Adolescent Suicide Prevention

Program Manual: A Public Health Model

For Native American Communities

Patricia Serna, LISW

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CONTACT INFORMATION

For more information about this manual and the Adolescent Suicide Prevention Program, please contact Patricia Serna at:

P.O. Box 617, Chama, NM 87520 575-756-2327 pserna@nccbs.org

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Denise Middlebrook, Ph.D., Native Aspirations

Ellyson Stout, Suicide Prevention Resource Center

Sidonie DeBruyn, Copy-Editor

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I. OVERVIEW

This manual describes the Adolescent Suicide Prevention Program, why the Program was developed, how it was created, and how it was maintained for sixteen (16) years, from 1989 to 2005.

Based on the principles of community involvement, ownership, culturally framed, and public health approaches, the Adolescent Suicide Prevention Program emphasized **community, school, outreach, surveillance, innovative behavioral health programs, ongoing Program evaluation, and sustainability**.

These principles guided the following Program components:

1. involving community members in identifying issues that needed to be addressed;
2. keeping and analyzing local records regarding suicidal activity;
3. offering a consistent array of behavioral health services with identifiable staff;
4. working closely with the local school through a Natural Helpers Program;
5. providing innovative clinical and community outreach;
6. creating the capacity to attract and find funding by making the Adolescent Suicide Prevention Program part of a system of care that addressed family violence, substance abuse, and other behavioral health issues; and
7. evaluating the entire Program and its components on a regular basis to determine Program efficacy.

The sections of the manual describe these components. That the Program received funding from different sources over time reflects the reality of community efforts in most fields, as rarely do Programs last without multiple funding sources. Limitations of applications of the Program may be apparent in

larger communities or reservations that have multiple remote community sites. However, the Adolescent Suicide Prevention Program has basic components that can be adapted to multiple sites. This manual describes the basic approach and systems model with the hope that other communities find them useful and adaptable for their respective cultures and geographies.

II. PROGRAM HISTORY

The Adolescent Suicide Prevention Program began in 1989 and continued for sixteen (16) years through 2005. In 1988 the suicide attempt rate in a rural isolated Tribal community in the southwest was fifteen (15) times the national average and five (5) times the rate of other Native Americans in the State. A study by Gonzales and Biernoff (1991) estimated that ten percent (10%) of adolescents between the ages of 15-19 on this reservation had made suicide attempts between January 1988 and May 1989. This study substantiated concerns among the community and Tribal leadership about the high rates of suicide attempts and completions among adolescents and young adults.

It is important to note that American Indian communities in western states typically have higher suicide rates than the general population and other Native American communities. Western states' rates are higher than those for the rest of the United States, except California. Homicide or suicide was the second or third leading cause of death among American Indian communities for individuals between the ages of 15-24 during the time period when the Adolescent Suicide Prevention Program was initiated. Suicide rates for American Indians and Alaska Natives is about 1.5 times higher than U.S. national rates (Centers for Disease Control and Prevention 2007).

To address the high rates of suicidal activity in the community, Tribal Council members approached the Indian Health Service (IHS) for assistance. In 1989 the IHS Special Initiatives Team (DeBruyn, Hymbaugh, and Valdez 1988; DeBruyn, Hymbaugh, Simpson, Wilkins, and Nelson 1994) redirected $75,000 to award the Tribe for the initial Program. In late 1989 the Tribe hired a Program Director and a part-time Psychologist to develop and implement the Adolescent Suicide Prevention Program. Also in 1989, the IHS Special Initiatives Team Leader and the Tribal Health Board Director wrote and submitted a proposal to the Indian Health Service Office of Policy Analysis and Evaluation (OPEL) to fund the Adolescent Suicide Prevention Program. The Tribe's Program Director

subsequently submitted a competitive proposal for $125,000 to OPEL each year. OPEL funded the Program for five (5) years from 1990 through 1994. At this time the Program was the only organized and funded suicide intervention and prevention program in the State.

During the Adolescent Suicide Prevention Program's sixteen (16) years of operation, there were three contributing factors that appeared to be highly related to completed suicides for this population. The first factor was a history of suicide in the family. During this time period, almost seventy percent (70%) of the individuals who committed suicide had a family member who had completed suicide. The second factor was the involvement of alcohol in almost eighty-three percent (83%) of all suicidal acts. The third factor was a history of trauma -- over ninety-five percent (95%) of the individuals who completed suicide had experienced some form of trauma.

The goals of the Program were to:

1. reduce the incidence of adolescent suicides and suicide attempts and
2. increase community education and awareness.

The objectives of the Program were to:

1. identify suicide risk factors specific to the Tribe which might be generalized to other Native American communities;
2. identify high risk individuals and families;
3. identify and implement prevention activities to target high risk individuals, families, and groups;
4. provide direct mental health services to high risk individuals, families, and groups; and
5. implement a community systems approach to increase community education and awareness.

To address the suicide problem, the Program used a public health community systems model that integrated all attributes of behavioral health. From the onset the Program addressed issues of child abuse and neglect, family violence, trauma histories, and alcohol and substance abuse. Every level of prevention – Universal, Selected, and Indicated – was included in all activities.

The Program chose a community systems model to form the foundation of the prevention and education component of the Program. This model includes all aspects of the community -- Tribal leadership, all health care providers, parents, elders, youth, and clients -- in identifying and implementing solutions that are culturally specific and appropriate for the Tribe. This prevention component was implemented in tandem with an intervention component designed to provide treatment services to individuals who have attempted suicide: "The community systems model includes the education and active involvement of all members of the community: hence, the entire community should be affected positively by the Program" (May and Del Vecchio, 1994, Final Year of Program Performance, prepared for the Division of Program Evaluation and Policy Analysis Research and Evaluation Programs).

Universal, Selective, and Indicated Prevention Strategies were implemented in the domains of community, family, school, and individual. The goal of the Adolescent Suicide Prevention Program was to provide services that would promote and sustain a healthy community, thereby breaking the cycle of self-violence.

The Tribal leadership made a commitment to the Adolescent Suicide Prevention Program and the efforts to address suicide and related issues on the reservation. This support was evidenced by the support for requests for additional funding to continue the efforts of the Program and to enhance services through the development of a department within the Tribal system, the construction of a new building to house the department to replace old unsafe trailers, and

assigning two houses to provide living space for non-Tribal members employed by the Program.

In designing the prevention strategy, Program coordinators stressed the importance of community involvement and ownership. Using community mobilization techniques to obtain input from community members, schools, Tribal employees and adolescents, information was gathered regarding relevant problems, potential solutions, and possible limitations to implementation of the Program (see section **III. PLANNING** for a description of the community mobilization program conducted by Rutgers University).

During the discussions to identify problems, community members cited various issues, such as family violence, as important contributors to suicide. Program staff initiated programs to address the identified issues. As a result of various interventions, suicide rates in the community dropped significantly over the Program's sixteen (16) years of operation, and the services that were implemented addressed a multitude of familial and community issues. By pooling funds, a broad array of multidisciplinary services was created that integrated suicide prevention and intervention with services for substance abuse, family violence, mental health, and social services. Program staff evaluated the Program's efficacy and assessed community needs on an ongoing basis.

From 1990 to 2005 the Program Director wrote successful proposals for competitive grants seeking other sources of funding (federal, State, and private) to build a comprehensive, culturally responsive, and relevant system of care, as resources would allow. What began as a time-limited project soon became a Program; and by 2002 the Program had become a department within the Tribal system with an annual budget of over one million dollars ($1 million).

In 1995 the Tribe entered into an Indian Self-Determination Agreement with the Indian Health Service. The Tribe combined the services of the Adolescent Suicide

Prevention Program with the IHS mental health and social services programs to form a new department. This new department provided comprehensive community-based services that were client- and family-centered as well as culturally relevant to Tribal members and residents of the reservation.

III. PLANNING

A. ASSESSMENT

The Program operated on the premise that suicide and suicide attempts are symptoms. The Program utilized a community and family systems approach in order to treat those symptoms. There were multiple risk factors -- economic, legal, social, familial, and individual -- affecting the high incidence of suicidal behaviors in this community. A community and family systems approach enabled the Program to address the risk factors at all levels.

