CLINICAL SCHOLARS

A Robert Wood Johnson Foundation program

Toolkit for Suicide Prevention and Mental Health Promotion in Tribal Communities

Prepared by:
***Monica Taylor-Desir**, MD, MPH, Department of Psychiatry and Psychology, Mayo Clinic, Rochester, MN*
***Anita Martin**, MD, FAAP, Chief Medical Officer, Three Affiliated Tribes, Elbowoods Memorial Health Clinic Center, New Town, ND*
***Kelly McGrady**, RN, Three Affiliated Tribes, Sage Coulee Outreach and Wellness Facility, Bismarck, ND*
***Leolani Ah Quin**, LCSW, DBH, San Carlos Apache Wellness Center, San Carlos, AZ*

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ABOUT THE PROGRAM

Clinical Scholars is a national leadership program of the Robert Wood Johnson Foundation led by the University of North Carolina at Chapel Hill. Learn more about RWJF's Leadership for Better Health programs by visiting: rwjf.org/leadershipforbetterhealth

ABOUT THE TOOLKIT

This toolkit provides information and recommendations on creating a suicide prevention campaign in tribal communities. This toolkit includes ideas for events, suicide prevention interventions and development of community support. For more information contact: taylor-desir.monica@mayo.edu

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TOOLKIT
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Toolkit for Suicide Prevention and Mental Health Promotion in Tribal Communities

American Indians have the highest suicide rate in the United States of any racial/ethnic group. Suicide is the second leading cause of death for American Indians ages 10-34 years old. The CDC notes that approximately 70% of American Indians that die by suicide reside in rural/nonmetropolitan areas. Survivors of suicide attempts require collaborative support. The American Association of Suicidology reports that for every death by suicide there are at least six people that experience a major life disruption. American Indians and Alaska Natives who die by suicide are 2.4 times more likely to have a friend or family member that died by suicide.

Our work was conducted on the Mandan, Hidatsa, Arikara Nation, also known as the Three Affiliated Tribes, which encompasses six different communities covering nearly one million acres. There are approximately 6,000 members living within the reservation along with American Indians from other tribes. We sought to close the gaps within the health care system by creating partnerships with local schools, the Tribal College, Tribal Social Services, and the Tribal Health Department. Elbowoods Memorial Health Center works with these agencies to develop early identification of persons at risk for suicide and referrals for treatment. There are minimal services to address the survivors of suicide attempts and their families or family members of those who have completed suicide. A person that is a survivor of suicide has an increased risk of dying by suicide. Every suicide attempt and completion impacts the community and without education, mental health services, and the availability and access to care the suicide rate will continue to climb. The barriers to conversation about suicide within American Indian Communities include guilt and shame, personal pain, collective grief, stigma and fear.

Promote resilience through in-person and virtual interventions

Our mental health promotion project, “Building Resilience, Building Health”, focused on empowering the community to decrease the stigma of mental health and suicide in the community. After an initial clinically based intervention during the first year we moved towards primary prevention strategies in order to lay the groundwork for sustainable change. These strategies included equipping community members to generate conversations and building social support networks that adolescents can easily access when they are feeling stressed. There were three main activities in our project. We focused on developing a community conference to provide a multigenerational forum for discussion about mental health and suicide prevention. We provided suicide prevention training to community members with a focus on reducing suicidal behaviors while highlighting life promoting activities. We also implemented a social media campaign to generate conversation and decrease stigma around mental health and suicide prevention. Information about our activities and videos of our webinars are housed at *buildingresiliencebuildinghealth.org*.

In June 2018 the CDC reported that the **suicide rate in North Dakota rose 57.6%, the highest in the country,** between the years of 1999-2016.

North Dakota ranks within the top twenty states for deaths by suicide and the occurrent **suicide rate for American Indians in North Dakota is three times the rate** of the general population.

The North Dakota Suicide Prevention Plan for 2017-2020 conservatively reports that in 2015 there were approximately 702 North Dakotan survivors (117 deaths by suicide).

