SPRC 2023 Tribal Suicide Prevention Needs Assessment

Aggregate Technical Report

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Background and Methods

Background

Between October and December of 2023, the Suicide Prevention Resource Center (SPRC) and its partner, Social Science Research and Evaluation, Inc. (SSRE), conducted a Tribal Suicide Prevention Needs Assessment (TNA). An invitation to participate in the TNA was sent to 200 suicide prevention coordinators or other individuals most knowledgeable about the suicide prevention efforts of Tribes, Tribal Health Boards (member organizations of the National Indian Health Board), and Tribal-focused health care organizations within the geographic borders of the United States.

The primary purpose of the TNA is to help SPRC better understand Tribal suicide prevention needs, track changes in Tribal suicide prevention capacity over time, and provide valuable information to Tribes, Tribal Health Boards, and Tribal-focused health care organizations on their own progress and collective Tribal suicide prevention infrastructure and programming across the United States. Findings from the TNA are also used by SPRC to identify and develop learning opportunities and resources to support Tribal suicide prevention efforts.

The assessment asked Tribal suicide prevention coordinators and other Tribal representatives to assess and describe their entity's suicide prevention strengths, challenges, and needs. It included four main sections: (1) Service Landscape, (2) Suicide Prevention Infrastructure [Structure and Support; Capacity and Collaboration; Data, Surveillance, and Evaluation; Strategic Planning and Implementation], (3) Crisis Resources, and (4) Technical Assistance Needs. Throughout the assessment, respondents were asked to assess the presence in their community or organization of factors that support suicide prevention infrastructure and detail major challenges in these areas. They were also given the opportunity to provide feedback about their needs in the upcoming year for technical assistance services (support, tools, resources) in a variety of areas related to suicide prevention.

Methods

The TNA was conducted as an online questionnaire. All representatives for whom contact information was available at the time of the assessment (representing 189 Tribes and 11 Tribal Health Boards and Tribal-focused health care organizations) were contacted via email and asked to participate. The assessment could be completed by one designated individual or by a team working together to submit one response. Representatives were strongly encouraged to gather input from fellow suicide prevention staff and other key partners to inform their responses.

Forty-six of the 200 invited representatives responded (23% response rate). Three opted out of the assessment, 41 completed it fully, and 2 completed it partially (22% participation rate). Thirty-eight of the 43 participating respondents (88%) represented Tribes and 5 represented Tribal Health Boards and Tribal-focused health care organizations (12%). Responses from Tribes largely represented the geographic distribution of invited representatives by both Indian Health Service (IHS) area and Bureau of Indian Affairs (BIA) region, with 9 of 12 IHS areas and 10 of 12 BIA regions represented. Over half of all respondents (60%, 26 of 43) indicated

that they were a member of a Tribe, with most of these individuals (49% of all respondents, 21 of 43) belonging to a Tribe served by their organization's suicide prevention efforts.

Limitations

Results from this assessment are limited by the number of Tribes, Tribal Health Boards, and Tribal-focused health care organizations for which accurate contact information was available and the final number of respondents. Given the large and diverse Tribal population in the United States, results may not be representative of all Tribal suicide prevention efforts.

Results

Service Landscape

As displayed in Table 1, most respondents indicated that their Tribe or Tribal Health Board's[1] suicide prevention efforts are implemented in one state (70%), in a rural setting (93%), serve a small population of between 1 and 5,000 Tribal members (67%), serve reservation-based Tribal populations (84%), and reach non-Tribal residents and citizens-at-large in addition to Tribal residents (65%). Additionally, 67% of respondents reported that the Tribal communities they serve experienced suicide in the past 12 months.

Table 1: Service Landscape of Suicide Prevention Efforts

	Percent	Count
Service Area (N=43)		
One state	70%	30
Multiple states	30%	13
Setting(s) Covered (N=43, multiple responses possible)		
Remote/Frontier	30%	13
Rural	93%	40
Suburban	21%	9
Urban	12%	5
Number of Individuals Who Are Part of the Tribe(s) Served (N=43)		
0	0%	0
1 to 5,000	67%	29
5,001 to 10,000	14%	6
10,001 to 25,000	9%	4
25,001 to 50,000	2%	1
50,001 to 75,000	0%	0
75,001 to 100,000	2%	1
More than 100,000	5%	2
Other Characteristics (N=43)		
Suicide prevention efforts serve reservation-based Tribal populations	84%	36
Suicide prevention efforts also serve non-Tribal residents and citizens-at-large	65%	28
Tribal communities served experienced suicide in the past 12 months	67%	29

[1] The term "Tribal Health Boards" is used in the remainder of this report as a shorthand reference to Tribal Health Boards and Tribal-focused health care organizations.

