

**An American Indian/Alaska Native Suicide Prevention Hotline:
Literature Review and Discussion with Experts**

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EXECUTIVE SUMMARY

Purpose

The purpose of this project is obtain background information related to an American Indian/Alaska Native (AI/AN) Suicide Prevention Hotline for youth and adults. The Substance Abuse and Mental Health Administration (SAMHSA) currently funds the National Suicide Prevention Lifeline and supports a pilot project entitled Lifeline Native American Community Liaison Initiative. They expressed an interest in a study that examined the literature and perspectives of experts regarding an AI/AN suicide prevention hotline, and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) staff agreed to conduct a quick-turnaround study with SAMHSA's support. The key research questions include:

- What is the perspective of those familiar with suicide prevention efforts in Indian Country about establishing a suicide prevention hotline designed to serve only AI/ANs and staffed by AI/ANs?
- Will AI/ANs use a suicide prevention hotline designed to serve them?
- What are the barriers to use of such a hotline?
- Would the use of text messaging instead of speaking increase the willingness of youth to use the hotline?
- Are there basic cultural competencies that the staff of this hotline should have?
- What type of a hotline model would be most useful and why?
- What is the most effective way for AI/AN callers to be transferred to a specific hotline that meets their needs and why?
- Are there special issues for rural or urban AI/ANs in relation to the hotline?
- Will AI/AN communities support and promote the idea of this hotline?
- What is the best way to involve AI/ANs in the establishment of a hotline?
- How should potential callers be made aware of the hotline?

Methodology

The methodology used in this study consists of two parts: 1) a literature review that provides background information on the problem of AI/AN suicide, the effectiveness of suicide prevention hotlines, and related issues and 2) telephone discussions with a convenience sample of 13 federal and non-federal respondents (4 federal and 9 non-federal) working in the area of AI/AN suicide prevention. The majority of these respondents are AI/AN. Because of the small sample size, findings from the telephone discussions are not generalizable.

Literature Review

Research in the area of AI/AN suicide is limited, but the data indicate that suicide is a serious problem in Indian Country with substantial variation by area and tribe. Studies have identified key risk and protective factors for suicide in the general population as well as for AI/ANs. In addition research indicates many barriers that AI/ANs may have to overcome to obtain mental health care; for example, affordability and a limited supply of mental health professionals in Indian Country. Studies pertaining to attitudes about help-seeking reveal that AI/AN adolescents and young adults who have thought about or attempted suicide more often confide in family or friends rather than mental health or other professionals, and that those who avoid either formal or

informal help do so for personal reasons such as embarrassment, stigmatization, lack of problem recognition, or self-reliance. Studies of adolescents in general indicate that although they are aware of hotlines, they may avoid using them for similar reasons as noted above. However, two studies conducted in the early 1980's clearly indicate that AI/ANs prefer helpers of their own background, and studies have identified key cultural factors unique to AI/ANs; for example, historical trauma, use of traditional healers, and cultural differences among tribes. Although no studies of AI/AN suicide prevention hotlines were located, evaluations of national suicide prevention hotlines have found positive results for proximal outcomes. Additional evaluations of suicide prevention programs (non-hotlines) have indicated the importance of cultural relevance in all aspects of the program as well as the importance of community involvement and comprehensiveness when addressing this issue.

Findings of Telephone Discussions

The following is a summary of the key findings from telephone discussions with the 13 federal and non-federal expert informants.

- *Perspective on an AI/AN Hotline.* All of the experts thought that an AI/AN hotline would be a good idea, but about half of them qualified their responses by saying that it would depend upon available technology, the design and implementation of the hotline, or the effectiveness of public awareness efforts and community support.
- *Use of an AI/AN Hotline by AI/ANs.* Although the research findings that indicated that AI/ANs may be skeptical about hotline use and prefer other methods of help-seeking, all the respondents indicated that they thought that AI/ANs would make use of the hotline. Reasons included the demonstrated need for a suicide hotline in Indian Country and the cultural understanding that could be provided by the AI/AN staff. However, eight of the experts thought that hotline use would depend on the effectiveness of public awareness efforts that describe the nature of hotline services and on satisfaction with the type of services provided by the hotline.
- *Barriers to Hotline Use.* All those contacted said that lack of access to phone services is a possible barrier for some, indicating that phone coverage varied with limited or no cell or landline coverage in reservation or remote areas. About half of those involved in the telephone discussions indicated that privacy may be a barrier depending on circumstances; however, others said privacy exists because of the use of cell phones. Some mentioned youth-specific barriers such as shyness or difficulty communicating due to being high on drugs. Finally, lack of knowledge about the existence of a hotline was mentioned as a barrier as well as stigma and potential disappointments with hotline service itself.
- *Use of Text Messaging.* Ten of the 13 informants perceived texting as common among youth and thought that the willingness of these youth to use a hotline service would be increased if they could use text messaging on their cell phones.
- *Basic Cultural Competencies.* Participants in the telephone discussions identified key cultural competencies or areas of knowledge that the staff of an AI/AN hotline should have in order to help, assess and refer callers. These areas included: universal Native

values, regional and cultural differences, AI/AN communication styles, historical trauma, structure of governments/programs in Indian Country, local resources, and helping skills.

- *Hotline Models.* Informants were presented with three models and asked to select their first, second and third choice. The models were: 1) a new National AI/AN-Specific Model, 2) a new Area/Region-Specific AI/AN-Specific Model, and 3) a Non-AI/AN Local Crisis Center Model. The majority of the informants (11 of 13) preferred the new Area/Region AI/AN-Specific Model because it would be staffed by AI/ANs who would take into consideration differences in areas/regions, tailor messages to the caller and his community accordingly, and provide the most appropriate referral information.
- *Transfer Options.* The experts were presented with three options for transferring AI/AN callers and asked to select their choices. Some of the options involved the SAMHSA-funded National Suicide Prevention Lifeline -- a national network of independent, certified telephone crisis services located across the U.S. linked by several national toll-free numbers. The options included: 1) Lifeline Number with Prompts and Automatic Transfer Option to AI/AN Center; 2) Lifeline Number and Local Crisis Center Non-AI/AN Assessment and Transfer Option to AI/AN Center; and 3) Separate AI/AN Hotline Number for either a national or regional AI/AN Center. Nearly all of the experts selected the Separate AI/AN Hotline Number because it offered the caller a live person in the most direct manner, allowed staff to address issues more immediately and enabled trust to develop more quickly than other options.
- *Special Issues for Rural and Urban AI/ANs.* Because AI/ANs are dispersed throughout the county, informants working in urban areas mentioned the invisibility of AI/ANs as a challenge in terms of informing them about resources and educating staff of urban crisis centers that serve only small numbers of AI/ANs. Those working in rural areas noted the lack of mental health services, poverty and unemployment, isolation, stigma, violence, resistance to collaboration, confidentiality, and racism as issues that contribute to the suicide problem and affect their communities.
- *Community Support for Hotline.* All of those contacted said that the communities they were familiar with would support and promote an AI/AN hotline. They said that statistical data as well as their knowledge and experience indicate that suicide continues to be a problem in some areas of Indian Country, and Tribal Councils are aware of the issue and the lack of resources to address it. The fact that the hotline would have AI/AN staffing was another reason given for the likelihood of community members' support.
- *AI/AN Involvement in Establishment of the Hotline.* Participants in the telephone discussions suggested working with Indian organizations, Tribal programs and Councils, and SAMHSA grantees involved in AI/AN suicide prevention activities. They also suggested forming a working group consisting of representatives from the 12 IHS areas, using video conferencing to reach local AI/AN experts, surveys, and experiential methods to give planners a feel for the hotline experience.
- *Promotion of the Hotline.* Informants suggested various strategies to promote the hotline in Indian Country including use of local materials that are customized using Native-specific images, familiar Native national or regional personalities, positive language

rather than the word suicide, role-playing to portray hotline services, and existing educational tools such as Question, Persuade and Refer or SafeTALK. In addition, specific methods for disseminating information about the hotline were suggested such as posters, presentations by Native speakers in schools, use of Tribal offices, radio PSAs, community events, and tribal newspapers.

Summary of Telephone Discussions

The experts participating in the telephone discussions think that an AI/AN hotline would be feasible in the sense it would be used by AI/ANs, but they point out that the service must be implemented by culturally responsive AI/AN staff, confidentiality must be protected, appropriate resource information must be provided, and public awareness efforts on national and local levels are critical for promoting awareness and use of the service in Indian Country. They noted that hotline use will be dependent on consumer satisfaction with the service as it evolves. They indicated that depending on circumstances, access to phone service is sometimes a barrier in Indian Country; thus, the hotline may not be available to everyone. One of the key advantages of a hotline that expert participants identified was AI/AN staffing, and they listed a wide range of cultural competencies that these staff would need to have to assess, help and refer callers. In their preferences for a new Area/Region AI/AN-Specific Model and a separate AI/AN hotline number, those involved in the discussions indicated these options provided advantages in terms of offering the most focused, direct and immediate service to the callers. They indicated that the AI/AN communities they were familiar with would support and promote a hotline, and they emphasized AI/AN involvement in its establishment and promotion.

BACKGROUND

Purpose

The purpose of this project is to obtain background information related to an American Indian/Alaska Native (AI/AN) Suicide Prevention Hotline for youth and adults. In discussions between staff from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the Substance Abuse and Mental Health Administration (SAMHSA), SAMHSA staff expressed interest in having this project conducted. With SAMHSA's support, ASPE staff conducted a quick-turnaround study including a literature review pertaining to AI/AN suicide and hotline effectiveness and telephone discussions with a small sample of persons working in the area of AI/AN suicide prevention to obtain their perspectives on an AI/AN hotline. The information gleaned from this study is a first step in providing SAMHSA with baseline qualitative information to assist them in considering the implementation of an AI/AN suicide prevention hotline.

Telephone Crisis Services

Telephone crisis services have provided crisis intervention and referral services in the U.S. for over 40 years. The conceptual basis for crisis intervention involves the fact that crises are time-limited and present an opportunity for positive or negative outcomes based on effective or maladaptive coping. During a crisis, due to failure of usual coping mechanisms and heightened vigilance, individuals are more open to intervention. Based on this rationale, a model of crisis services evolved that consists of 24-hour telephone services (often supplemented by mobile outreach teams) staffed by specially trained professionals and/or paraprofessional volunteers who provide one-time or time-limited interventions to clients at no charge (Kalafat et al, 2007) .

A consensus has evolved around a four to six step problem-solving intervention model first adopted by the Los Angeles Suicide Prevention Center (Farberow et al, 1968), consisting of establishing rapport, defining the problem(s), exploring callers' coping repertoires; and developing alternatives for addressing the problem (i.e., a plan of action and/or referral to formal or informal resources). For callers in more acute, imminent suicidal states, telephone crisis services may engage in more active interventions such as obtaining the location of callers through direct request, tracing calls, or employing caller identification and sending community emergency response personnel (Kalafat et al, 2007). The goal of telephone crisis intervention, then, is to reduce maladaptive cognitive and affective components of the crisis state, to attenuate maladaptive coping, and to help the caller find a plan for coping with the situation that precipitated the crisis and/or another agency that can provide assistance (Kalafat et al, 2007).