Planning

Within the first week of 2017 the city of New Town, ND and the Elbowoods Memorial Health Center on the Mandan, Hidatsa, Arikara Nation noted 10 suicide attempts of community members. Several of the attempted suicides were adolescents. Parents, grandparents, and concerned community members are often at a loss on how to help their teens. Once adolescents are psychiatrically hospitalized there is a lack of communication between the inpatient treatment team, the outpatient providers and the families. Teens often prematurely stop their medications because neither they nor their families understand their diagnosis, medication, or how to reintegrate into the school environment. Families are at a loss to recognize warning signs of a relapse or decompensation. Poor access to care, discrimination, and adverse early life experiences combined with historical trauma have made it challenging to combat the rate of suicide attempts in the community.

KEY SKILL SETS

We took an integrated multidisciplinary approach to suicide prevention in our community. It was important to have a community psychiatrist involved who could apply the primary tenets of community psychiatry which include epidemiology, advocacy, person-centeredness and recovery, health care financing, and public health and prevention to the challenge of suicide prevention. We also needed those who worked directly with youth and the systems where they were most involved. We needed a pediatrician due to our adolescents often returning directly to their primary care providers directly from psychiatric hospitalizations. We were privileged to have a provider trained in the integrated behavioral health model of mental health care who could easily move between specialty mental health care and primary care and who could also work at a systems level. We needed a person who was invested in our youth at the school level and was connected to families in the community.

- Monica Taylor-Desir, MD, MPH: Project Lead, Community Psychiatrist
- Anita Martin, MD, FAAP: Chief Medical Officer and Pediatrician
- Kelly Martin, BSN, RN: Health Facilitator and Community Liaison
- Leolani Ah Quin, DBH, LCSW: Director of San Carlos Apache Wellness Center

FUNDING

In 2017, funding from the Substance Abuse Mental Health Services Administration (SAMHSA) Tribal Training and Technical Assistance Center afforded a community readiness assessment and hold a Gathering of Native Americans (GONA) event. During the GONA, over 500 community members gathered to create a community prevention plan. We received the Robert Wood Johnson Foundation (RWJF) Clinical Scholars grant in September 2017 which allowed for funding of our clinical intervention, community activities, trauma informed care training of Elbowoods Clinic Personnel and the development of a website. The SAMHSA Native Connections grant received in 2018 provided for sustainability of the suicide prevention programs initiated during the Clinical Scholars grant period.

CLINICAL SCHOLARS FELLOWS

ADDITIONAL TEAM MEMBERS

- Levi Chapin: Project Director, Native Connections Grant
- Twyla Baker, PhD: President, Nueta, Hidatsa, Sahnish CC
- Polly Chase: Director, Mandan, Hidatsa, Arikara Nation Aging Service
- American Indian Public Health Resource Center: Ryan Eagle, Public Health Research Project Manager; Melanie Nadeau, PhD, MPH, Operational Director; Gretchen Dobervich, LSW, Public Health Policy Manager; Vanessa Tibbets, MA, Program Leader
- University of ND Masters Counseling Psychology and Community Service Program Interns: Amanda Young; Marc Dutch, MS; Caroline Perez
- Maura Munoz, MD: Child and Adolescent Psychiatry Fellow
- Tami DeCoteau, PhD: Trust-Based Relational Intervention Practitioner, Presenter on Trauma Informed Care
- Charlie Moran: Hidatsa Language and Cultural Studies
- Dyan Fox: Tribal Studies
- New Town Public Schools: Marc Bluestone, Sr., Superintendent; Nicholette Lahtinen, School Board Member; Chuck Hunter, HS Athletic Director; Chelsie Smith, HS Counselor; John Gartner, HS Principal