Suicide Prevention Infrastructure

Structure and Support

Designated Office or Division of Suicide Prevention

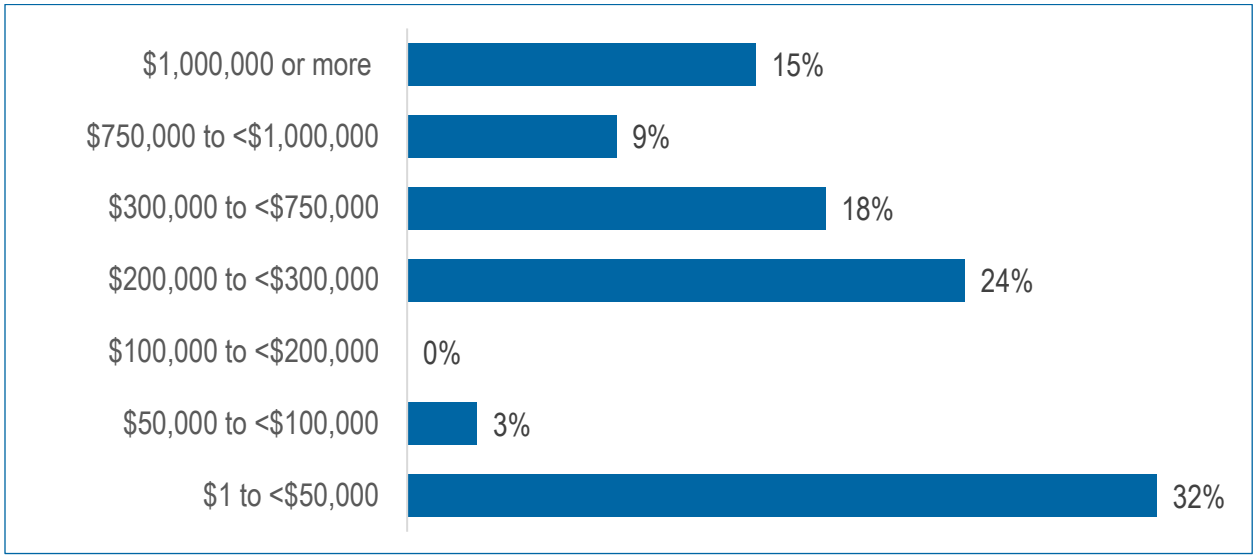
Thirty-seven percent of respondents (37%, 16 of 43) indicated that their Tribe or Tribal Health Board has a designated office or division of suicide prevention.

Value of Current Annual Budget for Suicide Prevention Efforts

Most responding Tribes or Tribal Health Boards (97%, 34 of 35) reported having a dedicated budget for suicide prevention efforts (8 were unsure). The majority of those with dedicated funding (59%) indicated that the annual value was less than $300,000. See Figure 1.

Figure 1: Approximate Annual Budget for Suicide Prevention Efforts Among Respondents With Dedicated Funding

(N=34)



Federal and Non-Federal Grant Funding for Suicide Prevention Efforts

Respondents were asked to identify any sources of *federal* funding that their Tribe or Tribal Health Board uses to support suicide prevention efforts. Excluding 6 respondents who were unsure, 89% of responding Tribes and Tribal Health Boards (33 of 37) indicated that they had at least one source of federal funding. As displayed in Table 2, the most common source of federal funding was the *SAMHSA Native Connections Grant* (61% of those with federal funding cited this as a funding source), followed by the *SAMHSA Tribal Opioid Response (TOR) Grant* (45%) and the *SAMHSA 988 Tribal Response Cooperative Agreement* (33%).

Table 2: Sources of Federal Funding for Suicide Prevention Efforts
(N=33)

Among those with federal funding; Multiple responses possible	Percent	Count
SAMHSA Native Connections Grant	61%	20
SAMHSA Tribal Opioid Response (TOR) Grant	45%	15
SAMHSA 988 Tribal Response Cooperative Agreement	33%	11
IHS Substance Abuse and Suicide Prevention Initiative Grant (Formerly MSPI)	24%	8
SAMHSA Circles of Care Grant	18%	6
SAMHSA Garrett Lee Smith (GLS) State/Tribal Youth Suicide Prevention Grant	15%	5
CDC Center for State, Tribal, Local, and Territorial Support (CSTLTS) Funding (e.g., Tribal COVID-19 Response, PHHS Block Grant)	12%	4
SAMHSA Zero Suicide Grant	12%	4
SAMHSA COVID-19 Emergency Response for Suicide Prevention Grant	6%	2
SAMHSA Garrett Lee Smith (GLS) Campus Suicide Prevention Grant	0%	0
SAMHSA National Strategy for Suicide Prevention (NSSP) Grant	0%	0
Other federal funding*	6%	2

*"Other" responses include: SAMHSA Mental Health Awareness Training (MHAT); SAMHSA Youth and Family TREE.

Respondents were also asked to identify any sources of *non-federal* funding that their Tribe or Tribal Health Board uses to support suicide prevention efforts. Excluding 11 respondents who were unsure, 53% of responding Tribes and Tribal Health Boards (17 of 32) indicated that they had at least one source of non-federal funding. As displayed in Table 3, the most common source of non-federal funding was a *Tribal budget line item* (65% of those with non-federal funding cited this as a funding source), followed by *Tribal gaming revenue* (12%), and *private donations* (6%). No respondents reported funding through *private foundation grant(s)*.

Table 3: Sources of Non-Federal Funding for Suicide Prevention Efforts
(N=17)

Among those with non-federal funding; Multiple responses possible	Percent	Count
Tribal budget line item	65%	11
Tribal gaming revenue	12%	2
Private donations	6%	1
Private foundation grant(s)	0%	0
Other non-federal funding*	35%	6

*"Other" responses include: state health authority; multi-Tribe council.