Mishara and Daigle (1997) point out that suicide call centers may provide additional services other than the initial hotline call including school suicide prevention programs, follow-up with suicidal clients, post-suicide interventions with the bereaved, and training for professional and nonprofessional helpers.

SAMHSA's Telephone Crisis Services

Currently SAMHSA funds the National Suicide Prevention Lifeline (hereafter referred to as Lifeline). The Lifeline is a nationwide network of independent, certified telephone crisis services

located across the U.S. linked by several national toll-free numbers. Persons in emotional distress or suicidal crisis can access the Lifeline network 24/7 from any location and be connected to the crisis center geographically closest to them. The Lifeline network includes 143 crisis centers in 49 states; these centers operate their own suicide prevention hotline numbers, but also agree to accept local, state or regional calls from the Lifeline and receive a small stipend for doing so. Veterans who call the Lifeline have the option of identifying themselves as veterans and when they do, they are routed to a VA call center staffed by professionals. If they do not, they are routed to their local crisis center (Broderick, 2009; SAMHA, 2009).

In addition, SAMHSA is currently supporting a pilot project entitled Lifeline Native American Community Liaison Initiative whose goal is to make the Lifeline a useful resource to select AI communities by building relationships with Tribes and the mainstream Lifeline crisis center serving that Tribe's geographic area. The Initiative involves six crisis centers located in Montana, Wyoming, North Dakota, South Dakota, and Minnesota. AI/AN callers are served by non-AI/AN staff who work with the Tribes in their area to develop cultural awareness and to compile a list of local resources. The Tribes also engage in marketing culturally sensitive materials pertaining to the Lifeline among their members.

METHODOLOGY

The methodology used in this study consists of two parts: 1) a literature review that provides background information on the problem of AI/AN suicide, the effectiveness of suicide prevention hotlines, and related issues and 2) telephone discussions with a convenience sample of nine non-federal and four federal respondents experts. Those who participated in these discussions were suggested by SAMHSA staff because of their expertise in the area of AI/AN suicide prevention, familiarity with AI/AN communities, and geographic representation including urban and reservation areas. Most of the participants assume leadership roles in their Tribes; for example, a suicide prevention coordinator or a project director of a federal suicide prevention grant, and some have leadership roles at the federal level. The majority of the experts were AI/AN. Telephone discussions were held in July 2009. Respondents were told that their names or that of their Tribe/ organization would not be used in the report. A copy of the Discussion Guide was sent to each person prior to the telephone discussion (see Appendix).

Limitations of the study include its small sample size which prevent findings from being generalized to other samples. Additionally, issues of resources and costs of establishing and operating hotlines were not addressed in this study.

REVIEW OF SELECTED LITERATURE

The following literature review is a summary of key information pertaining to AI/AN suicide that is relevant to the issue of the feasibility and desirability of establishing an AI/AN suicide prevention hotline. The main topics covered in this review include: the extent of the problem, risk and protective factors, effectiveness of hotlines, attitudes about help-seeking and preference for AI/AN helpers, lessons learned from suicide prevention programs, key cultural issues, barriers to mental health service delivery, and limitations of research.

What is the Extent of the Problem?

While the majority of AI/ANs are not suicidal and free of mental illness (U.S. DHHS, 1999), suicide remains a major public health problem for AI/ANs in the United States (Olson & Wahab, 2006) as indicated by the following data:

- The AI/AN suicide rate (17.9/100,000) for the three year period from 2002-2004 in the Indian Health Service (IHS) service areas is 1.7 times that of the U.S All Races rate (10.8/100,000) for 2003 (IHS, 2009c).
- Suicide is the second leading cause of death behind unintentional injuries for Indian youth, ages 15-24 residing in IHS service areas, and is 3.5 times higher than the national average (IHS, in press).
- Suicide is the sixth leading cause of death overall for males residing in IHS service areas and ranks ahead of homicide (IHS, in press). From 1999-2004, among the 15-42 year old age group, AI/AN males had the highest rate of suicide completions, 28.54/100,000, compared to White Non-Hispanic (23.59/100,000), Black Non-Hispanic (14.45/100,000), White Hispanic (11.56/100,000) and Asian/Pacific Islander (9.49/100,000) males of the same age (CDC).
- While there is a risk in all age groups, it is particularly high among AI/AN young people. AI/AN young people 15-34 make up 64 percent of all suicides in areas of the U.S. served by the Indian Health Service (IHS, in press).

Using data from the 1997 National School-Based Youth Risk Survey, Frank and Lester, (2002) compared AI/AN high school students (N=139) with White youth (N=5554) and Black youth (N=4558). They found that similar to these other racial/ethnic groups in the U.S., female AI/ANs of high school age attempt suicide (32.2 percent; N = 45) more often than males (22.2 percent; N= 31). Fatal suicide completions also mirror those of all other racial/ethnic groups in the US: among AI/AN 10-24 year olds, the male suicide rate in 2006 (25.41/100,000) rate far exceeded that of females (7.88/100,000) (NCIPC).

Those who attempt suicide appear to be different than those who complete suicide. Far more AI/ANs attempt suicide (about 13 to each suicide) than actually kill themselves. This compares to 16 attempted suicides for each completed suicide in the general population. The method most commonly used by AI/ANs for non-fatal attempts is an overdose of medication, while only about 2 percent of deaths occur by this means (May, 1987; May et al, 1973; Shore, 1975). In the general population, the most important correlate for youth suicide is a previous attempt; it is estimated that 40 percent of adolescents who complete suicide have made previous attempts, and attempters are 20-50 times more likely to complete suicide than peers without a history of attempts (Shafii et al, 1985; Shaffer, 1988).

Additionally, it is important to note that AI/ANs have a high rate of accidental deaths. For example, the death rate for all unintentional injuries combined among 10-19 year old AI/AN youths is 50 percent higher than the overall U.S. rate (CDC, 2006). Goldston et al (2008)

indicate that it is not clear if this high rate of accidental deaths reflects a lack of regard for the lethal consequences of some behaviors or unrecognized suicidal intent.

Regions and Tribes vary widely in reported suicide rates, with some Tribes reporting an annual suicide rate as high as 150 per 100,000 and others reporting a rate as low as zero per 100,000 [Olson and Wahab (2006); Borowsky et al (1999)]. Regional variations among the IHS areas have also emerged. The highest suicide death rates for all ages in 1996-1998 were documented in the Tucson, Arizona; Aberdeen; and Alaska service areas, while the lowest rates were found in the California; Nashville, Tennessee; and Oklahoma service areas (Centers for Disease Control, 2003; IHS 2004a, 2004b; Alcantara and Gone, 2007). In recent years, point clusters that occur locally involving victims who are relatively contiguous in both space and time have occurred on reservations in several states.

Tribal heterogeneity is also evidenced in the Novins et al (1999) study that examined 1,353 high school students representing three culturally distinct AI Tribes -- Pueblo, Southwest and Northern Plains. Their findings indicated that ideas or thoughts of suicide by youth in the three Tribes were related to the nature of their Tribe's social structure, conceptualization of individual and gender roles, support systems, and conceptualization of death. Examples from this study are provided in the What are Key Cultural Issues? section of this report.

What are the Risk Factors?

The factors predisposing indigenous persons to heightened suicide risk are multifaceted and complex (Alcantara & Gone, 2007). In fact, Borowsky et al (1999) found that the likelihood of either AI/AN males or females attempting suicide increased dramatically as the number of risk factors to which an adolescent was exposed increased.

Generally, the risk factors for suicide among AI/ANs are the same as for other populations. These include mental and addictive disorders including co-morbidity, access to firearms or other lethal means, recent and severe stressful life events, and intoxication (Alcantara & Gone, 2007; Moscicki, 1999). However, some risk factors for AI/ANs are different, and others differ in their importance for various AI communities (Olson et al, 2003).

Most of the research on AI/AN suicide has taken place with reservation youth rather than those living in urban areas. Risk factors in the literature identified with these reservation youth encompass a wide variety of types including environmental, familial, individual, cultural and historical. Some of the key risk factors associated with attempts and completions by these youth are listed below.

- *Rural Location.* Life in rural, often isolated, reservations appears to amplify risks by increasing the likelihood of economic deprivation, lack of education and limited employment, thereby contributing to a sense of hopelessness among young persons (Freedenthal & Stiffman, 2004). Furthermore, youths on reservations may be at particular risk for suicide contagion, perhaps because of small intense social networks among adolescents in these places (Wissow et al, 2001).
- *Lack of Mental Health Care.* Lack of access to specialty mental health services, including child and adolescent psychiatrists is particularly severe in AI/AN communities (American

Academy of Child and Adolescent Psychiatry, 2006). It may be difficult to seek or receive services in small isolated communities with limited availability of community mental health resources (De Couteau et al, 2006). Only a few published studies have examined AI/ANs use of mental health services or traditional healers during a suicidal episode. In studying 101 AI/ANs (ages 15-21) from a southwestern state who had thought about or attempted suicide, Freedenthal and Stiffman (2007) found that fewer than one half of the sample (N=41, 40.9 percent) saw a mental health professional. In another study looking at health service use prior to suicide on a Plains reservation (Mock et al, 1996), 24 percent of the 21 suicide decedents (ages 15-28) had consulted any type of medical professional, and 10 percent had received mental health services in the 6 months prior to their death. And among the 40 people who made a nonfatal suicide attempt, 57 percent had used any health services in the 6 months prior to the attempt, and 35 percent had talked with a mental health professional.

- *Alcohol and Drug Use.* AI populations have elevated rates of alcohol abuse and dependence and earlier and higher rates of alcohol and drug use among youths, relative to most other ethnic groups, although this varies by and within culture (Beals et al, 2005). Yoder et al (2006) found drug use to be the strongest correlate of suicidal ideation among the AI youth he studied living on or near three AI reservations in the upper Midwestern United States. CDC analyzed data from the National Violent Death Reporting System for the period from 2005-2006 and found that the blood alcohol concentration of persons over 10 years of age that was at or above the legal limit was nearly 24 percent among suicide decedents tested for alcohol, with the highest percentage occurring among AI/ANs (37 percent), followed by Hispanics (29 percent) and persons aged 20-49 (28 percent) (CDC, 2009).
- *Family Disruption.* Family disruption places AI/ANs at risk (Middlebrook et al 2001). This disruption may be due to high rates of adult alcohol use in some communities that weaken family support systems for at-risk youths (Goldston et al, 2008) or to early loss of parents or relatives to suicide (American Academy of Child and Adolescent Psychiatry, 2006)
- *Trauma.* Family history of trauma (e.g., violent death of relatives, physical or sexual abuse or neglect, intimate partner violence, interpersonal conflict) or significant individual trauma are related to suicide (May et al, 2005). A strong factor associated with suicide attempts by either male or female AI/AN youth is friends or family members attempting or completing suicide (Bender, 2006; Borowsky, 1999).
- *Difficult Current Life Circumstances.* Mental health problems may arise from the difficult life circumstances that many AI/AN families experience including poverty and unemployment (Olson & Wahab, 2006). For example, according to the 2004 American Community Survey, about 25 percent of AI/ANs were living below the poverty level compared with 9 percent of non-Hispanic Whites (U.S. Census Bureau, 2007). Additionally, the labor force participation rate for AI/AN men (66 percent) was lower than that of all men (71 percent), while the rate for AI/AN women (57 percent) was slightly lower than for all women (58 percent); these rates vary by tribe (U.S. Census, Bureau, 2006).