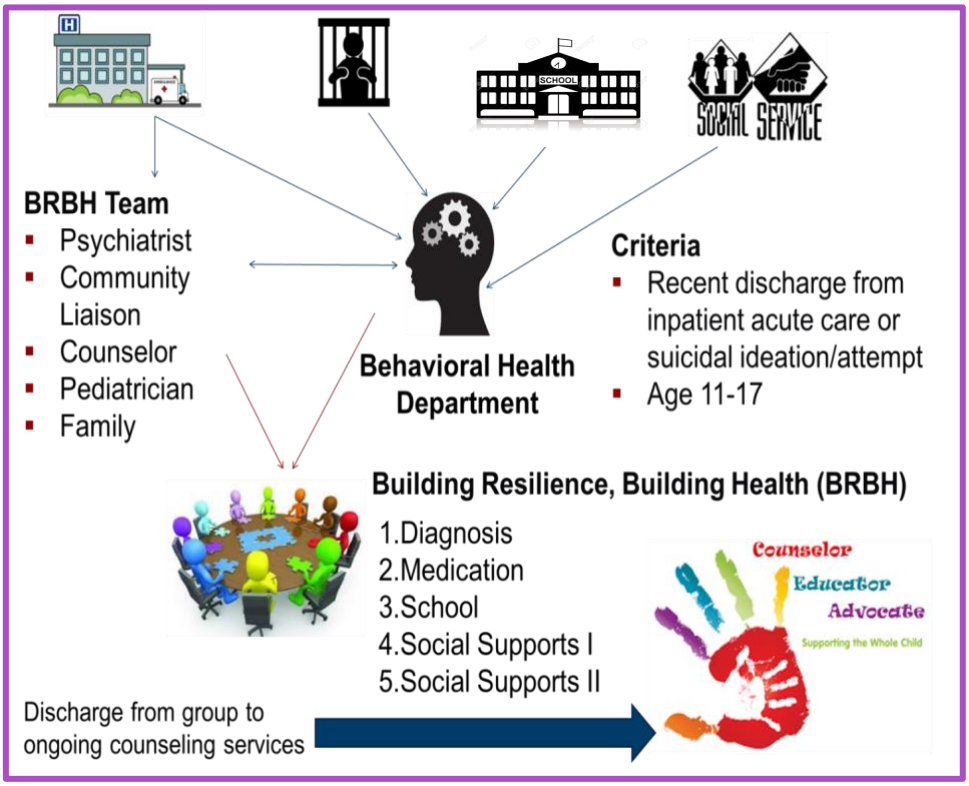
Project work

First, our team met with evaluation personnel from the American Indian Public Health Resource Center to provide guidance and training in developing an evaluation plan. Kelly McGrady, RN worked to reach and educate stakeholders at the local school district including the school superintendent, teachers, and counselors. Additionally, we sought to increase our clinical capacity by partnering with higher education institutes such as the University of North Dakota and the University of Cincinnati. We developed a psychiatric fellowship rotation for a Child and Adolescent Psychiatric Fellow which allowed the Fellow to have exposure to providing mental health care in a frontier community. Working with the Child and Adolescent Fellowship program also brought a rare and limited resource of child and adolescent specialty services into the clinic. In addition, we partnered with Decoteau Trauma Informed Care in Bismarck, ND to provide trauma-informed therapies for our patients. It is important to note that our work with schools and other tribal departments was defined through established Memorandum of Understanding (MOU). A MOU outlines an agreement of mutual respect that outlines the benefits to students and their families, educators and providers. MOUs help to create strong partnerships, streamline referrals, and a coordination and integration of services. An effective MOU will draw on the expertise of existing personnel in the current system. The MOU developed created a foundation for continued culturally responsive collaboration and service delivery.

YEAR 1

The five-week psychoeducational intervention was implemented entitled Building Resilience, Building Health (BRBH). The intervention implemented primary, secondary and tertiary prevention. Adolescents with possible mental health diagnoses were identified through the school environment by referrals to Kelly McGrady, RN and/or Dr. Leolani Ah Quin. Adolescents also accessed this program through a referral by a primary care provider or a pediatrician at the Elbowoods Memorial Health Care Center or one of their four satellite clinics. Referrals were also made directly through the psychiatry clinic through Dr. Taylor-Desir at Elbowoods Memorial Health Care Center or any of the satellite clinics.

Once an adolescent was referred, they received a full mental health evaluation from Dr. Ah Quin, Dr. Taylor-Desir or one of the behavioral health personnel within the behavioral health department. Once the mental health diagnosis was determined, the adolescent's parent/guardian was contacted and invited to participate in the BRBH program. The program was open to all members of an adolescent's household, regardless of age, and the input of all household members valued. The BRBH program consists of five sessions focusing on: diagnosis, medication, reintegrating into the educational system, and two sessions on social support. Groups last 60-90 minutes in length and can be single or multifamily groups. Sessions built on the wisdom of the family and community to increase resilience within the individual and ultimately within the community.



