



...I am lost for words
I know we need to grieve
And seven generations of loss is too much
for anyone to do it all at once ...

Ensuring the Seventh Generation: A Youth Suicide Prevention Toolkit for Tribal Child Welfare Programs



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NICWA
National Indian Child Welfare Association

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COVER ARTWORK

Healthy activities, like writing poetry, to express complicated emotions can prove helpful for youth impacted by suicide.

The poem fragment on the cover is from such a poem, which is printed in its entirety on page 23.

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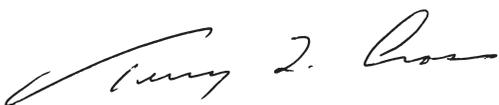
Purpose of “Ensuring the Seventh Generation: A Youth Suicide Prevention Toolkit for Tribal Child Welfare Programs”

The tragedy of suicide is dreaded by everyone. Tribal child welfare workers are no exception. Fortunately, they are in a position to do something about it. The purpose of this toolkit is to help tribal child welfare workers and care providers play an effective role in the prevention of suicide among the children and youth they serve. The tribal child welfare worker needs to consider several questions to be effective:

- What are the risk factors associated with child and youth suicide?
- Are there specific risk factors associated with children served in child welfare?
- What warning signs should caseworkers and care providers be alert to?
- What circumstances will require a tribal child welfare worker to have knowledge and skills to deal with the issue of suicide?
- What strategies can be applied in child welfare agencies to prevent or intervene in child and youth suicides?
- How can the child welfare worker mobilize support networks around particular children?
- What is the role of child protection in suicide prevention?
- What do I do in the case of a suicide attempt or completion by a child in care of my agency?

Each of these questions is addressed in this toolkit. In addition, the toolkit contains background reading on the issue of suicide in Indian Country and the use of cultural approaches to prevention and community healing. Several resources are also listed for further learning and follow-up.

This toolkit is meant to stimulate a conversation and spur tribal child welfare agencies to action. Policies and procedures need to be written and implemented. Crisis teams or collaborative protocols between service providers should be formed and periodically tested, practiced and revised. While every community hopes that they never have to confront these issues, too often they do, and frequently the children involved either were, or should have been, receiving some form of child welfare service.



Terry L. Cross, MSW, LCSW
NICWA Executive Director

Historical Background

American Indians and Alaska Natives (AI/AN) are at a heightened risk for suicide compared with other demographic groups in the country, according to the Suicide Prevention Action Network USA/Suicide Prevention Resource Center (SPAN USA/SPRC) fact sheet.

General Statistics:

- The AI/AN suicide rate from 1999 to 2004 was 10.84 per 100,000, higher than the overall U.S. rate of 10.75.
- Adults aged 25-29 had the highest rate of suicide, at 20.67 per 100,000.
- Suicide ranked as the eighth leading cause of death for American Indians/Alaska Natives of all ages.
- Suicide ranked as the second leading cause of death for those aged 10-34.

Why NICWA Developed This Toolkit

Every year NICWA's Board of Directors conducts focus groups at our annual conference to get direct feedback from our members and grassroots constituents to hear what issues are of concern in the field.

Based on feedback from the field, NICWA developed a workgroup of staff and board members in 2005. Since then, NICWA has annually addressed the issue in special issues of our newsletters, by dedicating an annual conference to this topic, and by conducting a national youth suicide prevention summit in 2007. In that summit, conducted in partnership with the National Congress of American Indians, Georgetown University, and the Center of Mental Health Services, NICWA learned that child welfare workers were untrained and unprepared to deal with the growing risk and incidence of suicide among youth. This toolkit is designed to help address that concern by informing workers and by supporting the development of appropriate policies.

Terms Used in the Toolkit

The phrase "tribal child welfare worker" is used extensively throughout this publication.

It is our intent that this phrase encompass all staff and organizers who endeavor to provide and improve social services, mental health services, clinical care, and child development.

Historical Background

Youth Statistics:

- In 2001, 16% of AI/AN youth attending Bureau of Indian Affairs schools had attempted suicide in the past 12 months.
- From 1999 to 2004, AI/AN males in the 15- to 24-year old age group had the highest suicide rate, at 27.99 per 100,000, compared to Caucasian (17.54 per 100,000), African American (12.80 per 100,000), and Asian Pacific/Asian Islander (AP/AI) (8.96 per 100,000) males of the same age.

How do you maintain a personal healthy balance in spite of the difficulties of this emotional work?

Delores Bigfoot, Director of Indian Country Child Trauma Center-University of Oklahoma Health Sciences Center

I think you really have to look at it in a bigger perspective and feel like it's a mission, it's not an employment opportunity, and that you think of particular children that have slipped through the cracks and you don't give up.

That there's always good works to be done, that you have a spiritual commitment to children, and that you use a lot of prayers and a lot of different kinds of blessings and different ways of connecting with people.

Developing Your Role

Tribal Child Welfare Workers and Child/Youth Suicide

Tribal child welfare workers frequently deal with children and youth who are at high risk for suicide (see Risk Factors for Child or Youth Suicide, page 20). However, child welfare deals with children in many different ways at different levels of intervention. Each of these levels will require a somewhat different level of response. Following are some of the possible circumstances in which a tribal child welfare worker might encounter and deal with the issue of suicide.

1. **Risk for suicide is complicated by parental negligence.** In this circumstance the child welfare worker receives a referral, usually from medical or mental health personnel seeking protective services for the child or youth at risk. The role of the child welfare worker is investigating; initiating court proceedings; developing a care plan that includes suicide prevention and intervention components; and engaging the parents, school, and care providers.
2. **A child who is currently the subject of an abuse or neglect investigation is identified as at risk of suicide.** A child whose family is in crisis is under a great deal of stress and may be in crisis related to the investigation. In this circumstance the child welfare worker's role includes risk assessment, mobilizing support systems, educating parents or care providers, and coordinating emergency response.
3. **A child whose family is receiving voluntary services, or living at home under court supervision, is identified as at risk for suicide.** To avoid removal, children or youth often remain at home while the family receives voluntary or court-ordered services. Frequently this type of arrangement is related to mental health or behavioral issues of the child. Such children or youth may be at risk for suicide. The child welfare worker's role includes case management, assessing or monitoring risk, coordinating with mental health care providers, mobilizing support systems, and educating and supporting the family.
4. **A child who is under the protective custody of the court, and who is placed with relatives or foster parents, is identified as at risk for suicide.** Children or youth in placement are at higher risk as a result of separation from parents and placement. These risk factors, along with possible risk factors related to victimization history or prior mental health issues, mean child welfare workers and care providers need to be on alert for suicide indicators. Workers need to know the risk factors, engage care providers in learning and monitoring the risks, and have a response network in place for assessment or intervention if necessary.
5. **A child or youth on your caseload attempts suicide.** Regardless of the services being provided, when a child or youth who is receiving child welfare services attempts suicide, the child welfare worker becomes part of, and may even be called on to lead, a crisis team.
6. **A child or youth on your caseload knows or has a significant relationship with someone in the community who commits suicide.** Risk for children or youth on your caseload is significantly increased when a relative or friend commits suicide. This may be current, but even a past event may trigger suicidal behavior, especially on the anniversary of the event. The role of the child welfare worker is to mobilize the support network, collaborate with colleagues, and closely monitor risk.
7. **A child or youth on your caseload commits suicide.** Despite our best efforts, occasionally a youth involved in child welfare will complete suicide. The worker's role will be to help limit the contagion factor by assessing risk to other youth, working with the family involved, cooperating with law enforcement, dealing with the media, and mobilizing supports for care providers and staff. It is important to remember that caseworkers will need professional debriefing and should seek mental health or employee assistance in response to such a loss. In addition, the tribal child welfare department will often need to deal with the media. A separate section of this toolkit is provided to guide that work (see pages 36-38, Mass-Communicating the Message of Prevention).

A Suicide Intervention Model for Child Welfare Workers

1. Assessment

Child welfare workers are often asked to make critical risk assessments under extraordinary time constraints. Thus, it is important for a risk assessment protocol to have a specific set of questions that will quickly and reliably obtain needed information. Questions often used address the following:

- What warning signs(s) initiated the referral?
- Has the youth/child thought about suicide? (Thoughts or threats alone, whether direct or indirect, may indicate low risk.)
- Has the student tried to hurt himself before? (Previous attempts may indicate moderate risk.)
- Does the student have a plan to harm herself now?
- What method is the student planning to use and does he have access to the means? (These questions would indicate high risk.)
- What is the support system that surrounds this child? (Including the parent or care provider in the risk assessment is critical to determining the adequacy of the child's support system.)

2. Duty to Warn Parents and Care Providers

Whether the child is in foster care or living at home, there is no question that parents must be notified. In addressing this aspect of suicide intervention, four critical questions need to be addressed.

- First, is the parent available?
- Second, is the parent cooperative?
- Third, what information does the parent have that might contribute to the assessment of risk?
- Fourth, what access and resources does the family have to acquire mental health services?

How do you maintain a personal healthy balance in spite of the difficulties of this emotional work?

Captain Andy Hunt, Project Officer, US Public Health Service-Center for Mental Health Services

I think nurturing a personal life that is fulfilling outside of work and career is critical to self-care. For me, this has always meant playing guitar, writing songs, and being in a band. I also keep physically active by participating in recreational sports teams and running. Having friends outside of work, spending time with family, and spirituality is also important to me.

Gathering Information About a Child and Family

Phone Assessment/Triage

(There may be times when we address all of these questions over the phone, and other times when some are addressed face to face. Use clinical judgment.)

- What is the child's age?
- Who else is with the child?
- What is the child currently doing? (Is the child threatening or calm? What is the child's current mood?)
- Is this a new behavior or is there a history of this type of behavior?
- Is the environment safe or does the child have access to dangerous objects? Does the family or responsible party have a safety plan that they feel is effective? Can they keep everyone safe?
- Is the child currently on prescribed medications? If so, what are they? Does the child take the medications as prescribed?
- Does the family have natural supports?
- Is the family involved with any service?
- What is the caller's perception of the problem?
- Consider developmental factors: What is age appropriate? Does the child typically function at age level?