Like many other Native American Tribes, the Tribe exists in dichotomized worlds – Tribes are caught straddling two juxtaposed realities. Inherent in the processes of transition and acculturation are significant stressors which impact all facets of community and family life.

The most critical element in the success of the Adolescent Suicide Prevention Program was the ongoing direction and support the Tribal leadership provided the Program. It was through their leadership that IHS provided technical assistance to the community for the Program. In addition, Rutgers University provided technical assistance on **community mobilization** -- an effort to address alcohol and substance abuse in the community. Because alcohol and drug abuse were associated with most of the suicide gestures, attempts, and completions, prevention of substance abuse was a goal both programs shared.

During 1990, the first year the Adolescent Suicide Prevention Program was in operation, The Rutgers community mobilization effort -- *Decade of Hope* -- was initiated. Program staff actively participated in the *Decade of Hope* program activities. In collaboration with this community mobilization project, the Program conducted over fifty (50) community focus groups, which included groups of students, Tribal employees, community members, IHS staff, and Bureau of Indian Affairs (BIA) staff. The focus groups were asked the following four questions:

1. What are the problems and issues in the community?
2. What are the barriers to resolving these problems or issues?
3. What strengths does the community have?
4. What can be done to address the problems and issues and overcome the barriers?

IHS staff and a contractor from Rutgers University trained community members and Program Staff to facilitate and record the focus group sessions. Each focus group gave feedback and comments, which were collected and compiled into one document. This document was distributed to Tribal leadership and all participants of the focus groups. This community assessment formed the foundation for the Adolescent Suicide Prevention Program components and also for **environmental strategies**. Environmental strategies included the development of a Family Violence Code, which has since served as a model for other Native communities, and amendment of the Tribe's Juvenile Code. The revised Juvenile Code provided a mechanism for the Tribal Courts to obtain clinical assessments for youth and families prior to sentencing or placement of children in residential or foster care.

Through the process of conducting community focus groups, Program staff noted that suicide was not one of the top ten issues the community had identified. When the group facilitators shared this observation, community members said that everything they had listed could lead to suicide. What needed to be addressed were the issues underlying suicide -- alcoholism, family violence, child abuse and neglect, depression, and unemployment.

The Program used the information gathered during the community mobilization process to develop and expand its services from 1990 to 2005, based on staffing and availability of funding. These services included prevention, direct clinical services, inpatient services, follow-up, and environmental strategies.

The continual process of assessing community needs and planning to address them, implementing programs to address the identified needs, and evaluating the process and outcomes is crucial to implementing and sustaining an effective program.

B. PLANNING

Information garnered from the community focus groups provided the initial data to begin planning for the Adolescent Suicide Prevention Program. Program staff met regularly with the Tribal leadership to plan for the implementation of the Program.

The community mobilization effort provided Program staff an opportunity to work collaboratively with all segments of the community. The focus groups provided the initial community assessment data. The meetings held after the focus groups provided an opportunity to identify community capacity, training needs, and Program planning and direction.

C. CAPACITY AND STAFFING

Prior to the implementation of the Adolescent Suicide Prevention Program, a part-time Psychologist, a part-time contract Counselor, and a local mental health technician (a Tribal member) provided outpatient counseling at the IHS clinic. The BIA provided social services, and a Tribal program provided substance abuse treatment. There was some informal interaction among programs but no formalized coordination or collaboration.

Program staff initiated and chaired the **Community Resource Action Group (CRAG)**. CRAG was comprised of a core group of Tribal administration, service providers, and community members who met monthly for breakfast to share information, review community needs, and plan for programs. CRAG was the primary mechanism for coordination of services in the community. CRAG members addressed issues of alcohol and substance abuse, family violence, and

child abuse and neglect, all of which are risk factors for suicidal behavior in this Tribal community.

Community capacity development was necessary for the implementation of the Program. Program Staff provided training and education to all segments of the community. Program staff also developed a training schedule and published a monthly newsletter -- *The Eagle Soars* -- which included a community calendar of prevention and training activities, short articles on prevention and positive mental health, and other items of community interest related to the Program's goals. *The Eagle Soars* was distributed throughout the community. Program staff coordinated community activities with State and federal agencies' training events and educational materials.

Program staff actively participated on the Tribal Health Board, in community traditional events, and in developing and hosting community events. Staff also participated on community committees -- such as the Family Violence Code Committee and the Children's Code Committee -- and developed policies and procedures for the Program and ultimately the Tribe's Behavioral Health Department.

The Program operated on the premise that the local community must be empowered to identify local problems and to participate actively in devising and implementing local solutions. Program staff believed that the best way to achieve this objective was to train local community members to provide services, whenever possible. This philosophy and practice required a capacity-building approach as well as a transfer of relevant technologies. To achieve this, the Program hired local community members and gave them extensive training in how to provide services.

Program staff provided training on the following topics and issues:

1. Signs and symptoms of suicidal behavior;
2. How to conduct a suicide assessment;

3. Completion of **PATIENT DATA REPORTING FORM** (see **APPENDIX D**) and **SUICIDE REPORTING FORM** (see **APPENDIX E**);
4. Substance abuse;
5. Anger and stress management;
6. Child abuse;
7. Parenting skills;
8. Communication skills;
9. Family violence;
10. Community, State, and regional resources;
11. *Natural Helpers*; and
12. Traditional role of family.

D. BUILDING PARTNERSHIPS

Program staff established partnerships among the Program and Tribal agencies, the schools, IHS, BIA, and State agencies. The Tribal leadership introduced Program staff to the community agencies and gave them access to individuals in leadership positions. This interaction provided an excellent opportunity to develop personal relationships. A Tribal Council Member was instrumental in supporting suicide intervention and prevention efforts. He made public service announcements encouraging community members to seek help and also supported efforts to develop intervention and prevention strategies. Program staff sat on numerous community boards, committees, and task forces and kept these groups informed on the suicide prevention efforts. Program staff kept Program activities and efforts transparent to the community through the community education, public service announcements, participation in community events, and training they provided.

Through their personal relationships, Program staff and community members formed the foundation for developing trust between them. Program staff incorporated cultural values and traditions with modern approaches; they provided services in a professional and confidential manner. Because of the trust built over time with Program staff, community members and agency staff often informed Program staff of individuals who were expressing **suicidal ideation**. Program staff were then able to intervene prior to a suicidal act.

A protocol was established to address referrals from the community. Program staff made contact with each individual and family, if appropriate, and saw individuals in the Program office, in jail, at their homes, or in the arroyos.

E. PLANNING FOR EVALUATION

From the Program's inception, staff established the need for evaluation of the Adolescent Suicide Prevention Program. Funding is often contingent upon evaluation in order to determine Program effectiveness, to make informed decisions about Program modifications, and for sustainability. While Program staff, Tribal leaders, and community members were involved in the evaluation, it was critical that an outside independent evaluation also be conducted. The first grant application submitted to OPEL in 1990 included a component for evaluation by an outside evaluator -- the University of New Mexico Center on Alcoholism, Substance Abuse, and Addictions.

This evaluation component initially focused on collecting data on suicide gestures, attempts, and completions for youth between the ages of 15-19. However, Program staff quickly realized the need to collect data on the entire population, and therefore expanded the database to include all Tribal members, family members, and community members. Family and community members may be enrolled in the Tribe, may be members of another Tribal group, or may not be Native American. Tribal support for Program evaluation facilitated the implementation of data collection.

A system for gathering data -- the **SUICIDE REPORTING FORM –** was developed and utilized by all Program staff. The data were entered into a secured computer database to be reviewed and analyzed. The Program implemented a **process evaluation** to document and to describe the processes and methods used to implement the Program. There was ongoing Program evaluation, which staff used to review the objectives of the Program every year. Based on the evaluation results, Program staff then adapted the Program to meet changing community needs.

The National Indian Health Service Institutional Review Board had conducted an institutional review of all research protocols proposed by the Program. Then the Board had approved the research protocols to be used by the Program. In addition, the Tribal Council had approved the collection and dissemination of the data. In order to facilitate the collection of data, Program staff developed the **ADOLESCENT SUICIDE PREVENTION PROGRAM CONSENT FORM** (see **APPENDIX C**).

IV. IMPLEMENTATION

A. CLINICAL INTERVENTION

Program staff provided direct mental health services to families, to individuals, and to groups considered to be high risk, and also as follow-up on suicide attempts. Clients generally participated on a voluntary basis. The Program also received referrals from families, schools, or other community members. Some clients were court-ordered for treatment or psychological evaluation.