- *Acculturation Stress.* Pressures for acculturation (i.e., modification of the culture of a group or individual as a result of contact with a different culture) and social change have been widespread in many AI/AN communities creating challenges to traditional ways of life, values and relational systems (Johnson & Tomren, 1999). Studies have found that in less traditional Tribes where pressures to acculturate have been great and Tribal conflict exists concerning traditional religion, governmental structure, clans, or the importance of extended families, the suicide rate in the adolescent and young adult populations is high (Garrett & Carroll, 2000; Johnson & Tomren, 1999). An IOM report (2002) cites studies that indicate that while AI/AN youth face the same turmoil as mainstream youth, their self-identity as a member of a minority group is also challenged by complex choices as to whether to adhere to mainstream or their traditional Native cultures.

- *Historical Trauma.* This is intergenerational or unresolved trauma that is internalized and passed on from generation to generation as a result of long term and cumulative exposure to traumatic events. This trauma may become normalized – “It’s just the way things are here on the rez” (Middlebrook, 2009) and is associated with demoralization and hopelessness. Conditions such as the historical removal of children from their families to attend boarding schools with associated problems at these schools, the forced relocation of AIs and the loss of traditional language and customs are examples of this trauma (Brave Heart, 1998; Brave Heart & DeBruyn, 1998; Whitbeck et al, 2004). Related to this trauma, several researchers have pointed out that perceived or persistent discrimination (Yoder et al, 2006; Whitbeck et al 2004) can contribute to stress and vulnerability.

- *Current Boarding School Attendance.* Over 15 percent of AI students attend boarding schools due to the rural nature of reservations, family dysfunction, and educational tradition. While contemporary boarding schools can serve as a protective environment, students may be at risk for suicide attempts and thoughts of suicide due to the characteristics that direct them there and also to disruption of critical developmental processes (Middlebrook et al, 2001). Dinges & Duong-Tran (1993, 1994) found high rates of suicide attempts (30 percent) and serious suicide ideation (44 percent) in their study of AI/AN youth in a boarding school. They explain these findings by selection factors by which higher-risk students of both sexes are referred from their communities because of inadequate or lack of treatment resources including residential treatment facilities for serious psychological dysfunctions. However, the schools they studied also served communities that had experienced recent cluster suicides.

Two studies were located which compare suicide risk factors between rural and urban AI/AN populations. Bender (2003) discusses findings from the American Indian Multisector Help Inquiry Study that sampled 205 reservation youth and 196 urban youth from the same southwestern state. Researchers found that the risk factor correlated with suicidal behavior unique to urban youth was less social support, and the risk factors unique to reservation youth were depression, a family history of drug abuse, alcohol abuse in youth, an arrest history, and racial discrimination. Other factors such as exposure to suicidal behavior by a friend or family member, history of physical and sexual abuse, or a diagnosis of conduct or substance abuse disorder were shared by both urban and rural AI/AN youth.

Using the same data, but analyzing only those adolescents who had spent at least two thirds of their life at the site from which they were sampled (144 urban and 170 reservation youth),

Freedenthal and Stiffman's (2004) analysis found that one fifth of urban youth and one third of reservation youth reported lifetime suicidal ideation, although similar numbers (14% - 18%) reported an attempt. They found that the urban youth had fewer psychosocial problems, and that the groups shared no common characteristics related to attempted suicide.

What are the Protective Factors?

Factors mentioned in the literature as being protective against AI/AN suicide include the following:

- *Relationships with Family and Friends.* Feeling connected to their families, discussing problems with friends or family members, and general emotional health were protective factors against suicide attempts for youth even if they had some of the characteristics that otherwise would significantly predict such attempts (Borowsky et al; 1999). Pettingell et al (2008) found in their sample of urban AIs that the perception that parents would disapprove of various antisocial, risky behaviors had a buffering effect for boys.
- *Positive Mood.* Pettingell et al (2008) found in their sample of 569 urban AIs age 9-15 that positive mood (i.e., positive feelings about self) was significantly and substantially protective for suicidal involvement in both boys and girls.
- *Spiritual Orientation.* Cultural spiritual orientation or AI cultural views of the connectedness of humans to all other physical and transcendental entities has been found to be related to a reduced history of suicide attempts among adolescents and adults even after levels of distress and substance abuse have been considered (Garrouette et al, 2003).
- *Enculturation.* Enculturation represents the degree to which an individual is embedded in his or her cultural traditions as evidenced by traditional practices, spirituality, and cultural identity. Enculturation has been found to be related to protective factors such as academic success and prosocial behaviors among AI adolescents (Whitbeck et al, 2001; Zimmerman et al 1994).
- *Cultural Continuity.* Chandler & Lalonde (2009) measured cultural continuity by the existence of the following markers in Tribal communities: land claims, self-government, police and fire protection, health services, education, and cultural facilities. These researchers found that the presence of cultural continuity was associated with reduced and in some cases non-existence rates of suicide in certain indigenous Tribal communities in Canada.

In their study of 11,666 7th-12th grade AI/AN reservation youth, Borowsky et al (1999) found that increasing the number of the three protective factors – discussing problems with friends/family, emotional health, and family connectedness – was more effective at reducing the probability of a suicide attempt than was decreasing risk factors. Even among adolescents without any of the risk factors they studied, they found that the presence of protective factors markedly decreased the risk of a suicide attempt. Pettingell et al (2008) found similar findings in their study of AI urban youth. Borowsky et al suggest that program and policy responses to the problem of adolescent suicidal behavior should focus on promoting these protective factors.

What are Barriers to Mental Health Service Delivery?

AI/ANs may have to overcome various barriers to obtain mental health services including limited phone service, cost of services, lack of mental health services in geographically remote areas, stigma, and a fragmented service system. However, even if services are available, this does not mean that they will be utilized. Several studies show that AI/ANs tend to underutilize mental health services, experience higher dropout rates than other ethnic groups, and have negative opinions about non-Native mental health providers (Olson & Wahab, 2006). A new AI/AN-specific suicide prevention hotline would have the advantage of addressing some of these barriers because it would be accessible in various geographic areas, staffed by AI/ANs, confidential, and free (King et al, 2003). Selected barriers are discussed below.

Limited Supply of Mental Health Professionals. There are approximately 101 AI/AN mental health professionals (e.g., psychiatrists, psychologists, psychiatric nurses, social workers) available per 100,000 AI/AN U.S. population compared with 173 per 100,000 for the White population (U.S. DHHS, 1999). Recruitment and retention of mental health staff is often difficult due to low salary levels and geographic isolation in rural areas. Furthermore, the high demand for services in many mental health programs, combined with the complexity and seriousness of mental health needs, frequently results in high rates of burnout and turnover among mental health professionals in Indian Country. As a result of these constraints, the majority of mental health care for AI/ANs is crisis-oriented with critical components of mental health, child abuse and social service programs including suicide prevention unavailable (Olson et al, 2003; Olson and Wahab, 2006; Johnson & Cameron, 2001). In some cases, youth in need of mental health services may be sent out of the community or even out of state to receive services (Freedenthal and Stiffman, 2007).

Phone Service. In a sample of 765,474 AI/ANs who described their race as only AI/AN, 11.9 percent were without telephone service (U.S Census 2000a) compared to 2.4 percent of U.S All Races who have no telephone service available (U.S. Census Bureau, 2000). Today, the lack of infrastructure and equipment is the greatest obstacle to connectivity in Native communities. Additionally, limited access to capital often prevents tribes from building telecommunications systems (Johnston, 2001). Disparities are particularly noticeable in rural areas. There are several federal programs offering assistance to qualified residents on Tribal lands that cover costs associated with connecting to the telephone network using a landline or wireless telephone for a primary residence (Johnston, 2001), and some Tribes have improved their telephone penetration by taking over the telephone utility (NTIA, 1999).

Affordability. Active users of the Indian Health Service (IHS)-funded services provided from IHS or tribal health programs comprise approximately 57% of the U.S. Indian population (IHS, 2009b). Although the IHS 's mission is to provide all types of health services (including mental health services) to AI/ANs, fewer than one half of the uninsured low-income AI/ANs have access to IHS programs, and the agency suffers from inadequate funding and staffing (Freedenthal and Stiffman, 2007). Nationwide data (which may not be representative due to small sample sizes) indicated that in 2006, 36 percent of AI/ANs had private insurance coverage, 24 percent relied on Medicaid, and 33 percent had no health insurance coverage in 2007 (Office of Minority Health). When looking specifically at payments to IHS by Indians served in predominantly reservation and similar communities, a high proportion of AI/ANs rely on public funding. Of the IHS payments received from public and private health insurance, 11.8 percent

are from private insurance, 20.9 percent are from Medicare, and 67.3 percent are from Medicaid and CHIP (DHHS, 2008).

A report focusing on the health of urban Indians (UIHI, 2008) found that almost 30% of these AI/ANs reported not having health coverage (including federal programs) compared to less than 18% of non-AI/ANs. Additionally, 20% of urban AI/ANs said they were unable to see a physician in the past year because of cost issues.

Service System. The system of services for treating mental health problems among AI/ANs is a complex and often a fractured web of Tribal, federal, state, local and community-based services. The availability of these programs varies considerably across communities. Behavioral health needs are largely unmet, services are generally lacking, and access is often costly (IHS, 2009a)

Confidentiality. Confidentiality becomes an issue in small isolated communities with limited availability of mental health resources (Goldston et al, 2008). Persons using Tribal or IHS behavioral health services are concerned with this issue especially in regard to receiving services at facilities where friends and relatives may work or receive services. They would not want to go to these behavioral health offices for fear of being seen by these persons (Duran et al, 2005)

Communication and Trust. Given the history of AI/ANs relationship with the U.S. Government, many may not trust institutional sources of care and may be unwilling to seek help from them (U.S. DHHS, 1999). Many AI/ANs believe that professional mental health services represent the “White man’s system and culture.” There is also the belief that professionals would not understand AI ways as well as a lack of faith in mental health care (Freedenthal and Stiffman 2007). Specific attitudes of adolescents about hotline use are discussed below in the section entitled, What are Adolescents’ Attitudes about Help-Seeking?

What are Key Cultural Issues?

Johnson and Cameron (2001) note that for AI/ANs, cultural meanings of illness have real consequences in terms of whether people are motivated to seek treatment, how they cope with their symptoms, how supportive their families and communities are, where they seek help, the pathways they take to get services, how they are assessed, and how well they fare in treatment. Selected cultural issues addressed in the literature that staff of an AI/AN hotline would need to have knowledge about are listed below.

Communication of Symptoms. Cultural differences in the expression and reporting of distress are well established among AI/ANs (U.S. DHHS, 1999). These differences often compromise the ability of mainstream assessment tools to capture the key signs and symptoms of mental illness (Kinzie & Manson, 1987; Manson, 1994, 1996). Words such as “depressed” and “anxious” are absent from some AI/AN languages (Manson et al, 1985). Other research has demonstrated that certain diagnoses such as major depressive disorder in the *Diagnostic and Statistical Manual of Mental Disorders* do not correspond directly to the categories of illness recognized by some AI/ANs. Furthermore, language is important when assessing the mental health needs of individuals and their communities. Approximately 280,000 AI/ANs speak a language other than English at home; thus, for some, evaluations of the need for mental health care may have to be conducted in a language other than English (U.S. DHHS, 1999).

