SPRC 2021 Tribal Suicide Prevention Needs Assessment

Aggregate Technical Report

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Background and Methods

Background

Between December 7, 2021, and January 28, 2022, the Suicide Prevention Resource Center (SPRC) and its partners at Social Science Research and Evaluation, Inc., (SSRE) conducted a Tribal Suicide Prevention Needs Assessment (TNA) with 200 suicide prevention coordinators or other individuals most knowledgeable about the suicide prevention efforts of tribes and tribal health boards (Area Health Boards that serve as member organizations of the National Indian Health Board) throughout the United States.

The primary purpose of the TNA is to help SPRC better understand tribal suicide prevention needs and track changes over time in suicide prevention capacity, while providing information to tribes and tribal health boards on their own progress and on tribal suicide prevention infrastructure and programming in the nation as a whole. Findings from the TNA are also expected to help SPRC identify and develop learning opportunities, supports, and resources for tribal suicide prevention coordinators.

The assessment invited 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 whether various factors considered beneficial to supporting an effective suicide prevention infrastructure were present in their tribe or tribal health board and detail their major challenges in these areas. They were also given the opportunity to rate their anticipated level of need in the upcoming year for technical assistance services (i.e., support, tools, resources) across a variety of areas.

Methods

The TNA was conducted as an online questionnaire. All tribal representatives for whom contact information was available at the time of the assessment (representing 192 tribes and 8 tribal health boards) were contacted via email and asked to participate. The assessment could be completed either by one designated individual or by a team submitting one formal response. Respondents could complete the assessment all at once or submit partial answers and return to complete it later.

Sixty-one of the 200 invited representatives responded (31% response rate). Six respondents opted out of the assessment, 43 completed it fully, and 12 completed it partially (28% participation rate). Fifty-three of the 55 participating respondents (96%) represented tribes and 2 represented tribal health boards (4%). 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 (tribal health boards are not categorized by IHS or BIA areas/regions), with 10 of 12 IHS areas and 11 of 12 BIA regions represented.

Limitations

Results from this assessment are limited by both the number of tribes and tribal health boards for which accurate contact information was available to distribute invitations and the final number of respondents. Given the large and diverse tribal population, 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/tribal health board's suicide prevention efforts are implemented in one state (75%), in a rural setting (92%), serving a small population of between 1 and 5,000 tribal members (65%), and reaching non-tribal residents and citizens-at-large in addition to tribal residents (71%).

Table 1: Service Landscape – Area, Setting, Population, Scope

	Percent	Count
Service Area (N=53)		
One state	75%	40
Multiple states	25%	13
Setting(s) (N=53, multiple responses possible)		
Remote/Frontier	19%	10
Rural	92%	49
Suburban	11%	6
Urban	9%	5
Number of Individuals Who Are Part of the Tribe(s) Served by Suicide Prevention Efforts (N=52)		
0	8%	4
1 to 5,000	65%	34
5,001 to 10,000	17%	9
10,001 to 25,000	4%	2
25,001 to 50,000	4%	2
50,001 to 75,000	0%	0
75,001 to 100,000	0%	0
More than 100,000	2%	1
Suicide Prevention Efforts Serve Non-Tribal Residents and Citizens-at-Large (N=52)		
No, our suicide prevention efforts only serve tribal members	29%	15
Yes, our suicide prevention efforts also serve non-tribal residents and citizens-at-large	71%	37

Suicide Prevention Infrastructure

Structure and Support

Designated Office/Division of Suicide Prevention

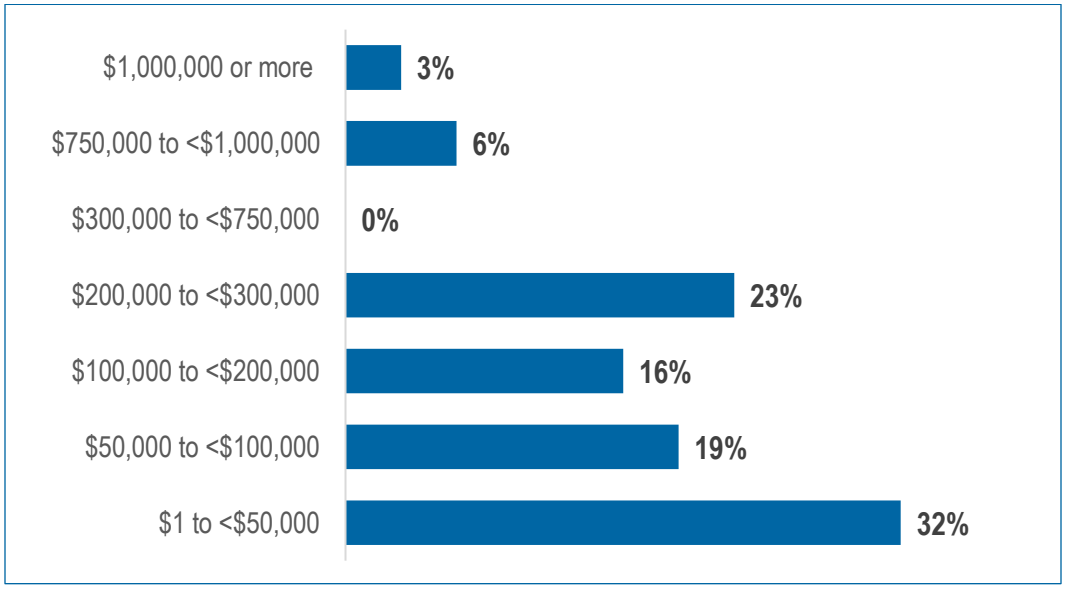
Seventy-three percent of respondents (73%, 37 of 51) indicated that their tribe/tribal health board has a designated office/division of suicide prevention.

