



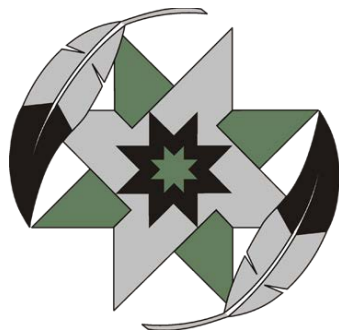
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The Evolving Paradigm: New Directions for Suicide Prevention

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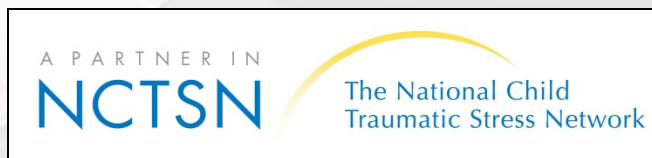
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The University of Montana-Missoula



National Native Children's Trauma Center

- **Established** in Fall 2007 to serve as a Treatment and Services Adaptation Center (Cat II) within the National Child Traumatic Stress Network (NCTSN)
- **Issue** Establishing trauma-informed system of care for suicide prevention in for rural tribal communities
- **Mission:** *In respectful partnerships with tribes, NNCTC will implement, adapt, evaluate and disseminate trauma interventions to decrease the social, emotional, spiritual and educational impact traumatic experiences have on American Indian and Alaska Native children*



As of the most recent data, Montana ranks 3rd in nation for deaths by suicide (behind WY and AK)



James and Janett Massolo with a portrait of their daughter, Shannon, who shot herself 17 years ago. (Photo by

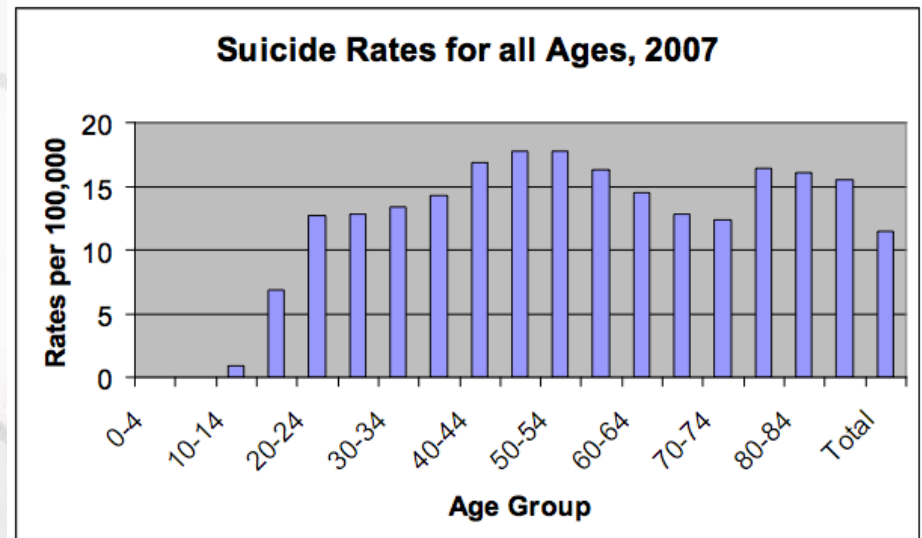
We have ranked
in the top 5 for the
last 30 years.

Information Source:

McIntosh, J.L., & Drapeau, C. W. (for the American Association of Suicidology). (2012). *U.S.A. suicide 2010: Official final data*. Washington, DC: American Association of Suicidology, dated November 28, 2012, downloaded from <http://suicidology.org>

Suicide Statistics Nationally

- Females attempt 3x more than males; but males *complete* 3.6x times more than females.
- It is the 11th leading cause of death across all age groups; but 3rd for ages 15-24 (behind accidents and homicides, CDC) and 2nd for ages 25-34.
- Completion rates between ages of 15-24 increased 200% from the 1950s - 70s, leveled until the 90's, decreased slightly until 2007, then rose again.
- There were just over 35,500 completions in 2007 - or 1 every 15 minutes.
- The Intermountain West is consistently the most deadly region with 6 of the top 10 states.