As displayed in Table 4, most respondents from Tribes and Tribal Health Boards that had some source of annual suicide prevention funding and who were familiar with that funding structure indicated that all of their funding comes from federal grants (61%, 19 of 31).

Table 4: Proportion of Suicide Prevention Funding That Comes From Federal Grants
(N=31)

Among those with funding	Percent	Count
None of It	6%	2
Less Than Half	6%	2
About Half	6%	2
More Than Half	19%	6
All of It	61%	19

Services Provided by Suicide Prevention Program

Prevention programming/services was identified as the service most commonly provided by Tribal and Tribal Health Board suicide prevention programs (identified by 72% of respondents), followed by *suicide prevention staff position(s)* (60%), *treatment* (56%), *strategic planning* (49%), *data collection* (47%), *postvention* (35%), *community coalition/advisory board/council support* (33%), *crisis lines/response services* (26%), and *research* (9%). Five percent (5%) of respondents did not identify any services being provided. See Table 5.

Table 5: Services Provided by Suicide Prevention Program

(N=43)

Multiple responses possible	Percent	Count
Prevention programming/services	72%	31
Suicide prevention staff position(s)	60%	26
Treatment services	56%	24
Strategic planning	49%	21
Data collection (assessment, evaluation)	47%	20
Postvention	35%	15
Community coalition/advisory board/council support	33%	14
Crisis lines/response services	26%	11
Research	9%	4
Other*	9%	4
None of the above	5%	2

*"Other" responses include: appropriate cultural activities; behavioral health outpatient services and health services; presence at community events/wellness fairs for education; trauma informed response.

Challenges – Developing and Maintaining Funding for Suicide Prevention

There are a number of significant challenges to funding Tribal suicide prevention efforts. As displayed in Table 6, *competing demands for staff time* was the most common challenge to developing and maintaining funding (identified as a challenge by 60% of respondents), followed by *inconsistent funding* (45%), *limited infrastructure* (43%), *competing priorities* (33%), and *insufficient funding* (28%). Only 3% of respondents stated that they had not experienced any challenges in developing and maintaining funding.

Table 6: Challenges in Developing and Maintaining Funding for Suicide Prevention

(N=40)

Up to 3 responses possible	Percent	Count
Competing demands for staff time (insufficient staffing and/or time to devote to developing/maintaining funding)	60%	24
Inconsistent funding (sporadic, dependent on grants, short-duration grants)	45%	18
Limited infrastructure (limited or no centralized suicide prevention office, limited or no strategic planning)	43%	17
Competing priorities (greater importance placed on other health/behavioral health areas)	33%	13
Insufficient funding (not enough funding)	28%	11
Lack of support or buy-in from internal leadership	18%	7
Limited external advocates/champions	8%	3
Competition between Tribes and/or Tribal Health Boards for funding	5%	2
Other	0%	0
We have not had any challenges in this area	3%	1

Capacity and Collaboration

Management of Suicide Prevention Efforts

Just over one-third of responding Tribes and Tribal Health Boards (36%, 14 of 39) have a single lead person who manages their suicide prevention efforts, with 26% of respondents indicating that they are the manager overseeing their Tribe or Tribal Health Board's efforts.

Staffing

Sixty percent of responding Tribes and Tribal Health Boards (60%, 26 of 43) employ full-time and/or part-time suicide prevention staff (44% employ only full-time staff, 7% employ only part-time staff, and 9% employ both full-time and part-time staff). See Table 7.

Table 7: Employment of Suicide Prevention Staff

(N=43)

	Percent	Count
Employ full-time **and/or** part-time staff	60%	26
- Employ full-time staff *only*	44%	19
- Employ part-time staff *only*	7%	3
- Employ full *and* part-time staff	9%	4

Challenges – Staffing Suicide Prevention Efforts

The most significant challenge facing Tribes and Tribal Health Boards when it comes to staffing suicide prevention efforts is *workforce shortage in relevant areas* (identified as a challenge by 48% of respondents), followed by *difficulty recruiting for time-limited (grant) positions* (43%), *insufficient funding to hire staff* (43%), and *limited infrastructure* (33%). Seven percent (7%) of respondents stated that they had not experienced any challenges in this area. See Table 8.

Table 8: Challenges in Staffing Suicide Prevention Efforts

(N=42)

Up to 3 responses possible	Percent	Count
Workforce shortage in relevant areas (e.g., lack of trained workforce)	48%	20
Difficulty recruiting for time-limited (grant) positions	43%	18
Insufficient funding to hire staff	43%	18
Limited infrastructure (limited or no centralized suicide prevention office, space limitations)	33%	14
Burdensome hiring process	19%	8
Staff burn-out (workload, vicarious trauma, turnover)	14%	6
Difficulty recruiting diverse workforce members	12%	5
Other	0%	0
We have not had any challenges in this area	7%	3

Communication Between Tribe or Tribal Health Board and State(s)

Respondents were asked to characterize the level of **communication** related to suicide prevention between their Tribe or Tribal Health Board and the state(s) in which they provide services. As displayed in Table 9, most respondents indicated that their communication with states is either *good* (37%), *fair* (33%), or *poor* (23%).