Face to Face

- Gather information about the child's risk of harming self or other: Has the child ever done either in the past? (This includes fire setting and cruelty to animals.)
- Is there a family history of aggression or domestic violence?
- Gather information about current situation: What precipitated the current crisis? Have there been recent changes or disruptions for the child? Family conflict?
- Screen for mood or anxiety disorders: problems eating or sleeping, physical complaints, mood instability, social withdrawal, panic, flashbacks, irritability, or anger.
- Screen for thought disturbance.
- Are there concerns related to impairment in functioning — school or developmental delays — or concerns related to response to trauma?
- Consider systems issues: family system and the child's larger environment (i.e., school, social services, legal system, peers) that might be contributing to the current situation.
- How is the child currently responding to caregiver? To other adults?

Assess for Safety

- Is the caregiver able to provide the structure and support that the child needs at this time to be safe? (Assess caregiver's judgment and how the child and caregiver are interacting.)
- What steps can family take to ensure safety in the environment (i.e., safeguard medicine, weapons)?
- Are there other natural supports that can assist the family?
- Can the parents and child agree on a safety plan? Can conflict be resolved or "put on hold" until tension decreases within the household?

It is essential that foster parents, relative care providers, or group care providers be informed of any suicidal risk of any child or youth before they agree to take the child into their home or facility. Doing otherwise puts both the child and the family at risk. Care providers must be able to make an informed decision as to whether they feel they can keep the child or youth safe in their home. It may mean removing dangerous items such as firearms or arranging for care teams with school personnel. Families and group home staff should be briefed on risk factors and warning signs and trained on what they can do to reduce or manage risk. Ultimately, it is their decision as to whether they can manage the risk, and they must have the option to say no. This possibility can be greatly reduced with proper training and by demonstrating that the child welfare department has a well-thought-out plan and a support network to help the family or facility deal with the risk.

3. General Guidelines for Working with Parents and Care Providers

Note: Local policies and procedures vary and where they exist should be applied. The information provided below is for general guideline purposes only. Where policies and procedure do not exist, these guidelines may provide help in their development.

If the parent has custody and is available and cooperative and the youth is judged high-risk, the worker must provide parent(s) with community referral resources specific to where the family resides. With parental permission, the child welfare worker should contact the mental health agency, provide pertinent referral information, and follow up to insure the family's arrival at the agency. If necessary, the worker should assist the parent in transporting the child to the agency. The worker should obtain a parental signature on a release-of-information form. It is recommended that the child welfare worker call the mental health provider to provide accurate information that the parent may omit or forget.

The worker may also develop a school support plan with parents. All actions must be documented.

Suicide Warning Signs: URGENT

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means.
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities—seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious or agitated, being unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

If the parent has custody and is unavailable and the youth is judged high-risk, then, at the discretion of the child welfare administrator, two members of the child welfare staff or crisis team should escort the child to the nearest emergency mental health facility and coordinate efforts with the agency to contact the parent. Alternatively, law enforcement may be asked to assist in transporting the suicidal youth. The agency will, at the same time, locate and engage the parent.

If it is determined that a parent is uncooperative and the youth is judged to be at high risk for a suicidal behavior, then local law enforcement and/or the child welfare department should determine if a petition should be filed in tribal or state court. Responsibility for child protection situations varies by tribe, and not all tribal child welfare departments handle child protection, so local policies and procedures apply.

Some parents or care providers are reluctant to follow through on agency or crisis team recommendations to secure outside counseling for the suicidal child and may simplify or minimize warning signals (e.g., “she’s just doing this for attention”). Personal, cultural, and language issues are frequent, and knowing the cultural protocol regarding talking about suicide is essential. It is important to give the parents or care providers appropriate opportunity and encouragement to follow through before assuming sole responsibility or proceeding to the next step. The child welfare case-worker must decide when it is appropriate to file a court petition initiating a child protective services proceeding. This should only be done if the parent’s or care provider’s reluctance is truly negligent and endangers the life of the child. When a child is already under court supervision the worker must decide when removal from the care provider is warranted and what other placement will be safer.

Protective Factors Against Youth Suicide

Four essential protective factors to consider when offering youth suicide prevention, intervention, and healing are:

1. Connection to and support from family
2. Connection to and support from school
3. Connection to and support from the community
4. Connection to spiritual support

Other Protective Factors

- Effective clinical care for mental, physical, and substance use disorders
- Easy access for a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem-solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

Living with Major Depression

People living with depression and having suicidal thoughts are finding solace in online communities, where they can speak candidly and anonymously about their worries to people who understand. The National Alliance on Mental Illness (NAMI) has a community of online discussion groups for people with major depression, bipolar disorder, and other mental illnesses.

Warning Signs and Symptoms of Depression

- Prolonged sadness or unexplained crying spells
- Significant changes in appetite and sleep patterns
- Irritability, anger, worry, agitation, anxiety
- Pessimism, indifference
- Loss of energy, persistent lethargy
- Feelings of guilt, worthlessness
- Inability to concentrate, indecisiveness
- Inability to take pleasure in former interests, social withdrawal
- Unexplained aches and pains
- Recurring thoughts of death or suicide

If the agency has custody and the youth is in placement with a foster parent or relative and the youth is judged high-risk, then, at the discretion of the care provider or child welfare administrator, the care provider and/or members of the child welfare staff should escort the child to the nearest emergency mental health facility. The child welfare worker will coordinate efforts to contact parent(s). Alternatively, law enforcement may be asked to assist in transporting the suicidal youth.

If the parent is uncooperative and the student is judged low-risk for suicidal behavior, then it is recommended that the parent(s) sign a "Notification of Emergency Conference" form, which serves to document that the parent(s) have been notified of their child's suicidal assessment in a timely fashion.

There will be occasions when a youth does not want a parent(s) notified. When children are thinking of harming themselves, they are not thinking clearly and, therefore, may not be the best judge of what their parent's response might be. The child welfare worker must ask: Will I place the child in a more dangerous situation by notifying the parent(s)? In such a situation, child protective action will typically be taken. The parent(s) must still be notified and it is the challenge of the child welfare worker to elicit a supportive response from the parent(s).

So What Is Depression?

There are two types of depression. The first type is characterized by relatively short periods of feeling discouraged and irritable. These periods last a few hours or days. Most children and adults have experienced this type of depression.

The more serious type of depression is longer in duration. It is characterized by symptoms that persist two weeks or more.

Depression can look and feel different in children as compared to adults. Unexplained aches and pains, social withdrawal and irritability, and anxiety can reflect childhood depression. Disruptive behavior and attention deficit disorder may coincide. If you think a child has symptoms of depression, talk with the child. Establish some rapport initially, before asking the child to share how he or she is feeling and what he or she is thinking. Use open-ended questions. If concerns arise, speak to the adults in the child's life, unless the child discloses harm by that caretaker.

For parents and other family members, it is important to tell children that you care, that you will do your best to be there for them in their times of need. Repeat this often, as discouraged children may feel unworthy of love and may be in need of serious attention. Children may appear detached, and even "prickly," when struggling with depression, but they need reassurance. This reassurance comes with the comfort of knowing that there are people who are invested in their happiness, want to understand their struggles, and are willing to help find solutions.

The parent often has critical information necessary to make an appropriate assessment of risk. Thus it is critical to include parents in the risk assessment. This information may include previous school and mental health history, family dynamics, recent traumatic events in the child's life, and previous suicidal behaviors. Interviewing the parent will also assist the worker in making an appropriate assessment of the support system that surrounds this youth.

Finally, it is important to determine what mental health insurance the parent/family has. This information is essential in directing families to appropriate community agencies. If a student is directed to an emergency clinic, they may later require emergency transport to another provider. This may not only further traumatize a suicidal child (because most transports must be done under restraints) but also generate a bill of great expense for the parent. It is certainly in the best interest of the child and family to limit the trauma of any student in need of emergency action.

4. Follow-up and support for the family.

Finally, it is important for child welfare staff to provide ongoing modifications to the case plan, perhaps utilizing multi-disciplinary teams to ensure that the parent or care provider has access to the appropriate supports.

Tips for Tribal Child Welfare Workers or Care Providers

1. **Collaborate with colleagues.** Having support from and consultation with a supervisor, administrator, another staff member, or even colleagues in other agencies (perhaps the school nurse, mental health counselor, or law enforcement officer) is both reassuring and prudent. A crisis team (formal or informal) can be invaluable when planning for and dealing with a suicidal youth. It is critical to stress the importance of identifying and collaborating with community agencies before the crisis occurs.
2. **Assign a “designated response lead.”** Tribal child welfare programs should identify one or more individuals to receive and act upon all reports from foster parents, schools, and other staff about children in care or under agency supervision who may be suicidal. This individual should be charged with maintaining suicide prevention skills, knowledge of related resources, and relationships with intervention professionals.
3. **Supervise the child/youth in crisis.** It is best to always inform the child/youth of what you are going to do every step of the way. Solicit the child’s assistance where appropriate. Under no circumstances should the suicidal child/youth be allowed to be alone. Reassure and supervise the child/youth until a mental health professional or law enforcement representative can assume responsibility.

A Crisis Intervention Model

One model addressed by Barrio includes a seven-stage crisis intervention. The model includes:

- “Plan and conduct a crisis assessment,
- Establish rapport and rapidly establish relationship,
- Identify major problems,
- Deal with feelings and emotions,
- Generate and explore alternatives,
- Develop and formulate an action plan,
- Establish follow-up plan.” (Barrio, 2007)

Barrio quoted Shea, 1999, by stating that “the primary purpose of suicide assessment is to collect information regarding risk factors and suicidal ideation so that the clinician may make an educated decision in client’s best interest.” (Barrio, 2007) Barrio, 2007, noted that clinical interviews are often unstructured and recommends general questions, such as, “Do things ever get so bad you think about hurting yourself?” The responses that are solicited from such general questioning can provide direction if additional assessment is necessary. Some additional questioning can include assessment of psychiatric history and recent decreases in self-care.

It is imperative that a clinician develop an understanding of local rules and regulations that pertain to the “rights of children, informed consent, a client’s right to confidentiality.”