American Association of Suicidology 2010 factsheet: http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-244.pdf

The discussions in Montana and in many other states after the Sandy Hook shooting - particularly around arming teachers - are missing the critical, more common issue of suicide

- Suicide is “absent from the discussion of gun policy,”
- “The availability of firearms does indeed increase the risk of suicide, but most people don’t see it that way.”

Daniel Webster, Director
Johns Hopkins Center for Gun Policy
and Research in Baltimore.

<http://www.washingtonpost.com/sf/feature/wp/2013/03/22/gun-deaths-shaped-by-race-in-america/>
<http://www.hsph.harvard.edu/means-matter/means-matter/risk/>

70% of older victims of suicide had visited with their primary care physician in the month prior to the suicide, 40% in the prior week.

Gatekeeper training for physicians is essential as is comfort asking about suicide and depression. For most of us, including most physicians, this is not a comfortable thing to do.

Suicide Prevention Toolkit For Rural Primary Care Providers



Suicide in Indian Country

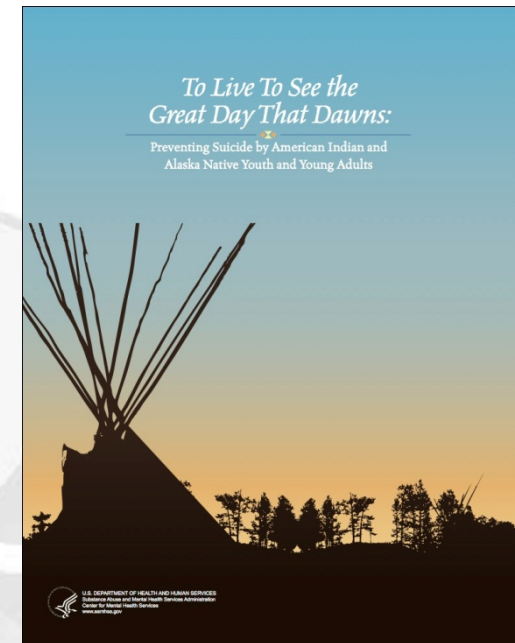
- Suicide is epidemic in Indian Country, with American Indian and Alaska Native (AI/AN) youth *more at risk than any other cultural or ethnic group*.
- Suicide is often associated with poverty, and many American Indian communities have the some of the highest poverty rates of any ethnic group in the Nation. 50-80% on many Plains Reservations....
- Native populations are disproportionately young compared to the rest of the nation. 38% are under the age of 19 and another 23% are between the ages of 20 and 34.
- Intergenerational trauma, decreased access to health care, a host of socioeconomic risk factors and extended families = greater chance of Native youth to experience familial loss, grief and traumatic stress.

Sources:
Suicide Prevention Resource Center, *Suicide Among American Indian/Alaska Native Youth Fact Sheet*. Retrieved from: <http://www.sprc.org/library/ai.an.facts.pdf>
National Congress of American Indians. Retrieved from <http://www.ncai.org/Economic-Development.45.0.html>
U.S. Department of Health and Human Services. (2010). *To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults*. DHHS Publication SMA (10)-4480, CMHS-NSPL-0196

What is a suicide cluster?

A suicide cluster is defined in the U.S. Substance Abuse and Mental Health Service Administration's 2010 report on American Indian/Alaska Native suicide prevention entitled ***To Live To See The Great Day That Dawns*** (pg 37), as:

"when a group of suicides or suicide attempts occur closer together in time and space than would be normally expected in a given community."