Value of Current Annual Budget for Suicide Prevention Efforts

Most responding tribes/tribal health boards (72%, 31 of 43) reported having a dedicated budget for suicide prevention efforts (8 were unsure). The majority of those with dedicated funding (90%) indicated that the annual value was less than $300,000. See Figure 1.

Figure 1: Approximate Annual Budget for Suicide Prevention Efforts Among Those with Dedicated Funding

(N=31)



Proportion of Annual Suicide Prevention Budget Derived from Federal Grants

As displayed in Table 2, most tribes/tribal health boards with some level of annual suicide prevention funding indicated that *all* of that funding comes from federal grants (71%) (5 were unsure).

Table 2: Proportion of Suicide Prevention Funding That Comes from Federal Grants

(N=34)

	Percent	Count
None of It	6%	2
Less than Half	9%	3
About Half	9%	3
More than Half	6%	2
All of It	71%	24

Federal Grant Funding for Suicide Prevention Efforts

Tribes/tribal health boards with some proportion of their annual funding derived from federal grants were asked to identify the source(s) of that federal funding. As displayed in Table 3, the most common source of federal funding was the *SAMHSA Native Connections Grant* (67% of those with federal funding cited this as a funding source), followed by *SAMHSA Tribal Opioid Response (TOR) Grant* (33%) and *IHS Substance Abuse and Suicide Prevention Initiative Grant (Formerly MSPI)* (31%).

Table 3: Sources of Federal Funding for Suicide Prevention Efforts
(N=36)

Multiple responses possible	Percent	Count
SAMHSA Native Connections Grant	67%	24
SAMHSA Tribal Opioid Response (TOR) Grant	33%	12
IHS Substance Abuse and Suicide Prevention Initiative Grant (Formerly MSPI)	31%	11
SAMHSA COVID-19 Emergency Response for Suicide Prevention Grant	11%	4
SAMHSA GLS State/Tribal Youth Suicide Prevention Grant	8%	3
SAMHSA Circles of Care Grant	6%	2
SAMHSA Zero Suicide Grant	6%	2
CDC Center for State, Tribal, Local, and Territorial Support (CSTLTS) Funding (e.g., Tribal COVID-19 Response, PHHS Block Grant)	3%	1
SAMHSA GLS Campus Suicide Prevention Grant	0%	0
SAMHSA National Strategy for Suicide Prevention (NSSP) Grant	0%	0
Other federal funding*	11%	4

*"Other" responses include: IHS Compact/Contract, OJJDP Tribal Youth Program (TYP) Grant, SAMHSA Project Aware.

Non-Federal Grant Funding for Suicide Prevention Efforts

Respondents who indicated that at least some portion of their annual suicide prevention budget is derived from non-federal sources were asked to identify the source(s) of that non-federal funding. As displayed in Table 4, the most common source of non-federal funding was a *tribal budget line item* (47%), followed by *tribal gaming revenue* (20%). No respondents reported receiving funding through either *private foundation grant(s) or private donations*.

Table 4: Sources of Non-Federal Funding for Suicide Prevention Efforts
(N=15)

Multiple responses possible	Percent	Count
Tribal budget line item	47%	7
Tribal gaming revenue	20%	3
Private foundation grant(s)	0%	0
Private donations	0%	0
Other non-federal funding*	40%	6

*"Other" responses include: Alcohol tax, Third party revenue, General fund, Behavioral health program funds, State health authority.

Services Provided by Suicide Prevention Program

Prevention programming/services was identified as the service effort most commonly provided by tribe/tribal health board suicide prevention programs (identified by 75% of respondents), followed by *suicide prevention staff position(s)* (57%), both *community coalition/advisory*

board/council support and *data collection (assessment, evaluation)* (45%, respectively), *strategic planning* (43%), *treatment services* (39%), *postvention* (35%), *crisis lines/response services* (31%), and *research* (8%). Ten percent (10%) of respondents indicated that their suicide prevention program does not provide any services. See Table 5.

