Suicide Surveillance: Challenges & Strategies in American Indian and Alaska Native Communities

Doreen M. Bird, MPH, (Kewa Pueblo)
Lead Investigator, Suicide Prevention Resource Center (SPRC), EDC

Melissa Adolfson-Co-Investigator, SPRC, EDC

Lauren Lockhart, LLMSW
American Indian Health and Family Services
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The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of CMHS, SAMHSA, or HHS.
Speakers

Doreen Bird, MPH, (Santo Domingo Pueblo) 
Senior Tribal Prevention Specialist 
Suicide Prevention Resource Center 
Education Development Center, Inc.

Lauren Lockhart, LLMSW, 
Program Manager 
American Indian Health and Family Services of 
SE Michigan
History of research with American Indian/Alaska Natives in the U.S.

- **1820**: Secretary of War, John C. Calhoun report to Congress on the missionary work with American Indians
- **1927**: U.S. Dept. of Interior, Office of Indian Affairs
  - Wards or Nations?
- **1944**: Old Oraibi: a study of the Hopi Indians of Third Mesa
- **1979**: The Center for Research on the Acts of Man
  - Barrow, Alaska
- **1989**: Havasupai Diabetes Study
  - ASU
- **Current**: CBPR approach to research widely accepted and supported
Study Rationale

- Garrett Lee Smith State and Tribal grants require demonstration of impact in reducing suicide deaths and attempts
- Tribal grantees encounter data collection challenges and are in need of effective strategies
- Results support TA provision
- Need for strategies that incorporate cultural sensitivity and awareness
Methods

- Lit Review Environmental scan
- 22 key informant interviews in 2016
- All 17 Tribal GLS grantees were sent a survey related to tribal suicide data and surveillance with a response rate of 100%.
- Results analyzed and will be shared with GLS grantees, Prevention Specialists, SAMHSA, and on sprc.org.
Types of Primary Data Collected by Current Tribal GLS Grantees, 2016

- Suicide deaths: 50%
- Suicide attempts: 86%
- Suicide plans: 43%
- Suicidal ideation: 79%
- Mental health: 86%
- Alcohol and drug use: 64%
- Other: 21%
Let’s hear from you?

1. What types of data do you collect on suicide deaths or attempts?

2. What types of data do you collect related to protective factors for suicide in your community?
Tribal GLS Grantee Challenges Related to Data Sharing, 2016

- Issues w/ privacy: 24%
- Lack of compatibility between systems: 53%
- Consistency in coding and definitions: 12%
- Lack of buy-in: 24%
- User-friendly data reporting: 41%
- Data reflecting negatively on community: 65%
- Cultural concerns regarding suicide: 35%
- Other: 18%
Challenge: Data Keepers

Unwilling to share data due to privacy, confidentiality, or other concerns.

Strategies:
- Meet with data keepers in person initially to build relationships
- Reach out to off-reservation providers/campus/state
- Partner with regional Tribal Epidemiology Centers
- Create MOU’s that set up protections for patient data
Challenge: Taboos

Cultural taboos related to talking about and/or measuring death and suicide.

- One Tribal Nation does not believe in counting deaths or how many children they have lost.
- Another does not believe in talking about people who have passed on.
Q9. What, if any, are the cultural barriers to counting suicide deaths in your community?

“Stigma in the community, not wanting to talk about suicide, beliefs that talking about suicide will lead to suicide, lack of knowledge about suicide and its prevalence in our population, not willing to see that some deaths labeled as "accidents," like overdoses, are actually suicides.”

- GLS Grantee
Strategies to Address Taboos

- Only collect as much data and information as you need.
- Engage elders and youth
- Incorporate other ways of knowing
Audience Brainstorm

What are your ideas for addressing taboos around suicide data?
Promising Strategies

- Use the platform of cultural preservation to make an opening for discussion

- “Suicide surveillance requires communication and is a form of preservation of our culture & people.“

  - Tribal GLS Survey Respondents
“This is good, noble work that we’re doing. It’s easy to get discouraged… And I get there about once a week. But this is good work, and we need to tell our people that are working in the field… that their work matters.”

-Key Informant
Limitations

Data presented in this report were from a sample of tribes receiving GLS funding and are not generalizable to the greater AI/AN population.
Questions?

Doreen Bird: 
Dbird@edc.org

www.sprc.org

Thank You!
SPRC Tribal Suicide Surveillance: Sacred Bundle Project Hope and Wellness Screenings

Lauren Lockhart, LLMSW
Program Manager for the American Indian Health and Family Services of Southeast MI (AIHFS) “Manidookewigashkibjigan” Sacred Bundle: R.E.S.P.E.C.T.” Project
Manidookewigashkibjigan-Sacred Bundle: R.E.S.P.E.C.T. Projects

First GLS SAMHSA Grant:
Awarded to American Indian Health and Family Services of Southeast Michigan, Inc. (AIHFS) and the U of MI School of Social Work: 08/01/11 - 07/31/14.