Tribal Diversity and Suicide. Goldston et al (2008) and Johnson and Cameron (2001) note that there are major cultural differences between different AI/AN groups; for example, Native groups may differ with regard to the degree of cohesion in their community; the degree to which individual achievement is emphasized; attitudes toward substance abuse, antisocial behavior, health, illness and death; and family structure and roles.

Two studies have examined the relationship between these cultural differences and suicide. Chandler and Lalonde (2009) found in examining Tribal bands and councils in British Columbia over a 14 year period (i.e., 1987-2000) that suicide rates for youth and adults were lower within communities that had practices related to “cultural continuity.” The researchers defined this concept as efforts to attain self-government; pursue land claims; exert control over education, health, police and fire, and child welfare services; construct cultural facilities in the community; and promote women to positions of leadership.

Novins et al (1999) studied suicidal ideation among 1353 AI adolescents representing three culturally distinct Tribes, and they found the factors associated with suicide ideation differed by Tribe. For example, in the Pueblo youth who live in the most tightly-knit communities with strong social networks, correlates of suicidal ideation included: reporting that a friend attempted suicide in the last 6 months, lower perceived social support and depressed affect. In another Southwest Tribe characterized by family, community and peer ties almost as strong as the Pueblo, analyses indicated that coming from a home without both biological parents and more stressful life events over the past 6 months were associated with suicidal ideation. In this culture both antisocial behavior and suicidal ideation are considered deviant, and those who acted out were also more likely to ignore cultural prohibitions regarding thinking about death. The Northern Plains Tribe emphasizes individual achievement and a more ego-centered conception of self. Among the youth in this Tribe, suicidal ideation was associated with low self-esteem and higher levels of depressed affect.

In spite of this Tribal diversity, some researchers have managed to isolate some common cultural themes applicable across Tribes. Mohatt et al (2004) and Allen et al (2006) have described efforts with Alaska Native cultures to identify common elements that could be incorporated into generalizable prevention programs to be used in multiple communities; for example, culture-specific factors that are protective in relation to sobriety. Goldston et al (2008) suggest that perhaps this model may be applicable to AI cultures, particularly those with closely related traditions.

Historical Trauma. Historical trauma refers to the concept of the collective emotional and psychological injury both over the life span and across generations resulting from the history of difficulties that Native Americans as a group have experienced in America (Steinman, 2005; Brave Heart 1998; Brave Heart & DeBruyn, 1998). These experiences are not “historical” in the sense that they are in the past and a new life has begun in a new land. Rather, the losses are ever present, represented by the ongoing economic conditions of reservation life, discrimination, and a sense of cultural loss (Whitbeck et al, 2004). Feelings associated with these losses include anger, a deep and persistent depression, intrusiveness of these thoughts, discomfort around White people, and fear and distrust of the intentions of White people (Brave Heart 1998; Brave Heart & DeBruyn, 1998). EchoHawk (1997) notes that indigenous clients must be allowed to grieve and talk about their feelings of historical trauma, alienation and poor sense of identity.

Use of Traditional Healers. Walls et al (2006) found in their study of 865 parents/caretakers of Tribally enrolled youth that these adults strongly preferred traditional informal services (e.g., family, talking to an elder, sweat lodge, pipe ceremony, offering tobacco, healing circle, traditional healer, traditional ceremony) to formal medical services. Even when AI/ANs seek specialized professional health services, Goldston et al (2008) note that they have strong beliefs about the healing nature of traditional knowledge and practices. Beals et al, 2005 found that lifetime help-seeking from traditional healers for mental health disorders was common in the 3,084 tribal members (ages 15-54) they studied from a Southwest and Northern Plains tribe. Finally, Novins et al (2004) found in their study of 2595 AI adolescents and adults ages 15-57 from two different Tribes that use of traditional healing for both physical health and psychiatric problems was associated with higher scores on spirituality and AI identity scales.

Additional Cultural Considerations. Brucker and Perry (1998) point out that when therapists work with an AI/AN individual or family, each family's identification with its own Tribe and cultural values must be understood and respected. In addition to the factors noted above, some areas for helpers to understand when working with AI/ANs include:

- *Relationships and networks* that may affect an individual or family. The average size of the family in some Tribes can be twice the size of the typical American family (i.e. including grandparents, uncles, aunts, cousins). Furthermore, many AI families do not draw distinctions between these relationships; for example, an AI may refer to a cousin as a brother or sister without distinguishing or recognizing a difference in the way that the dominant culture does, or when a person marries into another family, there is often no distinction between a sister from the family of origin and a sister-in-law.
- The AI perspective on the *exchange of goods and the importance of generalized sharing* is different from the typical Western value of accumulating wealth. In the dominant society, individual self-reliance is valued, while in many AI/AN cultures it is the group and helping others that is important. Thus, for AI/ANs, the worth of an individual is measured by the degree to which that person can and will share his or her resources.
- There is great diversity among Tribes in the degree of traditional distinctions in gender roles and the extent to which these distinctions are maintained in the present. Tribal members may experience conflict between their tribe's traditional gender roles and those of the dominant culture.

What Can We Learn from Hotline Evaluations?

While no evaluations of AI/AN-specific hotlines were located, studies have evaluated hotlines for the general or adolescent U.S. population. These studies are summarized because the findings can inform the establishment of hotlines for AI/ANs. Various methods of evaluation have been used including caller feedback/satisfaction, assessments of helping processes, proximate outcomes (changes in callers' suicide state from the beginning to the end of their calls), rates of follow-up with referrals, and assessments of distal outcomes consisting of changes in community suicide rates (Kalafat et al, 2007). None of the studies mentioned below included a control group, but the use of such a group would be unethical with suicidal callers. As a result, improvements in the crisis state found in these studies cannot be causally attributed to the crisis

intervention. However, the use of repeated measures designs in measuring proximal outcomes allows each caller to act as his own control (Kalafat et al, 2007).

Proximal Outcomes. Several studies were found which examined the effectiveness of proximal hotline outcomes. A two-part study examined both non-suicidal (Kalafat et al, 2007) and suicidal callers (Gould et al, 2007) utilizing the National Suicide Prevention Lifeline network with multiple sites that were geographically diverse. In the study focusing on the non-suicidal callers, the researchers assessed 1,617 crisis callers between March 2003-July 2004, and 801 (49.5%) participated in the follow-up assessment. Significant decreases in these callers' crisis states and hopelessness were found during the course of the telephone session, with continuing decreases in these areas in the following weeks. A majority of callers were provided with referrals and/or plans of actions for their concerns, and approximately one-third of those provided with mental health referrals had followed up with the referral by the time of the follow-up assessment. Of the 801 callers, 186 (23.2%) had re-contact with the center after their initial call. Crisis counselors developed plans of action with 464 (57.9 %) of callers, and 43.4 % completed their entire plan.

In the component of this study (Gould et al, 2007) that examined suicidal callers, 1,085 suicide callers were assessed during their calls between May 2003- July 2004, and 380 participated in the follow-up assessment. AI/ANs comprised 3.2 percent of this group, too small a number for group-specific analysis to be made. Findings indicated that there were significant decreases in suicidality found during the course of the session with continuing decreases in hopelessness and psychological pain in the following weeks, but no reduction in callers' intent to die¹. A caller's intent to die at the end of the call was the most potent predictor of subsequent suicidality. The study found that the profile of suicide callers indicated substantial levels of risk. Over half of the callers had current plans to harm themselves when they called, and nearly 10 % had taken some action to hurt or kill themselves immediately prior to the call. Nearly 60 % had made previous attempts. Approximately 30 percent of the callers had another contact with the center after their initial call. In both the studies of the non-suicidal and suicidal callers, the most common problem noted by the callers concerned the referrals. Some referrals were not appropriate for the callers' problems, but most of the issues were due to the agencies to which callers were referred such as cost, waiting lists and unhelpful responses.

Between 1997-2000, King et al (2003) evaluated telephone counseling services for callers less than 18 years of age under Australia's National Youth Suicide Prevention Strategy. Their study focused on the extent of change in suicidal ideation, suicidal intent, and mental state for young people who called Kids Help Line and indicated suicidality. Independent raters measured callers' suicidality and mental state at the beginning and end of 100 taped counseling sessions. Findings indicated that significant decreases in suicidality and significant improvement in mental state were found to occur during the course of the counseling sessions, suggesting positive immediate impact. However, a substantial minority of callers (14%) remained suicidal at the end of the call. Interestingly, Kids Help Line has a policy of encouraging those at ongoing risk or needing further assistance to re-contact, and callers are given information that will enable them to re-contact the counselor with whom they have formed a relationship if this is their preference. The Help Line's data suggests that 72 % of all callers coded as presenting suicidal problems do

¹ Intent to die was assessed by two questions: "How much do you really want to die?" and "How likely are you to carry out your thoughts/plans to kill yourself."

in fact call back. Where urgent referral is required, an immediate three-way call is initiated and the young person is introduced to a referral agency while still in contact with the Line.

Distal Outcomes. Some studies have examined distal outcomes or changes in community suicide rates in places where suicide prevention centers with hotlines exist. Lester (1997)'s meta-analysis of 14 such studies concludes that while the evidence provided support for a preventive effect from suicide prevention centers, the effect was small and inconsistent. Similarly, Leenaars and Lester (2004) study found a preventive but weak effect of suicide prevention centers in Canadian provinces; it replicated an earlier study with similar findings. In their discussion of this method, Mishara et al (2007) conclude that because of the multitude of possible influences on suicide rates and the fact that only a small proportion of the population actually contacts hotlines, it is not likely that preventive efforts can be convincingly demonstrated by population studies.

Process of Intervention. Two studies have examined the process of the intervention itself and the relationship of this process to client outcomes. In Mishara and Daigle's (1997) study of two French-speaking suicide prevention centers in Canada serving all ages, researchers listened unobtrusively to 110 volunteer helpers on 617 calls (some of the 263 persons made multiple calls) and categorized all responses according to a reliable 20-category checklist. Outcome measures showed observer evaluations of decreased depressive mood from the beginning to the end in 14% of calls, decreased suicidal urgency ratings from the beginning to the end in 27% of calls, and reaching a contract not to engage in suicide and to become involved in follow-up activities in 68% of calls, of which 54% of contracts were upheld according to follow-up data. Intervention styles were categorized as either directive, which included more investigation and direct questions as well as advice, or nondirective Rogerian² which consisted of more nondirective empathetic responses. They found that within a context where all calls were somewhat directive, having more nondirective Rogerian characteristics was related to a significantly greater decrease in depression, greater likelihood of making a contract with the caller at the end of the call, and greater likelihood of the caller keeping the contract. These researchers distinguish between acute and chronic suicidal persons or those experiencing a recent suicidal crisis and individuals who call repeatedly in state of perpetual crisis over a period of months or years. They learned that the repeated callers benefited most from a more directive approach, but new callers benefited significantly more from more nondirective techniques.