After Program staff had seen individuals, they completed both a **PATIENT DATA REPORTING FORM** (see **APPENDIX D**) and a **SUICIDE REPORTING FORM** (see **APPENDIX E**) for each client. These forms are described in more detail in section **A. SURVEILLANCE** under **V. MONITORING**).

Program staff in 1990 included a licensed Psychologist, a Master's level licensed social worker who was also the Program Director, a counselor aide, and a secretary. Through multiple funding sources in 2005, including **P.L. 638 Contracts [1]** with IHS and BIA, the Program had a staff of fifty (50), including: a contract Psychiatrist, a full-time Psychologist, social workers providing social services, social workers and Master's level counselors providing mental health counseling, family violence victim advocates, two prevention specialists, and staff of an inpatient social model detoxification Program.

Clinical outreach was a critical component in the success of the Program. Clients were not always seen in the Program office because, as in many small communities, confidentiality was an issue in this community. Many community members, particularly Tribal leaders, were concerned about being seen in the Program office. It was also clear from the beginning that clients would not always come to the office and were not always prepared for western model fifty minute counseling sessions. To meet their needs for confidentiality and comfort, clients were often seen in nontraditional counseling settings: in their offices, at school, or at home. The Program staff coined two terms -- **"Arroyo Outreach"**

and **"Cruise Therapy"** -- to describe two forms of nontraditional treatment. **"Arroyo Outreach"** was created to reach individuals who are in need of intervention exactly where they are physically located at the time. Arroyos are dry riverbeds where many individuals who are experiencing alcohol abuse problems spend their days. Program staff went to the arroyos and talked with clients, offered services, provided transportation, and conducted clinical assessments.

"Cruise Therapy" was initiated particularly for adolescents as a way to provide them with confidentiality in a setting where they felt comfortable. Program staff drove around the reservation with the client while discussing issues. Program staff often transported groups of youth to *Natural Helpers* meetings, to community and/or State presentations, and to community functions. During this time, **"Cruise Therapy"** became group counseling sessions where the youth could discuss their personal issues as well as issues in the community.

Program staff also provided transportation for individuals, families, and groups to attend educational sessions. These educational sessions were also opportunities for Program staff and other community members to network and establish support systems.

Program staff provided **24/7 crisis intervention – twenty-four hours a day/seven days a week**. Program staff trained detention staff and law enforcement personnel on suicide risk assessment, as most often they were the ones who called on Program staff for after-hours crisis intervention. During the growth of the Program's human resources, there were enough staff to provide 24/7 coverage, which demonstrated the staff's deep commitment to the Program. An on-call schedule was developed and implemented to rotate staff so that staff could be available after regular working hours. Because the Adolescent Suicide Prevention Program experienced minimal staff turnover, the trust between the Program and the community was enhanced. Constant vigilance and

commitment by Tribal leaders, Program staff, and the community is necessary to reduce the incidence of suicidal behavior.

Each suicidal act was reviewed by Program staff in order to implement the best response for the suicidal individual and his/her family. During the case staffing, clinical staff determined how to classify each nonfatal suicidal act through peer consultation. In-depth discussions often ensued to make sure the suicidal act was noted appropriately based on the criteria established by the Program.

Through collaboration with the IHS clinic, Emergency Medical Services, and the Police Department, Program staff were informed of all deaths. Every death was reviewed in a multidisciplinary case staffing to determine if it was a suicide, or alcohol-related, and to provide **postvention** services to the families and community. Members of the multidisciplinary review team, who were assigned by the Tribal leadership, signed confidentiality statements prior to each case staffing.

B. FAMILY VIOLENCE PREVENTION

Family violence was identified as an issue during the community mobilization efforts. In order to address this issue, the Tribal leadership directed Program staff to develop a committee comprised of community members to develop a Family Violence Code. The Tribal Chief of Police chaired a committee which was formed to research approaches and write a Family Violence Code for the Tribe.

This effort led to the development and funding of a family violence component within the Program. The objectives of this component were to:

1. provide victim advocacy services to victims of family violence;
2. provide a consistent and strong Program to prosecute, educate, and rehabilitate perpetrators of family violence;
3. develop a cooperative and unified response to incidents of family violence and sexual assault;

4. utilize the Tribal Prosecutor to provide training for the Tribal Court and Tribal Police Department as well as to provide consistent case prosecution and Code development; and
5. educate and inform the community about family violence, partner abuse, and sexual assault, and provide community education on the resources available for victims.

The Family Violence Program Coordinator formed a Family Violence Planning Team to develop an action plan to address the identified objectives. The Planning Team was comprised of a core group representing the Program, the Tribal Police, the Tribal Court, Emergency Medical Services, the Tribal Prosecutor's Office, Community Health Representatives, IHS, BIA Law Enforcement, and the school Nurse.

Family violence prevention services included:

1. victim advocacy;
2. transportation to shelters;
3. transportation to court or to other service providers;
4. court monitoring, which included tracking the disposition of all domestic violence cases and making recommendations to the court for sentencing;
5. follow-up on all reports of family violence;
6. conducting a women's support group;
7. conducting a male perpetrators education group based on the **Duluth Model [2]**;
8. conducting a female perpetrators education group;
9. providing community education and training to the community; and
10. counseling.

A reporting system was implemented which facilitated the gathering and analysis of family violence data, including information on arraignments and case disposition. Family violence staff were also responsible for completing the **SUICIDE REPORTING FORM** and the **PATIENT DATA REPORTING FORM**.

C. SCHOOL-BASED PREVENTION PROGRAMS

Several Universal, Selected, and Indicated prevention efforts were implemented in the local school, which is operated by the State. One of the most successful school-based programs was the ***Natural Helpers*** **[3]** program that was implemented in the high school. Being in the schools was absolutely critical in order to have direct access to the targeted age group. *Natural Helpers* was a model that could be easily adapted to the cultural context of the community. In 1991 the developers of the *Natural Helpers* program provided the training of trainers to the Program Director and staff Psychologist.

Natural Helpers is a peer-helping and leadership development program based on the premise that within every school an informal "helping network" exists among peers. Students with problems seek out other students whom they trust. The *Natural Helpers* program uses this naturally existing helping network. It provides training to students and adults who are already perceived as "natural" helpers to break down codes of silence and increase appropriate referrals to professional helping resources. The program gives them the skills they need to provide help more effectively, increase their coping skills, and change attitudes and norms related to substance abuse, suicide, teen pregnancy, and youth violence." **[4]**

The *Natural Helper* students also participated in community service activities as part of the program. The original guidelines for the *Natural Helpers* program were adapted in order to meet the needs of the Tribal community. The *Natural Helpers* participated in Red Ribbon week at the school, provided education on suicide prevention, prevention of alcohol and drug abuse, and self-esteem issues. They also assisted elders at cultural events and in their homes, planned

and hosted a statewide conference for youth on substance abuse prevention, developed brochures, posters, Public Service Announcements (PSAs), and became active leaders in their school and community.

Two other school-based initiatives were used less extensively. The first initiative was the ***Teens, Crime and Community*** **[5]** curricula, which Program staff taught at the school and during the summer to the Tribal Youth Employment Program participants. The second initiative was the elementary school staff's implementation of the ***Zuni Life Skills*** **[6]** curriculum in the elementary school for a few years.

D. COMMUNITY EDUCATION/AWARENESS/TRAINING

The Program provided a comprehensive approach to addressing community problems through community education. Education was provided to Tribal Leaders, Tribal Programs, the schools, IHS staff, BIA staff, and community members on the issues of suicide signs and risk factors, crisis intervention, the **SUICIDE REPORTING FORM**, family violence, child abuse and neglect, teen pregnancy and sexuality, substance abuse, and parent education.

The Program psychologist, Program Director, and paraprofessional staff received training on ***Question Persuade Refer*** **(QPR) [7]** and became certified as QPR trainers. QPR is a method for providing education and training to the general public on suicidal signs and symptoms as a means to identify and refer people to professional helping resources. QPR training was provided to staff of Tribal programs and community members

Over the course of the Program, community awareness activities were coordinated, developed, and implemented in collaboration with other community programs through the monthly meetings of the **Community Resource Action Group (CRAG)**. In order to facilitate training and education in the community and to heighten the efficient use of resources and delivery of services, Program staff collaborated with the community mobilization effort,

Community Health Representatives, the schools, the Tribal Department of Education, the Indian Health Service (IHS), and the Bureau of Indian Affairs (BIA) to develop a comprehensive annual schedule of community events and training programs.