4. **Mobilize a support system.** Assessment of the child's support system will contribute to evaluating the risk. It is often sensible to just ask the child/youth, "Who do you want or who do you think will be there for you now?" and assist them in achieving that support. It is important for youth to feel some control over their fate.
5. **Consider no-suicide contracts.** No-suicide contracts have been shown to be effective in preventing youth suicide. In cases where the suicide risk is judged to be low enough not to require an immediate treatment (e.g., there is only ideation and no suicide plan), a no-suicide contract is still recommended to provide the youth with alternatives should their suicide risk level increase in the future. Such a contract is a personal agreement to postpone suicidal behaviors until help can be obtained. The contract can also serve as an effective assessment tool. If a youth refuses to sign, they cannot guarantee they will not hurt themselves. The assessment immediately rises to high risk and the student should be supervised until a mental health professional or law enforcement personnel can assume responsibility in taking the youth for immediate psychiatric evaluation.
6. **Suicide-proof the environment.** Whether a child is in imminent danger or not, it is recommended that both the home and school be suicide-proofed. Before the child returns home and thereafter, all guns, poisons, medications, and sharp objects must be removed or made inaccessible.
7. **Call police.** All crisis plans should include representatives from local law enforcement. If a youth resists, becomes combative, or attempts to flee, law enforcement can be of invaluable assistance. In some cases they can assume responsibility for securing a "72-hour hold," which will place the youth in protective custody up to three days for psychiatric observation.
8. **Develop documentation.** Every tribal child welfare program should develop a documentation form for casework personnel and crisis team members to record their actions in responding to a referral of a suicidal youth.

Acknowledgement:

NICWA made extensive use of materials developed by the National Association of School Psychologists for school personnel to develop this section. We wish to thank the NASP for their important work and for making it free online. That information can be found at http://www.nasponline.org/resources/crisis_safety/suicidept2_general.aspx.

Assessment of Risk

Risk Factors for Child or Youth Suicide

There are many risk factors that contribute to the alarming rate of suicide among Native American youth. Although research is limited, many risk factors have been identified. Several of these risk factors are of specific concern in child welfare. The following lists are sorted by general risk and specific child welfare-related risks. Looking at the risk factors in this way points out the significance of this issue for Native children and youth in child welfare settings.

Child Welfare-Related Risks

- History of trauma or abuse
- Sexual abuse exposure, especially among females
- Neglect
- Family history of physical abuse and violence
- Relational or social loss
- Lack of social support and sense of isolation
- Feeling of alienation from family and community
- Family loss, separation, and disruption
- Rapid social change and devastating economic conditions
- Multiple home placements
- Involvement in the juvenile justice system
- Living with consistent family instability
- Poor parent-child communication

General Risk Factors

- Previous suicide attempt
- Acute suicidal ideation
- Mental disorders, depression, schizophrenia, anxiety disorders, certain personality disorders, and post traumatic stress disorder
- Hopelessness
- Parental suicidal behaviors, family history of suicide
- Suicide of a close friend or relative
- Exposure to suicides by others, either directly or through the media
- Local clusters of suicide that have contagious influence
- Not talking about suicide ideation
- Easy access to lethal means
- Early loss
- Chaotic or inflexible family structures, parental conflict
- Strained interpersonal relationships
- Deficit of coping and problem solving skills
- School problems, family conflict, unwanted pregnancy
- Impulsivity and aggression

- Being lesbian, gay, bi-sexual, transgender, questioning, and two-spirited
- Weekly consumption of alcohol or controlled substances
- Some major physical illnesses
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- Low self-esteem
- Contracting a sexually transmitted disease
- Poor self-perception of health status

Assessing Suicidality in Children

Risk Factors for Children:

- Early loss
- Parental conflict
- Chaotic or inflexible family structures
- Abuse
- Neglect
- Parental suicidal behaviors
- Quality of family life

Suicide and Mental Illness

Between 60 percent and 90 percent of suicide victims have a significant psychiatric illness at the time of their death. These are often undiagnosed, untreated, or both. Mood disorders (such as bipolar disorder, borderline personality disorder, depression, etc.) and substance abuse are the two most common.

When both mood disorders and substance abuse are present, the risk for suicide is much greater, particularly for adolescents and young adults.

Research has shown that when open aggression, anxiety, or agitation is present in individuals who are depressed, the risk for suicide increases significantly.

Research also shows that the risk for suicide is associated with changes in brain chemicals called neurotransmitters, including serotonin. Decreased levels of serotonin have been found in people with depression and impulsive disorders, in people with a history of suicide attempts, and in the brains of suicide victims.

Suicidal Thoughts

With prolonged depression, children experience a sense of hopelessness. They may turn towards thoughts of resolving their depression with suicide. Family members are better equipped to deal with depression when they become aware of the signs of suicidal thoughts:

- Giving away possessions or making plans for a future when they are gone
- Talk of unbearable feelings or situations
- New or more frequent thoughts of suicide or death
- New or worsened depression
- New or worsened anxiety
- Pronounced agitation or restlessness
- Difficulty sleeping (insomnia)
- New or worsened irritability
- New or increased social isolation
- Attempts to commit suicide
- Aggression, anger, or violence
- Acting on dangerous impulses
- Increased use of alcohol or controlled substances
- Extreme hyperactivity in behavior and speech
- Other unusual changes in behavior, including a sudden sense of calm as if a final decision has been made

Additional Indicators

- Picking fights, arguing
- Refusing help, feeling beyond help
- Sudden improvement in mood after being down or withdrawn
- Neglect of appearance, hygiene
- Dropping out of activities
- Verbal clues (see below)
- A detailed plan for how, when, and where
- Obtaining a weapon
- Suicidal gestures (e.g., overdose, cutting)

Less Direct Verbal Cues

- "You will be better off without me."
- "I'm so tired of it all."
- "What's the point of living?"
- "Here, take this. I won't be needing it anymore."
- "Pretty soon you won't have to worry about me."
- "Goodbye, we all have to say goodbye."
- "How do you become an organ donor?"
- "Who cares if I am dead anyway?"

This list of warning signs is promoted by the National Suicide Prevention Lifeline (www.suicidepreventionlifeline.org), and the other indicators come from the National Center for Suicide Prevention training.

For more information go to: www.ncspt.org

Risk Factors for LGBTQ Youth

Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) people have extremely high rates of depression, suicidal thoughts, and suicide attempts.

The feelings and experiences of LGBTQ teens, often elicited by their environment, are factors related to suicidal thoughts and attempts. These include “social isolation, anger, depression, repeated stress, feelings of inadequacy, and sexual identity difficulties.” (Quinn, 2002) “GLBTQ teens face mental health, self-concept, and identity issues; increased risk of suicide; and homelessness after being thrown out or running away. The lack of services for these teens is not only detrimental but can be fatal.” Suicide rates among GLBTQ teens “comprise 30% of all adolescent suicides,” and “gay youth are 2-3 times more likely to attempt suicide than heterosexual young people” (Quinn, 2002). “It has been found that the primary cause of suicide among GLBTQ teens, as reported by GLBTQ teens, is negative family interactions.” (Quinn, 2002) The role of the child protective worker is instrumental in the lives of GLBTQ teen clients.

- The bulk of reviews of the research on lesbian, gay, and bisexual (LGB) people who attempted suicide conclude that young LGB people have a significantly higher risk of attempting suicide than heterosexual young people and that most attempted suicides among LGB people occur during adolescence or young adulthood.
- Suicide attempt rates range from 52.4% (9th to 12th grade) for lesbian and bisexual (LB) females to 29% for gay and bisexual (GB) (9th to 12th grade) males, compared with heterosexual suicide attempt rates of 4.6 percent, according to the National Comorbidity Survey.
- According to a study by A.R. D’Augelli and S. Hersberger, LGB youth were three times more likely to report attempted suicide than heterosexual youth.
- Russell and Joyner (2001) found that the risk of attempting suicide was twice as high among LGB youth as among heterosexual youth.
- Though specifics vary, the research generally agrees that LGB youth face much higher levels of suicidal ideation than their heterosexual peers.
- Cochran and Mays (2001) found that 41.2% of gay men aged 17-39 reported suicidal ideation, while only 17.2% of similarly aged heterosexual men did so.
- Eisenberg and Resnick (2006) found that 47.3% of GB adolescent boys and 72.9% of LB adolescent girls reported suicidal ideation (compared with 34.7% non-GB adolescent boys and 53% non-LB adolescent girls).
- Ramafedi and his colleagues found that 31.2% of GB male high school students reported suicidal ideation, as did 36.4% of LB female students. The proportions for heterosexual students were 20.1% and 34.3%, respectively.

Kitts did a literature review and concludes that the research reveals that the elevated risk of suicide attempts among LGB adolescents is a consequence of the increased psychosocial stressors associated with being LGB, including gender nonconformity, victimization, lack of support, dropping out of school, family problems, acquaintances’ suicide attempts, homelessness, substance abuse, depression, and other psychological disorders. Although risk factors are experienced by heterosexual adolescents, they are more prevalent in LGB youth.

Perspectives: Youth-Research-Culture-Professional-Media

Reflections from a Youth Leader in Suicide Prevention Issues Written by Jasara Big Boy

We are all connected; we all feel and know the tragedy when a young person takes his/her life. At NICWA, the Mental Health and Suicide Prevention Committee reorganized itself to concentrate solely on one of our most pressing and urgent issues: youth suicide. Our youth attempt and commit suicide at five times the rate of other American teenagers. This alarming statistic illuminates the gap in mental health needs and the services provided to youth. A major barrier to the prevention of suicide is the stigma around the term “mental health” and the overwhelmingly formal settings. Frequently, mental health providers are non-Indian and do not have the cultural competency to understand various underlying issues. This can lead to misdiagnoses or recommendations for ineffective treatment. The committee has set up some preliminary goals to attempt to understand and eventually eliminate the gap in mental health care. The goals of the committee include information gathering and dissemination as a clearinghouse for research, identifying best practices, exploring and developing trainings, and finding funding sources for these goals.