In a related study also examining helper behaviors and intervention styles, Mishara et al (2007), studied the U.S. National Suicide Prevention Lifeline. A total of 2,611 calls to 14 helplines were monitored. The relationship between intervention characteristics and call outcomes were reported for 1,431 crisis calls. Helper behaviors were characterized as: a) supportive approach and good contact (i.e., moral support, offers call back, reframing, talks about own experience), b) active listening, c) collaborative problem solving, and d) negative style (i.e., makes value judgements, reads information). Empathy and respect, supportive approach and good contact, and collaborative problem solving were significantly related to positive outcomes or callers not wanting to kill themselves, but not active listening.

² Rogerian therapy also known as person-centered or client-centered therapy is a technique in which therapists create a comfortable, non-judgemental environment by demonstrating congruence (genuineness), empathy, and unconditional positive regard toward patients while using a non-directive approach. This aids patients in finding their own solutions to their problems.

What are Adolescents' Attitudes about Help-Seeking?

Freedenthal and Stiffman's study (2007) examined attitudes about help-seeking among suicidal AI/AN persons pertaining to formal resources (e.g., mental health professionals, teachers, medicine men) and informal resources (friends and family) but not hotlines. This was the only study of its kind that targeted AI/AN youth, but its sample size is clearly too small to be generalizable. The study focused on 101 AIs age 15-21 living in both urban and reservation communities in a southwestern state who had thought about or attempted suicide. Slightly more than three fourths of participants (N=77) turned to at least one person for help when they were suicidal. Almost two thirds (N=64) confided in family, friends or both. Less than one half (N=41) saw a mental health professional, 12.8 percent (N=13) consulted a school counselor or teacher, 2 percent (N=2) received help from a medicine man and 2 percent (N=2) talked with a minister. Almost one-fourth of the sample (N=24) chose not to use any help at all. Those who avoided at least one type of help reported reasons such as embarrassment and avoiding stigmatization, lack of problem recognition, a belief that nobody could help, and self-reliance. Overall, reasons articulated for not seeking care were based on "internally driven" barriers, and not structural barriers (e.g., insurance, access to services). The authors cite other studies with similar findings indicating that AI young persons most often consult friends and family during times of need, followed by schoolteachers, and other professionals outside of the specialty mental health sector.

Since no studies were found that focus on AI/AN adolescents and hotline use, it may be worthwhile to learn about the attitudes of non-AI/AN youth from studies that examine their use of crisis hotlines. For example, Gould et al (2006) studied 519 adolescents aged 13-19 attending mandatory health courses in six high schools in New York State. The ethnic distribution of the sample was approximately 78 percent White, 3 percent African American, 13 percent Hispanic, 1 percent Asian and 4 percent other. Although their awareness of the hotline service was high, few of the adolescents (2.1%) ever used hotlines, and negative attitudes were stronger toward hotlines than they were toward other formal sources of help. Commonly cited reasons for not using hotlines were thinking that the problem was not serious enough (35%) and that the problem could be solved by oneself (33.1%). Objections to hotlines were strongest among students most in need of help by virtue of impaired functioning or feelings of hopelessness.

Pnece et al (1988) also studied non-AI/AN adolescent attitudes about crisis hotlines. A total of 837 questionnaires were completed by 10th grade students attending Life Management Skills classes in five public high schools located in a medium-sized Southeastern city. Of the 11.6% of students who reported having attempted suicide, 41% said they would call a crisis line for help. In comparison, 37.7% of students without a history of a suicide attempt said they would use this service. While a majority of respondents said they would not call a crisis service, 56.9% reported that they would first confide their suicidal intentions to a friend. The most common reason students gave for not calling a crisis line was that they did not want to talk to a stranger. They did not regard the hotline counselors as trustworthy and did not believe the counselors could understand their problems without knowing the caller. In addition, there was a general lack of knowledge about the existence of the crisis line, its purpose, confidentiality of calls, and policies concerning the use of tracing procedures. Finally, the students feared punishment by their parents if their problem were discovered.

Gould et al's (2004) study explored the attitudes of high-risk non-AI/AN adolescents (those who are depressed, suicidal or engage in substance abuse) among 2,419 high school students in suburban schools located in Nassau, Suffolk and Westchester counties in New York State. The ethnic distribution of the sample was 77.7 percent White, 5.5 percent African American, 7.4 percent Hispanic, 3.8 percent Asian, and 5.7 percent other. They found that the attitudes of these students were characterized by core beliefs that support the use of maladaptive coping strategies such as isolative behaviors and a tendency toward self-sufficiency rather than help-seeking. For example, they indicate that these high risk youths would think that people should be able to handle their own problems without outside help, that it is a good idea to keep feelings of depression to yourself or alleviate these problems with drugs and alcohol. Rather than getting help for a suicidal friend, these youths would prefer to keep the confidence of their friend or not take it seriously.

Do AI/ANs prefer AI/AN Helpers?

There is little information to indicate whether AI/ANs are more likely to seek care if it is available from those of similar backgrounds, as opposed to dissimilar providers (U.S. DHHS, 1999). Two studies conducted in the 1980's explored this issue. One study investigated AI college students' preference for counselor race and sex and the likelihood of their using a counseling center (Haviland et al, 1983). Findings from this study indicated that both females and males demonstrated a strong preference for AI counselors, regardless of problem situation. Males preferred male counselors, but females expressed a preference for female counselors only if they had a personal problem. The likelihood of using the counseling center increased if students could be seen by a counselor of the same background regardless of problem situation. Dauphinais et al (1981) studied 102 AI 11th and 12th grade high school students attending boarding schools in Oklahoma and South Dakota and also found that AI counselors were perceived as more effective than non-AI/AN counselors.

Are there Lessons Learned from Suicide Prevention Programs?

Middlebrook et al (2001) reviewed nine evaluations of suicide prevention programs for persons of various ages in AI/AN communities. These programs were either implemented to specifically address rising suicide rates in AI/AN communities or they contained suicide prevention components as part of broader efforts to address problem behaviors such as alcohol and drug abuse or teen pregnancy. Although they did not include hotlines, because they focused on suicide prevention in AI/AN communities, the lessons learned from evaluations of these programs may be applicable to the issues of whether and how an AI/AN hotline could be an effective strategy.

Evaluations of these programs concluded that the majority of programs support two main themes: 1) the need for cultural relevance in all aspects of program development and implementation and 2) the importance of community involvement. Additionally, they noted the need for comprehensiveness when identifying ways of addressing the problem of suicide; for example, considering its relationship with other life events such as substance abuse and unemployment as well as the need for all sectors of the community to become involved in solutions.

May et al (2005) also reported on the efficacy of a public health-oriented suicidal-behavior prevention program among AI youths from the Western Athabaskan Tribal Nation located in New Mexico that was 15 years in duration. Among the lessons learned from this evaluation were: 1) a suicide prevention program should not focus on a limited range of self-destructive behaviors, rather it must include an emphasis on root conditions and an array of social, psychological and developmental issues and 2) community involvement from the beginning is critical in developing strategies with which to address issues identified in a culturally, environmentally, and clinically appropriate manner.

Limitations of Research on AI/AN Suicide

Alcantara and Gone (2007) outline the major limitations of research pertaining to AI/AN suicide. They note that data regarding suicide completion and suicidal behaviors are primarily based on reservation-based samples, as few studies have investigated AI/ANs living in urban areas. Additionally, study samples are often drawn from school-based settings, excluding the frequently absent and drop-outs. Furthermore, there is limited research pertaining to suicidal behaviors such as suicide attempts in AI/AN communities, and few studies have examined why some Tribes have high suicide rates while others do not. Clarke et al (1997) also point out that reported suicides among AI/AN adolescents may be an underestimate of true incidence due to misclassification or underreporting; for example, deaths classified as motor vehicle accidents or homicides may be suicides. Furthermore, suicides among AI/ANs may be underreported due to cultural or religious taboos or medical files may be incomplete not stating the cause of death in cases that may be suicides. Additionally, reports are limited by misclassification of race and ethnicity on death certificates.

Summary of Literature Review

Research in the area of AI/AN suicide is limited, but the existing data indicate that suicide is a serious problem in Indian country with substantial variation by area and tribe. Studies have identified key risk and protective factors in the general population as well as for AI/ANs. In addition research indicates barriers that AI/ANs may have to overcome to obtain mental health care; for example, affordability and a limited supply of mental health professionals in Indian Country. Studies pertaining to attitudes about help-seeking reveal that AI/AN adolescents and young adults who have thought about or attempted suicide more often confide in family or friends rather than mental health or other professionals, and that those who avoid either formal or informal help do so for internal reasons such as embarrassment, stigmatization, lack of problem recognition, or self-reliance. Studies of adolescents in general indicate that although they are aware of hotlines, they may avoid using them for similar reasons as noted above. Two studies indicate that AI/ANs prefer helpers of their own background, and studies have identified key cultural factors unique to AI/ANs; for example, historical trauma, use of traditional healers, and cultural differences regarding suicide among tribes. Although no studies of AI/AN suicide prevention hotlines were located, evaluations of national suicide prevention hotlines have found positive results for proximal outcomes. Additional evaluations of suicide prevention programs (non-hotlines) have indicated the importance of cultural relevance in all aspects of the program as well as the importance of community involvement and comprehensiveness when addressing this issue.

ANALYSIS OF TELEPHONE DISCUSSIONS

The following is an analysis of telephone discussions with the 13 federal and non-federal informants who work in the field of AI/AN suicide prevention. The topics of the discussions focused on perspectives about an AI/AN hotline and its use, barriers to use, implementation models, phone transfer options, cultural competencies needed by the staff of the hotline, community support, AI/AN involvement in establishing a hotline, and promotion of the hotline. The Discussion Guide used in the telephone conversations can be found in the Appendix.

Previous Experience with the Lifeline

Those identified for their expertise were asked if they had had any experience with the National Suicide Prevention Lifeline, and if they had what this experience has been like. Nine of the 13 informants had some experience with the Lifeline, while 4 did not. Those who had experience described it positively. Two of the federal experts served on committees pertaining to the Lifeline or acted as a liaison between their agency and SAMHSA. The remainder of those with experience used the Lifeline as a referral resource or distributed information about the Lifeline to Tribes in their communities; for example, Lifeline posters that included local logos or local posters with the Lifeline number.

One expert expressed concerns about the 143 local crisis centers that are part of the Lifeline network in terms of their diversity and cultural responsiveness. She indicated that some centers are culturally responsive, while others are not. She said that it takes time and trust to develop relationships with Native communities, and some local centers are not ready to devote this time and provide this commitment.

Perspective on Establishing an AI/AN Suicide Prevention Hotline

Informants were asked their view of establishing a suicide prevention hotline designed to serve only AI/ANs and staffed by AI/ANs familiar with Native culture and mental health issues. All of their views were positive with 6 of the 13 indicating unequivocally that they thought such a hotline was a good idea. These persons referred to the high AI/AN suicide attempt and completion statistics. Others thought that AI/ANs are more likely to access a specific AI/AN hotline designed to address their issues versus a non-AI/AN hotline -- “a Native staff person would approach things differently.” Similarly, some expressed the view that knowledgeable AI/AN staff would eliminate barriers by having an investment in the community and familiarity with appropriate resources. Another person said that such a hotline would ensure suicide prevention efforts were comprehensive. Finally, one respondent familiar with SAMHSA’s Lifeline Native American Community Liaison Initiative said that an AI/AN hotline might work better than this pilot effort in which AI/AN callers are served by non-AI/AN crisis center staff who work with the Tribes in their area. He indicated difficulty promoting the pilot because some AI/ANs were uncomfortable calling the Lifeline number because they felt they were not treated with respect by the non-Indian staff. Another person said, “If one kid can be saved, it would be worth it.”