E. SOCIAL SERVICES

In 1997 the Tribe entered into a P.L. 638 contract with the Bureau of Indian Affairs (BIA) to provide social services. Social services were incorporated into the newly-formed Tribal Mental Health and Social Services Department (previously the Adolescent Suicide Prevention Program) that eventually became the Tribal Behavioral Health Department.

Social Services included:

1. investigations of child abuse and neglect;
2. placement of children in foster homes, group homes, or residential facilities;
3. licensing and monitoring of foster homes;
4. family preservation to reduce the risk of children being removed from their homes;
5. adult protective services; and
6. financial assistance.

Integrating social services into the Tribal Mental Health and Social Services Department provided community members “one-stop” services. A person could provide his/her history once and receive an assessment to determine services that could be provided, which ranged from financial assistance to mental health counseling.

V. MONITORING

A. SURVEILLANCE

From 1980 to 1989, archival data were collected on individuals who had gestured, attempted, or completed suicide. Data prior to 1985 were incomplete.

The data collected were used to create an **aggregate risk profile** in order to identify youth who may be at risk for suicidal behavior and to establish a data baseline. Data were gathered from the IHS Health Clinic, IHS Hospital records, and records of a nearby public hospital through an agreement between the hospital and the Tribe. Tribal data from Emergency Medical Services (EMS) records and jail records were available to Program staff through the Tribal leaders' authorization. The Program Director and Clinical Psychologist were credentialed at the non-Tribal facilities.

The **SUICIDE REPORTING FORM**, adapted from one developed by the National IHS Mental Health Social Services Programs Branch Special Initiatives Team, was maintained to collect data and to identify high risk youth and families. The **PATIENT DATA REPORTING FORM**, modeled after the **SUICIDE REPORTING FORM**, was developed to gather similar data on all patients/clients seen by Program staff. Because the **SUICIDE REPORTING FORM** and the **PATIENT DATA REPORTING FORM** were parts of the patient's file, the information was protected. Before Program staff collected data at the Program site, they explained a patient's rights and privileges, including the right to patient record privacy and confidentiality. Program staff provided each client or his/her parent/guardian with the **ADOLESCENT SUICIDE PREVENTION PROGRAM CONSENT FORM** (see **APPENDIX C**), which the patient or his/her parent/guardian signed and dated to give permission for the patient to participate in the Program. The Indian Health Service National Institutional Review Board carried out and approved the institutional review.

Program staff recorded all suicidal acts -- including completions, attempts, gestures, threats, and ideations. Incidents of family violence, alcohol and substance abuse, child abuse and neglect, significant family history, and trauma history were also documented. Program staff provided training to the IHS clinic staff, Emergency Medical Services staff, and Police Department on how to use

the **SUICIDE REPORTING FORM**. The Tribal leadership had authorized these agencies to report data to the Program.

Suicidal behaviors include suicide completions, suicide attempts, suicide gestures, and suicidal ideations. The Program defined these behaviors as:

1. **suicide attempt** -- a life-threatening effort to kill oneself by self-inflicted means which would have led to death if no intervention had occurred.
2. **suicide gesture** -- a self-destructive act that is not life-threatening.
3. **suicidal ideation** -- verbalization of thoughts or threats of suicidal behavior without an actual act.

B. RECORD-KEEPING AND DATA ANALYSIS

All patient records were locked in secure file cabinets at the Program site. The Program Psychologist developed a computer database protected with appropriate password security. Prior to construction of a suicide risk profile using the data, all qualitative information -- such as name, date of birth, and address -- were removed from the research database. Identifying numbers, such as birthdates and chart numbers, were also removed. No variables were included which could be used to identify a specific individual. Program staff constructed a profile of youth suicidal behavior using the anonymous data format.

Program staff collected the data, which they entered into the data system. The Program Director and Program Psychologist conducted a preliminary analysis of the data. Program evaluators conducted a complete analysis of the data and reported the findings in their final evaluation report in 1994 (May and Del Vecchio, 1994, Final Year of Program Performance, prepared for the Division of Program Evaluation and Policy Analysis Research and Evaluation Programs).

The Program Director and Program Psychologist completed annual reports, which included a description of Program activities as well as data on frequencies

of suicide attempts, gestures, and completions by age, gender, alcohol/substance abuse related, history of trauma, significant family history, method, and previous attempt history. Each annual report was provided to the Tribal leadership, funding agencies, and Program staff. These reports were used to guide Program planning, assessment, and future funding (see examples in **APPENDIX A: SUICIDAL BEHAVIOR BY HISTORY OF FAMILY TRAUMA 1988 – 2005** and **APPENDIX B: SUICIDAL BEHAVIOR 1988 - 2005**).

VI. EVALUATION

Program evaluation was critical to Program development. Three formal evaluations were conducted during the course of the Program's history:

1. **National Model Adolescent Suicide Prevention Program, Final Year of Program Performance, 1994** (Philip A. May, Ph.D., Principal Investigator, and Ann Del Vecchio, Ph.D., Prepared for the Division of Program Evaluation and Policy Analysis, Research and Evaluation Programs, Indian Health Service, 1994);

2. **Suicide Intervention and Prevention, Evaluation of Community-Based Programs in Three American Indian Communities,** Final Report (Lemyra M. DeBruyn, Ph.D., Philip A. May, Ph.D., and Marilyn O'Brien, MPH, Atlanta: Centers for Disease Control and Prevention, U.S. Dept. of Health and Human Services, 1997); and

3. **Evaluation of the National Model Adolescent Suicide Prevention Program—A Comparison of Suicide Rates Among New Mexico American Indian Tribes, 1980-1998,** Report to the Tribe and IHS (Nancy Van Winkle, Ph.D., Mary Williams, M.S., Oklahoma State University, College of Osteopathic Medicine, 2001).

A review of the Program was also reported in "Suicide Prevention Evaluation in a Western Athabaskan American Indian Tribe – New Mexico, 1988-1997." Morbidity and Mortality Weekly Report (MMWR), Centers for Disease Control and Prevention, U.S. Dept. of Health and Human Services, April 10, 1998, Vol. 47/No.13. p. 257.

The Final Year of Program Performance for IHS OPEL funding in 1994 included three major components: stakeholder interviews, process evaluation, and outcome evaluation. The process evaluation included:

1. a detailed history of the Program,
2. descriptions of key players and their positions within the community, and
3. a review of all activities.

The **process evaluation** was conducted primarily through interviews and questionnaires and secondarily through the review of files, sign-in sheets, meeting minutes, and evaluation questionnaires.

The **outcome evaluation** was designed to measure how well the Program was able to address its goals and objectives.

Risk factors were identified through the **SUICIDE REPORTING FORM** and the **PATIENT DATA REPORTING FORM**. The **PATIENT DATA REPORTING FORM** was also used to collect family and mental health history for each client.

The Program database was used to determine an unduplicated count for suicidal behavior as well as the number of individuals with multiple acts.

Evaluation findings were consistently reviewed and used for continued Program development, intervention efforts, and prevention planning. Program changes that were made based on evaluation data include:

1. continuing to add to services offered,
2. hiring of additional qualified staff,
3. ongoing training of local staff,
4. continuing to grow the Program, and
5. development of a Behavioral Health Department.

VII. SUSTAINABILITY

The Program offered a consistent array of culturally relevant behavioral health services provided by professional identifiable staff. Program staff developed long-term, positive, collaborative relationships within the community.

The Adolescent Suicide Prevention Program became part of a system of care that addressed family violence, substance abuse, and other behavioral health issues. By becoming an integral part of the larger system of care, funding for continuation of Program strategies was incorporated into the Tribal budget.