YEAR 2 AND 3

During the second year, the goal was to continue the psychoeducational groups and identify topics that should be included in the family group sessions. We planned to expand the reach of the BRBH Groups to have a consistent presence across all segments of the community.

During the third year, the BRBH project focused on empowering the community to decrease the stigma of mental health and suicide in the community. In order to lay the groundwork for a sustainable change in the mental health culture we focused on primary prevention strategies. These strategies included equipping community members to generate conversations and building social support networks that adolescents can easily access when they are feeling stressed. There were two main activities for the third year. We developed a social media suicide prevention campaign that will provide a multigenerational forum for discussion about mental health and suicide prevention. The social media campaign promoted the initiation of conversation by community role models in order to decrease the stigma around mental health and suicide prevention. We provided suicide prevention training to the community with a focus on reducing suicidal behaviors and highlighting life promoting activities.

RECRUITMENT AND BUILDING AWARENESS

During the first year, we focused on building awareness of the BRBH psychoeducational intervention by increasing communication internally with our own health care providers and medical staff. In addition, we increased awareness of services in the community by having psychology interns providing services in the school, holding screening events of a film highlighting adverse child experiences, and working with community members to hold the community's first suicide prevention awareness walk.

ENGAGING YOUTH

As several of the grant team members geographically located the focus of the intervention changed from the five-week psychoeducational program to outreach and incorporation of youth leaders in the development of suicide prevention campaign that would reach other youth and community members. The New Town High School Students Step Out and Represent (SOAR) group become involved in the planning of a community mental health summit in collaboration with the grant team. The youth shared their lived experience of multiple family, social and emotional challenges. These challenges included: struggling with suicidal ideations and suicide attempts; deaths of family members and loved ones; the responsibility of raising younger siblings; substance use disorders; bullying; physical, sexual and emotional abuse; all while trying to focus on obtaining an education. The youth were eager to share the development of their resilience skills with other students that faced the same challenges.

SUICIDE PREVENTION WALK 2018

BUILDING RESILIENCE, BUILDING HEALTH CURRICULUM

The five-session psychoeducational program is designed to help adolescents and their family support each other and foster the mental health and the well-being of the adolescent. The benefits of participating in the program include increasing the knowledge of the adolescent's mental health condition, identification of the adolescent's strengths and social networks, and learning how to build resilience and returning to a journey of wellness. The general agenda for each session begins by welcoming families and sharing a meal with them. Formal introductions and an icebreaker are followed by the educational portion of the evening. Each session ends by allowing each participant to provide feedback to the team. The curriculum session content is as follows:

- **Diagnosis** – The diagnosis module allows families time to learn about the diagnoses of their adolescent. Diagnoses covered in this module include: Major Depressive Disorder, Bipolar Disorder, Disruptive Mood Dysregulation Disorder, Substance Use Disorder, and Attention Deficit Hyperactivity Disorder. The topics covered are based on the diagnoses of the adolescents present. This module is designed to help patient and family members identify and understand the symptoms of their adolescent's mental health condition.
- **Medication** – This module is designed to help adolescents and family members learn classes and names (generic and brand) of their medications, side effects of medications, and who to talk to about their medications.
- **Returning to School/Bullying Prevention** – Returning to a normal school routine after being in the hospital can be challenging. This module is designed to help families identify school policies and personnel that can be helpful in promoting the academic success of their adolescents such as Individual Education Plans and 504 plans. Bullying is associated with increases in suicide risk in youth who are bullied. This module also addresses bullying and cyberbullying in the adolescent's school and social media interactions.
- **Social Support I** – There are two modules on social support in this curriculum. The first module on social support provides an opportunity for the adolescent to identify persons in their social networks that they view as supportive to them. This module also gives families the opportunity to highlight additional supportive persons that the adolescents may have not recognized. During this module the families learn about instrumental and emotional support
- **Social Support II** – The second module of social support provides an opportunity for families to learn about emotional and appraisal support and provides an opportunity for role-playing and providing positive feedback to the adolescent.

Once the adolescent has completed five sessions a graduation is held for the adolescent and the contributions of each family member is recognized.