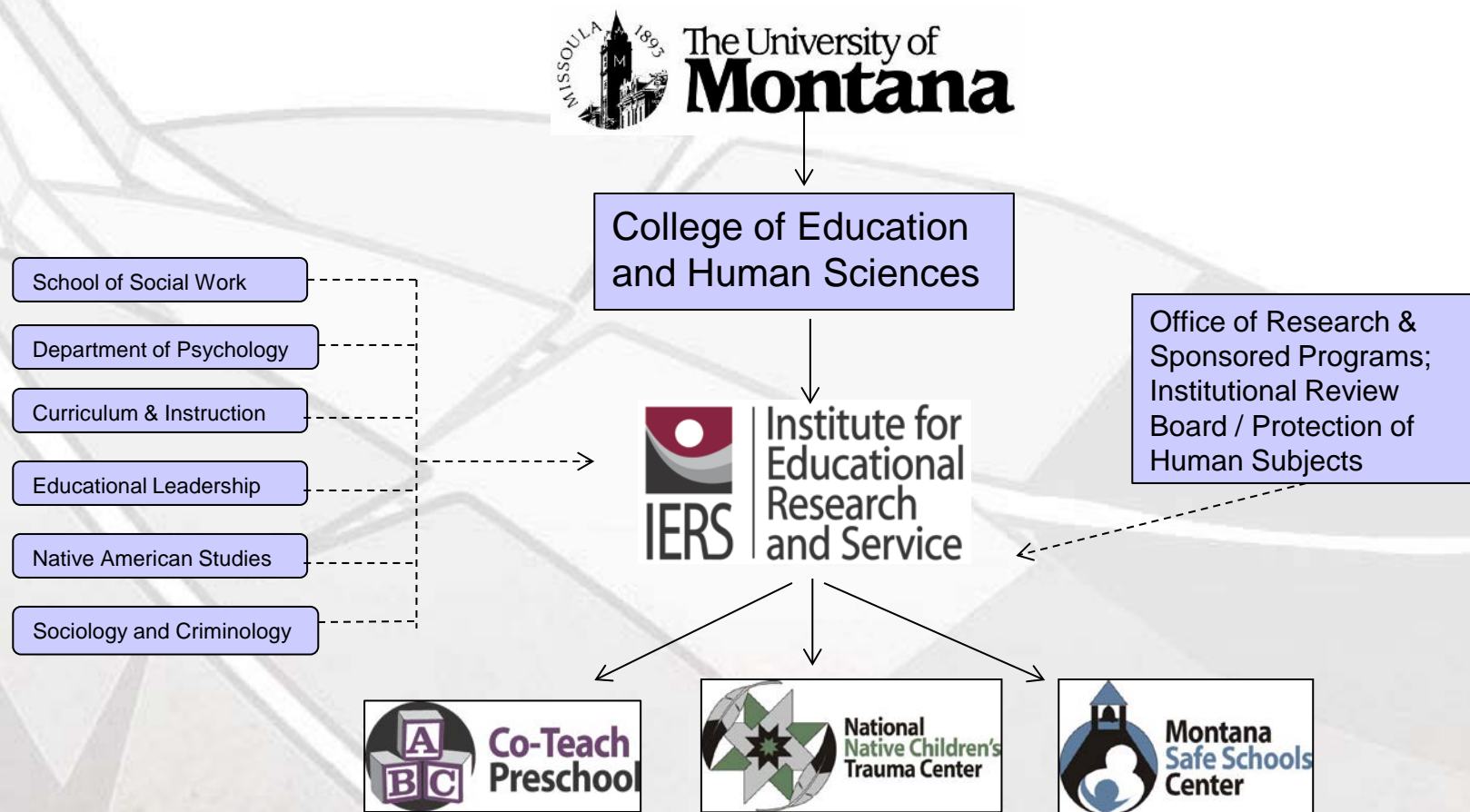
Protective Factors

Essential Understanding for Suicide Prevention
In Indian Country

- **Effective clinical care** for mental, physical, and substance use disorders
- Easy **access** to a variety of clinical interventions and support for help-seeking
- **Decreased access to** highly lethal **means** of suicide
- **Strong connections** to family and community support
- Support through **ongoing** medical and mental health care relationships
- Problem solving, conflict resolution, and **nonviolent handling** of disputes
- Cultural and religious **beliefs** that discourage suicide and support resilience
- Safe, supportive **school environments**
- **Trusting**, positive, role models and mentors.
- Healthy and safe peer **activities**

Lesson Learned 1: Building an interdisciplinary capacity for suicide prevention that is relevant across multiple community agencies requires collaboration, new perspectives & engaging future leaders.

For example, IERS/NNCTC's suicide prevention initiative collaborates with multiple academic and University departments to enhance the skills of future clinicians, public health workers and researchers.