Sustainability was facilitated by:

1. Tribal leadership support
2. community participation and buy-in
3. strong behavioral health program
    a. recognized, trusted, committed staff
    b. integrated services, suicide a component
4. ongoing evaluation to:
    a. demonstrate Program success
    b. find areas for Program improvement and Program gaps
    c. attract funding to address Program gaps and needs
5. strong grant-writing capacity that integrates evaluation findings

VIII. SUMMARY

The Adolescent Suicide Prevention Program was developed to address the high rate of suicidal behavior among adolescents in a small southwest Tribal community. A community systems model was implemented to form the foundation of the prevention and education components of the Program.

From 1989 -- the year prior to the beginning of the Adolescent Suicide Prevention Program -- to 2005, there was a seventy percent (70%) decrease in suicidal behavior.

Program staff conducted a community assessment utilizing the community mobilization model. This process involved all stakeholders: Tribal leaders, community agencies, community members, and youth. The information gathered from the community assessment formed the foundation for the Program components.

Capacity for community and staff was developed through in-service training, community education and training, and educational opportunities. Building capacity prepared the community and staff for the implementation of the Program.

Planning was an ongoing process conducted through the Community Resource Action Group (CRAG), staff meetings, and work with the independent evaluators.

Prevention, clinical services, follow-up, and postvention were provided throughout the course of the Program. Prevention services included:

1. community education and awareness activities;
2. *Natural Helpers*;
3. other curricula, such as the *Zuni Life Skills* and *Teens, Crime and the Community*;
4. development of the Family Violence Code;

5. revision of the Juvenile Code; and

6. development of Program policy and procedures.

Clinical services included:

1. individual, family, couple, and group counseling;

2. crisis intervention;

3. “Arroyo Outreach”; and

4. “Cruise Therapy.”

Follow-up services were provided to all individuals who were identified for being at risk of suicidal behavior, to those who made a suicide attempt, and to families following a family member’s completed suicide. Postvention services occurred in the schools, the community, and for first responders.

Consistent evaluation efforts were a critical component of the Program. The numerous evaluations conducted over time informed the process for the Program. Staff regularly used evaluation results to make ongoing Program modifications. The Tribal leadership’s support and guidance were instrumental in the Program’s success and the subsequent development of the Behavioral Health Department.

IX: CONCLUSION

The underlying and constant lesson involved in suicide prevention in a community is the constant vigilance that must be maintained to address suicidal behaviors and all their components. As leadership changes and the rates of suicidal behavior decrease due to Program success and the fluctuation of suicidal behaviors, it is tempting to reduce the specific focus on suicide. Suicide is one of the most difficult human behaviors to understand and embrace. Philosophically, the human capacity for suicide challenges us to face the reality that only human beings are capable of choosing to take our own lives. At best suicide is a stigma most communities would rather avoid. When suicidal behavior lessens, many communities have turned to other issues.

The power and effectiveness of the Adolescent Suicide Prevention Program is that suicide was addressed as part of a system of care and response to overall behavioral health issues. The focus on suicide need never be short changed when it is addressed as part of a system of care. For those communities who have experienced suicidal behaviors cyclically over time or for the first time, it is hoped that this manual will be useful in helping to create programs that can prevent suicide as well as the risk factors that lead to suicidal behaviors. Our children, families, and communities deserve the best programming we can provide to prevent the tragedy, trauma, and grief of suicide among those we cherish the most.

X. FOOTNOTES

1. A **P.L. 638 Contract** is a mechanism for Tribes to contract with a federal agency to assume the management and implementation of services that are often provided to Tribes by the federal agencies. An example of services provided by federal agencies that are assumed by Tribes through the P.L. 638 Contract mechanism are: medical services provided by the Indian Health Service (IHS), law enforcement provided by the Bureau of Indian Affairs (BIA), social services provided by the BIA, and community health services provided by IHS.

2. **The Duluth Model of Batterer Intervention** is based on **cognitive-behavioral counseling**, reinforcement from the criminal justice system, and coordination of community services.

3. **Natural Helpers***,* Roberts, Fitzmahan & Associates, Comprehensive Health Education Foundation (CHEF), 1989.

4. **Overview of the Natural Helpers Program**, CHEF, 1989.

5. **Teens, Crime and Community**, a joint publication of the National Institute for Citizen Education in the Law and the National Crime Prevention Council, West Publishing Company, 1986.

6. **Zuni Life Skills**, LaFromboise, T.D. American Indian Life Skills Development Curriculum. Madison, WI: University of Wisconsin Press, 1996.

7. **Question, Persuade, Refer (QPR)**, Quinnett, Paul, Ph.D. QPR Institute, 1995.

XI. REFERENCES

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Homicide and Suicide Among Native Americans, 1979-1992 Violence Surveillance Summary Series, No.2., 1992.

Centers for Disease Control and Prevention. "CDC recommendations for a community plan for the prevention and containment of suicide clusters." Morbidity and Mortality Weekly Report, CDC, 37 (no. S-6), 1988.

Centers for Disease Control and Prevention. "CDC Programs for the prevention of suicide among adolescents and young adults. Morbidity and Mortality Weekly Report, CDC, 43 (no. RR-6), 1994.

Centers for Disease Control and Prevention. "Suicide prevention evaluation in a Western Athabaskan American Indian Tribe: New Mexico, 1988-1997." Morbidity and Mortality Weekly Report, CDC, 47, 1998. 257-261.

Chavis, D.M., Speer, P., Reznick, I., and Zippay, A. "Building community capacity to address alcohol and drug abuse." Davis, R.C., Lurgio, A.J., and Rosenbaum, D.P., eds. Drugs and the Community. *S*pringfield, IL: Charles C. Thomas, 1993. 251-284.

DeBruyn, L.M., Hymbaugh, K., Simpson, D., Wilkins, B., and Nelson, S. "When Communities are in Crisis: Planning for Response to Suicides and Suicide Attempts among American Indian Tribes." American Indian and Alaska Native Mental Health Research, 4, Monograph, 1994.

DeBruyn, L.M., Hymbaugh, K., and Valdez, N. "Helping Communities Address Suicide and Violence: The Special Initiatives Team of the Indian Health Service." American Indian and Alaska Native Mental Health Research, 1(3), 1988. 56-65.

DeBruyn, L.M., May, P.A., and O'Brien, M. Suicide Intervention and Prevention: Evaluation of Community-Based Programs in Three American Indian Communities. Atlanta, GA: Division of Injury Control, U.S. Centers for Disease Control and Prevention, 1997.

Doka, Kenneth J., ed. Living with Grief after Sudden Loss: Suicide, Homocide, Accident, Heart Attack, Stroke. Bristol, PA: Taylor and Francis, 1996.

Grollman, Earl A. Suicide, Prevention, Intervention and Postvention. Boston, MA: Beacon Press, 1988.

Hybels-Steer, Mariann. Aftermath: Survive and Overcome Trauma. New York, NY: Simon and Schuster, 1995.

Institute of Medicine. Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research. Washington, D.C.: National Academy Press, 1994.

LaFromboise, T.D., and Howard-Pitney, B. "The Zuni Life Skills development curriculum: description and evaluation of a suicide prevention Program." Journal of Counseling Psychology, 42, 1995. 479-486.

LaFromboise, T.D. American Indian Life Skills Development Curriculum. Madison, WI: University of Wisconsin Press, 1996.

May, P.A. "Suicide and self-destruction among American Indian youths." American Indian and Alaska Native Mental Health Research, 1, 1987. 52-69.

May, P.A. "Suicide and suicide attempts among American Indians and Alaska Natives: A Bibliography." Omega, 21, 1990. 199-214.

May, P.A., Van Winkle, N.W., Williams, M., McFeeley, P.J., DeBruyn, L.M., and Serna, P. "Alcohol and suicide death among American Indians of New Mexico: 1980-1998." Suicide and Life-Threatening Behavior, 32, 2002. 240-255.

May, P.A., and McCloskey, J. Suicide and Suicide Attempts Among American Indians and Alaska Natives, An Annotated Bibliography. 3rd ed. Center on Alcoholism, Substance Abuse and Addictions, University of New Mexico. Indian Health Service Contract #7-650319 and #60760/3800, 1997.

May, P.A., and Van Winkle, N.W. "Durkheim's suicide theory and its applicability to contemporary American Indians and Alaska Natives." Lester, D., ed. Emile Durkheim: Le suicide 100 Years Later. Philadelphia, PA: Charles Press, 1994. 296-318.