The remaining seven informants also thought the hotline was a good idea, but included caveats in their positive responses. For example, they indicated that this would depend on the available

technology in the area. Furthermore, several persons were concerned about what would happen if a non-Indian caller called the hotline -- if the staff asks, "Are you Indian?" and the caller is not, then what is the staff response? Staff cannot say they will not talk to this person. Another said that the design of the hotline is important -- that sensitivity and confidentiality must be emphasized. Several people indicated that the hotline must be marketed as Native-friendly, and information must be made public through education and public awareness efforts. Along these lines, one respondent noted that, "In Indian Country, it takes time for people, especially young people to become aware of services," and another noted that upfront work must be done at the community level to prepare for the hotline, and the hotline must be supported by local health professionals.

Hotline Utilization Issues

View of Use by AI/ANs

Participants in the telephone discussions were asked if they thought AI/ANs would call a suicide prevention hotline that was specifically designed for them. Of the 13 experts, 5 gave an unequivocal yes answer to this question, while 8 persons gave a yes response but qualified it in some way. Of those who gave an unequivocal yes, several indicated that cultural understanding would be important -- "Natives would appreciate speaking to someone who understood rural reservation communities, family networks, how IHS and Tribal health works, use of humor, understanding of intergenerational trauma, multiple grief experiences and spiritual practices." Several persons also indicated that some persons do not call the Lifeline because they know it is staffed by non-AI/ANs, and they thought that people would be more comfortable with AI/AN staff. Another person indicated she thought providers such as IHS clinics, Tribal programs and Indian organizations would be more comfortable with making referrals to an AI/AN hotline. Several experts referred to the fact that they knew that Tribal members made calls to suicide hotlines; for example, one Tribe is connected to a Native hotline in another state and this has been useful, and in other Tribes, even with the Lifeline in place, Tribes continually receive 911 calls on suicide³. Additionally, one person indicated that a psychologist who sees suicidal patients has made it a point to look at their cell phones and has found the Lifeline number on their phone, while another person indicated he found the Lifeline number on the cell phones of those who had completed suicide.

Of those who indicated AI/ANs would use such a hotline, but added caveats to their response, several noted that response would vary depending on public awareness efforts in the form of Native-specific advertising and promotional activities; for example in the schools. These awareness efforts would need to make clear that the hotline was run by AI/ANs who were familiar with region-specific issues and who reflected the culture of the region. Several persons also indicated that a key would be consumer satisfaction with the services that were provided -- the hotline must provide anonymity and area-specific resource information⁴. One informant

³ A suicide hotline does not replace 911. Ideally 911 and suicide hotlines should have protocols defining their differing, but at times overlapping roles. Most crisis centers will make calls to 911 in instances where immediate police or ambulance intervention is required offered referred to as "Emergency Rescue."

⁴ Anonymity and confidentiality are respected with hotline callers; however for those in acute, imminent suicidal states or overdose situations, hotline services may engage in more active interventions such as obtaining the location of callers through direct request, tracing calls, or employing caller identification and sending community emergency response personnel (Kalafat et al, 2007).

said, “Yes, if it is structured and staffed and if the staff are culturally responsive Native Americans who are familiar with the issues; for example, with the ways of communicating and interacting with Indians.” One person said that she was not sure the hotline would be used if it focused only on suicide, and she indicated that if broader crisis services were offered, more AI/ANs might use it. Another person cautioned, “Expect very few calls initially because it will take time to percolate, but eventually it will.”

Barriers to Use

Phone Access. All 13 informants mentioned lack of access to phone service as a possible barrier for some persons. They indicated that phone coverage varied, cited limited or no landline or cell coverage in reservation or remote areas, and said coverage may depend on the carrier that is utilized. They described various circumstances that could result in limited coverage; for example, technology issues could result in downed phone lines or prevent the installation of additional lines. On one reservation, the youth have cell phones, but these phones cannot access long distance numbers. Additionally, one person reported there may be difficulty in finding pay phones or limited access to such phones after 5 pm. In urban areas, due to poverty, phone service may be disconnected due to lack of payment.

However, three of the 13 informants indicated that most of the members in the AI/AN communities that they were familiar with had phones. Two persons indicated that their Tribal communities owned their own utility companies. One person indicated that cell phones were cheap in her community; members could obtain these phones for \$3.00/month, and she indicated that elders and medicine men had cells, while another person said that the elderly are provided with free service on the reservation. In some urban areas, 1-800 calls are free if pay phones are used.

Privacy. Seven of the 13 respondents said that the possibility of a private conversation would vary depending on the circumstances and whether the caller had access to a cell phone. Several persons indicated that many AI/AN families live in homes that are crowded, and this would limit privacy. Others indicated that if a caller is calling a hotline staffed by a relative or members of their own community, this could raise confidentiality issues or concerns about gossip; however, they indicated that this would not be a problem if a national hotline was used. A related concern that callers might have is what happens to the information they provide on the call and how a hotline works i.e, if someone will show up at their door if they are suicidal.

Six of those participating in the telephone discussions indicated that the necessary privacy to make such a call exists. They said that the use of cell phones provided this privacy and that hotline numbers have been found in the pockets of youth. Others indicated that behavioral health or suicide prevention program offices could be used for private conversations or that gatekeepers such as police or hospitals could be conduits to a phone.

Non-AI/AN Callers. One expert brought up issues pertaining to non-AI/ANs calling the hotline. She referred to “checkerboarding” which occurs on some Native lands -- Native land is intermingled with non-Native land, and non-Natives can claim land within these areas. She was concerned that someone who lives on a checkerboard reservation but who is not AI/AN might see a poster advertising the hotline and wondered what would happen if this person tried to use

the service. She had also heard of a situation in which a person who was not a Tribal member called a local hotline and the staff hung up on the person.

Youth-Specific Barriers. Barriers specific to youth were mentioned; for example, although they may chat with others on the Internet, youth may be shy or uncomfortable when talking to strangers. Also, one person mentioned that some youth might have difficulty communicating on a hotline if they were intoxicated or high on drugs.

Additional Barriers. Several additional barriers were mentioned. Lack of knowledge about the existence of the hotline could be a barrier and in this regard, one respondent noted that “In some areas, there may not be venues to promote the hotline such as TV, radio or newspapers.” Stigma was also mentioned as a potential barrier; suicide is a taboo subject in some Tribal communities. The inability of a caller to trust anyone to talk to about his or her situation was also mentioned. Finally, one informant thought that disappointments with an AI/AN hotline service itself could be a barrier. He said that in order to avoid such disappointments, “The operation of the hotline has to move forward from Day 1 – the response of hotline staff has to be immediate and the service must be implemented by people who know how to respond to a person in stress/crisis.”

Use of Text Messaging

Ten of the 13 telephone discussants viewed texting among youth as common and thought that the willingness of youth to contact a suicide hotline would be increased if they could use text messaging on their cell phones.

However, several informants indicated that due to the cost, some youth don't have cell phones. They also noted that cell phones that include text messaging cost more, so some plans may not include this feature. Additionally, one person was concerned about safety issues with a suicidal person who is texting and thought that a hotline protocol regarding texting would be necessary. He said it is not easy to respond back to a suicidal person with just text; the person could shut off his text messaging, or if the caller gets a call while texting, this could interrupt the flow of the conversation. He noted that these issues would be less serious with a caller who is thinking about suicide, but not serious about it. Finally, one informant was not sure that youth would use texting on the hotline – she indicated that the AI/ANs she knew tend to be verbal rather than use written words.

Cultural Competencies

Those participating in the telephone discussions were asked if there are basic cultural competencies or areas of knowledge that staff of an AI/AN hotline should have in order to assess, help and refer callers. Respondents mentioned the following areas of knowledge that these staff should have:

- Universal Native values (e.g., extended family and kinship ties, spiritual relationships, mutual respect for elders and women, taboos);
- Regional and cultural differences (e.g., traditional language and cultural practices, spiritual belief systems, urban versus reservation communities, level of acculturation);

- AI/AN Communication styles (e.g., importance of nonverbal messages, silence, tempo of speech, humor, indirect communication, story telling);
- Community structures/governments/programs in Indian Country;
- Local resources (e.g., traditional healers, primary care resources);
- Historical trauma, events and losses; and,
- Helping skills (listening skills, nonjudgmental attitude, “psychological first aid,” knowledge of AI/AN role models who had been through crises).

Hotline Model Options

Three models of a suicide prevention hotline for AI/ANs were described to the experts, and they were asked to select their first, second and third choices and give the reasons for these choices. The three models included:

- *A new National AI/AN-Specific Model.* A toll-free national AI/AN suicide prevention center serving the whole country could be established. After calling the mainstream Lifeline number, AI/AN callers would be directed to this center if they decided to identify themselves as AI/AN. The staff of this center would be AI/AN and would be trained to work with AI/ANs in a culturally competent manner.
- *A new Area/Region AI/AN-Specific Model.* Several AI/AN suicide prevention hotlines would be established by area or region. Each of these hotlines would have its own toll-free number and would be staffed by AI/ANs familiar with the culture of the Indians living in their area.
- *A Non-AI/AN Local Crisis Center Model.* This model builds on the current National Suicide Prevention Lifeline AI Initiative in which local crisis centers are supported in collaborating with Tribes. AI/AN callers who call the Lifeline number have their calls answered at a local center staffed by non-AI/AN staff. These staff work collaboratively with the AI/AN communities in their areas to receive training in culturally competent approaches and to develop a list of local referral resources for use with the AI/AN callers.

Table 1 summarizes the results. The majority of those asked (11 of 13) selected the new Area/Region AI/AN-Specific Model as their first choice. They preferred this model because it would be staffed by AI/ANs who would take into consideration differences in areas/regions and thus could more effectively create relationships and provide appropriate referral information pertaining to local/regional resources. These staff would have knowledge of regional customs, traditions and local events and this knowledge would add credibility to the service. One person said, “In this model, the cultural knowledge would be easier to learn (i.e., narrower) and the message to the community would feel more special, more tailored.” Furthermore, in this model, the staff could link with areas within a region to learn what type of response teams the Tribes or urban areas have set up to mobilize for assistance to the callers. Additionally, one

person thought that this approach may receive more buy-in from the IHS because this agency is organized on a regional basis. Finally, one person preferred this model because unlike a new National AI/AN-Specific Model, there would be less chance for acrimony between different Tribes -- “Tribes are very territorial and proud of who they are.”

The experts were split in their second choice of a model; seven selected the National AI/AN-Specific Model and six selected the Non-AI/AN Local Crisis Center Model. Those who selected the National Model indicated its advantages as AI/AN staffing and its focus on the unique needs, norms and philosophies of the target population, although one person said that if the caller and staff were from different Tribes, this might be a problem. Those who selected the Non-AI/AN Local Crisis Center Model, viewed it as a model that is currently partially in place and saw its staff as having specialized community-level knowledge, but they did not like the idea of non-Native staff. One respondent said, “When our people hear a White American voice, they feel fear. Local Non-Natives might be the best intentioned, but racism has been ingrained in them.”

