemic in 1993, gestures were lowered by 20 per year (- 71.7%) attempts increased by 13 per year (+ 49%), driven largely by the older age groups, and completions dropped 1.5 people per year (42.9%). No specific age groups were targeted with the Western Athabaskan reservation programmatic efforts, but the impact seemed to be greatest on those under 25 and 20 years of age, specifically. The staff model of suicide prevention utilizing a coordinated system of paid outreach workers also took advantage of the relatively larger number of mental health resources available. Centralization of clinical supervision at the Behavioral Health Services also served the program well, despite some confusion with administrative supervision, since the paid outreach staff (Suicide Outreach Intervention Team) was under the auspices of the tribal police department. Because the special suicide outreach activities were controlled by the police department, some problems of coordination arose. It may be that more centralized administrative as well as clinical supervision of the outreach network and activities would have made this program even more effective than it was.

At the Western Athabaskan reservation, the program evaluation process was difficult. The local evaluator (Project Coordinator) was hired late in the process, was known to the tribe but not a tribal member, and was sporadic in his

performance. Similar issues occurred as in the other communities in having the local evaluator supervised by the very program he or she was to evaluate. This situation seemed to present special problems of access to clients and time for evaluation. The Western Athabaskan reservation, as with the other two sites, clearly needed an outside evaluator to work closely with local health service staff.

The Northern Woodlands community also registered a reduction in suicide attempts. The reduction in suicide attempts was not as great as in the other communities, but may be due to a confound in the data in that the Northern Woodland Tribe combines suicide attempts and gestures under attempts, and does not separate the two categories. The attempt rate seemed to be starting back up at a rapid rate in 1995, the fifth year of the program. Again, these data be driven more by gestures than attempts because of a more sensitive surveillance effort. There was less change in the older age groups than in the under 20 age groups. The reduction of suicide attempts between 63 and 55% in these lower age groups was impressive, showing the effectiveness of a volunteer program challenged by decentralized services.

For the Northern Woodlands community, evaluation was also a special problem. Local concerns about confidentiality and the mechanism for follow-up on the Suicide Intervention Team were not compatible with the implementation of the client evaluation interviews. The interviews were seen as too sensitive by

the overseers of the program in the community and, therefore, were not done.

Furthermore, the program evaluation seemed to suffer from not having a critical mass of full time employed staff to assist with some of the other evaluation tasks.

Like the others, this program suffered from not having an evaluator more independent from the community. The evaluator (Project Coordinator) was from outside of the community and hired for this effort. However, she was supervised by those she was to evaluate. The evaluator in this instance had “outside” objectivity but was subject to the political forces in the community, making the role difficult and fraught with conflicting demands of program and community.

The volunteer nature of the Northern Woodlands program is extremely commendable. However, the program faced a number of specific challenges in both program operation and evaluation which contrast to the other two programs which were staffed by full-time personnel.

Overall, we have learned a number of things from this particular project. First, that evaluation, both surveillance and process, might be best accomplished by sensitive and knowledgeable outside evaluators who relieve the burden of the local suicide prevention staff. Surveillance can to be well done, either locally or by centralized IHS systems, as long as the local staff are vigilant. However, outside evaluators can provide extra person-power, technical assistance, and oversight with the local staff members. Furthermore, it seems imperative that all of the process evaluation, particularly client and stakeholder interviews, should

be carried out by outside evaluators. This removes some of the political implications of the evaluation process for all of the local service providers.

Outside evaluators have a number of advantages which would correct some of the issues raised here, particularly more daily and weekly attention to surveillance and data collection.

It seems that the two reservations which had staff models and more centralized populations were more consistently successful on a year to year basis. That is, having employees specifically paid to carry out suicide prevention and oversee the evaluation worked best. The more centralized health care system at the Jicarilla Apache Tribe seemed to be more efficient than the models at the other two reservations. This observation comments only on the efficacy of particular models, tempered with the realization that a centralized population seems to be critical in the application of program efforts.

Finally, the smaller more centralized and cohesive reservation communities had the greatest measurable impact of suicide attempt reduction. Given the suggestive nature of self-destructive behaviors, particularly among young Indian youths, the small communities seemed most amenable to a special suicide prevention initiative. Therefore, the Jicarilla Apache Reservation was more of an ideal community in which to carry out the suicide prevention program. However, all American Indian and Alaska Native communities do not have centralized clustered populations. Consequently, the results obtained in the

Western Athabaskan and the Northern Woodlands communities, respectively, are extremely exciting. This report documents that, even in communities challenged by decentralization, with marginal control over certain parts of the suicide prevention system and other infrastructure capacities of the tribe, substantial gains in preventing suicide can be made and documented.

CONCLUSION

This report describes three relatively different models for suicide prevention in American Indian and Alaska Native communities. While not all evaluation efforts were the same and not all results were similar, all of the results were positive **particular** for younger age groups, and hold promise for the development of future suicide intervention and prevention programs for adolescents and young adults. Challenges remain regarding preventing suicidal activity in older age groups.

This study demonstrates that suicide prevention can be carried out in diverse communities using different types of approaches. And, while all suicide attempts were not eliminated and all suicides not prevented, the data indicate that a number of lives were saved in each of the respective communities.

While this evaluation project was an exercise in cultural sensitivity and a demonstration of diversity of suicide intervention and prevention methods, it is consistent in its positive results. Suicide attempts and suicide completions have been substantially reduced in each of these three communities. Continued

surveillance and consistency of programs will be necessary to determine the lasting effects of the respective suicide intervention and prevention activities. We have demonstrated that programs do not have to be the same to accomplish positive results.

A number of factors are probably true, however, in the development and maintenance of effective suicide intervention and prevention programs, regardless of the difference of approaches, as demonstrated in this evaluation study. Consistency of programmatic efforts over time coupled with a capacity for program flexibility to “ride out the storms” of local community politics and change are two critical elements for the efficacy and maintenance of any suicide prevention program. All too often American Indian communities cease being “constantly vigilant” when suicidal activity lessens or “ceases” after a critical outbreak. The suicide intervention and prevention programs in the three American Indian communities evaluated in this study have demonstrated the need for consistent and flexible locally coordinated suicide prevention efforts that are sensitive to the diverse and changing needs of those they serve.

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