May, P.A., and Del Vecchio, A. National Model Adolescent Suicide Prevention Program: Evaluation Report to the Western Athabaskan Tribe. Albuquerque, NM: Center on Alcoholism, Substance Abuse and Addictions, University of New Mexico, 1994.

May, P.A., Serna, P., Hurt, B.L., and DeBruyn, L.M. "Outcome Evaluation of a Public Health Approach to Suicide Prevention in an American Indian Tribal Nation." American Journal of Public Health, 95(7), 2005. 1238-1244.

Middlebrook, D.L., LeMaster, P.L., Beals, J., Novins, D.K., and Manson, S.M. "Suicide prevention in American Indian and Alaska Native communities: A critical review of Programs." Suicide and Life-Threatening Behavior, 31 (supplement), 2001. 132-139.

National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, D.C.: U.S. Public Health Service, 2002.

Quinnett, Paul, Ph.D. Question, Persuade, Refer (QPR). QPR Institute, 1995.

Roberts, Fitzmahan & Associates. Natural Helpers, Comprehensive Health Education Foundation, 1989.

Rogers, D.D. "Community crisis intervention in suicide epidemics." Arctic Medical Research, 50, 1991. 276-280.

Teens, Crime and Community. A joint publication of the National Institute for Citizen Education in the Law and the National Crime Prevention Council, West Publishing Company, 1986.

The Surgeon General's Call to Action to Prevent Suicide. Washington, D.C.: U.S. Public Health Service, 1999.

To Live to See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults. Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Dept. of Health and Human Services, 2010.

A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country. U.S. Commission on Civil Rights, July 2003.

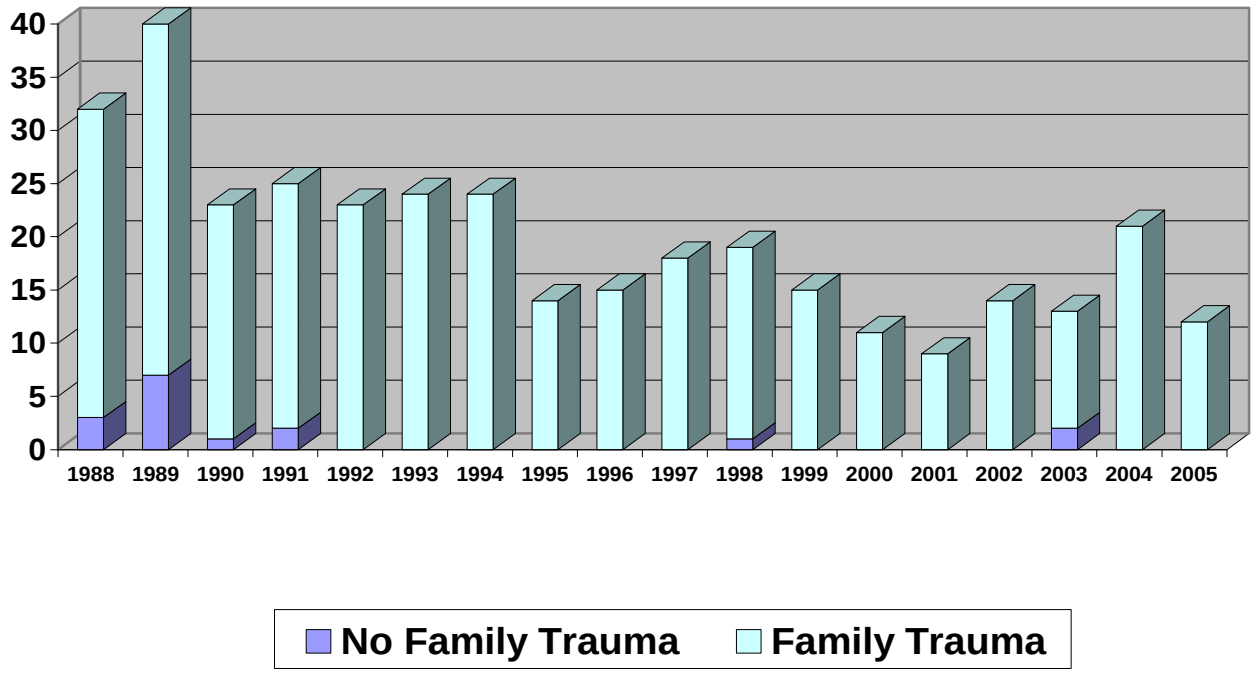
Van Winkle, N.W., and Williams, M. Evaluation of the National Model Adolescent Suicide Prevention Program: A Comparison of Suicide Rates Among New Mexico American Indian Tribes, 1980-1998. Tulsa, OK: Oklahoma State University School of Osteopathic Medicine, 2001.

Van Winkle, N.W., and May, P.A. "Native American Suicide in New Mexico, 1957-1979: A Comparative Study." Human Organization, 45, 1986. 296-309.

APPENDIX A

SUICIDAL BEHAVIOR BY HISTORY OF FAMILY TRAUMA

1988 - 2005

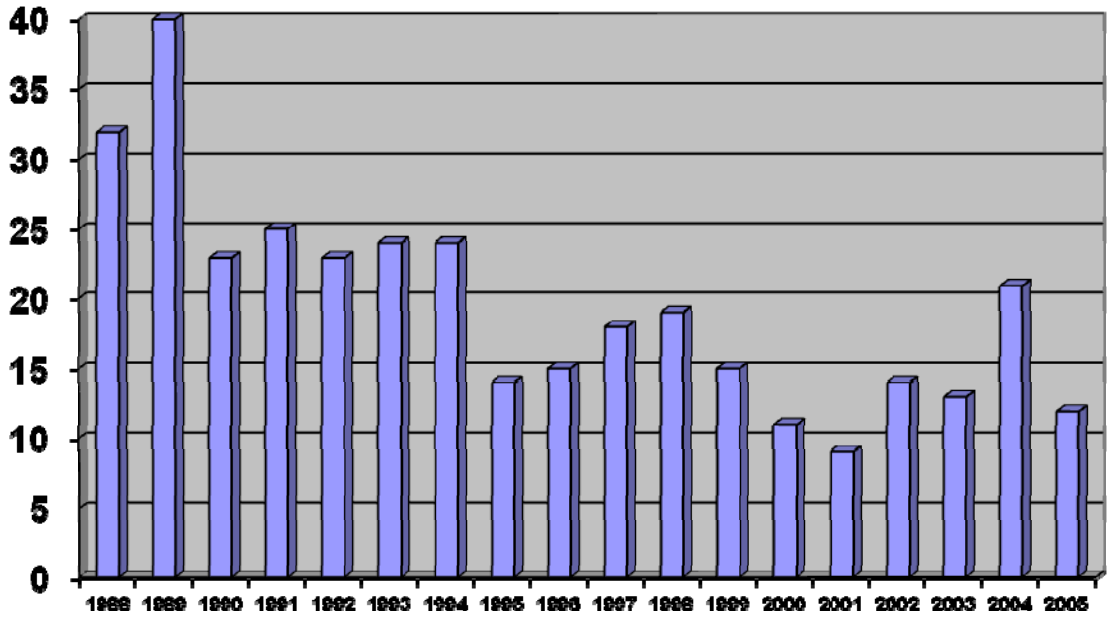


Most **(95 percent)** of the individuals gesturing, attempting, or completing suicide grew up in families who had experienced significant trauma, such as previous suicidal behavior, family violence, child abuse and neglect, and drug or alcohol abuse.

APPENDIX B

SUICIDAL BEHAVIOR

1988 –2005



There was a significant decrease **(63 percent)** in suicide gestures, attempts, and completions (suicidal behavior) for all age groups from the baseline year of 1988 (the year the community became quite concerned about the suicide problem) to 2005. From the year prior to the beginning of the National Model Suicide Prevention Program (1989) to 2005 there was a **70 percent decrease** in suicidal behavior.

APPENDIX C

ADOLESCENT SUICIDE PREVENTION PROGRAM

CONSENT FORM

I agree to participate in a research demonstration Program being conducted by the Adolescent Suicide Prevention Program. The purpose of this study is to identify suicide risk factors, identify and implement prevention activities, and to identify high risk individuals and families. The Adolescent Suicide Prevention Program is a comprehensive multifaceted Program that provides prevention services at primary, secondary, and tertiary levels in order to impact the incidence of suicide on the reservation.