Suicide can be, and often is, a highly misunderstood phenomenon. Risk factors increase the probability of suicide while certain protective factors prevent and deter youth from suicide. Risk factors that contribute to suicide ideation and attempts are complex and difficult to address. Most common are alcohol/drug abuse, physical or sexual abuse, high poverty rates, family or peer suicide, and low levels of family/community support. Other risk factors include previous mental health history, low self-esteem, and few life or problem-solving skills. Intensifying all of these factors, historical oppression, internal colonization, and intergenerational trauma still have deep consequences (Crofoot Graham, 2002), not always immediately noticeable. However, despite all of this, the rates of suicide can vary greatly between tribes and tribal regions. Tribes with greater integration into dominant society see higher rates of suicide than those that have maintained their cultural traditions and lifestyles (Levy, 1965). Instead of focusing on complex risk factors, enhancing protective factors can be more effective for prevention.

Of all the protective factors against suicide, culture and tradition appear as two of the most influential and important suicide preventions for American Indian youth. Tradition and cultural orientation as a suicide prevention approach is holistic and includes the family, the adolescent, and the community. Balance and harmony remain the ultimate goal. Instead of isolated visits with a non-Indian provider in a rigidly formal and time-restrictive setting, the healing would be continuous, occur within the community, and be in a familiar, comfortable environment. Connection with traditional culture equips youth with a perspective on the past and presents a framework for the future.

Specifically, this would be a wraparound approach, which integrates care naturally into every aspect of the youth’s environment. A whole person deserves consideration as a whole person and holistic care as such. In the relational worldview proposed by Terry Cross, context, mind, body, and spirit all should be in harmony and in balance to face the complexities of life. Community, family, and history are to be considered “context.” The “mind” is intellect, emotion, experience, and judgment, whereas the “body” is genetics, nutrition, substance abuse/use, age, and sleep. “Spirit” includes spiritual practices and teachings, intuition, and dreams/symbols/stories (Cross, 2000). Each part is connected to the other and cannot be appraised alone.

Ceremonies and traditional teachings support design and practices for wellness and harmony. Elders and spiritual leaders’ teaching of wisdom can help youth find a dream and passion for the future and develop spiritual strength. Indeed, they would provide the context for understanding the

community issues the suicidal individual may be confronting. With this knowledge of culture, mental health services would have a better perspective of the dynamic interrelationships that affect the adolescent. Mental health providers working with elders and community members could set up trainings and programs for life or problem-solving skills, awareness of risky behaviors, and/or simply talking circles.

A youth is less likely to attempt suicide if he/she believes his/her family and community love him/her too much to see him/her die—thinking, “I could never hurt my family like that.” Even further, strong tribal leaders can effectively inspire youth and provide good role models whereupon the youth might reflect, “Maybe, maybe, someday I could, too.” A study found that both males and females perceived that tribal leaders demonstrated a sense of caring and instilled hope. Caring from other adults on the reservation or in the community gave youth a connection and support needed to prevent self-destructive behaviors (Pharrus, Resnick, & Blum, 1997). Instead of only focusing on internal mental or emotional factors of suicide, the whole human (the human with a family, with a community, and with a spirit) should be considered. In a circle, no sides exist nor is one part more important than the other. As we are all connected, when one is out of balance, we should all take notice and act, for we are affected, too.

Mitakuye Oyasin

The Messenger

The dark cloud inside is brewing like a brutal storm
I cannot see the beauty around
It clouds all the windows in and out of my soul.

The Messenger is waiting
For the clouds to clear so he can give his message.

I walk around an empty arbour amongst what remains of the winter
Small symbols on the ground of lost hopes and dreams, lost children and childhoods
Broken glass, broken promises and broken hearts.

Yet, the Messenger still circles
His duty is clear and he is unwilling to leave until his message has been delivered.

I am lost for words
I know we need to grieve
And seven generations of loss is too much for anyone to do it all at once.

The Messenger is here
I tell him I am alone
He tells me I am alone no more.

About the author: Jocelyn Formsma (Swampy Cree) resides in Ottawa, Ontario, Canada. A full time college student, Jocelyn is a program officer for the National Association of Friendship Centres. Jocelyn was also the first youth elected to the board of directors of the National Indian Child Welfare Association's (NICWA).

About the poem: “I wrote this while visiting a community in Northwestern Ontario, near the Manitoba border. It's a community that has some of the highest suicide rates in the region. It was a beautiful day and it was quiet. Eagles came to visit and we spent a lot of time in the Roundhouse sharing our own experiences with suicide. For the first time in my life, I was able to share with the group about how suicide had affected me. It was a day filled with so many emotions: sadness, relief, anger, happiness—most of all it made me commit even more to wanting to make sure that all young people had the opportunity to realize their dreams.”

A Review of Literature of Suicide Prevention Issues

Written by Brad Dennis, MSW

As a child protective worker, you will be highly likely to encounter clients who experience “drastic responses” to stressful events or “risk factors.” The drastic responses in this article include any action that is fatal or non-fatal, deliberate self-harm, or para-suicidal behaviors. (Regardless of the threat, “all threats should be taken seriously.” (Proctor, 2005) Proctor further noted that “suicide in an Aboriginal person is usually impulsive and often occurs in the context of intoxication or in its aftermath.”

“The disintegration and destruction of community and cultural life has meant that young people growing up in these circumstances have had diminished access to identity-forming structures which help the transition from childhood to adolescence into adulthood and provide a young person, particularly males, with positive role models and coping behaviors in times of conflict. In the experience of psychological insecurity, depression, loss of relationships and meaning, conflict with others, including kinship networks and parents, and the perceptual and cognitive disturbances associated with alcohol or substance use, young people might have felt extremely strong responses of guilt, shame, rejection or despair. Such a scenario might lead to severely diminished or absent future orientation associated with no will to live.” (Proctor, 2005)

Proctor found that communities that had more “established structures, community programs and institutions experienced much lower rates of suicide.” (Proctor, 2005) Key to the success of such communities is that the solutions came from within the community, were culturally appropriate, and were adapted to the socioeconomic, psychological, and cultural context of the community. Within these successful communities it was found that in a cross-cultural setting, non-Aboriginal mental health workers and Aboriginal people were valued equally, “allowing for an interchange based on equality, respect, and partnership.” (Proctor, 2005)

Suicide among 14-to-25-year-old Native American youth is 2.5 times that of the general population and represents the second leading cause of death of this population. (Shaughnessy, Doshi, Jones, 2004) “Suicide is considered as the most tragic of all mental health disorders evident among American Indian youth.” (Brave Heart, DeBruyn, 1998) “American Indian youth experience the highest rates of suicide in the nation.” (Gary, Baker, Grandbois, 2005) “Current data on suicide risk factors among ethnic minority youths are scarce.” (Hallfors, et al., 2006)

“Suicide is a complex end point on a continuum ranging from ideation to gestures, plans, attempts, and completions.” (Hallfors, et al., 2006). Adolescent suicide is often precipitated by psychosocial stressors such as recent loss, rejection, or a disciplinary crisis, although such events are common in this age group. In fact, only a fraction of adolescents among whom these risk factors are present actually commit suicide. Strong social support networks and peer relationships are protective factors against suicide. (Hallfors, et al., 2006)

“Research shows that more than 80% of people who commit suicide have seen their health care provider within 12 months of their death and more than 65% have visited a health clinic within the last 30 days. Routine screening to assess for the presence of depressive symptomatology and suicide risk, coupled with immediate referral to mental health staff when such symptoms and evidence of risk are present, has the potential to alleviate unnecessary suffering of those in psychological pain and prevent untimely and unnecessary loss of life.” (Niven, 2007)

“Prevention training programs emphasize that asking about suicidal thoughts does not make suicide more likely, but instead opens the door to exploration of thoughts that an individual might otherwise be reluctant to voice on his or her own.” (Niven, 2007) “Studies show that screening for suicide in primary care settings can increase identification of people experiencing depressive disorders and suicidal ideation, reduce suicidal ideation in those identified, and decrease suicide attempts overall. Screening in primary care has the potential to ease suffering and save lives in all age groups.” (Niven, 2007)

“Straightforward questions aimed at screening for depressive symptoms and suicide risks are perhaps the simplest and most effective way to uncover these serious problems.” (Niven, 2007) Borowsky, Resnick, Ireland and Blum (1999) recommend that “routine screening of youth in this population for exposure to suicidal behavior and the development of depression should be considered so that appropriate treatment can be given.”

Clinicians should examine their thoughts, feelings, and fears regarding suicide prior to assessing clients. Some responses of a clinician that has not properly dealt with these issues include: likelihood of denying the seriousness of the situation, acting on misinformation, or nervously and indirectly rushing the interview. For a child who is overwhelmed by feelings of hopelessness and suicidality, a well-prepared and calm clinician will help in the suicide assessment process. It has been noted that we can appropriately address our feeling of discomfort with suicide in consultation, supervision, and peer support.

Parents and foster parents are also often unaware and seem to have little knowledge of the typical warning signs of suicide.

According to Quinn (2002) gay, bisexual, transgender and questioning youth within the child welfare system are particularly vulnerable to risk of suicide. There are several risk factors that put this already vulnerable population at risk.

To effectively address youth that are experiencing suicidal ideation or thoughts of self-harm, it has been noted that a clinician must form a connection with a youth that involves active listening. Active listening involves:

- being attentive to the meanings behind the youth's stories and conversation
- listening with an open mind
- questioning with genuine curiosity to better understand
- being non-judgmental and non-blaming
- using open ended questions
- avoiding lecturing
- viewing the challenges within the context of the youth's family, social, and school environment and the broader community and environment
- identifying the youth's strengths
- supporting and encouraging youth to identify "what needs to change in their environment (school, home, and social context) and what is getting in the way of challenging behavior"

Several risk factors noted in this toolkit reference such things as:

- loss of culture
- loss of language
- loss of cultural identity
- family disruption

As we look at the children around us, it is not easy to admit that some of them are actually experiencing depression. We hope that our children are just having a "bad day," or "feeling a little sad." The reality is that depression in children really does exist.

Suicidal Thoughts in Children

It is crucial for professionals, while taking a look at depression in children, to understand the paramount role that historical trauma and unresolved grief play in the mental health of American Indian and Alaskan Native (AI/AN) children and their extended network of family and community. The long-term impact of relocation, as well as intergenerational trauma, can seriously affect the mental health of AI/AN children.

