# Recommendations from an American Indian reservation community-based suicide prevention program

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## Abstract:

Purpose – Effective community-based suicide prevention strategies require culturally relevant contextually driven approaches, validated by community members. Existing literature, funding agencies, and polices do not adequately address the differences in community vs non-community definitions and approaches to suicide prevention. These differences and the process must be articulated to fully understand the complexities of effective American Indian community-based suicide prevention strategies. This paper aims to discuss these issues.

Design/methodology/approach – This study uses a qualitative methodology to understand the process and meaning of an American Indian reservation's community-based approach to suicide prevention.

Findings – Seven recommendations emerge. These include: expand the understanding of suicide; plan activities and outreach early; uphold cultural values; build administrative and community capacity; prepare and respond to community needs and situations; anticipate challenges and develop solutions; and recognize the spiritual aspects of the endeavor.

Originality/value – This study provides new insight about the process in which American Indian communities define, develop and implement suicide prevention strategies that are culturally relevant and community driven. The process and recommendations may be useful for institutions, funding agencies, policy makers, and tribal leaders, and community-based prevention partners.

**Keywords:** Community | Ethnicity | Diversity in health and social care provision | Health | Race | American Indian

## Article:

> [...] our community is one of the top two in the country for high risk youth for environment, poverty, and isolation. I cannot think of another reservation that needs prevention and wellness more (Community Team Member, 2013).

## Background

Culturally relevant community-driven approaches are needed to address high rates of suicide in American Indian communities. Marked variation exists between rates of suicide in American Indians based on age, geographic region, and urban vs rural environments (Rutman et al., 2008). American Indian youth are more likely to commit suicide than American Indian elders; however, in the US general population, deaths from suicide most often occur in the elderly. Montana is a mostly rural state and has the second highest rate of suicide in the nation (American Association of Suicidology, 2007). Montana has ranked among the top five for suicide rates in the nation for 30 consecutive years (Montana Department of Public Health and Human Services, 2010); and previous efforts to address disparate rates have not adequately addressed prevention needs. This may be partially due to the fact that little is known about how communities develop strategies and effective prevention programs (Middlebrook et al., 2001). Few data sources or surveillance systems exist to examine risk factors and behaviors that may lead to suicide in American Indian populations (Mullany et al., 2009); however, most suicide prevention programs require the use of data-driven, evidence-based practices or interventions (Iglehart, 2009; National Registry of Evidence-Based Programs and Practices (NREPP), 2014) that target risks. In most American Indian communities, the evidence regarding suicide prevention from randomized control trials, longitudinal studies, and epidemiological data sets are not available. American Indian communities are addressing this gap by developing strategies and best practices to prevent suicide based on their own experiences and definition of what works (evidence). This is in contrast to the National Registry of Evidence-Based Programs and Practices (NREPP) that are often viewed as more desirable and effective by funding agencies and Western science. For example, a search in the NREPP using the terms “community” and “suicide” resulted in 12 interventions. Of these, only one, the Community Trials Intervention to Reduce High Risk Drinking, was a community-based approach that uses community-based strategies to prevent alcohol use, but it does not directly target suicide (NREPP, 2014). Other evidence-based therapies such as dialectical behavioral therapy (DBT) do not originate in or with the community; they are derived from Western behavioral health principles and perspectives. The fundamental problem with DBT and other non-community driven strategies is that they often have as their focus individual’s mental health while neglecting to recognize the unique culture, history, or community context.

This paper examines the experiences and activities that occurred during the first 12-months of a suicide prevention program located in a rural American Indian reservation-based community in Montana. The purpose of this review was to answer the following question, “What are some recommendations for developing an American Indian reservation community approach to suicide prevention?”. Results from this process may be helpful and instructive for other communities as they build effective suicide prevention programs, and for non-community based institutions, funding agencies and policy makers as they work with community-based suicide prevention programs. To begin, this process requires one to recognize epistemological differences between American Indian and non-American Indian communities.

*Defining health*

There are fundamental differences in how American Indian communities view health and the social and cultural determinants of health (King et al., 2009). For example, in American Indian communities, health determinants may include community level conditions: family support, a strong connection to the land and culture, fluency in the native language, strong cultural identity, access to a traditional healer or medicine man, and healing from historical and present day traumas (Willmon-Haque and BigFoot, 2008). In contrast, non-American Indian communities and institutions may view health determinants based on individual level factors and may include health care access and treatment, financial status, or education attained (Stokols, 1992; Zuckerman et al., 2004). Fundamental differences in defining what is considered good health often complicate suicide prevention efforts by not viewing individuals within their cultural context of health and wellbeing.

*Defining suicide*

There is not a standard definition for suicide among non-community based institutions (i.e. federal agencies, universities, scientific bodies, states, legislative bodies, non-community agencies) (Centers for Disease Control (CDC), 2012) and for American Indian communities, there is not a standard definition of suicide either. As would be common for conflicting or differences in definitions, surveillance and reporting of suicide and related risk factors are inconsistent and often inaccurate (CDC, 2012). Another issue with defining suicide relates to behavioral health providers, clinicians and health care systems, where they often define suicide based on a bio-medical definition acquired through medical and professional training (Stein and Stein, 1990); however, this definition differs from culturally constructed concepts of suicide. For example, in this American Indian community, suicide is viewed by some as a spirit that comes to help those in spiritual pain, this spirit also comes to listen and guide individuals that need help. This differs considerably from commonly used definitions, where suicide is often defined by an individual's thoughts or actions which may include ideation, attempt, or physical death caused by self-directed injurious behavior (CDC, 2012).