During this study, all individuals seen by Program staff will be requested to provide information to their counselor which will be recorded on the **PATIENT DATA REPORTING FORM**. The information will be used to develop a treatment plan as well as to obtain information on suicide risk factors.

Your confidentiality and all information obtained during the course of the study or in the course of treatment will be protected. Your participation in this Program will only be known by Program staff and members of the research evaluation team.

There are no known risks for participation in this Program.

Your participation in this Program is voluntary. If you do not wish to participate, you will have no penalty and lose no IHS or other services to which you are otherwise entitled. You may stop your participation in this Program at any time.

Information obtained from this research will be used to develop a profile of suicide gestures, attempts, and risk factors using an anonymous data format. All data will be analyzed and reported in aggregate form. Your name or identifying information about you will not be used.

If you have any questions regarding this Program or about your rights as a research subject, you may contact your counselor or the Program Director.

I have read and understand the above consent and I voluntarily consent to participate in this research demonstration Program.

Name: _____ Parent/Guardian:_____

Date: _____

APPENDIX D

The **PATIENT DATA REPORTING FORM**, modeled after the **SUICIDE REPORTING FORM**, was developed to gather data on all patients/clients seen by Program staff. The data was utilized for Program evaluation and to identify community members who may be at risk for suicidal behavior.

PATIENT DATA REPORTING FORM

LAST NAME:_____ FIRST NAME:_____

MAIDEN OR OTHER:_____ INITIALS:_____ SEX:_____

CHART NUMBER:_____ DOB:_____/_____/_____ AGE:_____

TRIBE:_____ DATE OF 1st MENTAL HEALTH VISIT:_____/_____/_____

DATE REFERRAL RECEIVED OR DATE APPOINTMENT MADE:_____/_____/_____

PURPOSE OF VISIT:_____ Screening = 11 Assessment / Evaluation = 12 Ind Tx/Counseling = 13
Family TX = 14 FSA = 60 Group Tx = 15 Info/Referral = 16 Medication = 17 Psych Eval = 18 Other = 10

REFERRAL SOURCE:_____ REFERRAL NAME:_____
Self = 1 School=3 CHR = 5 BIA Dorm = 7 Police =9 Mental Health = 11 Other = 13
Friend = 2 Medical=4 Family = 6 Alcohol = 8 Social Service = 10 Court or Correctional Agency = 12

STREET / PO BOX:_____ CITY:_____

STATE:_____ ZIP:_____ PHONE:_____

PSYCHOSOCIAL / PSYCHOLOGICAL ASSESSMENT

PRESENTING PROBLEM:_____ SPECIFY:_____

Medical = 4 Depression = 14 Anxiety / Panic = 18 Personality = 19 Sexual = 20 ETOH dep = 21

Drug dep = 21 ETOH abuse = 23 Drug abuse = 24 Sleep dis = 26 Eating dis = 27 Adjustment = 28

Suicide att, gest, or idea = 38 Suicide compl. = 39 Phase of life = 40 Child abuse = 42 Rape = 44

Spouse abuse = 45 Sex abuse = 47 Child neglect = 50 Marital = 56 Family = 60

Interpersonal - 61 School behavior = 90 Other psych = 99

MENTAL STATUS: Appearance:_____ Speech:_____

Orientation:_____ Attention / Concentration:_____

Affect / Emotional status:_____ Memory (recent):_____

Memory (remote):_____ Judgment:_____ Insight:_____

Thought content / Process:_____ Intellectual functioning:_____

AXIS I: DIAGNOSIS 1 / DX1:_____ _____

AXIS I: DIAGNOSIS 2 / DX2:_____ _____

AXIS II: DIAGNOSIS 3/ DX3:_____ _____

AXIS III: SIGNIFICANT MEDICAL DX:_____ (Y or N)

If yes: SPECIFY MEDICAL DIAGNOSIS/DX1:_____

MEDICAL DIAGNOSIS/DX2:_____

SEVERITY OF PSYCHOSOCIAL STRESSORS: _____ Specify stressors:_____

1 = None 2 = Mild

3 = Moderate 4 = Severe _____

5 = Extreme 6 = Catastrophic

0 = Inadequate information _____

GLOBAL ASSESSMENT OF FUNCTIONING:_____ _____

1 - 90 (1 = Danger to self or others 50 = Serious symptoms 90 = No symptoms)

SUICIDE POTENTIAL:_____ (From Suicide Potential Scale)

0 = Not at risk 7, 8, 9 = Severe risk

1, 2, 3 = Low risk Blank = Inadequate information or unknown

4, 5, 6 = Medium risk

PSYCHOLOGICAL / SUBSTANCE ABUSE / MEDICAL HISTORY

NUMBER OF PREVIOUS SUICIDE ATTEMPTS HX:_____ (Blank for unknown)

NUMBER OF MENTAL HEALTH HOSPITALISATIONS:_____ (Blank for unknown)

IF ANY; DATE OF LAST MENTAL HEALTH HOSPITALIZATION:_____/_____/_____

SUBSTANCE ABUSE HISTORY:_____ (Y or N) If yes:

ALCOHOL: _____ DETAILS:_____

MARIJUANA: _____

COCAINE: _____ _____

CRACK: _____

VOLATILE: _____ _____

OTHER SUBSTANCE: _____

ETOH INVOLVED CURRENTLY:_____ PERPETRATOR OF SPOUSE ABUSE:_____

PERPETRATOR OF CHILD ABUSE:_____ TRAUMA HX:_____ (Y or N)

IF YES: SPECIFY TRAUMA:_____

ADDITIONAL TRAUMA:_____

MENTAL HEALTH TREATMENT HX:_____ (Y or N) DETAILS:_____

If yes: PSYCHOTROPIC DRUG: _____

COUNSELING/PSYCHOTHERAPY: _____ _____

CRISIS INTERVENTION: _____

MENTAL HEALTH TX REFUSED: _____ _____

SUBSTANCE ABUSE TX: _____

OTHER TX: _____ _____

CURRENT PSYCHOTROPIC MED 1:_____ DOSAGE:_____

CURRENT PSYCHOTROPIC MED 2:_____ DOSAGE:_____

CURRENT OTHER MED 1: _____ DOSAGE:_____

CURRENT OTHER MED 2: _____ DOSAGE:_____

OTHER POSSIBLE CONTRIBUTING FACTORS:_____ (Y or N) If yes:

FRIEND SUICIDE:_____ PROBLEMS WITH LAW/LEGAL PROBLEMS:_____

SIGNIFICANT OTHER DEATH:_____ OTHER CONTRIBUTING FACTORS: _____

SIGNIFICANT OTHER BREAKUP:_____ LOSS OF JOB:_____

SPECIFY OTHER:_____

FAMILY HISTORY

MARTIAL STATUS:_____ DETAILS:_____

1 = Single 5 = Cohabitating

2 = Married 6 = Remarried _____

3 = Div/Sep 9 = Unknown

4 = Widowed _____

SPOUSE/S O L NAME:_____ F NAME:_____

NUMBER OF CHILDREN:_____

1st CHILD L NAME:_____ F NAME:_____

2nd CHILD L NAME:_____ F NAME:_____

3rd CHILD L NAME:_____ F NAME:_____

4th CHILD L NAME:_____ F NAME:_____

5th CHILD L NAME:_____ F NAME:_____

6th CHILD L NAME:_____ F NAME:_____

PATIENT FATHER L NAME:_____ F NAME:_____

PATIENT MOTHER L NAME:_____ F NAME:_____

MATERNAL GRANDFATHER L NAME:_____ F NAME:_____

MATERNAL GRANDMOTHER L NAME:_____ F NAME:_____

PATERNAL GRANDFATHER L NAME:_____ F NAME:_____

PATERNAL GRANDMOTHER L NAME:_____ F NAME:_____

PATIENT PRIMARILY RAISED BY:_____

1 = Both natural parents
2 = Mother only
3 = Father only
4 = Mother and Stepfather
5 = Father and Stepmother
6 = Aunt/Uncle
7 = Grandparent(s)
8 = Various Relatives
9 = Foster family(s)
10 = Dormitory
11 = Other or Unknown

Specify by whom patient was raised in chronological order (if more than one family) and outline other related family hx:_____