Table 9: Communication Between Tribe or Tribal Health Board and State(s)
(N=43)

	Percent	Count
Extremely Poor	5%	2
Poor	23%	10
Fair	33%	14
Good	37%	16
Excellent	2%	1

Collaboration Between Tribe or Tribal Health Board and State(s)

Respondents were also asked to describe the level of **collaboration** related to suicide prevention between their Tribe or Tribal Health Board and the state(s) in which they provide services. As displayed in Table 10, most respondents indicated that their collaboration with states could be best characterized as *networking* (back and forth sharing of information) (35%), followed by *awareness (knowledge of each other's activities)* (28%), and *none (no awareness or interaction)* (23%).

Table 10: Collaboration Between Tribe or Tribal Health Board and State(s)
(N=43)

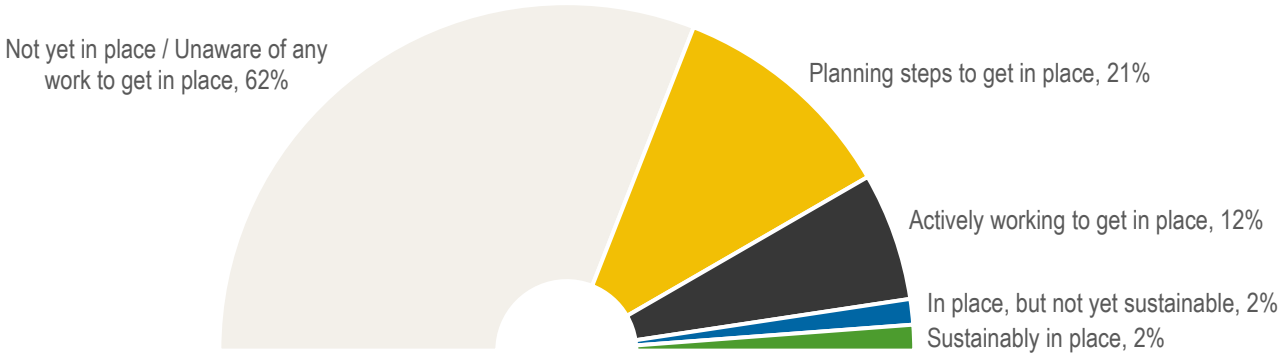
	Percent	Count
None (no awareness or interaction)	23%	10
Awareness (knowledge of each other's activities)	28%	12
Networking (back and forth sharing of information)	35%	15
Coordination (common and often interactive efforts)	14%	6
Collaboration (shared goals and decision-making)	0%	0

Data, Surveillance, and Evaluation

System for Collecting and Analyzing Suicide Death Data

As displayed in Figure 2, only 4% of respondents indicated that their Tribe or Tribal Health Board has a system in place to collect and analyze suicide death data, with 2% indicating that the system is sustainable. Most (62%) reported that no such system is in place and they are unaware of any work being done to get it in place; 33% are either planning (21%) or actively working (12%) to get such a system in place.

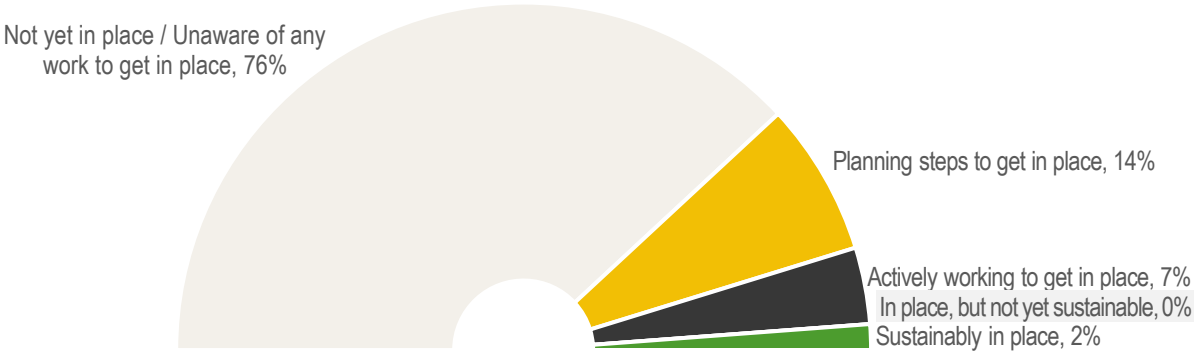
Figure 2: Progress Toward Having System in Place for Collecting and Analyzing Suicide Death Data
(N=42)



Linking Data From Different Systems

As displayed in Figure 3, just 2% of respondents indicated that their Tribe or Tribal Health Board has the ability to link suicide prevention data from different systems (e.g., connecting mental health system records with death certificate records, securely sharing data between different medical record systems). Three quarters (76%) reported that this capacity is not yet in place and they are unaware of work being done to advance it, while 21% are either planning (14%) or actively working (7%) to get this capacity in place.