Table 5: Services Provided by Suicide Prevention Program
(N=51)

Multiple responses possible	Percent	Count
Prevention programming/services	75%	38
Suicide prevention staff position(s)	57%	29
Community coalition/advisory board/council support	45%	23
Data collection (assessment, evaluation)	45%	23
Strategic planning	43%	22
Treatment services	39%	20
Postvention	35%	18
Crisis lines/response services	31%	16
Research	8%	4
Other*	8%	4
None of the above	10%	5

*"Other" responses include: Question/Persuade/Refer (QPR), Referrals, Volunteer outreach, Cultural and healing interventions and activities (ceremonies, Inipi, customs, traditional practices).

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 priorities (greater importance placed on other health/behavioral health areas)* was the most common challenge to developing and maintaining funding for tribal suicide prevention efforts (identified as a challenge by 43% of respondents), followed by *inconsistent funding* (31%) and *competing demands for staff time* (29%). Only 6% of respondents stated that they had not experienced any challenges in developing and maintaining funding, while at least one-fifth identified each of the listed options as an impediment.

Table 6: Challenges in Developing and Maintaining Funding for Suicide Prevention
(N=51)

Up to 3 responses possible	Percent	Count
Competing priorities (greater importance placed on other health/behavioral health areas)	43%	22
Inconsistent funding (sporadic, dependent on grants)	31%	16
Competing demands for staff time (insufficient time to devote to developing/maintaining funding)	29%	15
Lack of support or buy-in from internal leadership	26%	13
Limited external advocates/champions	24%	12
Insufficient funding (not enough funding)	20%	10
Other*	26%	13
We have not had any challenges in this area	6%	3

*"Other" responses include: COVID-19, Insufficient staffing (lack of professional staff), Lack of infrastructure (lack of centralized suicide prevention office, lack of strategic planning), Lack of partner follow-through on coordinated efforts, Competition between tribes and tribal health boards for grants, Short duration grants (3-year timeframe instead of 5-10 years).

Capacity and Collaboration

Staffing

Fifty-nine percent of responding tribes/tribal health boards (59%) employ full-time and/or part-time suicide prevention staff (39% employ only full-time staff, 12% employ only part-time staff, and 8% employ both full-time and part-time staff), employing an average of 1.53 individuals among all respondents and 2.67 among only those who employ staff. Just under half of all respondents (47%) employ full-time staff while 20% employ part-time staff. See Table 7.

Table 7: Employment of Full-Time and Part-Time Suicide Prevention Staff

(N=49)

	Percent	Count	Average Number of Staff – Of All Respondents	Average Number of Staff – Of Those Who Employ Staff
Employ full-time **and/or** part-time staff	59%	29	1.53	2.67
- Employ full-time staff *only*	39%	19	-	2.74
- Employ part-time staff *only*	12%	6	-	2.00
- Employ full *and* part-time staff	8%	4	-	3.33

Management of Suicide Prevention Efforts

Just over half of responding tribes/tribal health boards (53%, 26 of 49) have a single lead person who manages their suicide prevention efforts, with 37% of TNA respondents indicating that they are the manager overseeing their tribe/tribal health board's efforts.

Challenges – Hiring and Maintaining Suicide Prevention Staff

The most significant challenge facing tribes/tribal health boards when it comes to hiring and maintaining suicide prevention staff is *workforce shortage in relevant areas* (identified as a challenge by 38% of respondents), followed by *insufficient funding to hire staff* (30%) and *difficulty recruiting for time-limited (grant) positions* (28%). Eleven percent (11%) of respondents stated that they had not experienced any challenges in this area. See Table 8.

Table 8: Challenges in Hiring and Maintaining Suicide Prevention Staff

(N=47)

Up to 3 responses possible	Percent	Count
Workforce shortage in relevant areas	38%	18
Insufficient funding to hire staff	30%	14
Difficulty recruiting for time-limited (grant) positions	28%	13
Difficulty hiring during COVID-19	23%	11
Non-competitive salaries	21%	10
Burdensome hiring process	15%	7
Difficulty recruiting diverse workforce members	13%	6
Staff burn-out (workload, vicarious trauma, turnover)	11%	5
Other*	15%	7
We have not had any challenges in this area	11%	5

*"Other" responses include: Lack of coordination among funded efforts, Lack of full-time opportunities, Lack of trained and motivated workforce, Logistics (e.g., space limitations).

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

Respondents were asked to characterize the level of **communication** related to suicide prevention between their tribe/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 *poor* (31%) or *fair* (29%).

Table 9: Communication Between Tribe/Tribal Health Board and State(s)

(N=48)

	Percent	Count
Extremely Poor	13%	6
Poor	31%	15
Fair	29%	14
Good	23%	11
Excellent	4%	2

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

Respondents were also asked to describe the level of **collaboration** related to suicide prevention between their tribe/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 *awareness (knowledge of each other's activities)* (41%), followed by *none (no awareness or interaction)* (25%).