CREATING AN ONLINE PLATFORM

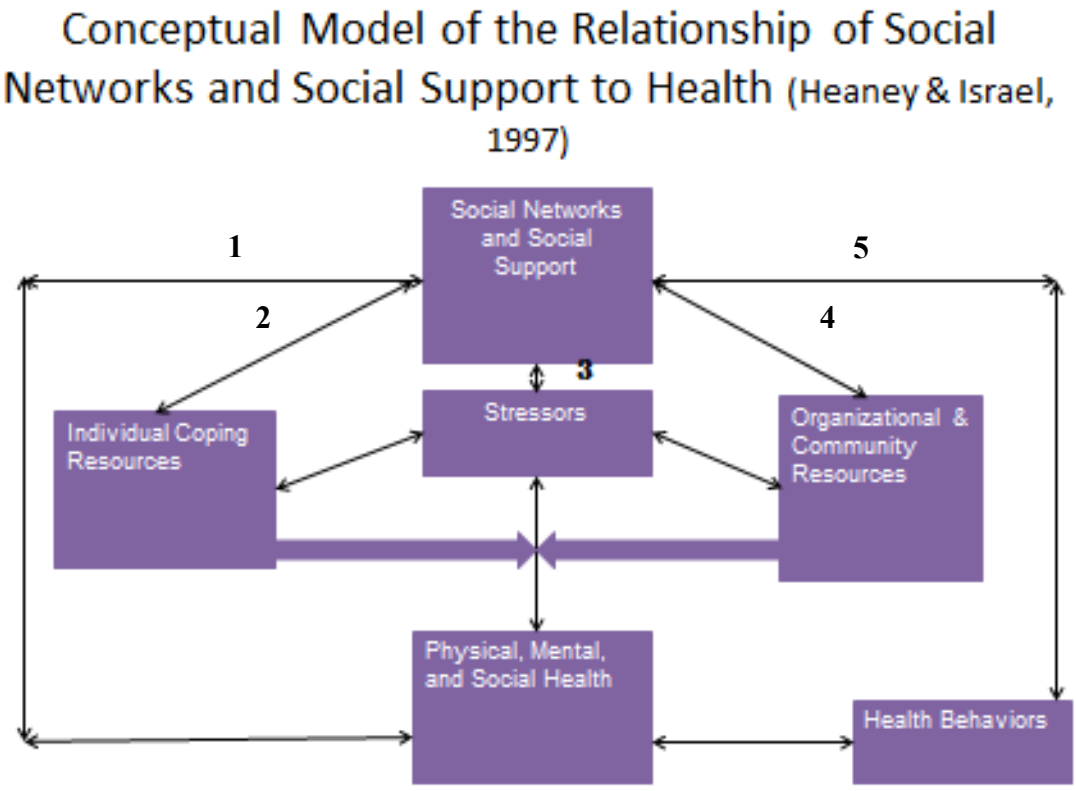
The use of telehealth services and on-line resources became more important during the 2019-2020 school year. The grant team was able to provide networking resources to engage New Town High School Students with Telemental Health through Regroup Telehealth company and psychiatric services via telehealth. These services were provided once a week. The New Town High School Counselor monitored referrals and assisted with scheduling appointments with the providers.

SOCIAL RESOURCES TO SUPPORT HEALTH

According to the model of Social Networks and Social Support to Health when people experience stressors, the availability of individual or community resources increases the likelihood that stressors will be handled or coped with in a way that reduces both short-term and long-term adverse health consequences. There are direct effects of social support and social networks on health and an indirect buffering effect on health. Pathway 1 in the model illustrates a direct effect on physical, social and mental health. This is a reciprocal pathway illustrating the fact that one's health also has a direct influence on the ability to form and utilize one's social networks and social support. Pathway 2 illustrates the reciprocal influence that social support and social networks have on one's ability to utilize individual coping resources. Examples of individual resources include: problem-solving skills, utilizing new information, and perception of control. Pathway 4 illustrates the reciprocal influence that social support and social networks have on one's ability to utilize organizational and community resources. Community and organizational resources can help bolster one's social network and social support. Pathways 2 and 4 illustrate the buffering effect. Individual coping resources and organizational and community resources buffer the effect of stressors on one's health. Social networks and social support also have direct and reciprocal effects on one's health behaviors which include risk factors, preventive practices, and illness behaviors (Heaney & Israel, 1997).