For their third and last choice, seven persons selected the Non-AI/AN Local Crisis Center Model, four picked the National AI/AN-Specific Model and two selected the Area/Region AI/AN-Specific Model. Those who selected the Non-AI/AN Local Crisis Center Model said that this approach would take time and effort to develop as well as dedication from staff at both the crisis centers and the Tribes to implement. One person thought that with non-Native staff, AI/ANs would be a secondary audience rather than the primary focus; thus, he thought that there would be limited outreach to AI/ANs, not as much effort put forth to serve them, and less familiarity with AI/AN views, values and philosophies. Additionally, another expert thought that other organizations may not understand the government-to-government relationship that tribes have. As a result, the staff of a Non-AI/AN Local Crisis Center might not understand why access to certain services is only for AI/ANs, and thus, misunderstandings could occur about the differences in service availability. Race could become an issue and the staff might think, “They (AI/ANs) have the best of everything.” Finally, one person said that since this model currently exists in his state, it would not involve any kind of a change. Four persons selected the National AI/AN-specific model at their third choice, and one of these respondents said, “You cannot have a suicidal person jumping through hoops. The caller needs to be able to speak to someone right away rather than being put on hold or being referred elsewhere.”

TABLE 1: THREE HOTLINE MODELS for AI/ANs

	1 st Choice	2 nd Choice	3 rd Choice
Hotline Models			
National AI/AN-Specific	2	7	4
Area AI/AN-Specific	11	0	2
Non AI/AN Local Crisis Center	0	6	7
Total	13	13	13

Hotline Transfer Options

Three ways of transferring AI/AN callers to hotline services were described to those participating in the telephone discussions, and they were asked to select their first, second and third choices and give reasons for their choices. The transfer options were:

- *Lifeline Number with Prompts and Automatic Transfer Option.* AI/AN caller dials the existing Lifeline national suicide prevention hotline number 800-273-TALK (8255) and hears a series of prompts asking him or her to indicate if he or she is veteran, another prompt asking whether the caller is Hispanic, and finally a prompt asking if the caller is AI/AN. If the AI/AN caller self-identifies, then he or she is automatically transferred to the AI/AN center. If caller doesn't choose to identify as AI/AN, he/she would remain with the national hotline.
- *Lifeline Number and Local Crisis Center Non-AI/AN Assessment and Transfer Option.* AI/AN caller dials the existing toll-free Lifeline national suicide prevention lifeline number 800-273-TALK and is first assessed by the local crisis center's non-AI/AN staff. At a clinically appropriate time during the call, the caller is asked if he or she wishes to identify as AI/AN. If so, the staff person could offer the option of transferring the caller to an AI/AN center. If the caller accepts, the staff person calls the AI/AN center, introduces the AI/AN caller, then hangs up, leaving the caller and the AI/AN center connected. If the AI/AN caller does not self-identify, he/she continues to be served by the national hotline staff.
- *Separate AI/AN Hotline Number.* AI/AN caller dials a separate suicide prevention hotline number (i.e., not 800-273-TALK) that is supported by the existing National Suicide Prevention Lifeline technology infrastructure, and the call is answered by either a national or regional AI/AN call center.

Table 2 summarizes the results. The majority of those participating in the telephone discussions (11 of 13) selected a separate suicide prevention hotline number with the call being answered by a national or regional AI/AN call center as their first choice. They liked this option because they thought it offered the caller a live person in the most direct manner, allowed staff to address issues more immediately and thus enabled trust to develop more quickly. One person said, "People are often referred elsewhere, and they are tired of this treatment," and another said, "These people are on the verge of suicide and need immediate attention. They might hang up." Another liked this option because the callers would be Native and thus would not have to self-identify as AI/AN. Finally, when selecting this option one of the informants noted that even if a separate number were an option, an AI/AN still would have a choice of using the Lifeline or the Veterans Administration prompt on the Lifeline.

TABLE 2: TRANSFER OPTIONS FOR AI/AN HOTLINE CALLERS

	1 st Choice	2 nd Choice	3 rd Choice
Transfer Options			
Lifeline Number, Prompts, Automatic Transfer Option to AI/AN Center	2	3	8
Lifeline Number, Local Non-AI/AN Crisis Center Assessment, Option to transfer to AI/AN Center	0	9	4
Separate AI/AN Number	11	1	1
Total	13	13	13

Note that in addition to a transfer option, this strategy could be considered a variation of the first model discussed above – a new National AI/AN-specific model. It differs in that the caller dials a separate suicide prevention hotline number, not the Lifeline number and there are no prompts asking the caller to identify as AI/AN.

SAMHSA staff have indicated that a separate AI/AN hotline number could still make use of the existing Lifeline telephone structure, thereby avoiding an excessive duplication of telephone systems; for example, if there were regional centers, the system could allow the different regions to back up each other. It would also allow existing Lifeline centers to back up the AI/AN centers. This is important because even a well staffed center (e.g., six staff around the clock) will at times get more calls than they can handle, leading to busy signals or long waits unless there is a back up system. Also, without a back up system, one outage can shut the system and damage trust in the system.

For their second choice, the majority of the informants (9 of 13) selected the Lifeline Number and Local Crisis Center Non-AI/AN Assessment and Transfer Option. They liked this option because it offered human contact and time for an assessment of the caller's needs. However, several persons expressed concerns about asking the caller if he/she was AI/AN. One person said, "Asking a person if she/she is AI/AN amounts to categorizing them and dumping on them." Another person wondered how the staff would determine if the person was AI/AN – would the staff ask upfront or would he determine the caller's identify from cues? This person noted that it may be hard for a non-Native person to determine Indian identity. Three informants selected the Lifeline Number with Prompts and Transfer Option as their second choice. While they thought this was a more direct option than the Lifeline Number and Non-AI/AN Crisis Center option, they also indicated that suicidal callers do not have patience – they have already tried other calls and left messages on these calls; thus, this option may lose them.

The majority of those asked (8 of 13) selected the Lifeline Number with Prompts and Transfer Option as their third and last choice. Many of these persons objected to the prompts, the slow process and lack of human contact in the beginning of this sequence. Several of them said it reminded them of the automated system that they encounter when calling their bank. One person said that this type of "electronic bureaucracy" can result in frustration and create reluctance, and another noted that in her state people have guns and, "If they have to go through these prompts, they will just commit suicide rather than go through this process." However, this respondent noted that this option may be acceptable for those who are just thinking about suicide, but not serious about it. Four persons selected the Lifeline Number and Local Crisis Center Non-AI/AN Assessment and Transfer Option as their third choice. One of these persons thought that a caller will not want to be transferred after talking with someone, and thought that the same person should talk to the caller from start to finish. Others who selected this option as their third choice thought that the caller might hang up if there are too many hoops to go through and noted that some AIs are leery of any cues they receive that the person they are talking to is not AI or AN.

Special Issues for Urban and Rural AI/ANs

The expert informants were asked if there were special issues for rural or urban AI/ANs in regard to a suicide prevention hotline. The special issue mentioned for urban areas was AI/AN *invisibility*. One person indicated that the county she was familiar with has a large urban AI population which is widely dispersed; thus, there is no central location in which AI/ANs live. As a result, it is a challenge to get the word out about agency resources and AI/ANs may not come to the agency. Furthermore, in urban crisis centers, AI/AN youth may be invisible because they are only a very small population that is being served, and the staff of these centers have had no training in working with AI/ANs.

The special issues mentioned in regard to rural areas included:

- *Lack of mental health services.* Several of the telephone discussants talked about the lack of mental health services and/or referral resources. They said that as a result, people may have to be referred off site as there are no in-patient facilities or out-patient mental health providers. One person said, “We have one psychologist who comes every day from 96 miles away. A person must get an appointment, and if the psychologist is busy, there may be a wait of up to 6 weeks. Parents, not knowing what else to do with children who have mental health or behavioral issues call the police, and the police incarcerate the child until the mental health appointment. We lost two teens this way; they hung themselves in jail.” Another informant suggested that “a call-down tree” that contains numbers to use in an emergency (e.g., Tribal police, suicide prevention team) is needed for Native communities.
- *Poverty and unemployment.* Geographically isolated reservations may increase the likelihood of economic deprivation, lack of education, and limited employment opportunities, all contributing to a sense of hopelessness among members of the community. One respondent indicated that, “When the price of gas is high, it is difficult for people even to get to their medical appointments.”
- *Isolation.* There are vast distances to travel. “Walmart is 190 miles round trip and the movie theatre is 140 miles round trip. Grocery stores and restaurants are far away. There is no electrician or plumber; thus, we must do everything ourselves.”
- *Stigma.* There is reluctance on the part of some rural or reservation residents to talk about suicide. One expert said, “Suicide has different meanings, and not all of them are good. Suicide attempters or completers are a symbol of hopelessness and engender a sense of shame and disconnection.” Another emphasized that the hotline should be promoted *as a crisis hotline* rather than as a suicide prevention hotline. He said that when he talks to groups about the local crisis hotline, he uses the example of “an older man who loses his glasses” in order to make listeners feel more comfortable with the idea of calling a hotline for various problems.
- *Violence.* One informant said the school district in his area was very dangerous and characterized by lots of violence. As a result, cameras had to be put on the school buses.

He also said parents neglect to supervise their children, and the children get involved in hard core gangs. Access to weapons and drugs is also an issue.

- *Region-specific issues.* In Alaska, many communities depend on subsistence foods and hunt and fish to obtain these foods, but there are state and federal limits on how much they can engage in these activities. ANs may be arrested for gathering food in traditional ways. In Prince William Sound, life styles are still impacted by the Exxon Valdez Oil Spill.
- *Collaboration Difficulties.* One expert explained that collaboration around addressing suicide may be difficult as some people are “territorial” and do not want to work together. As a result, she said she had to go to her Tribal council to get a resolution to allow her to coordinate suicide prevention efforts and get people from different tribal programs to work together.
- *Privacy Concerns.* Anonymity is important. One expert suggested that a caller be given a “Code Word” to use when they are referred to local resources. Then they could just use this word instead of their name.
- *Racism.* One participant in the discussions described overt racism against AI/ANs; for example, they may be refused a motel room with no justification. He said that AI/ANs have learned to tolerate such treatment.

AI/AN Community Support for a Hotline

Informants were asked if the community they were familiar with would support the idea of an AI/AN suicide prevention hotline and promote awareness of it among their members. All 13 participants responded affirmatively. Several indicated that this idea has been talked about for a long time. One of the reasons given for anticipated community support was that suicide remains a crisis as indicated by statistics, and that Tribal councils are aware of this problem along with the lack of resources to address it. Another person said, “The enormity of the issue dictates that action and resources be directed toward the problem. We need proactivity. Now is the time for this.” Community support was also expected if Natives would be staffing the service. Several informants indicated that outreach should be done with Tribal leaders and organizations to involve them and give them a sense of ownership – “Ownership brings a comfort level”, one person said. Furthermore, participants in the discussions indicated that the hotline would be supported if the community has positive experiences with it over time and it is perceived as a trusted and dedicated resource for AI/ANs. One person noted that the hotline would be very advantageous for smaller Tribes without large health departments.