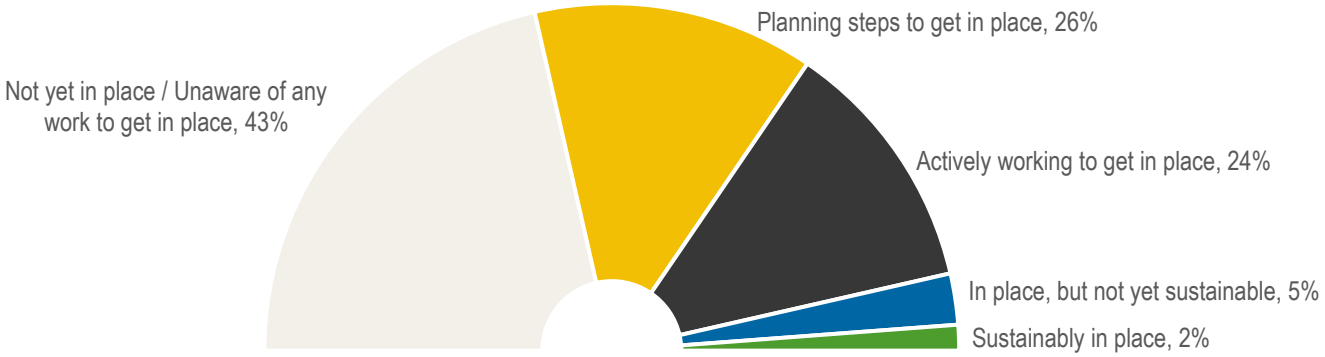
Figure 3: Progress Toward Linking Data From Different Systems
(N=42)



Ensuring Data Representation of Populations That Are High Risk and Underserved

Only 7% of respondents reported that their Tribe or Tribal Health Board can ensure that populations that are high risk and underserved (e.g., Two-Spirit, LGBTQ, youth in foster care, veterans, crime victims, those with suicide-centered lived experience) are sufficiently represented in their suicide-related data. Just 2% indicated their ability to ensure these populations are represented is sustainably in place. Most (43%) reported having no system in place for ensuring data representation and are unaware of work being done on the matter, while 50% are either planning (26%) or actively working (24%) to ensure data representation. See Figure 4.

Figure 4: Progress Toward Ensuring Representation of Populations That Are High Risk and Underserved in Suicide-Related Data
(N=42)



Challenges – Collecting, Storing, and Analyzing Suicide Data

As displayed in Table 11, *limited infrastructure (limited or no centralized suicide prevention office, lack of coordinated efforts)* was the most common challenge identified by Tribes and Tribal Health Boards in collecting, storing, and analyzing suicide data (identified as a challenge by 55% of respondents), followed by both *insufficient staffing (lack of dedicated staff, limited time, turnover)* and *no centralized system to store data* (36%, respectively), and *difficulty accessing data (no access, no data sharing agreement)* (31%). Only 5% of respondents stated that they had not experienced data-related challenges.

Table 11: Challenges in Collecting, Storing, and Analyzing Suicide Data
(N=42)

Up to 3 responses possible	Percent	Count
Limited infrastructure (limited or no centralized suicide prevention office, lack of coordinated efforts)	55%	23
Insufficient staffing (lack of dedicated staff, limited time, turnover)	36%	15
No centralized system to store data	36%	15
Difficulty accessing data (no access, no data sharing agreement)	31%	13
Lack of data on specific populations (LGBTQ2S+)	24%	10
Difficulty linking data (confidentiality/privacy laws)	17%	7
Insufficient funding (lack of funding for linking/retrieving data)	14%	6
Offices/Divisions protective of data (ownership, bureaucracy)	14%	6
Challenging to analyze data (missing data, data suppression)	5%	2
Data lag (delays, embargo, bureaucracy)	5%	2
Other*	10%	4
We have not had any challenges in this area	5%	2

*"Other" responses include: Electronic Health Record (EHR) system; Tribes housing own data and no central sharing place between Tribes; gaps in suicide reporting by families who experience a suicide; lack of training.