“Although completed suicide among children is low in comparison to other age groups, suicidal thought and behaviors are reportedly quite common” (Barrio, 2007). Although suicide completions are considered low, it must be noted that “youth make approximately 100-200 suicide attempts for each completed suicide” (Barrio, 2007). With such a high statistic, clinicians must be prepared to address suicidal thoughts and behaviors. It has been noted that clinicians are likely to encounter children who are suicidal; however, many clinicians are unprepared for such an assessment and intervention. Some possible reasons given in research for a clinician’s unpreparedness are:

“Unwillingness to believe that children can and do plan and implement suicides” (Barrio, 2007).

“Lack of preparation for dealing with child suicide, discomfort, and denial” (Barrio, 2007).

This general disbelief in a child's ability to plan and implement a suicidal plan seems to be based upon misconceptions about child development. Developmentally, children have greater impulsivity and experience the world in a very concrete manner; they often lack a future orientation and can not see past a stressful event. Barrio pointed out that “children are at risk for suicide due to higher degrees of impulsivity that are related to opportunity and require little planning,” such as “running in front of a car or jumping out of a window.” (Barrio, 2007) From a psychological perspective, “children are more likely to internalize problems and stressors and present with poor coping skills, such as hopelessness about the future” (Barrio, 2007).

Webb and Harden point out that the “expressed goal of child welfare services and the provision of appropriate mental health services is critical.” They further state that “strong linkages between child welfare and mental health systems are requisites for a child welfare agenda that place primacy on the emotional well-being of maltreated and abandoned children.” (Webb, Harden, 2003)

The Role of Native Culture in Preventing Suicide

Written by Terry Cross, MSW, LCSW

In their study on youth suicide in British Columbia, Chandler and Lalonde (1998) found that positive identification with tribal culture acts as a protective factor against youth suicide. Several other studies (Lafromboise, T., 2006, Navajo study, 2007, etc.) have affirmed this finding. Communities where the Native culture is intact have the least suicide, and youth with the strongest cultural identification are least likely to commit suicide.

Child welfare workers can actively participate in creating the conditions known to be protective by ensuring that the children and youth in their caseloads have access to cultural activities. Children from families with strong cultural identity should be kept in close connection with their cultural resources as part of their permanency plan. Children who are not closely affiliated with their tribe should be introduced to and included in available cultural activities. These activities may be formal or informal, family- or organization-based, or may be part of a school curriculum. Whether in a culture club or with an extended family or mentor, participation in cultural activities reduces risk. The following list of cultural activities is derived from research conducted by NICWA and includes items identified by SAMHSA and an Oregon tribal workgroup on culturally based evidence.

Cultural Activities Known to Contribute to Resilience

Kinship/Family/Gender Roles

- Participating in extended family culture
- Learning about family structure and traditions
- Maintaining strong family ties
- Hearing or telling family stories (knowing their family/cultural history)
- Participating in traditional male and female cultural roles
- Searching for a connection with relatives or Native ancestry

Tribal Arts and Crafts

- Making cradleboards and dream catchers
- Making shawls, sewing quilts, carving
- Weaving baskets, making flints
- Making jewelry, beading, doing quill work

Tribal Clothing

- Making traditional attire/regalia for pow-wows and other ceremonies
- Making ribbon shirts
- Making moccasins, tanning hides, working with animal skins

Subsistence/Food/Medicines

- Gathering, harvesting, planting, growing, preserving, or cooking traditional foods
- Hunting, fishing, exercising treaty rights
- Knowing or participating in hunting/gathering-related ceremony
- Knowing plants, bark, roots, herbs, medicines
- Learning the teaching about plants, animals, foods, and medicines

Music/Dance/Pow-wows

- Attending a pow-wow, dancing, drumming, singing
- Learning lyrics or specific dances and the history behind songs and dances
- Learning song etiquette: where and when a song can be sung

Games/sports

- Playing culture-specific games such as hand/stick games
- Playing indigenous sports such as lacrosse

Ceremony, Rituals, and Protocol

- Participating in rituals, knowing how to act, how to prepare
- Participating in smudging, mediation, sacred dance, fasting, visioning
- Paying attention to dreams
- Participating in a talking circle
- Practicing Native protocol for showing respect and honor
- Developing communication skills with elders
- Practicing spirituality
- Knowing and practicing protocols for handling sacred or traditional items
- Showing respect for beliefs at ceremony
- Seeing traditional healers for help
- Learning rules for who can attend ceremonies
- Knowing passing away (death) ceremonies
- Knowing sacred animals
- Understanding people's interconnectedness with the natural world

History/Cultural Knowledge/Cultural Skills

- Knowing tribal history, laws, treaty rights, reservations, clans
- Knowing the meaning of sovereignty
- Learning Indian names for places
- Speaking a Native language
- Knowing sacred places—protecting them as cultural monuments
- Learning about traditional living houses/buildings/lodges
- Understanding the impact of colonialism—genocide, blankets to spread diseases
- Understanding the history of activism, importance of protesting
- Understanding sport mascots and their negative impact

Traditional Forms of Living

- Learning to tell tribal stories and legends
- Learning about canoe journey/families
- Learning horsemanship
- Learning about the birds and what they do
- Camping and participating in survival retreats
- Taking care of Mother Earth

Perspectives from the Field Told by Public Health and Community Organizers

In an effort to provide helpful information for those in the field of Indian child welfare, this section contains interviews with several child welfare professionals who provided their insight and experience.

Further information is available at their organizations' websites. The NICWA staff would like to thank these individuals for their commitment in making a difference for our American Indian/Alaska Native youth and families.

BIOGRAPHIES

Delores Bigfoot, PhD

Dolores Subia BigFoot, PhD, is an enrolled tribal member of the Caddo Nation of Oklahoma and is an Assistant Professor in the Department of Pediatrics, Center on Child Abuse and Neglect at University of Oklahoma Health Sciences Center. Dr. BigFoot directs the Indian Country Child Trauma Center that is part of the National Child Traumatic Stress Network and Substance Abuse Mental Health Service Administration. As a doctoral-level counseling psychologist she provides consultation, training, and technical assistance to tribal, state, and federal agencies on child maltreatment, child trauma, and cultural issues.

Tillie Blackbear

Tillie Blackbear is executive director of the White Buffalo Calf Women's Society, the longest-running shelter for battered women and rape victims in Indian Country, located in Mission, South Dakota. They have expanded their programming in 2007 to include suicide prevention due to the increase in suicides locally.

Dr. Daniel Foster, PsyD

Dan Foster completed his doctorate in Clinical Psychology at Baylor University in 1980. He is a past president of the Society of Indian Psychologists (1989). He has worked in various capacities as a psychologist, supervisor, and administrator with the US Bureau of Prisons for many years. Since 1993, he has worked for the Indian Health Service as a psychologist.

Sandra Parsons, PhD

Sandra Parsons graduated with a doctorate in 1992 from the University of North Dakota, later working with a mental health agency in South Dakota and earning her master's degree in Counseling. Her entry into tribal child welfare was with the Standing Rock reservation; since then, she has spent 17 years working at Wahpeton Boarding School, White Earth Band of Chippewa, and Red Lake Band of Chippewa. On January 1, 2009, Sandra will have been at Red Lake Children and Family Services for four years. Their office has an ICWA advocate off-reservation for urban families, uses foster care and home-based services, and recently added a children's mental health specialist to their staff of 23; this specialist worked with 900 children in the last year.

Delores BigFoot

I think a lot of it is determined not by the ICWA worker's role, but by that person's place in the community and that they're serving as an ICWA worker. I think what I have seen is that as ICWA has been much more overwhelmed by more and more children being in foster care, that at one time there was a very strong sense of determination on ICWA workers to bring children back and now community members are viewing ICWA workers as taking children away. So I think that the ICWA worker has to determine for themselves if they are viewed as someone who will be helpful to that family and how much they can contribute; or if they are seen as someone who is pulling families apart and this is just another aspect of loss that they are contributing to. I think it would be very important that in the assessment of family, that the ICWA worker recognizes how they are viewed—that would be part of that assessment.

Dr. Daniel Foster

What I would want the ICWA workers to do would be to work in collaboration with faith-based support, both traditional and Western, that the family is already connected with. I would see them (ICWA workers) more as referring and providing support, reassurance, and never feeling the burden of being the primary support person. I think that would be inappropriate and unfair, because they're going to be asking themselves to do something that even people with years of experience and professional training are still at the edge of their knowledge and skill base.

I think it would be important to not take on the burden of the primary healer, but rather to take on the burden as a member of a larger support network—to be familiar with the network available.

In terms of response, usually what we seek to do is to contact as many of the families, the network of the families, and friends as possible. To gather them together, to allow them to support each other, but also to validate one another's shock and grief. Suicide is particularly cruel, though any sudden death is a particularly cruel grief issue. Because there were no goodbyes—there usually is no ... we use the word closure maybe too much, but there was no closure. Where we find that deaths that occur from debilitating illness ... there was a preparation time. We don't have the trauma in terms of their grief, the kind of unresolved grief afterwards. It is very important that we do what we can to gather that network of family and friends.

We find, for example, most of our suicides here occur at night. And typically the first that will be here to the hospital will be people that were partying. And so often the first on the scene aren't the sober people, but the people who are somewhat intoxicated. And I find it very important to identify either the family matriarch or patriarch or to identify a spiritual leader or religious person that the family holds in high esteem so we get someone here, other than police, to manage. Because the grief has a way of dis-inhibiting and if people are intoxicated at the time, there can be serious acting out ... we want to gather the family, the relatives, and we want them to be there to support and care for one another, as well as to help manage anyone losing control.

In our community, people want to see the body. I try to discourage that, particularly with the hangings ... that's not a sight that a mom, or a dad, or a grandmom, or a wife, or a husband, or a child, that's not a memory that they want to hold on to. I would discourage people from viewing the body when it has been obviously damaged, until the mortician and so forth has done what they do, and I would especially encourage that where there are gunshot wounds to the head.