AI/AN Involvement in the Establishment of a Hotline

Informants were asked about the best way to involve AI/AN representatives in the development and implementation of the hotline. They suggested various partners to collaborate with as well as methods of involving AI/ANs. One category of partners was Indian organizations and the relevant committees or representatives of these organizations. Organizations that were mentioned included: the National Indian Health Board, the National Council of Urban Indian Health, the Indian Health Service, Area Indian Health Boards, and other relevant Indian

organizations. They also suggested outreach to Tribal programs and Tribal Councils; for example, Tribal health directors, health aides, suicide prevention personnel, and high school and college students. They also thought that Tribal Councils could provide guidance regarding key players to involve, and that all the relevant players should be at the table.

Additionally, participants suggested that SAMHSA grantees working in the area of suicide prevention be contacted in order to learn from their experiences; for example, the Native Aspirations grantees whose purpose it is to address youth violence, bullying, and suicide prevention through evidence-based interventions and community efforts; the Garrett Lee Smith Campus Suicide Prevention Grant Program that focuses on enhancing services for students with mental and behavioral health problems; or the Garret Lee Smith State/Tribal Youth Suicide Prevention Program in which 18 of the 54 grantees are Tribes or Tribal organizations. State and regional suicide prevention groups were also suggested as a resource.

There were several suggestions regarding the methods to use to involve AI/AN representatives, including forming some type of working or advisory group. It was suggested that members of this group could be identified by existing advisory groups that represent the 12 IHS areas such as HHS' Health Research Advisory Council or CDC's Tribal Technical Advisory Committee. Video conferencing was suggested as a way to involve knowledgeable AI/ANs living in Tribal communities. An assessment or survey was also mentioned in order to examine the views of community members about the usefulness of an AI/AN hotline.

Finally, several experiential methods were suggested to help those involved in the planning of the hotline get a feel for the problem; for example, having the planners shadow staff who work with callers going through crises in order to get a feel for what this experience is really like. Another suggestion was to ask those who have called the Lifeline to speak about what was helpful and not helpful about this experience or even to ask those who have attempted suicide but have not called the Lifeline to talk about their experience.

Promotion of the Hotline

Informants were asked for their ideas about how potential callers should be made aware of the AI/AN hotline. They suggested various strategies to enhance the acceptability of the promotional materials. They thought it important that local materials be customized using Native-specific images; for example art designs, local logos or seals, or youth symbolizing contemporary Native culture. However, one informant noted that some local people did not want their pictures on promotional posters or billboards for the Lifeline Native American Community Liaison Initiative (pilot project with local crisis centers) because they did not want to be associated with suicide. For regional or national promotional materials, they suggested use of familiar Native national or regional persons (e.g., Native state legislators), high profile Native celebrities, or cultural cross-over entertainers (Native or non-Native); for example, those who are known for music popular with indigenous peoples.

Additionally, several persons suggested addressing the stigma associated with suicide by not using the word suicide in the name of the hotline (i.e., crisis hotline) or in promotional materials, but rather using positive or substitute language such as "hurting yourself" or "If you have a problem, talk about it." One person said, "Talking about suicide could be detrimental to your

health” meaning that rather than focusing on negative suicidal behavior, the emphasis should be on positive life-affirming behaviors and community activities.

Other creative strategies were suggested such as a video with a Native youth calling the hotline or role playing whereby a caller and helper act out their roles in order to educate an audience about what such a call might be like. Two existing educational tools were also mentioned: 1) Question, Persuade and Refer (QPR) that involves learning how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone for help and 2) SafeTALK – suicide prevention training that also teaches participants to recognize and engage people who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention.

One informant said that for some people, the current Lifeline phone number is difficult to translate into numbers or remember; thus, in creating a new telephone hotline number, it would be important have simple Native-specific words that would correspond to the telephone number..

Finally, a general approach was proposed by one expert. She said,

“First outreach and education must be done at the national level, and then there must be follow-up at the local level. Outreach must be visible. There must be serious outreach to the AI/AN community; not a job halfway done. Every Tribe must be made aware of the hotline and sent information, posters and other materials. Resources including funding must be devoted to this effort.”

Specific methods of providing information about the hotline and its telephone number were also suggested including:

- Posters located in clinics, schools, community centers, and post offices;
- Presentations by Native speakers in every local school;
- Use of Tribal offices (e.g., health offices);
- Radio public service announcements (PSAs) using Native networks and public radio;
- TV including regional networks;
- Community events including pow-wows, health fairs;
- Tribal newspapers;
- Flyers (from Health Departments or clinics) in both traditional Native language and English;
- Outreach to service and community organizations (e.g., Head Start);
- Billboards;
- Wallet cards;
- Promotional materials: stress balls, T-shirts, megaphones, coasters, sweat shirts;
- Training of county, state and Tribal social services workers in a region about how to use the hotline and what happens when someone calls;
- Federal agency websites (e.g., IHS, SAMHSA); and
- AI/AN conferences.

Summary of Telephone Discussions

Participants in the telephone discussions working in the area of AI/AN suicide prevention think that an AI/AN hotline would be desirable and feasible in the sense it would be used by AI/ANs, but they point out that the service must be implemented by culturally responsive AI/AN staff, confidentiality must be protected, appropriate resource information must be provided, and public awareness efforts on national and local levels are critical for promoting awareness and use of the service in Indian Country. They noted that hotline use will be dependent on consumer satisfaction with the service as it evolves. They indicated that depending on circumstances, access to phone service is sometimes a barrier in Indian Country; thus, the hotline may not be available to everyone. One of the key advantages of a hotline that participants identified was AI/AN staffing, and they listed a wide range of cultural competencies that these staff would need to have to assess, help and refer callers. In their preferences for a new Area/Region AI/AN-Specific Model and a separate AI/AN hotline number, the experts indicated the advantages of that providing the most focused, direct and immediate service to the callers. They indicated that the AI/AN communities they were familiar with would support and promote a hotline, and they emphasized AI/AN involvement in its establishment and promotion.

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APPENDIX

DISCUSSION GUIDE

Feasibility of American Indian/Alaska Native Suicide Prevention Hotline

Name: _____

Position: _____

Agency/Tribe: _____

Location: _____

Phone and Email: _____

Introduction: The Substance Abuse and Mental Health Services Administration has asked the Office of the Assistant Secretary for Planning and Evaluation in DHHS to explore the feasibility and desirability of creating a suicide prevention hotline that would serve only American Indians and Alaskan Natives (AI/ANs). This hotline would be intended for people to call who are in crisis, emotional distress, or at risk of suicide.

I would like to ask your opinions about several issues related to a hotline specially designed for AI/ANs. There are no right or wrong answers. Your responses will be confidential, and your name or your agency or Tribe's name will not be used in the write-up of the results.

1. Currently, a 24/7 toll free national suicide prevention hotline exists. This is called the National Suicide Prevention Lifeline and utilizes the number of 800-273-TALK (8255). Anyone may call it and calls are confidential.
 - Have you had any experience with the National Suicide Prevention Lifeline?
 - If so, what has that experience been like?
2. What is your view of establishing a suicide prevention hotline designed to serve only AI/ANs and staffed by AI/ANs familiar with AI/AN culture and mental health issues?
3. Do you think AI/ANs would call a suicide prevention hotline that was specifically designed to serve them?
 - If yes, explain.
 - If no, what type of barriers would prevent them from calling?
4. Would members of the AI/AN communities you are familiar with (such as rural or urban AI/AN communities) have access to phone service—either land line, cell, or other?
 - Would they have the necessary privacy to enable them to call an AI/AN suicide prevention hotline?
 - Do you think that the willingness of AI/AN youth to contact and interact with an AI/AN suicide prevention hotline would be increased if they could use text messaging on their cell phones?

- Are there any [other] special issues for rural AI/ANs?
5. We know that AI/ANs have diverse cultures; however, are there basic cultural competencies or areas of knowledge that staff of an AI/AN hotline should have in order to assess, help and refer callers?
- Please describe them.
6. Many Tribes would like to set up their own suicide prevention hotlines. However, a scarcity of resources often prevents this. There are a number of ways in which suicide prevention hotlines could be set up to serve AI/AN communities. Which of the following three models do you think would be the most useful and why?
- *The first is a new National AI/AN-Specific Model.* A toll-free national AI/AN suicide prevention center serving the whole country could be established. AI/AN callers would be directed to this center if they decided to identify themselves as AI/AN. The staff of this center would be AI/AN and would be trained to work with AI/ANs in a culturally competent manner
 - *The second involves a new Area/Region AI/AN-Specific Model.* Several AI/AN suicide prevention hotlines would be established by area or region. Each of these hotlines would have its own toll-free number and would be staffed by AI/ANs familiar with the culture of the Indians living in their area.
 - *The third involves building on the current National Suicide Prevention Lifeline AI Initiative. This is a Non-AI/AN Model involving local crisis centers who are supported in collaborating with Tribes.* AI/AN callers who call the Lifeline number have their calls answered at the local center. Non-AI/AN staff working in these centers work collaboratively with the AI/AN communities in their areas to receive training in culturally competent approaches and to develop a list of local referral resources for use with the AI/AN callers.
7. If a national AI/AN suicide prevention hotline is implemented, there are various ways that AI/AN callers could get transferred toll-free to their special hotline. Which of these ways do you think would work the best and why?
- AI/AN caller dials the existing national suicide prevention hotline number 800-273-TALK (8255) and hears a series of prompts asking him or her to indicate if he or she is veteran, another prompt asking whether the caller is Hispanic, and finally a prompt asking if caller is AI/AN. If the AI/AN caller chooses to self-identify, then he or she is asked to press a certain number and would automatically transferred to the AI/AN center. If caller doesn't choose to identify as AI/AN, he/she would remain with the national hotline.
 - AI/AN caller dials the existing toll-free national suicide prevention lifeline number 800-273-TALK and is first assessed by the local crisis center's non-AI/AN staff. During the discussion, the caller is asked if he or she wishes to identify as AI/AN. If so, the staff person can offer the option of transferring the caller to an AI/AN center. If the caller accepts, the staff person calls the AI/AN center, introduces the AI/AN caller, then hangs up, leaving the caller and the AI/AN center connected. If the AI/AN caller does not self-identify, he/she continues to be served by the national hotline staff.

- AI/AN caller dials a separate suicide prevention hotline number (i.e., not 800-273-TALK) that is supported by the existing National Suicide Prevention Lifeline technology infrastructure, and the call is answered by either a national or regional AI/AN call center.
8. Do you think the AI/AN communities you are familiar with would support the idea of a AI/AN suicide prevention hotline (either national, area/region or local collaborative model) and promote awareness of it among their members?
 - Could you tell me more?
 9. What would be the best way to involve AI/AN representatives in the development and implementation of a suicide prevention hotline serving AI/AN communities?
 10. How should potential callers be made aware of the special AI/AN suicide hotline?
 - For example, what kind of advertising, outreach and education should be done?
 10. Do you have any other thoughts you have about the feasibility of implementing an AI/AN Suicide Prevention Hotline?

Thank you for your time and your thoughtful comments. May we be back in touch with you if we have further questions?