Across Systems

- ED
- Schools
- Mental Health
- Youth Courts
- Law Enforcement
- Substance Abuse
- Spiritual Leaders



Coalition Building

- Tribal Resolution
 - MOU
 - Schools
 - Tribal Health
 - Tribal Suicide Prevention Project
 - BIA CPS
 - DV
 - Sheriff's dept.
 - City Police
 - BIA Law and Justice
 - Tribal Courts
 - Boys and Girls Club
 - Churches/Tribal Spiritual Leaders
 - JDC/TLU
 - Substance abuse tx
 - Emergency Department
- Need
- County Health
- County Mental Health
- Head Start

Lesson Learned 2: Suicide prevention must engage with **emergency departments, schools**, child welfare and juvenile justice programs in rural, underserved, Native communities, providers must seek to engage *culturally*

To do this, we need to:

- Understand cultural norms including taboos about suicide,
- Seek guidance from traditional/spiritual leaders,
- Increase Emergency Department (ED) Response
- Respect tribal sovereignty (especially regarding data), and
- Ensure that our service provision, training and outreach to policy leaders does not further pathologize groups of people or reinforce unhelpful stereotypes.



Process



- Reduce Stigma
 - Placing service in a primary health care setting
- Assessment
 - Evidence-based
 - Suicide risk
 - Trauma
 - Substance Abuse

Process continued

- Referral/Connections
 - Hospital clinician and case manager
 - I.H.S Behavioral Health
 - School based counselors
 - Spiritual leaders
- Follow up
 - Calls
 - In person
 - Support for tx plan
 - Transportation



Providing Support to Suicide Attempters and their Families



- Train Emergency Department and Clinic Primary Health Care Providers
- Provide evaluation and psycho-education to attempter and caregiver/family
- Follow up contact includes referral, evaluation, support

Emergency Department

- Adaptation of the World Health Organization's (WHO) Brief Intervention and Contact (BIC)
- Train ED staff
- Hospitalist Champion
- Case manager
- Clinician

Effectiveness of brief intervention and contact for suicide attempters: a randomized controlled trial in five countries
Fleischmann et al., Bulletin of the World Health Organization 2008;86:703–709.

Assessment and Professional Development



- Creation of a primary care suicidal risk assessment tool
- Adaptation of WHO BIC for local patient population
- Creation of web-based training for primary care providers treating suicidal patients

****Lesson Learned 3:** Tracking the multiplier effect of trainings (such as how many children, families, individuals receive enhanced services from those that have been directly trained) and clinical services is difficult but is invaluable in helping to sustain collaborative networks and inform policy: *It must be planned from the start.*



Examples of School Suicide Response Strategies in Indian Country

- Lifeline (crisis call centers) & ASIST/QPR/Native HOPE (trainings)
- Community outreach (including community dinners)
- Parental outreach/consent
- Triage/nomination process
- 1:1 information gathering/assessments
- Mentoring nominations/check-in
- Self Care plans
- Cognitive Behavioral classroom/group work (ongoing)
- Healing Circles (future)
- Traditional Ceremonies
- School-wide interventions
- After-school/summer programs
- Community Centers
- Safe houses - with safe transportation



Lesson Learned 4 : To strengthen youth resilience and reduce suicidal ideation, programs are well served when they take a *whole child* approach that addresses:

Crisis Response System in place

Response in primary health care settings especially

Emergency Departments

Adolescent skill building

Peer leadership and referral skill building

Child serving system supports

Community and family supports

Without such an approach, programs risk not being well integrated or understood, referral systems may be inefficient and initiatives may be short-lived.