TRAUMA-INFORMED CARE TRAINING

Dr. Tami DeCoteau presenting in Mandaree, ND



Evaluation and dissemination

In order to provide culturally appropriate care, an indigenous lens is required. The American Indian Public Resource Center (AIPHRC) Team provided training to our clinical team to emphasize core cultural values in our evaluation and our dissemination. Programs and interventions are place based and must be grounded in the community. Community is essential to identity as a people and should be considered in any evaluation method. AIPHRC also emphasized tribal sovereignty which dictates that evaluation belongs to the tribe and community and should be practiced in ways that help the community to learn and move forward. Each tribal community has protocols for projects, community assessments and those seeking to conduct these activities should consult the tribal council or governing body of the community in which they are seeking to implement a project.

At the beginning of our project the team administered pre and post assessments of parent and adolescent communication and perceived social support by the adolescent. In addition, at the end of each session we asked participants three things they learned during the session and what the clinical team could do better.

Dissemination of our work occurred through community events and national conferences which included the following:

- Integrated Behavioral Conference, Phoenix, AZ
- Community Recovery Event, MHA Earth Lodge, New Town, ND
- National Indian Health Board Behavioral Health Conference, Albuquerque, NM
- Rocky Mountain Research Institute, Aurora, CO
- Life is Precious Suicide Prevention Conference, San Carlos, AZ
- Native American Interest Group, Rochester, MN

We also disseminated our work through a social media campaign during National Suicide Prevention Month 2020 in addition to the development of the **Building Resilience, Building Health website** which houses mental health resources.

KEY MESSAGES

- Assess the community's needs for services, resources, and their readiness to participate in conversations about suicide prevention and the impact of suicide completions in the community
- When conducting a stakeholder analysis, it is important to include adolescents
- Interventions should be culturally sensitive, and care should be taken in deciding what places interventions occur
- Social Media can be a tool to disseminate information. Choose your platform based on the target audience
- Actively engage youth in planning: Ask what they need
- Trauma Informed Care should be an integral part of any intervention

ADOLESCENT AND FAMILY EXPERIENCE

Prior to engaging our team, this teen had not engaged in consistent behavioral health services.

We were able to encourage, support, and facilitate improved communication between parents, parent and teen, as well as the teen and her siblings.

During our time together we were able to prevent further readmission to inpatient acute care and increase medication/ treatment adherence.

The family appreciated the "dedicated" time set aside to engage each other during the five-week intervention and asked for monthly support group/family nights.

Challenges, successes, and lessons learned

COVID-19 brought challenges to every person and every community. At the beginning of the third year of the grant our team focused on developing a live mental health summit to be held on the Mandan, Hidatsa, Arikara Nation with the hopes of having Native youth attend from other local reservations. The "World of Opportunities in Healing" Native American Youth Suicide Prevention Summit was planned for April 8-9, 2020 at the Four Bears Casino & Lodge with a full schedule.

Once the prevailing recommendation was made across the country to shelter-in-place, cease unnecessary travel, and social distance our live summit was sadly postponed then canceled. We again regrouped and decided to bring the planned events to a virtual platform by using the hashtags #ResilienceIsInOurDNA and #ItsOK2TalkaboutIT. The goal was to provide various avenues for various ages to be impacted as well as hosting a virtual run with the Gas Cap Runagades who share messages of physical, mental, and spiritual wellbeing, while sharing Indigenous Humor on how to care for your body. The Gas Cap Runagades also promotes proper nutrition to compete in 100 mile or less trail running for mental health.

- **Engaging stakeholders** – As the project began to focus on prevention and sustainability the team went back to the community and sought out stakeholders who were vested in suicide prevention.
- **Ongoing sustainability after the team members moved to various locations** – As team members began new roles in separate locations it became evident that scheduled team meetings, coaching sessions, and email communication would require consistent efforts to keep the team on task.
- **Limited resources** – Limited access to funding caused the New Town team members to seek alternative funding to support the youth's efforts to lead a youth conference focused on prevention. Local Businesses, School, and community leaders were approached to financially partner to move youth suicide prevention forward.