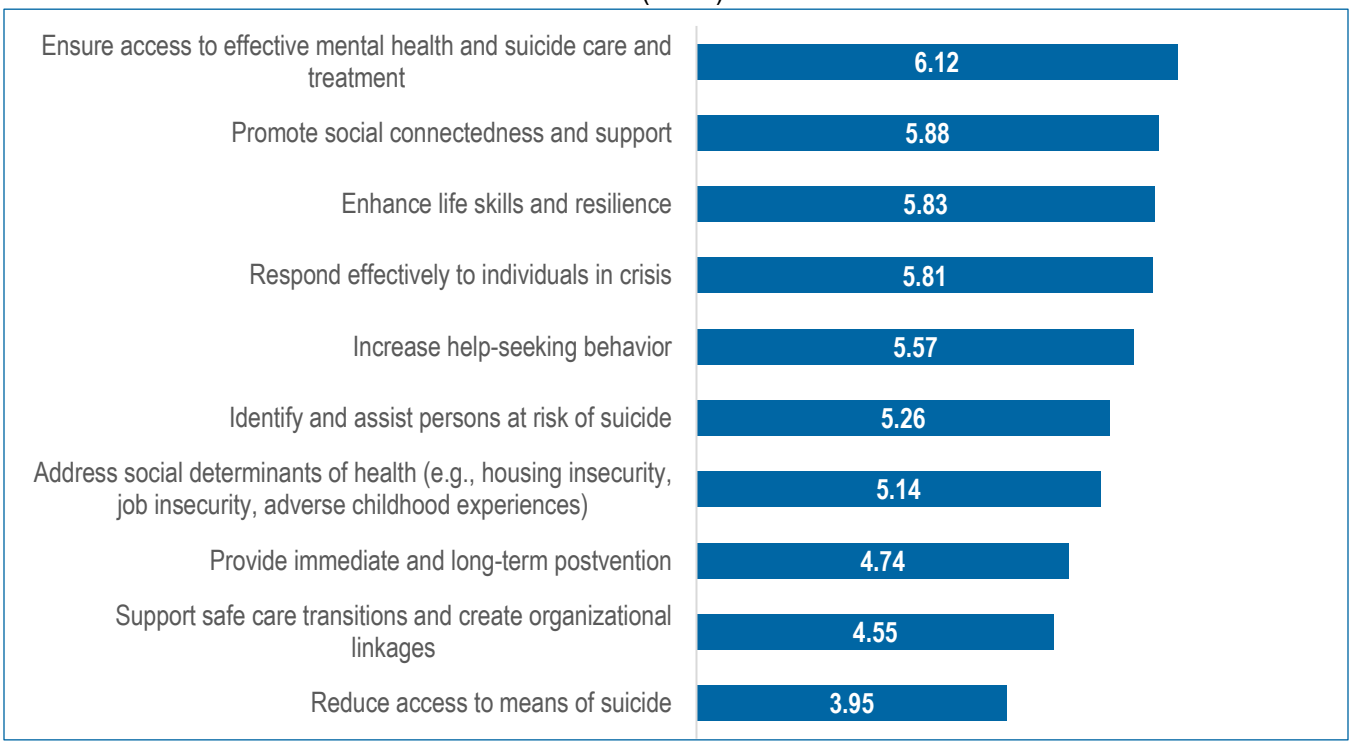
Strategic Planning and Implementation

Emphasis on Addressing High-Level Strategies

Respondents were asked to assess the level of emphasis that their Tribe or Tribal Health Board places on addressing 10 high-level strategies from SPRC's Comprehensive Approach to Suicide Prevention and the Centers for Disease and Control and Prevention's *Suicide Prevention Resource for Action*, considering factors such as the relative amount of funding focused on the strategy, the number of activities implemented to address the strategy, and the level of effort expended to implement those activities. Level of emphasis was assessed on a scale of 0 (low) to 8 (high).

As displayed in Figure 5, Tribes and Tribal Health Boards place the greatest emphasis on *ensuring access to effective mental health and suicide care and treatment* (6.12), followed by *promoting social connectedness and support* (5.88), *enhancing life skills and resilience* (5.83), and *responding effectively to individuals in crisis* (5.81). They were less likely to emphasize *reducing access to means of suicide* (3.95), *supporting safe care transitions and creating organizational linkages* (4.55), and *providing immediate and long-term postvention* (4.74).

Figure 5: Emphasis on Addressing High-Level Strategies – Mean Ratings
(N=42)



Focused Tribal Prevention Strategies

Respondents were asked to detail which *specific* populations their Tribal prevention strategies—programs, services, campaigns, and/or policies—are *designed to reach*. Acknowledging that many initiatives may reach multiple populations, whether intended or unintended, respondents were asked to answer based only on whether they currently have prevention strategies *intentionally focused on* the populations listed. Most Tribes and Tribal Health Boards indicated they have suicide prevention strategies specifically intended to reach

location-based populations (86%), followed by 76% for age-based populations, 69% for populations with suicide-centered lived experience, 67% for populations that are marginalized, and 43% for occupational populations at high risk. The most commonly prioritized populations were those between the ages of 18-24 (69%) and 10-17 (67%), people with substance use disorders (67%), reservation-based communities (62%), and impacted families and friends (60%). See Table 12.

Table 12: Populations Specifically Prioritized by Suicide Prevention Strategies
(N=42)

Multiple responses possible	Percent	Count
AGE-BASED POPULATIONS		
Under 10 years of age	26%	11
10-17	67%	28
18-24	69%	29
25-44	40%	17
45-64	29%	12
65 years or older	26%	11
We do not currently have targeted strategies for these populations	24%	10
LOCATION-BASED POPULATIONS		
Reservation-based communities	62%	26
Rural communities	43%	18
Suburban communities	12%	5
Urban communities	17%	7
We do not currently have targeted strategies for these populations	14%	6
OCCUPATIONAL POPULATIONS AT HIGH RISK		
Agricultural/farming/forestry industry	0%	0
Construction industry	0%	0
Mining/quarrying/oil-gas extraction industry	0%	0
First responders	24%	10
Law enforcement	21%	9
Detention/correctional staff	5%	2
Healthcare professionals	31%	13
Veterinarian professionals	0%	0
Military/veteran	19%	8
We do not currently have targeted strategies for these populations	57%	24
LIVED EXPERIENCE POPULATIONS		
Impacted families and friends	60%	25
Individuals with serious mental illness	45%	19
Suicide attempt survivors	45%	19
Suicide loss survivors	38%	16
We do not currently have targeted strategies for these populations	31%	13
POPULATIONS THAT ARE MARGINALIZED		
People with serious physical health problems or disabilities	21%	9
People with substance use disorder	67%	28
Two-Spirit, Lesbian, Gay, Bisexual	29%	12
Transgender	19%	8
We do not currently have targeted strategies for these populations	33%	14