● Successes

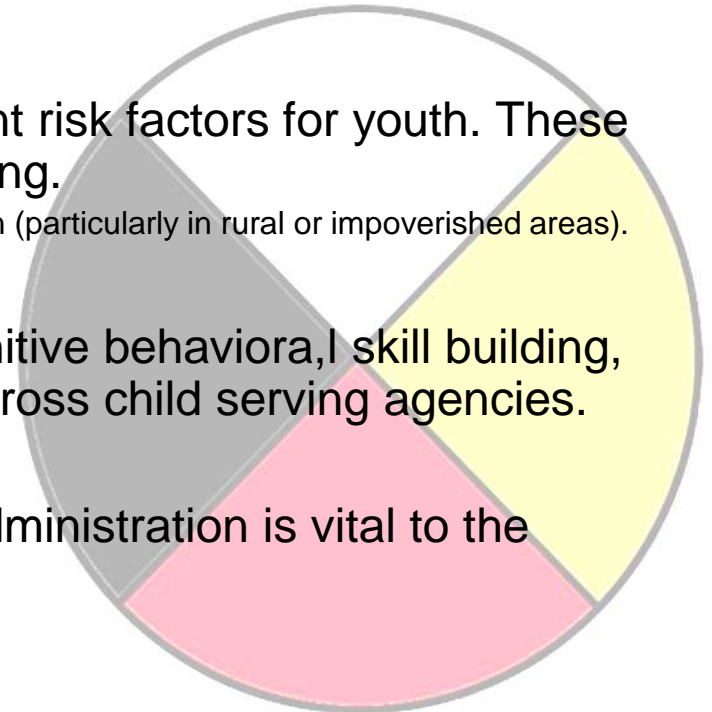
- Increased help seeking behavior increased
- Reduction of stigma
- Increased number of community members participating in gatekeeper training
- Increased number of patients receiving clinical services is increased
- Increased Number of patients finding support after treatment being served
- In hospital safe room is constructed

● Challenges

- Tribal code that criminalizes suicidal behavior
- Underutilization of the safe room
- Patient population that is transient and difficult to find for follow up support
- Transportation for hospitalization

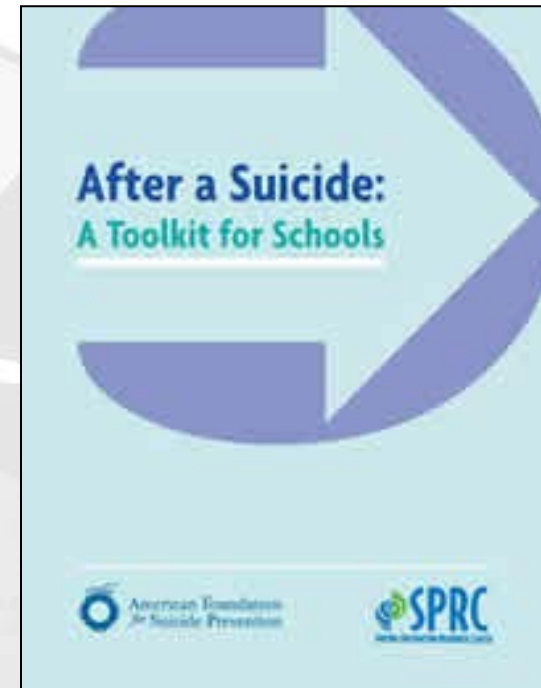
Conclusions

- Resources are out there.
 - Tribal Elders and the youth themselves
 - Emergency Departments/Primary Health Care settings
 - SAMHSA's Lifeline Program & The Suicide Prevention Resource Center's Best Practices Registry
 - OSDFS School Emergency Response to Violence (SERV) & the REMS TA Center
 - National Center for School Crisis and Bereavement, National Child Traumatic Stress Network, Indian Health Service Youth Suicide
- Youth suicide is a community problem, Response efforts should reflect this.
- Communities must have integrated community policies and procedures to be prepared.
- Trauma and exposure to violence are significant risk factors for youth. These must be addressed because they impact learning.
 - Schools are the de-facto mental health provider for most children (particularly in rural or impoverished areas). Policy, programming and funding should reflect this reality.
- Behavioral health issues - with a focus on cognitive behaviora,l skill building, resiliency and wellness - must be integrated across child serving agencies.
- Structured self-care for caregivers, staff and administration is vital to the health of the community.