Table 10: Collaboration Between Tribe/Tribal Health Board and State(s)

(N=49)

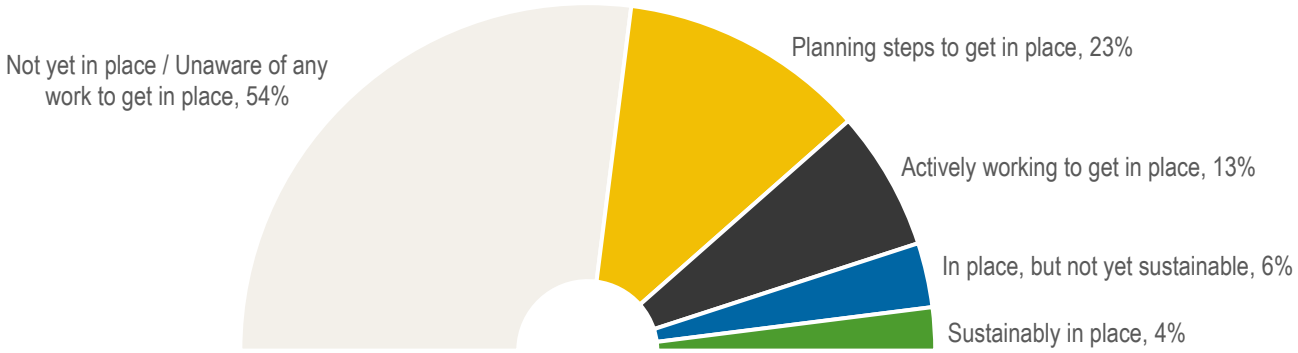
	Percent	Count
None (no awareness or interaction)	25%	12
Awareness (knowledge of each other’s activities)	41%	20
Networking (back and forth sharing of information)	18%	9
Coordination (common and often interactive efforts)	10%	5
Collaboration (shared goals and decision-making)	6%	3

Data, Surveillance, and Evaluation

System for Collecting and Analyzing Suicide Death Data

As displayed in Figure 2, 10% of respondents indicated that their tribe/tribal health board has a system in place to collect and analyze suicide death data, with only 4% indicating that the system is sustainable. Over half (54%) reported that no such system is in place and they are unaware of any work being done to get it in place, while 36% are either planning (23%) or actively working (13%) to get it in place.

Figure 2: Progress Toward Having System in Place for Collecting and Analyzing Suicide Death Data
(N=48)



Linking Data from Different Systems

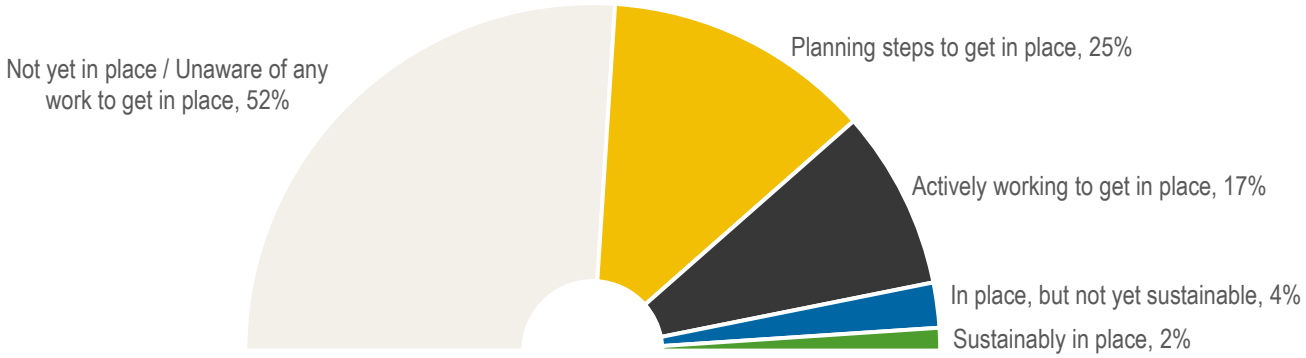
As displayed in Figure 3, just 8% of respondents indicated that their tribe/tribal health board has the ability to link suicide prevention data from different systems (e.g., connecting mental health system records with death certificate records, securely sharing data between different medical record systems), with half of those (4%) reporting that the capability is sustainably in place. Over two-thirds (69%) reported that this capacity is not yet in place and they are unaware of work being done to advance it, while 23% are either planning (19%) or actively working (4%) to do so.