Involvement of Priority Populations in Suicide Prevention Activities

Respondents were asked how they involve members of populations they are trying to reach (priority populations) in suicide prevention activities. As displayed in Table 13, the most common way priority populations were involved was through collaboration to *help to identify unique community needs, challenges, and/or strengths* (67%), followed by *help to choose prevention activities* (64%), *provide ongoing feedback on activity practices, effectiveness, and/or opportunities for improvement* (48%), and *help to implement targeted activities* (38%). It was less common for priority populations to *provide ongoing feedback on policies* (12%) or *help collect, analyze, and/or evaluate data* (17%). Eight Tribes and Tribal Health Boards (19%) indicated that priority populations are not involved in such efforts.

Table 13: Involvement of Priority Populations in Suicide Prevention Activities

(N=42)

Members of priority populations… *(Multiple responses possible)*	Percent	Count
Help to identify unique community needs, challenges, and/or strengths	67%	28
Help to choose prevention activities	64%	27
Provide ongoing feedback on activity practices, effectiveness, and/or opportunities for improvements	48%	20
Help to implement targeted activities	38%	16
Help collect, analyze, and/or evaluate data	17%	7
Provide ongoing feedback on policies being drafted or implemented	12%	5
Are involved in other ways*	12%	5
None of the above	19%	8

*Other identified ways include: advisory councils, youth in GONA, planning meetings open to the community.

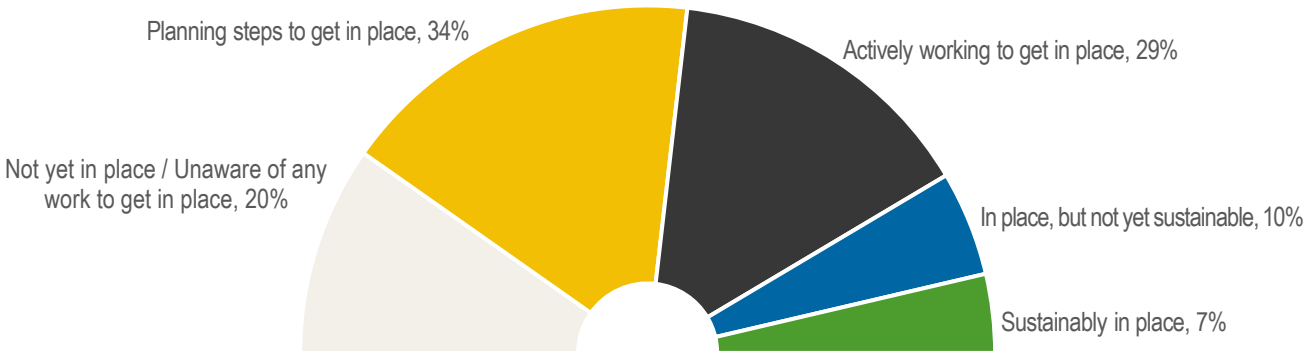
Crisis Resources

Coordinating Services Across the 988 Crisis Care Continuum

As displayed in Figure 6, 17% of respondents indicated that their Tribe or Tribal Health Board has coordinated services across the 988 crisis care continuum (outpatient behavioral health, crisis call centers, mobile crisis teams, crisis stabilization, residential crisis care, emergency departments), with 7% reporting that the coordination is sustainably in place. One-fifth (20%) reported that such coordination is not yet in place and they are unaware of work being done to advance it, while 63% are either planning (34%) or actively working (29%) to do so.

Figure 6: Progress Toward Coordinating Services Across the 988 Crisis Care Continuum

(N=41)



988 Suicide and Crisis Lifeline

Most respondents (85%, 35 of 41) reported that their Tribe or Tribal Health Board advertises or hands out information about the 988 Suicide and Crisis Lifeline.

Primary Promoted Crisis Resource

Respondents were asked to identify the primary resource their service population is encouraged to contact if they are experiencing emotional distress and/or suicidal thoughts. As displayed in Table 14, the *988 Suicide and Crisis Lifeline* was the most commonly identified resource (46%), followed by *911* (15%), *Tribal health departments* (12%), and *Tribal police* (10%). Seventeen percent (17%) of respondents identified other resources such as *behavioral health departments*, *other lifelines* (county, mobile mental health crisis), and *Tribal services* (general, healthcare system, mental health services).

Table 14: Primary Promoted Crisis Resource
(N=41)

	Percent	Count
988 Suicide and Crisis Lifeline	46%	19
911	15%	6
Tribal Health Department	12%	5
Tribal Police	10%	4
Indian Health Service	0%	0
Tribal Elders	0%	0
Other*	17%	7

*Other identified resources include: behavioral health department (2), other lifelines (county, mobile mental health crisis), Tribal services (general, healthcare system, mental health services).