Excellent resources & references for schools:

- U.S. Department of Education REMS Technical Assistance Center
 - Lessons Learned Publications (www.rems.edu.gov)
- *When Grief Visits Schools*. By: Dr. John Dudley (2003, 2nd edition)
- National Center for School Crisis and Bereavement website
 - <http://www.cincinnatichildrens.org/svc/alpha/s/school-crisis/guidelines-bereavement.htm>
- National Association of School Psychologists' website
 - *School Crisis Prevention & Intervention*, Brock et al, 2009 (PREPaRE)
 - *After a Suicide: Answering Questions from Students* by Dr. Scott Poland
 - <http://www.nasponline.org/resources/principals/aftersuicide.aspx>
- *After a Suicide: A toolkit for Schools*
 - (Harpel, West, Jaffe & Amundson, 2011)
 - *Published by the Suicide Prevention Resource Center and American Foundation for Suicide Prevention*
 - <http://www.sprc.org/afterasuicideforschools.asp>
- National Child Traumatic Stress Network
 - Trauma Toolkit for Educators
 - <http://www.nctsn.org/resources/audiences/school-personnel/trauma-toolkit>



Crisis Hotline Numbers

Suicide Prevention Lifeline Number:

- 1-800-273-TALK (8255)

National Domestic Violence Hotline:

- 1-800-799-SAFE (7233) or TTY 1-800-787-3224

National Child Abuse Hotline:

- 1-800-4-A-CHILD

Sexual Assault Hotline:

- 1-800-262-9800

Thank You!

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ADDITIONAL REFERENCES

American Foundation for Suicide Prevention. (2011). from http://www.opi.mt.gov/pdf/YRBS/09/Reports/09MT_YRBSFullRpt.pdf

Anda, R. F., Whitfield, C. L., Felitti, V. J., Chapman, D., Edwards, V. J., Dube, S. R., & Williamson, D. F. (2002). Adverse, childhood experiences, alcoholic parents, an later risk of alcoholism and depression. *Psychiatric Services*, 53(8), 1001-1009.

Braveheart, Y. (2003). The historical trauma response among natives and its relationship with substance abuse: a Lakota illustration. *Journal of psychedelic drugs*, 35(1), 7-13.

Fleischmann, A., Bertolote, J. M., Wasserman, D., De Leo, D., Bolhari, J., Botega, N. J., . . . Thanh, H. T. T. (2008). Effectiveness of brief intervention and contact for suicide attempters: a randomized controlled trial in five countries. *Bulletin of the World Health Organization*, 86(9), 703-709. doi: 10.2471/blt.07.046995

Hunt, K. A., Weber, E. J., Showstack, J. A., Colby, D. C., & Callaham, M. L. (2006). Characteristics of frequent users of emergency departments. *Annals of Emergency Medicine*, 48(1), 1-8. doi: 10.1016/j.annemergmed.2005.12.030

Morsette, A., Swaney, G., Stolle, D., Schuldberg, D., van den Pol, R., & Young, M. (2009). Cognitive Behavioral Intervention for Trauma in Schools (CBITS): School-based treatment on a rural American Indian reservation. *Journal of Behavior Therapy and Experimental Psychiatry*, 40, 169-178.

ADDITIONAL REFERENCES CONTINUED

Service, U. S. P. H. (2010). final Deployment Summary Report: Fort Peck Emergency Response.

Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W. L., Elliott, M. N., & Fink, A. (2003). A mental health intervention for schoolchildren exposed to violence - A randomized controlled trial. *Jama-Journal of the American Medical Association*, 290(5), 603-611.

Taylor, M., & Zimmerman, M. B. (in press). Lessons Learned: Promoting life, wellness and resiliency in response to cluster suicides in Indian Country. (Readiness and Emergency Management for Schools Technical Assistance Center): Department of Education.
U.S. Department of Health and Human Services. (2010). To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults. DHHS Publication SMA (10)-4480,CMHS-NSPL-0196.

Whitbeck, L. B., Adams, G. W., Hoyt, D. R., & Chen, X. J. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology*, 33(3-4), 119-130.

Wyman, P. A., Brown, C. H., LoMurray, M., Schmeelk-Cone, K., Petrova, M., Walsh, E., . . . Yu, Q. (2010). An Outcome Evaluation of the Sources of Strength Suicide Prevention Program Delivered by Adolescent Peer Leaders in High Schools. *American Journal of Public Health*, 100(9), 1653-1661. doi: 10.2105/ajph.2009.190025