SHIFTS IN THINKING

The team recognized that the initial psychoeducational intervention needed to move away from sole reliance on clinicians and include a more sustainable community partner focus. The team shift from intervention to community-based prevention on a larger scale with "new stakeholders" was refreshing and allowed us to generate the motivation/influence needed to move forward with virtual interventions.

SUCCESSES

Through networking, strong community partnerships and previous efforts established through a suicide prevention grant, the team was able to secure follow up funding for five years which aims at sustainability of our project efforts. The partnership with Decoteau Trauma Informed Care significantly improved the process of securing outpatient care for adolescents. The partnership with higher institutes of educations also allowed for an enrolled community member to have educational and professional experiences within her own community. The partnership with University of North Dakota and the University of Cincinnati also provided for significant staff training and development.

PLANNED ACTIVITIES

- Tipi Talks (TED talk format),
- Speed Wisdom (youth/elders) visiting about issues/prompts to get multi-generational dialogue
- Youth Mental Health First Aid Training for Adults working with youth
- A fashion show
- Social hour with comedians
- Inspirational run
- LGBTQ supports
- Dealing with Grief and Loss
- Dealing with a child who died via suicide
- Relaxation Methods
- How to Cope with Dysfunction in Family Dynamics

Recommendations

The Building Health, Building Resilience family psychoeducation intervention model is suitable in settings that offer collaborative care across medical, behavioral health and community support agencies to inform and support mental health recovery of youth and their families for the prevention of suicide and readmission to inpatient acute care centers.

GETTING STARTED

- Know your community needs and identify key stakeholders and a core team of champions that are dedicated, willing and able to Influence, educate, develop, and implement interventions.
- Use a two-pronged approach – community-based awareness, education and prevention as well as targeted intervention with families.
- Identify potential funding resources and supports for ongoing maintenance of intervention and create solid agreements with partners that can support and sustain the intervention in the long term.
- Identify key trainings necessary to equip stakeholders, champions, leaders, and youth with the skills and knowledge to facilitate, support, manage, and maintain the intervention group.

When beginning a suicide prevention project, do not assume that because suicide is prevalent in your community that it is a priority to the community. For various reasons, people may feel overwhelmed, like the issue is too big or that suicide in the community is inevitable. It is critical to identify the stakeholders and champions that are truly vested in the issue. Do not exclude community-based services like churches and individuals who are passionate about these issues; they may prove to be the best assets and allies in this work. Do not forget to include the youth; their ideas, energy, and passion is important.

BEST PRACTICES

- It is difficult to keep stakeholders accountable to follow through and support the work; learning to navigate leadership systems and use external pressure to influence outcomes is a powerful tool. Use both informal and formal networks to influence collaborative work.
- Institutional Review Boards (IRB) are not well-versed in tribal sovereignty or processes. When developing an evaluation process that involves multiple agencies education of the Institutional Review Board regarding tribal processes may be necessary. Academic centers, government agencies, and tribes may each have their own IRB. Some tribal communities do not have their own IRB. Some academic centers also require project protocols to undergo a review by a cultural IRB.

LESSONS LEARNED

- A True change in the Culture of Health comes from engaged and invested community stakeholders – interventions cannot solely rely on clinicians
- Include families and youth from the start to help develop the community-based prevention efforts AND mentor them so the families and youth can create a support group and assist facilitation of interventions
- The “elevator pitch” is important for quickly educating and engaging individuals, especially when talking to individuals that influence funding and resources
- Be flexible
- No plan is final: “Shift Happens”

Appendix

Building Resilience Building Health website:

https://www.buildingresiliencebuildinghealth.org/

Resources for suicide prevention and psychoeducation:

- https://suicidepreventionlifeline.org/help-yourself/native-americans/
- https://www.ihs.gov/suicideprevention/
- https://www.sprc.org/settings/aian

The impact of the COVID-19 pandemic on suicide rates:
https://academic.oup.com/qjmed/article/doi/10.1093/qjmed/hcaa202/5857612

Suicide risk and prevention during the COVID-19 pandemic:

https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30171-1/fulltext