Crisis Center

One half of respondents (51%, 21 of 41) reported that their service area has a crisis center to connect callers experiencing mental health crises to providers in their community, while 34% (14 of 41) said that they do not have one and 15% (6 of 41) were unsure.

Tribal or Indian Health Service Mental Health Support or Emotional Crisis Hotline

Most respondents (66%, 27 of 41) reported that their service area does *not* have a Tribal or Indian Health Service (IHS) mental health support or emotional crisis hotline, while 20% (8 of 41) said that they did and 15% (6 of 41) were unsure. Of those who have a hotline, most indicated that the hours of operation were *24 hours a day, 7 days a week (24/7)* (63%, 5 of 8).

Mobile Crisis Response Teams

Just over one-half of respondents (56%, 23 of 41) reported that mobile crisis response teams (whose main role is to de-escalate mental health crises and suicide risk) exist in their service area, while 29% (12 of 41) said that they did not exist and 15% (6 of 41) were unsure.

Technical Assistance Needs

Respondents were asked to rate their Tribe or Tribal Health Board's anticipated level of need in the upcoming year for technical assistance services (i.e., support, tools, resources) in the following areas.

- **Partnerships and Collaboration** – Agreeing on clear roles, functions, and responsibilities with partners; developing a plan to communicate regularly with key entities (e.g., Tribal leadership/administration, funders, advisory boards, youth groups) to ensure buy-in, ongoing support, and sustainability; developing and implementing formal written agreements with partners (e.g., memorandums of agreement, memorandums of understanding, data-sharing agreements, Tribal resolutions)
- **Leadership** – Navigating competing demands to keep goals, objectives, and activities on course; planning for changes in project leadership and staff transitions to ensure continuity; learning from other organizations and programs that have created lasting results in their community
- **Community and Political Support** – Identifying and approaching potential community champions and leaders who can help advance prevention efforts; creating public policy, Tribal resolutions, and/or Tribal codes to advance suicide prevention; assessing and improving community readiness for suicide prevention
- **Data and Surveillance** – Identifying data sources (e.g., national, state, local/community, populations that are high risk or underserved) to guide planning and priorities; accessing data on related health issues (e.g., substance misuse, violence, social determinants of health) that can influence suicide; developing and sustaining partnerships with key data sources (e.g., local clinics and hospitals, behavioral health/substance misuse programs, community health representatives, IHS, schools and law enforcement) to ensure regular access to suicide and related surveillance
- **Strategic Planning** – Identifying and using data to guide and culturally contextualize planning; identifying or adapting evidence-based and/or cultural best practice strategies that can address identified objectives; monitoring program and/or strategy progress and using this information to guide future planning and adjust efforts
- **Capacity Building and Workforce Development** – Building staff and/or partner capacity in needed areas (e.g., grant management, data collection, coalition building, suicide prevention basics); building the skills of mental health and health care providers to assess, manage, and treat patients with suicide risk; building community capacity and awareness around suicide prevention (e.g., gatekeeper and other trainings, communications campaigns, community events)
- **Multicultural Competence** – Identifying and providing opportunities for staff to increase cultural responsiveness in working with specific groups in the community (e.g., LGBTQ2S, veterans, families, youth); researching and understanding the cultural context of communities reached by strategies and interventions (priority populations); tailoring and/or developing interventions and resources to address the values, beliefs, culture, and language of the populations served
- **Community Engagement** – Building community engagement processes into suicide prevention planning; strategies, processes, and practices to ensure equitable community

engagement in data collection and analysis; ways to involve diverse communities in selecting and implementing suicide prevention programming and services

- **Communication and Marketing** – Establishing sufficient staff and/or professional network capacity to respond to information requests from officials, communities, the media, and the public; ensuring messages about suicide adhere to safety guidelines; identifying ways to include messages that are action-oriented and promote hope, resiliency, recovery, and prevention successes in communication campaigns
- **Evaluation** – Addressing barriers to effective evaluation (e.g., limited resources, low response rates, historical experiences); presenting evaluation data to strengthen key support and buy-in from Tribal leaders and community members; collaborating with partners (e.g., local clinics/hospitals, Tribal behavioral health/substance misuse programs, schools) to collect and/or access outcome data to determine objective achievement and overall impact
- **Infrastructure Development** – Disseminating and educating partners on crisis response protocols; assessing and improving the availability of community mental health services that can effectively treat individuals experiencing a suicidal crisis; advising policymakers/Tribal council members on needed policies to support suicide prevention long-term
- **Sustainability** – Prioritizing and operationalizing successful program elements and partnerships after the end of targeted funding; connecting to state, public, and private funders to increase opportunities for future support; documenting and sharing successes and impacts with key supporters to strengthen program work

Needs were assessed on a scale with options that included "not a need" (scored as a 1), "low need" (2), "medium need" (3), "high need" (4), and "critical need" (5). As displayed in Figure 7, respondents anticipated a fairly strong need for assistance across all areas, most prominently addressing *data and surveillance* (3.42 average need score), *capacity building and workforce development* (3.37), and *community and political support* (3.34).