Northwest Suicide Prevention Tribal Action Plan

A Five-Year Strategic Plan for the Tribes of Idaho, Oregon and Washington

2009 – 2013

Portland Area Indian Health Service &
Northwest Portland Area Indian Health Board

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Tribal Action Plan Mission Statement

Our mission is to reduce suicide rates among American Indians and Alaska Natives living in the Pacific Northwest by increasing tribal capacity and improving collaboration. It is our hope that the Action Plan will be used by the Northwest Tribes and by our partnering agencies to guide program planning, catalyze community outreach efforts, and foster a coordinated response to suicide in our tribal communities.

Planning Process

The Northwest Suicide Prevention Tribal Action Plan is the product of a collaborative, year-long planning process, initiated by the Northwest Portland Area Indian Health Board (NPAIHB). The suicide prevention planning team met quarterly in 2008, and included tribal health representatives, the Indian Health Service, the Northwest Portland Area Indian Health Board, State Health Departments, State Departments of Education, Universities, regional tribal planning groups, and the EDC Suicide Prevention Resource Center. The plan spans a five year period, and is designed to include the 43 federally-recognized Tribes located in Idaho, Oregon and Washington.

The planning process involved multiple phases, beginning with a review of suicide rates and risk factors for American Indians and Alaska Natives (AI/AN) living in this region. To inform the planning process, the team then gathered more information about available and needed suicide services, and assessed the capacity of the region's Tribes to address suicide at the community level. A Tribal Suicide Capacity Assessment Survey was administered that explored a broad array of related topics, including prevention activities, treatment services, crisis response teams, and perceptions about community knowledge and concern. Once the assessment was complete, the planning team discussed the region's current level of readiness across six important dimensions: 1) Community Efforts 2) Community Knowledge of those Efforts 3) Leadership 4) Community Climate 5) Community Knowledge about Suicide, and 6) Resources Related to Suicide. This information was then used by the planning team to select and design intervention strategies that were responsive to the current level of community readiness present within the Northwest Tribes.

A draft of the Northwest Suicide Prevention Tribal Action Plan was completed in September 2008, and circulated among partners for critical review and feedback. Once complete, the plan was reviewed by the delegates of the Northwest Portland Area Indian Health Board and the behavioral health sub-committee. A resolution supporting the plan's implementation was passed in January 2009.

Suicide Rates for AI/ANs Living in the Pacific Northwest

Suicide is a sensitive issue, but one that is of great concern to many American Indian and Alaska Native (AI/AN) communities. Data suggest that suicide is a significant problem throughout Indian Country, particularly among Native youth, males, veterans, and elders. From 2000-2005, the average suicide death rate was highest among AI/AN youth aged 15-24 (at 18.7 cases per 100,000, compared to 10.7 per 100,000 for White youth and 7.1 for Black youth). Nationwide in 2005, suicide was the second leading cause of death for AI/AN youth in that age range.

Rank	Cause of Death
1	Unintentional Injury
2	Suicide
3	Homicide
4	Malignant Neoplasms
5	Heart Disease

5 Leading Causes of Death for AI/AN Youth Age 15-24, United States, 2005

The Portland Area has one of the higher suicide death rates for AI/AN among the IHS service areas. The IHS reported that, from 1996-1998, the age-adjusted suicide death rate for the Portland Area was 22.0 per 100,000, a rate that was exceeded only by Aberdeen, Alaska, Bemidji, and Tucson.

At the state level, annual suicide rates for AI/AN tend to fluctuate widely because the actual number of deaths each year is relatively small. In 2005, for example, 12 AI/AN suicides occurred in Washington, 3 took place in Oregon, and 5 in Idaho. While males typically *complete* suicide more often that women, studies suggest that women actually *attempt* suicide more frequently than men. This pattern is also present among AI/ANs in the Pacific Northwest.

Data on suicide risk factors and attempts, as opposed to mortality, are available from a variety of sources, including the CDC's Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey (YRBS). Data from these sources and other studies have found that several factors can put a person at higher risk for attempting suicide, including: • Previous suicide attempt(s) • History of depression • Alcohol or drug abuse • Family history of suicide or violence • Physical illness • Feeling alone. Additional research is needed to identify and explore the culturally unique factors that affect AI/ANs.