Figure 3: Progress Toward Linking Data from Different Systems
(N=48)

Ensuring Data Representation of Populations that Are High Risk and Underserved

Only 6% of respondents reported that their tribe/tribal health board can ensure that populations that are high risk and underserved (e.g., Two-spirit, LGBT+, Youth in Foster Care, Veterans, Crime Victims, Lived Experience) are sufficiently represented in their suicide-related data, with 2% indicating that the ability to do so is sustainably in place. Most (52%) reported having no system in place for doing so and are unaware of work being done on the matter, while 42% are either planning (25%) or actively working (17%) 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=48)



Challenges – Collecting, Storing, and Analyzing Suicide Data

As displayed in Table 11, *insufficient staffing (lack of dedicated staff, limited time, turnover)* was the most common challenge identified by tribes/tribal health boards in collecting, storing, and analyzing suicide data (identified as a challenge by 54% of respondents), followed by both *difficulty accessing data (no access, no data sharing agreement)* and *no centralized system to store data* (44%, respectively). Only 4% of respondents stated that they had not experienced data-related challenges.

Table 11: Challenges in Collecting, Storing, and Analyzing Suicide Data
(N=46)

Up to 3 responses possible	Percent	Count
Insufficient staffing (lack of dedicated staff, limited time, turnover)	54%	25
Difficulty accessing data (no access, no data sharing agreement)	44%	20
No centralized system to store data	44%	20
Lack of data on specific populations (LGBTQ2S+)	26%	12
Challenging to analyze data (missing data, data suppression)	20%	9
Data lag (delays, embargo, bureaucracy)	15%	7
Difficulty linking data (confidentiality/privacy laws)	11%	5
Insufficient funding (lack of funding for linking/retrieving data)	11%	5
Offices/Divisions protective of data (ownership, bureaucracy)	7%	3
Other*	9%	4
We have not had any challenges in this area	4%	2

*"Other" responses include: Coordinating efforts (creating a system, how data would be submitted, data ownership, data management, fiscal responsibility), Race/Ethnicity/Language Data (REL).

Strategic Planning and Implementation

Emphasis on Addressing High-Level Strategies

Respondents were asked to assess the level of emphasis that their tribe/tribal health board places on addressing 10 high-level strategies from SPRC's Comprehensive Approach to Suicide Prevention[1] and the Centers for Disease and Control and Prevention's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*[2], 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/tribal health boards place the greatest emphasis on *promoting social connectedness and support* (5.66), followed by *responding effectively to individuals in crisis* (5.64) and *enhancing life skills and resilience* (5.62). They were less likely to emphasize *providing immediate and long-term postvention* (3.97), *reducing access to means of suicide* (4.11), and *supporting safe care transitions and creating organizational linkages* (4.19). Table 12 contains additional details on ratings for each strategy.

Targeted Tribal Prevention Strategies

Representatives 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 targeting* the populations listed. Most tribes/tribal health boards indicated they have suicide prevention strategies intentionally targeting age-based populations (77%), followed by 73% for location-based populations, 68% for populations with lived experience, 55% for populations that are marginalized, and 36% for occupational populations at high risk. The most commonly targeted populations were youth 10-17 (75%), rural communities (71%), young adults 18-24 (66%), and impacted families and friends (61%). See Table 13.

Involvement of Priority Populations in Suicide Prevention Activities

Respondents were asked how they involve members of populations they are trying to reach through targeted initiatives (priority populations) in suicide prevention activities. As displayed in Table 14, the most common involvement of priority populations was through them *helping to choose prevention activities* (64%), followed by *helping to identify unique community needs, challenges, and/or strengths* (61%), *providing ongoing feedback on activity practices, effectiveness, and/or opportunities for improvement* (52%), and *helping to implement targeted activities* (41%). It was less common for priority populations to *provide ongoing feedback on policies* (32%) or *help collect, analyze, and/or evaluate data* (25%). Nine tribes/tribal health boards (21%) indicated that priority populations are not involved in efforts.

[1] https://www.sprc.org/effective-prevention/comprehensive-approach
[2] https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf

Figure 5: Emphasis on Addressing High-Level Strategies – Mean Ratings

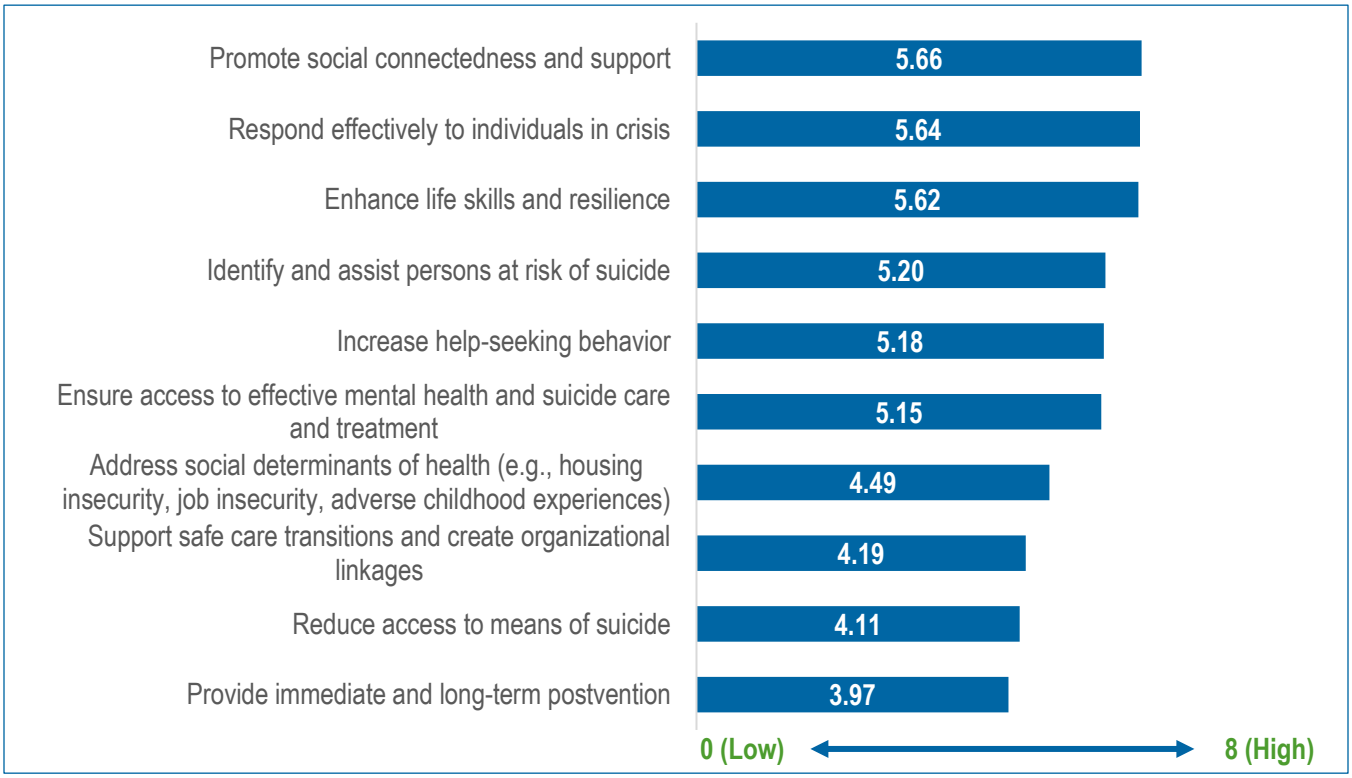


Table 12: Emphasis on Addressing High-Level Strategies – Detailed Response Data

	Low 0	1	2	3	4	5	6	7	High 8	Mean (Count)
Promote social connectedness and support	2% (1)	0% (0)	0% (0)	5% (2)	7% (3)	39% (16)	15% (6)	15% (6)	17% (7)	**5.66** (41)
Respond effectively to individuals in crisis	0% (0)	3% (1)	0% (0)	5% (2)	15% (6)	26% (10)	21% (8)	13% (5)	18% (7)	**5.64** (39)
Enhance life skills and resilience	3% (1)	3% (1)	0% (0)	3% (1)	10% (4)	31% (12)	21% (8)	13% (5)	18% (7)	**5.62** (39)
Identify and assist persons at risk	3% (1)	5% (2)	8% (3)	10% (4)	8% (3)	18% (7)	20% (8)	8% (3)	23% (9)	**5.20** (40)
Increase help-seeking behavior	0% (0)	5% (2)	5% (2)	8% (3)	11% (4)	30% (11)	16% (6)	14% (5)	11% (5)	**5.18** (38)
Ensure access to effective mental health and suicide care and treatment	0% (0)	3% (1)	5% (2)	18% (7)	15% (6)	15% (6)	15% (6)	15% (6)	15% (6)	**5.15** (40)
Address social determinants of health (e.g., housing insecurity, job insecurity, adverse childhood experiences [ACEs])	5% (2)	11% (4)	5% (2)	8% (3)	19% (7)	19% (7)	8% (3)	11% (4)	14% (5)	**4.49** (37)
Support safe care transitions and create organizational linkages	5% (2)	0% (0)	19% (7)	22% (8)	11% (4)	19% (7)	0% (0)	16% (6)	8% (3)	**4.19** (37)
Reduce access to means of suicide	3% (1)	14% (5)	3% (1)	29% (10)	9% (3)	9% (3)	14% (5)	17% (6)	3% (1)	**4.11** (35)
Provide immediate and long-term postvention	8% (3)	8% (3)	5% (2)	21% (8)	18% (7)	15% (6)	15% (6)	5% (2)	5% (2)	**3.97** (39)

Table 13: Populations Specifically Targeted by Suicide Prevention Strategies
(N=44)