So I would encourage the ICWA worker not to be a therapist, but to be a therapeutic agent and to encourage them to seek and identify resources available. Usually we can find some community mental health professionals, school-based counseling professionals, church-based helpers, traditional leaders and helpers, social workers, Catholic Social Services, etc. In many communities, the Head Start organization will keep a directory of all the agencies that serve the reservations, including all the tribal entities. So I think it would be real valuable for your ICWA workers to have that directory. And usually they'll include the faith-based people, which would include the traditional leaders, the men and women, the patriarchs as well as the church. It's good to know who those leaders are in case that's who the family turns to for spiritual solace while grieving.

If you don't have enough mature adults that can speak with the kids ... who can help the kids, particularly in culturally relevant ways—the time of death is not really a time for strangers ... that's a very intimate time, birth and death, a very intimate, personal time for the family and at those times too, it varies but it's also useful to have some of the language. I find that particularly the parents or grandparents, it's easier to comfort them in their own language at those times, because there tends to be kind of a ... not a regression, but you tend to go back to the time in your life you felt the safest and often that was when you were a child with your parents or grandparents and often the language spoken then wasn't English. Again it would be important to try to draw some Native speakers among those that arrive among the sober, mature adults.

Sandra Parsons

I think one of the first things is to be permissive of the grieving, the sadness, the guilt: those typical kinds of feelings and behaviors that people feel, and kids, too, long after the event. You need to make sure that maybe the safety concerns need to be escalated or reevaluated at that time, that there's no alcohol, whatever kinds of things. A lot of people do a lot of self-medicating with drugs and alcohol. And so it's those things that can be monitored and not encouraged.

We need to have specific child care for the children who are not always related to the victim, but may be aware who this person is and those kinds of things, in the child care who can help them deal. We have a children's mental health specialist on board here at the agency who can, with art therapy or play therapy or music and dance therapy, can help work these kids through a lot of their grief and sadness and feelings of ... it goes back to that, "Why?" question again. The main thing is to let them talk, let them talk and listen to their talk, and then, go from there with it.

How do you maintain a personal healthy balance in spite of the difficulties of this emotional work?

Sandra Parsons, Executive Director, Family and Children Services-
Red Lake Band of Chippewa Indians

For me, the biggest piece is that we don't lose our sense of humor.
I love listening to the staff, the laughter, the teasing, and
the craziness.

I travel with a fishing pole in my car during the
summer, and I can stand around the lake
and throw that out in the water, and things
are a whole lot better for the staff.

Tillie Blackbear

I guess what a person or group of people can do really is just to be there in support of the family. Sometimes we don't know how to address a family member who has lost somebody to suicide. We don't know how to approach them, let alone visit with them. A community member could really be in support at that time—just calling them up or going to see them and just telling them, "I'm really sorry about your loss."

The other part of it is that it ties into that family's spirituality. I think that's really key because one can not only help with prayers, but if you take a more traditional approach you're using the different elements to initiate the process for healing. Smudging is a good one. Oftentimes what we do with individual families is to take them into a purification lodge, to get them connected with a medicine person and for them to sit down with that medicine person to talk about their loss. And from there, the next step would be to put on a ceremony for the spirit of the one that took their life so quickly.

I think the key thing really, it's a hard place for them to be, but it's really about being connected spiritually to a greater power. I think that's really important for suicide survivors, to make that connection. Because then on that path of healing they can forgive themselves or forgive the person for doing it, it's that forgiveness.

Suicide is a real hard area to approach and one of the cultural things for us is we have what we call a "wiping of tears" ceremony. And to me that's really been helpful in working with survivors of suicide. And we've been able to utilize it even in the school systems with the youth who have lost friends to suicide, who were in their grades. That way, culturally, the information is really, really key—information about suicide, the warning signs of depression.

Mass-Communicating the Message of Suicide Prevention

written by Kristy Alberty

Indian Country's Media

Many tribal communities own media outlets: print, television, and radio. The advantage for tribal clinical and administrative services is that these tribal-owned media are a more “friendly” source of mass communication that you can gain easy access to coverage, compared to the mainstream media.

It's true for nearly all media groups that they rely heavily on outside sources of news and information and, therefore, finding out what your local media needs from you is key to your coverage success.

Develop Relationships for Proactive Efforts

Setting up media relationships can be as simple as a phone call to the editorial manager or programming director. Call and ask for their submission guidelines, deadline days/times, a personal contact phone number or e-mail address, and how to format submissions for greatest convenience to the editorial staff.

Your media partners could assist your program with coverage of events such as observances and actions on Children's Mental Health Awareness Day, special days when enrollment for services/ classes are open, or particular community events that your program is organizing.

Another area of assistance could be printing public service announcements (PSA) from NICWA, National Alliance on Mental Illness (NAMI), Substance Abuse and Mental Health Services Administration (SAMHSA), and other sources. PSAs are more effective when the models are American Indian or even feature community leadership or elders. A media campaign could be organized once the relationship is there; be aware that media groups are usually on deadline and short on time, which could make extra projects for their staff challenging.

Media Reporting of a Suicide

Reporting on suicides in your community can have an impact, positive and negative. The following article is available online at the American Foundation for Suicide Prevention. The website address is http://www.afsp.org/index.cfm?fuseaction=home.viewpage&page_id=7852EBBC-9FB2-6691-54125A1AD4221E49.

It could be helpful to share this article with the tribal media's editorial staff in order to help develop a policy for language use and coverage of a suicide.

Reporting on Suicide: Recommendations for the Media

(American Foundation for Suicide Prevention, American Association of Suicidology, and Annenberg Public Policy Center authored this article.)

Suicide Contagion Is Real

Research finds an increase in suicide by readers or viewers when:

- The number of stories about individual suicides increases^{3,4}
- A particular death is reported at length or in many stories^{3,5}
- The story of an individual death by suicide is placed on the front page or at the beginning of a broadcast^{3,4}
- The headlines about specific suicide deaths are dramatic³ (A recent example: “Boy, 10, Kills Himself Over Poor Grades”)

Recommendations

The media can play a powerful role in educating the public about suicide prevention. Stories about suicide can inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. They can also highlight opportunities to prevent suicide. Media stories about individual deaths by suicide may be newsworthy and need to be covered, but they also have the potential to do harm. Implementation of recommendations for media coverage of suicide has been shown to decrease suicide rates.^{1,2}

- Certain ways of describing suicide in the news contribute to what behavioral scientists call “suicide contagion” or “copycat” suicides.^{7,9}
- Research suggests that inadvertently romanticizing suicide or idealizing those who take their own lives by portraying suicide as a heroic or romantic act may encourage others to identify with the victim.⁶
- Exposure to a suicide method through media reports can encourage vulnerable individuals to imitate it.¹⁰ Clinicians believe the danger is even greater if there is a detailed description of the method. Research indicates that detailed descriptions or pictures of the location or site of a suicide encourage imitation.¹
- Presenting suicide as the inexplicable act of an otherwise healthy or high-achieving person may encourage identification with the victim.⁶

Interviewing Surviving Relatives and Friends

Concerns:

Dramatizing the impact of suicide through descriptions and pictures of grieving relatives, teachers, or classmates or community expressions of grief may encourage potentially suicidal youth to see suicide as a way of getting attention or as a form of retaliation against others.

Using adolescents on TV or in print media to tell the stories of their suicide attempts may be harmful to the adolescents themselves or may encourage other vulnerable young people to seek

attention in this way.

Language

Referring to a “rise” in suicide rates is usually more accurate than calling such a rise an “epidemic,” which implies a more dramatic and sudden increase than what we generally find in suicide rates.

Research has shown that the use in headlines of the word “suicide” or referring to the cause of death as self-inflicted increases the likelihood of contagion.³

Recommendations for language:

- Whenever possible, it is preferable to avoid referring to suicide in the headline. Unless the suicide death took place in public, the cause of death should be reported in the body of the story and not in the headline.
- In deaths that will be covered nationally, such as those of celebrities, or those apt to be covered locally, such as persons living in small towns, consider phrasing for headlines such as: “Marilyn Monroe dead at 36,” or “John Smith dead at 48.” Consideration of how they died could be reported in the body of the article.
- In the body of the story, it is preferable to describe the deceased as “having died by suicide,” rather than as “a suicide,” or having “committed suicide.” The latter two expressions reduce the person to the mode of death, or connote criminal or sinful behavior.
- Contrasting “suicide deaths” with “non-fatal attempts” is preferable to using terms such as “successful,” “unsuccessful” or “failed.”

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Taking Action in Your Community

Community Action and Suicide Prevention and Intervention

Tribal child welfare departments, in isolation, can be prepared to address the issues of suicide among children they serve or are called on to protect. However, the most effective approach is a comprehensive interagency collaboration, also known as a systems of care approach. Frequently, different service providers will have developed their own independent approach. In addition to formal systems such as schools and health care providers, culturally based and faith-based helpers have their own concepts and approaches to suicide. Because child welfare interacts with many different systems both formal and culturally based, it is recommended that the tribal child welfare department take an active role in searching out and learning about the various strategies among providers and, if possible, convene a cross-agency community dialog or crisis team to coordinate efforts. The following partners should be considered:

- Cultural or faith-based helpers: Both traditional spiritual helpers and Christian church leaders play an important role in tribal communities and are often the most intimately involved when suicide occurs. Including these informal service providers can greatly enhance the effectiveness of collaborative efforts and promote a community-wide approach to reducing suicidal behavior. Such providers will sometimes have traditional cultural strategies for reducing suicidal behavior.
- Schools: Children and youth spend a large percentage of their time in school. Over the last several years schools have taken a more active role in suicide prevention and intervention.

Creating School-Based Prevention Methods

The following suicide prevention strategies have worked in a variety of educational settings:

- School gatekeeper training: in-service training for school staff on identifying students at risk for suicide and where to refer them for help
- Community gatekeeper training: training similar to school gatekeeper training but designed for parents, recreation staff, and other community members
- General suicide education: school-based program for students geared to help them identify the warning signs of suicide and to build self-esteem and coping skills
- Screening programs: programs to identify high-risk youth for targeted assistance
- Peer support programs: programs to foster peer relationships, competency development, and social skills among high-risk youth
- Crisis centers and hotlines: emergency counseling for those who may be suicidal
- Means restriction: activities designed to restrict student access to firearms, drugs, and other common means of committing suicide (Maples, et al., 2005)

Note: Research confirms, "Increasing the number of protective factors . . . was more effective than decreasing risk factors." (Borowsky, et al., 1999)

Most schools have well developed policies and procedures and many have crisis teams identified to deal with suicide risk. Schools also have access to training materials and other resources for crisis teams and are essential partners in community-based prevention and intervention efforts.