Background Research

In order to better understand the capacity of the Northwest Tribes to prevent and treat suicide, the NW Tribal EpiCenter, located at the Northwest Portland Area Indian Health Board, administered a comprehensive Tribal Suicide Capacity Assessment Survey modeled after the *Community Readiness Model* (developed by the Center for Applied Studies in American Ethnicity - CA7AE). The model was tailored by the NW Tribal EpiCenter to include locally-relevant indicators of suicide capacity and to assess community readiness at the regional level, rather than for individual Tribes. Though each of the Northwest Tribes reported varying levels of capacity around suicide prevention and treatment issues, these data were aggregated to determine regional readiness.

From May to June 2008, the Tribal Suicide Capacity Assessment Survey was completed by 25 people representing 11 Tribes in the Pacific Northwest and 7 partnering agencies. This information was collected from a variety of perspectives, including tribal clinic representatives, tribal health department representatives, community health educators and CHRs, tribal Council members, tribal treatment programs, partnering agencies, youth program representatives, and other health advocates interested in suicide prevention and treatment.

The results of the Tribal Suicide Capacity Assessment Survey were discussed by both the planning team and the delegates of the Northwest Portland Area Indian Health Board, and can be downloaded at www.npaihb.org [under Key Indian Health Issues – Suicide]. By obtaining information about a variety of capacity indicators, the suicide planning team was able to tailor health promotion strategies in response to identified needs.

Baseline Capacity

The *Community Readiness Model* was designed to improve community-based prevention efforts by acknowledging and responding to a Tribe's unique culture, resources, and level of readiness. This model identifies six dimensions of readiness that influence a community's ability to take action to prevent suicide:

1. **Community Suicide Prevention and Treatment Efforts:** To what extent are there efforts, programs, and policies that address suicide?

2. **Community Knowledge about local Prevention and Treatment Services:** To what extent do community members know about local suicide prevention efforts and their effectiveness, and are these efforts accessible to all segments of the community?

3. **Leadership:** To what extent are appointed leaders and influential community members supportive of the Tribe's suicide prevention efforts?

4. **Community Climate:** What is the prevailing attitude of the community towards suicide prevention and treatment? Is it one of fear, silence, and helplessness or is it one of responsibility and empowerment?

5. **Community Knowledge about Suicide:** To what extent do community members know about or have access to information about suicide signs and risk factors?

6. **Resources Related to Suicide Prevention and Treatment:** To what extent are local resources – people, time, money, and space - available to support the Tribe's suicide prevention and treatment efforts?

Based on the results of the Tribal Suicide Capacity Assessment Survey, the region's current level of readiness was determined across each of the six dimensions:

1. **Regional Suicide Prevention and Treatment Efforts**: **Preparation**. Suicide prevention planning is taking place and focuses on practical details. General information about suicide rates and suicide prevention resources are available, but little is based on local, formally collected data. Volunteer staff members are active and energetic. Decisions are being made about what will be done and who will do it.

2. **Community Knowledge about local and regional Suicide Prevention and Treatment Services**: **Vague awareness**. There is a general feeling among community members that suicide is a problem that ought to be addressed, but for many there is no immediate motivation to do so. There may be stories or anecdotes about suicide, but ideas about why the problem occurs tend to be stereotyped and/or vague.

3. **Leadership**: **Vague awareness**. No identifiable leadership for suicide prevention exists in most NW Tribes, or leaders lack the sustained interest that is needed to deal with the issue.

4. **Community Climate**: **Vague awareness**. There is a general feeling among community members that suicide is a problem that ought to be addressed, but for many there is no immediate motivation to do so. The community climate does not serve to motivate leaders.

5. **Community Knowledge about Suicide**: **Preplanning**. In the region as a whole, there is a clear recognition by some that there is a local problem that must be addressed. There are identifiable leaders and a planning team, but efforts are not focused or detailed. Among some, the community climate is beginning to acknowledge the necessity of dealing with the problem.

6. **Resources Related To Suicide Prevention and Treatment**: **Initiation**. Enough information has been collected to justify prevention efforts. Activities have started and are underway, but they are still rather new. Staff time and funding have been given to the effort. Staff members are in training or have just finished. There is modest involvement of community members in prevention efforts.

Using this information, the suicide prevention planning team strategically selected a variety of intervention activities to increase the readiness of Northwest Tribes to prevent suicide. These indicators will be reassessed periodically, and will be used to evaluate the impact of the Action Plan over time.