Multiple responses possible	Percent	Count
AGE-BASED POPULATIONS		
Children Under 10	30%	13
Youth 10-17	75%	33
Young Adults 18-24	66%	29
Adults 25-44	25%	11
Middle-Aged Adults 45-64	21%	9
Older Adults 65+	14%	6
We do not currently have targeted strategies for these populations	23%	10
LOCATION-BASED POPULATIONS		
Rural Communities	71%	31
Suburban Communities	11%	5
Urban Communities	9%	4
We do not currently have targeted strategies for these populations	27%	12
OCCUPATIONAL POPULATIONS AT HIGH RISK		
Agricultural/Farming/Forestry Industry	7%	3
Construction Industry	5%	2
Mining/Quarrying/Oil-Gas Extraction Industry	2%	1
First Responders	14%	6
Law Enforcement	21%	9
Detention/Correctional Staff	5%	2
Healthcare Professionals	25%	11
Veterinarian Professionals	2%	1
Military/Veteran	16%	7
We do not currently have targeted strategies for these populations	64%	28
LIVED EXPERIENCE POPULATIONS		
Impacted Families and Friends	61%	27
Individuals with Serious Mental Illness	43%	19
Suicide Attempt Survivors	48%	21
Suicide Loss Survivors	48%	21
We do not currently have targeted strategies for these populations	32%	14
POPULATIONS THAT ARE MARGINALIZED		
People with serious physical health problems or disabilities	23%	10
People with substance use disorder	48%	21
Two-Spirit, Lesbian, Gay, Bisexual	39%	17
Transgender	21%	9
We do not currently have targeted strategies for these populations	46%	20

Table 14: Involvement of Priority Populations in Suicide Prevention Activities
(N=44)

Members of target populations… *(Multiple responses possible)*	Percent	Count
Help to choose prevention activities	64%	28
Help to identify unique community needs, challenges, and/or strengths	61%	27
Provide ongoing feedback on activity practices, effectiveness, and/or opportunities for improvements	52%	23
Help to implement targeted activities	41%	18
Provide ongoing feedback on policies being drafted or implemented	32%	14
Help collect, analyze, and/or evaluate data	25%	11
Are involved in other ways*	14%	6
None of the above	21%	9

*Other identified ways include: Community and traditional activities (walks, Zoom groups, community consortia pow-wows, involving traditional healers and community natural helpers to host cultural activities), Serve as facilitators, Focus groups.

Crisis Resources

National Suicide Prevention Lifeline

Most respondents (91%, 38 of 42) reported that their tribe/tribal health board advertises or hands out information about the National Suicide Prevention Lifeline.

Primary Promoted Crisis Resource

Respondents were asked to identify the primary resource their service population is encouraged to call if they are experiencing emotional distress and/or suicidal thoughts. As displayed in Table 15, the *National Suicide Prevention Lifeline* was the most commonly identified resource (34%), followed by *911* (18%) and *tribal police* (11%). Twenty-five percent (25%) of respondents identified other resources such as *behavioral health services*, their *tribal services department*, and *local resources* (crisis lines, resource lists).

Table 15: Primary Promoted Crisis Resource
(N=44)

	Percent	Count
National Suicide Prevention Lifeline	34%	15
911	18%	8
Tribal Police	11%	5
Tribal Health Department	9%	4
Indian Health Service	2%	1
Tribal Elders	0%	0
Other*	25%	11

*Other identified resources include: Behavioral health services, Tribal services department, Local resources (crisis line, resource list, text line), Crisis Intervention Resource Team, Friends/family.

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

Most respondents (59%, 26 of 44) reported that their service area does not have a tribal or Indian Health Service (IHS) mental health support/emotional crisis hotline, while 21% (9 of 44) said that they did and 21% (9 of 44) 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)* (67%, 6 of 9) and 33% (3 of 9) reported *Daytime business hours ONLY (e.g., 8 or 9 am – 4 or 5 PM)*.

Mobile Crisis Response Teams

Fewer than one-quarter of respondents (23%, 10 of 44) reported that mobile crisis response teams (whose main role is to de-escalate mental health crisis and suicide risk) exist in their service area, while 57% (25 of 44) said that they did not exist and 21% (9 of 44) were unsure.

Technical Assistance Needs

Respondents were asked to rate their tribe/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 people (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., LGBTQ2-S, veterans, families, youth); researching and understanding the cultural context of communities reached by strategies/interventions (target 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; how to involve diverse communities in selecting and implementing suicide prevention programming/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 stakeholders on crisis response protocols; assessing and improving the availability of community mental health services that can effectively treat suicidal individuals; 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 of "not a need" (scored as a 1), "low need" (2), "medium need" (3), "high need" (4), and "critical need" (5). As displayed in Figure 6 and Table 16, respondents anticipated a strong need for assistance across all areas, most prominently addressing *data and surveillance* (3.70 average need score, identified as a critical need by 23% of respondents) and *community engagement* (3.63 average need score, identified as a critical need by 32% of respondents). Respondents were also invited to identify other areas of need beyond those listed in the survey. Common requests centered around *funding* (identifying additional funding sources, obtaining funding to sustain time-limited staff positions tied to grants), *trauma-related training for staff* (suicide and related trauma, how to assist families impacted by suicide trauma, adverse childhood experiences [ACEs]), and *establishing crisis lines and/or crisis response teams*.