Second GLS SAMHSA Grant:
Awarded to AIHFS and the U of MI School of Social Work to continue and expand the work to the 12 Tribes of Michigan: 09/30/14 - 09/29/19.
Hope and Wellness Screening Documents

PH-Q 9

CRAFFT (10-17 year olds)

DAST & AUDIT (18-24 year olds)

Demographic Survey

Wrap-Up Questions
Hope and Wellness Screenings Staff

Event Coordinator – plans and oversees activities.
Flow Manager – assigns tents, keeps tracks of who is where.
2 Intake staff – welcome, sign-in, assign screeners.
7-10 Screeners – conduct screenings (trained in safeTALK/ASIST).
1-2 Behavioral Health providers – conduct interventions and check all paperwork.
2 Check-out staff – double-check paperwork, give youth resources (locally based) and incentive, secure materials.
1-2 additional “floating” staff/volunteers.
Hope and Wellness Screenings Set-up

Staff/volunteers arrive 3 hours before screenings to set up.
Large tent and 4-5 tables with chairs for check-in, check-out, and consent process.
4-5 small tents with a small table, chairs, and lighting for conducting private screenings.
Station for Behavioral Health Provider to conduct interventions.
DIY Smokeless Smudge Bundle Table for youth/parents waiting
Screenings: Process

Youth are welcomed, signed in, and introduced to a screener. Screener explains the process, and youth and parents sign consents/assents. The youth completes the paperwork, or the screener does an interview-style screening, in the private tents. Screeners score the PHQ-9, CRAFFT, AUDIT, DAST and discuss any items of concern with the youth (debriefing).
Screenings: Consents/Assents/IRB

Youth completes a consent/assent form.
Youth under 18 get parent/caregiver consent.
Consent forms have standard IRB components:
  Purpose/description.
  Benefits/risks.
  Voluntary nature/compensation.
  Confidentiality.
  Contact information.

NOTE: IRB was required for first grant only.
Behavioral Health Provider Role

Youth who are determined to be at risk are immediately referred to an on-site Behavioral Health Provider.

BH Provider may conduct an intervention, develop a safety plan, and/or make referrals for the youth to get mental health or other services (youth program, traditional healing, for example).

Crisis Line

We contract with a local crisis line (Common Ground) that has agreed (through an MOU) to make follow-up calls to at-risk youth within 24-48 hours–if youth and parent/caregiver consent.
Wrap up Questions - Youth Designed

Who is the person that brings you the most joy or happiness in your life?
What are the two things you are most grateful for?
What is your favorite time of year and why?
What was the greatest experience in your life?
Who is the person you can trust or go to talk to when you are feeling down?
Demographics - Youth 10-24

GLS-1
Demographics of Youth Screened
April 2013 – July 2014

Age 10-13: 46
Age 14-17: 36
Multiracial: 55
AIAN/FN: 41
Non-AIAN/FN: 27
Missing Race: 11
Female: 2
Male: 54
Other: 2
Missing Gender: 1

GLS-2
Demographics of Youth Screened
April 2015 – April 2017

Age 10-13: 77
Age 14-17: 48
Multiracial: 60
AIAN/FN: 45
Non-AIAN/FN: 74
Missing Race: 47
Female: 10
Male: 9
Other: 4
Missing Gender: 3
EIRF/Healing Helper

After the screening the screener fills out a Healing Helper survey with Early Identification Referral and Follow-up (EIRF) SAMHSA required information:
- About the individual identified as being at risk,
- About the person who identified them as being at risk
- About circumstances of identification.
In our efforts to ensure that at-risk youth receive the help they need we are documenting dates when follow-up calls are made and number of attempted calls.
For GLS 2, we are developing a Toolkit to help other communities plan and implement screenings—presently piloting with Michigan Tribes.

The toolkit for community screening provides information on:

- Community Readiness Assessment.
- Training gatekeepers.
- Documents (surveys, consents, etc.).
- Planning and staffing community screenings.
- Partnerships and follow-up.
- Data use for grant applications and programming, for example.
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Questions?

Doreen Bird
dbird@edc.org
www.sprc.org

Lauren Lockhart
(313) 846-3718
llockhart@aihfs.org

https://www.facebook.com/sacredbundlehealinghelpers/

Thank You!

Nytra!

Miigwetch!