Contributing Members

To achieve the goals outlined by the Northwest Suicide Tribal Action Plan, a number of Tribes, agencies, and programs will work collaboratively to complete the tasks and activities proposed by the plan. Different entities will be responsible for different portions of the plan. Contributing members will include:

- **The 43 federally-recognized Tribes in Idaho, Oregon, & Washington**
  - Tribal Health Departments
  - Behavioral Health Programs and A&D Treatment Programs
  - Youth Rehabilitation and Treatment Centers – Wembly House and Healing Lodge
  - Law Enforcement personnel and Correctional Facilities
  - Tribal and Public Schools
  - Youth Leaders

- **National and Regional Suicide Prevention Partners**
  - Education Development Center - Suicide Prevention Resource Center
  - Indian Health Service
  - Native American Rehabilitation Association - NW Native Youth Suicide Prevention Project
  - Northwest Portland Area Indian Health Board
  - Oregon Health Sciences University - One Sky Center
  - Portland State University
  - State Departments of Education – Idaho, Oregon, Washington
  - State Health Departments – Idaho, Oregon, Washington
  - Suicide Prevention Hotlines
  - University of Washington - Alcohol and Drug Abuse Institute

Northwest Suicide Prevention Tribal Action Plan

Tribal Action Plan Mission:
Reduce suicide rates among American Indians and Alaska Natives living in the Pacific Northwest by increasing tribal capacity to prevent suicide and by improving regional collaborations.

Primary Goals for 2009-2011

Goal 1: **Increase knowledge and awareness about suicide among Tribal community members, and in doing so, take steps to address the *silence* and *fear* that exists in many of our communities preventing use of available prevention and treatment services.**

Goal 2: **Improve intertribal and interagency communication about suicide prevention and treatment in order to share and maximize limited resources, by working collaboratively on this five-year Action Plan.**

Goal 3: **Increase the capacity of Tribal health programs to track, prevent, and treat suicide.**

Goal 4: **Improve understanding among Tribal staff, Tribal decision-makers, State Health Departments, and potential funding organizations about suicide issues affecting NW Tribes.**

Northwest Suicide Prevention Tribal Action Plan

GOAL 1: Increase knowledge and awareness about suicide among Tribal community members, and in doing so, take steps to address the *silence* and *fear* that exists in many of our communities preventing use of available prevention and treatment services.

Strategies and Interventions	Lead	Year 1 - 2009	Year 2 - 2010	Year 3 - 2011	Year 4 - 2012	Year 5 - 2013
A. Host a community forum, dinner, or cultural event to discuss local suicide concerns, possible solutions, and share available resources.	Tribal Health Programs	2 per year	2 per year	2 per year	2 per year	2 per year
B. Develop and disseminate culturally appropriate articles about suicide prevention and treatment activities for placement in Tribal newspapers.	NW Tribal Suicide Prevention Team	2 per year	2 per year	2 per year	2 per year	2 per year
C. To prevent suicide and foster cultural exchange, create or expand intergenerational gatherings, mentoring opportunities, and prevention activities targeting youth and elders.	Tribal Health Programs, Tribal Elder Programs, Tribal Youth Programs	■ Host 2 intergenerational learning/mentoring events per year				
D. Develop and disseminate a social marketing campaign that addresses the *silence* and *fear* that exists in many of our communities, preventing use of available prevention and treatment services.	NW Tribal Suicide Prevention Team	Select audience; Identify products and placement.	Work collaboratively with Native Media design firm.	Disseminate Media Campaign	Disseminate Media Campaign	Disseminate Media Campaign

GOAL 2: Improve intertribal and interagency communication about suicide prevention and treatment in order to share and maximize limited resources, by working collaboratively on this five-year Action Plan.