Figure 6: Technical Assistance Needs – Mean Ratings

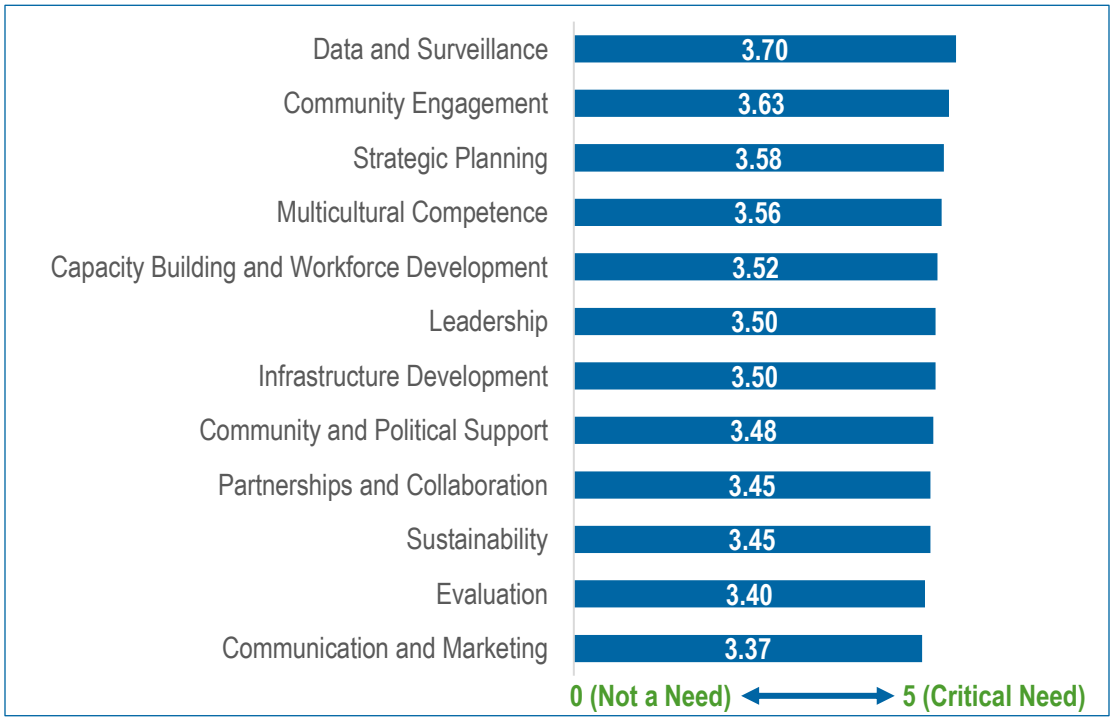


Table 16: Technical Assistance Needs – Detailed Response Data

	Not a Need 1	Low Need 2	Medium Need 3	High Need 4	Critical Need 5	Mean (Count)
Data and Surveillance	7% (3)	2% (1)	28% (12)	40% (17)	23% (10)	**3.70** (43)
Community Engagement	5% (2)	7% (3)	39% (16)	17% (7)	32% (13)	**3.63** (41)
Strategic Planning	7% (3)	16% (7)	12% (5)	42% (18)	23% (10)	**3.58** (43)
Multicultural Competence	5% (2)	7% (3)	33% (14)	40% (17)	16% (7)	**3.56** (43)
Capacity Building and Workforce Development	5% (2)	12% (5)	31% (13)	31% (13)	21% (9)	**3.52** (42)
Leadership	5% (2)	9% (4)	36% (16)	32% (14)	18% (8)	**3.50** (44)
Infrastructure Development	5% (2)	7% (3)	43% (18)	24% (10)	21% (9)	**3.50** (42)
Community and Political Support	7% (3)	11% (5)	30% (13)	32% (14)	21% (9)	**3.48** (44)
Partnerships and Collaborations	5% (2)	14% (6)	30% (13)	36% (16)	16% (7)	**3.45** (44)
Sustainability	8% (3)	13% (5)	28% (11)	33% (13)	20% (8)	**3.45** (40)
Evaluation	9% (4)	12% (5)	33% (14)	23% (10)	23% (10)	**3.40** (43)
Communication and Marketing	7% (3)	15% (6)	29% (12)	32% (13)	17% (7)	**3.37** (41)