- **Law Enforcement/Emergency Responders:** As first responders to crisis situations law enforcement personnel and emergency responders are often trained in suicide intervention strategies. Emergency and law enforcement agencies are likely to have clear policies and procedures that guide their actions in such situations.
- **Health Care Providers:** Indian Health Service facilities, private physicians, and school-based clinics may all be present in tribal communities. Some communities may be miles or even hours from the nearest provider and rely heavily on community help representatives (CHRs) for health care services. Regardless of the local provider system, health care providers are essential partners in suicide prevention and intervention. Doctors and nurses may be the only available resource in a mental health crisis and most facilities have well developed protocols for dealing with suicide risk. Child welfare protocols should be closely coordinated with health care procedures.
- **Mental Health Providers:** While mental health providers in tribal settings are still rare, coordination is essential where services exist. Even where services do not exist, a mental health specialist is often accessible via phone or internet or through a regional hospital. Such resources may have training or resource materials for community partners and can provide the leadership needed for team development and coordination.
- **Detention and Incarceration Facilities:** Frequently, suicide attempts occur when youth are in detention facilities. Such facilities should have clear protocols for dealing with suicide risks. Close coordination with the facilities regarding any child at risk is essential in child welfare agencies.
- **Care Providers:** Group homes, foster parents, and relative care providers are all partners in suicide prevention when risk is present. Community prevention efforts will be strengthened by including care providers. Child welfare staff should consider having a core group of foster parents who are trained as part of a community crisis team.
- **Youth and Families:** Many tribal communities have well organized youth councils, youth services, or recreation programs. Youth and families are important resources for early identification, peer counseling, and support and as advocates for community collaboration. Foster children and mental health consumers can be effective advocates for prevention and collaborative services.

The tribal child welfare department should actively seek out and engage with suicide prevention and intervention efforts in its community. When such efforts do not exist, or where they do not address children and youth, the child welfare agency should consider taking a leadership role in developing such an effort. Tribal leaders and the community partners listed above will be key to developing such an effort.

How Do You Begin?

First, don't wait until you have a crisis to act. The following steps may be helpful in starting or joining a suicide prevention and intervention effort in your community:

1. Devote a child welfare department staff meeting to the topic of suicide prevention and intervention using the information in this toolkit as a discussion guide.
2. Ask staff to make a list of efforts under way in the community or of those who would be interested in convening a dialog about the issue.
3. Call the agency leaders and informal helpers and have an informal conversation regarding your concerns, and to learn what others are thinking. Ask if the agency would be willing to attend a meeting or if the child welfare department could join in any meetings conducted by that agency or its partners.
4. Attend any meetings that may be underway locally or convene a meeting of partners to discuss the issue. One way to have people attend is to have a guest speaker or consultant who is knowledgeable about the topic.
5. Ask potential partners if they would help develop and join in a cross-agency plan for coordination purposes and determine if written agreements are necessary or if informal relationships are enough.
6. Meet and develop three to five collaborative goals and actions to be accomplished over six months to one year.
7. Assign one individual as a project manager whose job will be to schedule meetings, monitor progress, and provide support to the effort.
8. Recognize participants for their efforts publicly.
9. Start the process again in one year by rotating the leadership to another partner organization or to a youth commission.

These tips are useful for a range of issues and can promote collaboration on a range of topics. The better service organizations get at working together on prevention in one area, the better they get at collaboration across other service areas and challenges. When crisis situations develop, lines of communication are already established and relationships are in place to support an effective team response.

Mental Health Services Considerations

When compared with other racial and ethnic groups, AI/AN youth have more serious problems with mental health disorders related to suicide, such as anxiety, substance abuse, and depression.

Mental health services are not easily accessible to American Indians and Alaska Natives due to:

- Lack of funding
- Culturally inappropriate services
- Mental health professional shortages and high turnover.

Creating an Effective Team Response

- 1. Devote a child welfare department staff meeting to the topic of suicide prevention and intervention using the information in this toolkit as a discussion guide.**

Staff Meeting Date/Time
to Discuss Suicide Issues _____

First Choice

Second Choice

- 2. Ask staff to make a list of efforts under way in the community or of those who would be interested in convening a dialog about the issue.**

Current Community Efforts

List of Interested Individuals

- 3. Call the agency leaders and informal helpers and have an informal conversation regarding your concerns and to learn what others are thinking. Ask if the agency would be willing to attend a meeting or if the child welfare department could join in any meetings conducted by that agency or its partners.**

Agency Name for Collaborative Meeting

Meeting Date/Time

- 4. Attend any meetings that may be underway locally or convene a meeting of partners to discuss the issue. One way to have people attend is to have a guest speaker or consultant who is knowledgeable about the topic.**

Possible Guest Speakers/Consultants of Interest

E-mail/Phone Number/Agency Name

5. Ask potential partners if they would help develop and join in a cross-agency plan for coordination purposes and determine if written agreements are necessary or if informal relationships are enough.

Agencies Committed to Joint Project

Formal Agreement in Place?

6. Meet and develop three to five collaborative goals and actions to be accomplished over six months to one year.

Goal/Action

Date to Be Accomplished

7. Assign one individual as a project manager whose job will be to schedule meetings, monitor progress and provide support to the effort.

Name of Project Manager and Contact Information

8. Recognize participants for their efforts publicly.

Ideas for Culturally Appropriate, Meaningful, and Responsible Public Recognition of Collaborative Agencies

9. Start the process again in one year by rotating the leadership to another partner organization or to a youth commission.

Resource Centers, Funding, Programs, Tools

The following is a list of resource centers, federal funding, programs, toolkits, and other resources regarding suicide prevention in American Indian and Alaska Native communities. The list below was developed in an effort to provide American Indian and Alaska Native individuals and communities with an “at a glance” listing of primarily culturally relevant youth suicide prevention resources. The information provided herein is not exhaustive and is listed in no particular order.

Resource Centers

One Sky Center

The One Sky Center, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), is the first National Resource Center dedicated to the prevention and treatment of substance abuse and the mental health needs of American Indian and Alaska Native communities. The Center provides training, technical assistance, and referrals to American Indian and Alaska Native communities so that they may effectively evaluate, plan, develop, and employ successful prevention and treatment services. The One Sky Center also produced a suicide prevention toolkit specific to American Indian and Alaska Native communities. This toolkit, entitled *A Guide to Suicide Prevention for American Indian and Alaska Native Communities (Draft)*, provides detailed information on contributing factors, warning signs, prevention strategies and programs, funding programs, technical assistance, and consultants. More information about One Sky and their services can be found at www.oneskycenter.org or by contacting the center at 503-494-3703 or onesky@ohsu.edu.

Suicide Prevention Resource Center

Established in 2002, and funded by SAMHSA by way of a cooperative agreement, the Suicide Prevention Resource Center (SPRC) is the first federally funded center of its kind. The SPRC supports the technical assistance and information needs of states, government agencies, American Indian and Alaska Native tribes, territories, private and faith based-based organizations, colleges and universities, consumer groups, and individuals. These prevention support, training, and resource materials are provided in an effort to strengthen suicide prevention networks. More information about the SPRC can be found at <http://www.sprc.org/index.asp>.

IHS American Indian and Alaska Native Suicide Prevention website

The IHS American Indian and Alaska Native Suicide Prevention website, also known as the IHS Community Suicide Prevention website, provides American Indian and Alaska Native communities with information on suicide prevention practices, programs, funding, and other available resources. The purpose of the website is to supply American Indian and Alaska Native communities with the information and tools needed to establish their suicide prevention and intervention programs or that can be adapted to existing programs. More information on the IHS American Indian and Alaska Native Suicide Prevention Website can be found at <http://www.ihs.gov/NonMedicalPrograms/nspn> or by contacting Rose Weahkee at Rose.Weahkee@ihs.gov or 301.443.1539.

Federal Funding

The Center for Mental Health Services (CMHS) of SAMHSA administers many grant programs that are either directly aimed at youth suicide prevention and intervention or deal specifically with children's mental health needs. The following is a list and brief description of these federally funded programs:

- The Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention, also called the State/Tribal Youth Suicide Prevention Grants, are three-year programs authorized by the Garrett Lee Smith Memorial Act. These programs fund collaborative youth suicide prevention and intervention strategies. SAMHSA announced twelve new State/Tribal Youth Suicide Prevention Grants awardees on August 20, 2008, totaling over \$16 million in awarded funds. Per SAMHSA's RFA announcement for FY 2008, each successful applicant may be awarded up to \$500,000 per year for up to three years.
- Circles of Care grants are three-year infrastructure planning grants that enable American Indian and Alaska Native communities to assess their current children's mental health systems and develop a model program based on the systems of care philosophy and principles. Circles of Care is the only CMHS grant exclusively available to American Indian and Alaska Native tribes, tribal organizations, tribal colleges and universities, and tribal consortia. Since the inception of the program in 1999, SAMHSA has awarded funds to 31 successful tribal applicants. This total includes the most recent group of FY 2008 tribal grantees, announced on September 18, 2008, and totaling more than \$6 million in awarded federal funds. Per SAMHSA's RFA announcement for FY 2008, each successful applicant may be awarded up to \$305,857 per year for up to three years.
- The Community Mental Health Services for Children and Their Families Program, also known as the Child Mental Health Initiative or the Systems of Care program, is a six-year implementation grant based on the systems of care philosophy and principles. SAMHSA has awarded Systems of Care grant funds to eighteen American Indian and Alaska Native applicants since 1994. This total includes the three latest tribal awardees, two of which are graduates of the Circles of Care infrastructure planning grant programs. Per SAMHSA's RFA announcement for FY 2009, each successful applicant may be awarded an annual allowance ranging from \$1–2 million per year for up to six years.
- The Technical Assistance Center for Mental Health Promotion and Youth Violence Prevention, also referred to as the TA Center grant, is a five-year planning and implementation program intended to support the federally funded Safe Schools/Healthy Students (SS/HS) and Linking Actions for Unmet Needs in Children's Health (Project Launch) grant programs. The TA Center grant supports planning, implementation, and evaluation of an array of prevention activities, services, and curricula aimed at preventing mental and behavioral disorders. Although CMHS anticipates awarding these funds to only one successful applicant, multiple centers, programs, and/or community service providers may apply together as one applicant. As of June of 2007, SAMHSA had awarded TA Center funds to eight tribal applicants, totaling almost \$20 million dollars.