Strategies and Interventions	Lead	Year 1 - 2009	Year 2 - 2010	Year 3 - 2011	Year 4 - 2012	Year 5 - 2013
A. Use NPAIHB QBMs, conference calls, and email to work collaboratively on activities for the *Suicide Prevention Tribal Action Plan*.	NPAIHB Office Manager	4 meetings per year	4 meetings per year	4 meetings per year	4 meetings per year	4 meetings per year
B. Create a list-serve that disseminates information about available training, funding, curricula, prevention or treatment resources, model programs, and tribal successes.	NPAIHB Office Manager	Send 1-2 updates per month	Send 1-2 updates per month	Send 1-2 updates per month	Send 1-2 updates per month	Send 1-2 updates per month
C. Jointly host a NW Tribal Suicide training or prevention event that brings in experts in the field.	NARA & the NW Tribal Suicide Prevention Team	▪ 1 Event per year - such as the NW Tribal ASIST training, Gate-keeper training, White Bison, or a speaker like Clayton Small.				
D. Collaborate with Idaho, Oregon, and Washington Health Departments to seek funding and improve tribal access to State programs, services, and AI/AN suicide data.	Idaho, Oregon, and Washington Health Departments	▪ Attend at least one QBM meeting per year to discuss progress on the *Suicide Tribal Action Plan*. ▪ Produce at least one AI/AN-specific suicide data report per year.				

GOAL 3: Increase the capacity of Tribal health programs to track, prevent, and treat suicide.

Strategies and Interventions	Lead	Year 1 - 2009	Year 2 - 2010	Year 3 - 2011	Year 4 - 2012	Year 5 - 2013
A. Develop culturally-appropriate informational fact sheets about suicide. Make materials available on the www.npaihb.org website and send copies to all NW tribes.	NARA, NPAIHB, State Health Departments	Update annually	Update annually	Update annually	Update annually	Update annually
B. Tribes will establish multidisciplinary Crisis Response Teams (CRT). For tribes that do not have their own, NPAIHB will create a Directory of NW Tribal CRT Contacts.	NPAIHB, Crisis Response Teams (CRT)	■ Ongoing Activity - Crisis Response Teams (CRT) will be comprised of staff and volunteers representing the Tribal Health Program, Behavioral Health Program, Law Enforcement, Schools, and other partners.				
C. Tribal leadership will encourage their staff to participate in at least one suicide prevention event or training per year, such as Gatekeeper, ASIST, or QPR.	Tribal Council	1 per year	1 per year	1 per year	1 per year	1 per year
D. Tribal programs will host meetings to discuss prescription medications and the potential for misuse.	Tribal Health Programs	■ 4 Meetings per year – Meetings will include Tribal Health Programs, Law Enforcement personnel, School Administrators, etc. Meetings will be used to discuss challenges and identify solutions to increase community awareness and prevent overdose.				
E. Identify, adapt, share, and/or design suicide prevention interventions targeting: youth, elders, veterans, and other high-risk groups.	NW Tribal Suicide Prevention Team	■ Ongoing Activity				

GOAL 4: Improve understanding among Tribal staff, Tribal decision-makers, State Health Departments, and potential funding organizations about suicide issues affecting NW Tribes.

Strategies and Interventions	Lead	Year 1 - 2009	Year 2 - 2010	Year 3 - 2011	Year 4 - 2012	Year 5 - 2013
A. NW Tribes, Urban Indian Health Centers, and the NPAIHB will work collaboratively to seek funding that addresses the suicide prevention and treatment needs of AI/ANs.	NW Tribal Suicide Prevention Team	■ At least one grant per year, or as available.				
B. NW Tribes will actively seek to have tribal representation on State or regional suicide planning groups.	Idaho, Oregon, and Washington Health Departments	■ At least one AI/AN on each state planning group.				
C. NW Tribes will work together to obtain better AI/AN suicide data and identify strategies to reduce misclassification and underreporting, including use of RPMS and other available tracking systems.	NW Tribal Suicide Prevention Team	■ Ongoing Activity –Annually collect, tabulate, and disseminate results to Tribal Leaders and staff.				
D. Collaborate to develop and validate more culturally-appropriate qualitative and quantitative risk assessment tools for AI/ANs, and encourage their use and application.	NW Tribal Suicide Prevention Team	Identify and/ or develop AI/AN suicide risk assessment tool(s)	Validate risk assessment tool(s), make needed revisions	■ Integrate new tool(s) into use in the NW. Collect, tabulate, and disseminate results.		

Next Steps

Without funds to support the ongoing work of the NW Tribal Suicide Prevention Team (at present), the Team will use other gatherings and periodic conference calls to support our continued collaboration on the goals and objectives contained in this plan. When funding becomes available, additional staff time will be allocated to coordinate the implementation of this plan.

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