_____

_____

BIRTH ORDER:_____ 1 = First child 2 = Second child, etc. Blank = Unknown

1st SIBLING L NAME:_____ F NAME:_____

2nd SIBLING L NAME:_____ F NAME:_____

3rd SIBLING L NAME:_____ F NAME:_____

4th SIBLING L NAME:_____ F NAME:_____

5th SIBLING L NAME:_____ F NAME:_____

6th SIBLING L NAME:_____ F NAME:_____

CURRENT LIVING ARRANGEMENTS / DOMICILE:_____ Blank for unknown

1 = Alone 4 = Spouse and Children 7 = Residential Facility (e.g. Dorm)

2 = Parents 5 = Children 8 = Extended Family

3 = Spouse 6 = Significant Other 9 = Other

SIGNIFICANT FAMILY HX:_____ (Y or N) If yes, specify:_____

FAMILY MEMBER COMMITTED SUICIDE:_____ _____

FAMILY MEMBER ATTEMPTED SUICIDE:_____

FAMILY VIOLENCE IN FAMILY: _____ _____

VICTIM OF FAMILY VIOLENCE: _____

CHILD ABUSE IN FAMILY: _____ _____

VICTIM OF CHILD PHYSICAL ABUSE: _____

VICTIM OF CHILD SEXUAL ABUSE: _____ _____

FAMILY LOSS: _____

FAMILY ALCOHOLISM: _____ _____

OTHER SIGNIFICANT FAMILY HISTORY: _____

EDUCATIONAL / EMPLOYMENT HISTORY

EDUCATION (Highest grade completed):_____ 1 - 12th grade Blank = Unknown

13 = GED 14 = Some college 15 = College graduate 16 = Vo-Tech / Other

TREATMENT PLAN

_____

_____

_____

_____

_____

REPORTING

THERAPIST 1:_____ THERAPIST 2:_____

REPORT COMPLETED BY STAFF MEMBER (Name):_____

DATE REPORT COMPLETED:_____/_____/_____

APPENDIX E

The **SUICIDE REPORTING FORM** was maintained for data collection and to identify high risk youth and families. The form was completed by Program staff on all reports received including information from clinical staff, EMS, law enforcement, detention center, and health clinic staff.

SUICIDE REPORTING FORM

LAST NAME:_____ FIRST NAME:_____

CHART NUMBER:_____ SSN:_____/_____/_____

DATE OF ACT:_____/_____/_____ TRIBE:_____

TRIBECODE:_____ COMMUNITY:_____

COMMCODE:_____ DATE OF BIRTH:_____ AGE:_____ SEX:_____

SELF DESTRUCTIVE ACT:_____

1 = Completed Suicide: Death caused by a self-destructive act.

2 = Attempt: A genuine, life threatening effort to kill oneself by self-inflicted means which would have led to death if no intervention had occurred -- not an accident or manipulation.

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

9 = Unknown

MARITAL STATUS:_____ 1=Single 2=Married 3=Divorced/Separated
4=Widowed 5=Cohabitating 9=Unknown

METHOD:_____ 1=Gunshot 2=Hanging 3=Drug ingestion 4=Stabbing/laceration
5=Motor Vehicle 6=Carbon Monoxide 7=Other 9=Unknown

NUMBER OF PREVIOUS ATTEMPTS HISTORY:_____ 0 for None - Blank for Unknown

PREVIOUS MENTAL HEALTH HOSPITALIZATION:_____

If yes: Date of hospitalization:_____/_____/_____

LOCATION OF ACT:_____

1=Home or vicinity 2=Jail 3=Public place
4=School/place of employment 5=Isolated place 6=Other
7=Alcohol establishment or vicinity 8= Res facility 9=Unknown

SUBSTANCE ABUSE RELATED:_____

If yes: Alcohol:_____ Marijuana:_____ Cocaine:_____
Crack:_____ Volatile:_____ Other sub:_____

TRAUMA HISTORY:_____

If yes: Specify Trauma:_____

Additional Trauma:_____

MENTAL HEALTH TREATMENT RECOMMENDED / RX:_____

If yes: Psychotropic Drug RX:_____ Counseling / Psychotherapy:_____
Crisis Intervention: _____ Mental Health RX Refused: _____
Other RX: _____

LIVING ARRANGEMENTS / DOMICILE:_____

1=Alone 2=Parents 3=Spouse 4=Spouse and Children 5=Children

6=Significant other 7=Residential facility 8=Other 9=Unknown

NATAL COMPLICATIONS:_____

If yes: Specify Natal Complication:_____

Other Natal Complication:_____

EMPLOYMENT:_____ 1=Employed 2=Unemployed 3=Seasonal/Temp/Subs

4=Student 5=Other 9=Unknown

EDUCATION:_____ 1 - 12th grade (highest grade completed)

12=HS Grad 13=GED 14=Some college 15=College graduate 16=Other

Blank=Unknown

SIGNIFICANT FAMILY HISTORY:_____

If yes: Family member committed suicide:_____ Family violence:_____

Family member attempted suicide:_____ Child abuse:_____

Family loss:_____ Family alcoholism:_____

Other significant family history:_____

POSSIBLE CONTRIBUTING FACTORS:_____

If yes: Friend committed suicide:_____ Significant other death:_____

Significant other breakup:_____ Loss of job:_____

Problems with the law or legal problems:_____ Other factors:_____

CLINIC VISIT WEEK PRIOR TO ACT:_____

BIRTH ORDER:_____ 1=First child 2=Second child, etc. Blank=Unknown

DISPOSITION:_____

If yes: Inpatient admit:_____ Outpatient treatment / RX:_____

Referral for substance abuse RX:_____ Referral to State Facility RX:_____

Family follow up:_____ Other disposition:_____

REPORT COMPLETED BY STAFF MEMBER (name):_____

DATE REFERRAL RECEIVED BY MH OR PROGRAM STAFF:_____/_____/_____

DATE OF FOLLOW UP BY MH OR PROGRAM STAFF:_____/_____/_____

GLOSSARY OF TERMS

Aggregate Risk Profile – the total exposure of an entity to changes.

Arroyo Outreach – nontraditional treatment created to reach individuals who are in need of intervention exactly where they are physically located at the time.

BIA – Bureau of Indian Affairs

CASAA -- Center on Alcoholism, Substance Abuse, and Addictions, University of New Mexico

CDC – U.S. Centers for Disease Control and Prevention

Cognitive Behavioral Counseling – therapy based on the idea that our thoughts cause our feelings and behaviors -- not external things like people, situations, and events. The benefit of this fact is that we can change the way we think in order to act/feel better even if the situation does not change.

Completed Suicide – death caused by a self-destructive act.

CRAG – Community Resource Action Group

Critical Incident – any incident that causes a person to have unusually strong emotional reactions, which have the potential to interfere with his/her ability to function.

Cruise Therapy -- initiated particularly for adolescents as a way to provide them with confidentiality in a setting where they felt comfortable. Program staff drove around the reservation with the client while discussing issues.

IHS – Indian Health Service

MMWR – Morbidity and Mortality Weekly Report, CDC

Natural Helpers – a peer-helping and leadership development program based on the premise that within every school an informal "helping network" exists among peers. Students with problems seek out other students whom they trust.

OPEL – Office of Policy Analysis and Evaluation

Outcome Evaluation – designed to measure how well the Program was able to address its goals and objectives.

Postvention – work with the survivors of a traumatic event or a critical incident to assist them in dealing with the experience.

Process Evaluation – documents and describes the processes and methods used to implement the Program.

Program – Adolescent Suicide Prevention Program

Question, Persuade, Refer (QPR) -- a method for providing education and training to the general public on suicidal signs and symptoms as a means to identify and refer people to professional helping resources.

SAMHSA – Substance Abuse and Mental Health Services Administration

SPRC – Suicide Prevention Resource Center

Suicide Attempt – a genuine life-threatening effort to kill oneself by self-inflicted means which would have led to death if no intervention had occurred – not an accident or manipulation.

Suicidal Gesture – a self-destructive act where the primary motive is not death but an attempt to cause someone or something to change; the self-destructive act is often not life-threatening.

Suicidal Ideation – verbalization of thoughts or threats of suicidal behavior without an actual act.

Teens, Crime and Community – a joint publication of the National Institute for Citizen Education in the Law and the National Crime Prevention Council.