- The National Child Traumatic Stress Initiative Community Treatment and Services Center Grants, also known as the CTS Centers, are four-year community-focused implementation and evaluation programs. As part of SAMHSA's larger National Child Traumatic Stress Initiative, CTS Centers employ and evaluate trauma-informed practices and interventions.
- The Campus Suicide Prevention Grants program is a three-year planning and infrastructure development grant. This program funds higher educational institutions such as colleges and universities so that they may evaluate, plan, and implement comprehensive suicide prevention strategies and improve their mental and behavioral health services for at-risk students. Although SAMHSA does not explicitly state that American Indian and Alaska Native educational institutions are eligible to apply for these grants, one grantee, The University of North Dakota, worked with neighboring tribal colleges to promote suicide prevention. There is reason to believe that this effective collaboration is replicable. Per SAMHSA's RFA announcement for FY 2009, each successful applicant may be awarded up to \$100,000 per year for up to three years. The grant requires an equivalent match from the applicant institution.
- The Knowledge Dissemination Conference Grants Program, also known as the SAMHSA Conference Grants Program is a twelve-month project grant administered through CMHS and CSAP. This program funds direct costs incurred by applicants who are disseminating knowledge about mental health services and substance abuse prevention in an effort to improve practice. Per SAMHSA's RFA announcement for FY 2009, each grantee may be awarded up to \$50,000 per year for up to 12 months.

More information about SAMHSA's grant opportunities can be found online at <http://www.samhsa.gov>.

Programs

IHS Suicide Prevention Programs

IHS has four suicide prevention programs as of fiscal year 2005. These include the IHS National Suicide Prevention Network (NSPN), the IHS Substance Abuse and Mental Health Services Administration/Center for Mental Health Services (SAMHSA/CMHS) "Suicide Collaborative" (an interagency agreement), the IHS Behavioral Health – Management of Information Services (BH-MIS) Suicide Surveillance, and the IHS/Health Canada Suicide Memorandum of Understanding (MOU). For more information on these initiatives, visit www.ihs.gov, or contact Rose Weahkee at Rose.Weahkee@ihs.gov or 301.443.1539.

Native Aspirations

Native Aspirations is a national community-based project administered by Kauffman & Associates, Inc., which provides consultation, technical assistance and budget support to 24 American Indian and Alaska Native communities. This project supports the most at-risk tribal communities in their efforts to evaluate, develop, and implement effective programs to prevent youth violence, bullying, and suicide. More information about Native Aspirations can be found online at <http://www.kauffmaninc.com/index.cfm?page=clientinfo.cfm&view=samhsa>.

American Indian Life Skills Development Curriculum (AILSD)

The AILSD curriculum is an evidence-based high school intervention program specifically tailored for American Indian youth. Based on social cognitive theory, the AILSD is characterized by increased self-esteem and life skills among its participants, including communication and problem-solving, emotional and behavioral management, and goal-setting skills. This training program was developed in collaboration with students and community members from the Zuni Pueblo and Cherokee Nation and has been successfully implemented in many tribal communities. More information about AILSD can be located online at www.wisc.edu/wisconsinpress/books/0129.htm.

Native H.O.P.E. (Helping Our People Endure)

The Native H.O.P.E. training program aims to increase the capacity of American Indian, Alaska Native, and First Nations youth to support each other, their families, and their communities. By building upon their awareness and strengths, the curriculum helps Native youth to break the "Code of Silence" as well as unhealthy multigenerational cycles. The Native H.O.P.E. Training Facilitators Manual is also available to adults and experienced youth who ultimately develop and employ an action plan to reduce suicide. Additional information on Native H.O.P.E. can be found online at www.oneskycenter.org

Applied Suicide Intervention Skills Training (ASIST)

ASIST is the most widely used suicide prevention program in the world. It provides its participants with gatekeeping knowledge and skills, including information on suicide warning signs and intervention practices. Although ASIST is not culturally specific to American Indian and Alaska Native communities, it has partnered with the State of New Mexico and the IHS Albuquerque Area Office and has provided trainings to many Native communities. Some of these include the Standing Rock Sioux Tribe, North Dakota and South Dakota, and the Warm Springs Reservation, Oregon. More information about ASIST can be located online at www.livingworks.net.

Toolkits

Assessment and Planning Toolkit for Suicide Prevention in First Nations Communities

The *Assessment and Planning Toolkit for Suicide Prevention in First Nations Communities* outlines how tribal communities may evaluate and develop a suicide prevention plan.

This toolkit can be found online at www.naho.ca/firstnations/english/documents/NAHO_Suicide_Eng.pdf or by contacting the National Aboriginal Healthcare Organization (NAHO).

Acting on What We Know: Preventing Youth Suicide in First Nations

The *Acting on What We Know: Preventing Youth Suicide in First Nations* report of the Advisory Group on Suicide Prevention examines suicide data and provides useful recommendations for preventative action in tribal communities. This toolkit can be found online at <http://www.hc-sc.gc.ca/fniah-spnia/pubs/promotion/index-eng.php#suicide> or by contacting The Publication Resource Centre First Nations and Inuit Health Branch, Health Canada.

A Guide to Suicide Prevention for American Indian and Alaska Native Communities (Draft)

A Guide to Suicide Prevention for American Indian and Alaska Native Communities (Draft) is a practical guidebook that provides detailed information on contributing factors, warning signs, prevention strategies and programs, funding programs, technical assistance, and consultants. This guide also contains a suicide assessment tool designed specifically for American Indian and Alaska Native communities. This toolkit can be found online at www.oneskycenter.org/documents/AGuidetoSuicidePreventionDRAFT.pdf or by contacting the One Sky Center (mentioned above).

Comic Books

In an effort to change statistics that show Aboriginal youth as a high-risk group, the Healthy Aboriginal Network launched a program to create a series of comic books dealing with Aboriginal health issues. Emerging and established Aboriginal cartoonists drew the comic book artwork. The first comic addresses the disturbing trend of youth suicide attempts in Aboriginal communities in British Columbia. The comic was set up to encourage youth to recognize their own feelings, to be aware of the behavior of others, and to reach out before a suicide attempt is made. Content of the first issue was reviewed for authenticity by Aboriginal youth focus groups and two professors, Michael Chandler and Chris Lalonde, who have studied Aboriginal youth and suicide extensively. The above information and more can be found by contacting the Healthy Aboriginal Network.

Testimonies

US Senate Committee on Indian Affairs Testimony: Suicide Prevention Hearing, June 15, 2005, and Senator Gordon Smith's Statement to the Committee on Indian Affairs, June 15, 2005. A copy of Senator Gordon's testimony may be found online at www.oneskycenter.org.

On June 22, 2005, the National Indian Child Welfare Association (NICWA) submitted a statement to the Senate Committee on Indian Affairs regarding suicide prevention in American Indian and Alaska Native youth.

Summary of NICWA's Recommendations:

- Increase the number of trained child therapists and mental health professionals in Indian Country.
- Require Indian Health Services to expand its children's mental health programming to include promising practices in Indian Country such as the systems of care approach.
- Increase funding for Systems of Care and Circles of Care grants to allow more tribal access to these important programs.
- Require Indian Health Services to regularly report data that describes how many American Indian/Alaskan Native children are being provided mental health services through IHS or IHS contractors, the types of services provided, and the number of mental health referrals received, as well as other significant data developed in consultation with tribes, to help inform policymakers and service providers.

A copy of NICWA's testimony can be located online at http://www.nicwa.org/policy/legislation/S556_HR2440/T24000-0.pdf#search='NICWAsuicide'.

Notes

In response to the need for trained Indian child welfare workers, the Northwest Indian Child Welfare Institute was established in 1983.

In 1987, it became regional, and in 1994, the organization became national in scope and was renamed...



NICWA

National Indian Child Welfare Association

Protecting our children • Preserving our culture

NICWA has grown from a two-person training project with an initial budget of \$60,000 to a successful national organization to serve tribal programs and communities on services and issues affecting American Indian/Alaska Native children and families.

Community Development

- Training: Provides workshops in all aspects of child welfare practice using the NICWA-developed resources described below, as well as others.
- Consultation and Technical Assistance: NICWA conducts needs assessments, assists with program design and development, helps negotiate tribal-state agreements, and advises programs on information systems and policies.
- Evaluation: Contracts with tribes to conduct project or program evaluations.
- Child Abuse/Neglect Prevention and Public Awareness: Publishes culturally specific materials including booklets, posters, and public service announcements.

Information Exchange

- Curricula: Developed over 20 different curricula and resource manuals geared to an American Indian audience. *Heritage and Helping: A Model Curriculum for Indian Child Welfare Practice* is the only comprehensive curriculum specific to Indian child welfare (ICW).
- Regional and National Conferences: NICWA conducts the annual Protecting Our Children: The National American Indian Conference on Child Abuse and Neglect, as well as the Region X and IV-E Conferences.
- Library/Information Clearinghouse: NICWA maintains a library of over 4,000 books and articles for use by child welfare professionals and others.
- Newsletters: *Pathways* is a journal on ICW practice issues. *NICWA News* is published quarterly and addresses developments in the field.

Public Policy Work

- Legislative Advocacy: Monitors legislation that may impact Indian children and families.
- Monitoring Access to Funding: Studies the funding sources and problems of tribal access to child welfare- and mental health-focused programs.
- ICW Compliance/Cultural Competence: Advocates for the proper implementation of the Indian Child Welfare Act of 1978 and provides training for improving organizational cultural competence.



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NICWA

National Indian Child Welfare Association

Protecting our children • Preserving our culture