When these differences are not well understood or articulated, this leads to a lack of consideration about what needs to be prevented, how prevention might be accomplished, and why prevention methods needs to be instituted. Different definitions of health and suicide create a challenging environment for communities to develop effective prevention strategies.

*An American Indian community approach*

American Indian communities may conceptualize and implement suicide prevention approaches differently than non-American Indian community-based programs. American Indian community approaches include a deep understanding of their culture, values, norms, and healing practices (LaFromboise and Lewis, 2008; Wexler and Gone, 2012). Therefore, such indigenous approaches are more desirable to communities than non-community based approaches. For example, within most non-American Indian community-based institutions, a public health approach to suicide prevention is described as the most significant and sustained approach for

reducing suicide (SPRC, ND). This systematic approach is based on evidencebased programs that have undergone scientific review (i.e. NREPP), and deemed effective by individuals who are not members of the community for which the intervention or approach was designed. In contrast, a community-based prevention approach recognizes the inherent knowledge of community members and their expertise (Israel et al., 2010). In this way, community-based approaches are informed by evidence gathered from and in the community of what works. A community-based approach may define the extent of the problem (suicide) and solution (strategies) based on what they experience, perceive, feel, or intuitively know whereas non-American Indian community-based approaches often define suicide and risk factors based on normative assumptions and the medicalization of suicide where sophisticated surveillance or reporting techniques are used. In contrast, American Indian communities may identify risk and protective factors related to suicide based on the context, culture, history, or recent events opposed to the scientific literature, where risk and protective factors are defined by previous studies in different populations (Wexler, 2011). Also, the concept of intervening with at risk populations is different with an American Indian community-based approach because of how they define intervention and risk (Middlebrook et al., 2001). For example, published suicide risk factors (trauma, grief, substance abuse, relationship problems) may be ongoing and persistent in a community (Willmon-Haque and BigFoot, 2008; Duran and Duran, 1995) – an American Indian community approach to prevention requires intuitive knowledge and is based on what is known about an individual in need, and the kinds of support and services that exist in the community that might help them. This American Indian community-based approach to suicide prevention acknowledges the community context and setting, commitment of team members, program goals and objectives, the analysis process, and sharing results.

## Methods

### *Community context and setting*

The American Indian reservation community is located in south eastern Montana. According to the 2010 Census, the reservation population is approximately 5,000 people and of these 92 percent are American Indian clustered in housing-based villages and very small towns. The entire reservation area is considered a Medically Underserved Area and marked health disparities exist among tribal members including higher rates of death from cancer, heart disease, stroke, infant mortality, and diabetes (Montana Department of Public Health and Human Services, 2006). Substance abuse usage in the community increases the risk for self-harm and suicide. This results in high exposure to severe trauma spanning generations resulting in physical, emotional, and psychological injury that demands immediate attention.

### *The team*

The strategies and experiences described represent the efforts of a dynamic team with enduring commitments to the community and American Indian culture. The tribal community health programs director, program consultants, and various program partners started working together in 2008 on this specific task of suicide prevention. Most are longtime residents living in the community as well as tribal members. Other team members live outside the reservation

community with strong family-kinship-friendship ties and established long-term relationships with community members.

*Program*

This community-driven approach to suicide prevention started in August 2012 after the team submission of a grant proposal that was successfully funded by the Substance Abuse and Mental Health Services Administration. This three-year funded program is administered by the tribal health department under the community health programs director. The suicide prevention program works closely with other tribal health programs including the following: behavioral health, environmental health, tobacco prevention, diabetes prevention, community health representatives and home outreach, health education, and others. Cultural leaders, elders, and natural helpers also work closely with the suicide prevention program as healers, advisors, and cultural resources. A community advisory board oversees the program and includes community representatives from youth and family supporting organizations, cultural programs, traditional knowledge keepers and elders, public and tribal schools, social service organizations, law enforcement, juvenile justice, community-based organizations, and others.

*Program goals*

The goals of this prevention program are to: increase the understanding of suicide prevention, help individuals in need through culturally based coordination of services and support, and to promote partnerships that increase community involvement in suicide prevention activities.

Program objectives were designed to cover a wide range of topics relevant to suicide prevention and wellness.

Culturally based prevention program objectives:

- strengthen the team and workgroup by forming an advisory board comprised of representatives from the entire community including elders, ceremonial people, and each district;
- promote communication and activities to educate and engage others in suicide prevention based on the community context, culture and values;
- increase the number of community members engaged in culturally based interventions; and
- utilize community members, natural helpers, and families to support individuals in need.

*Data sources*

Program data were compiled monthly throughout the first 12-months of the project. Data included monthly reports, key-informant interviews, funding agency reports, tribal program reports, meeting minutes, observations, evaluation summaries from weekly or monthly community-based events, and other information. Key informant interviews were conducted in the first 12 months of the program with key program personnel, community members, and consultants. Informants were selected by the program coordinator and advisory board based on

their involvement with the program. They represented various perspectives and values of the community including a traditional person, an educator, a grandmother, a natural helper, a Western trained psychologist, and a community member. All data were collected and analyzed following local tribal protocols and ethical standards of research with American Indians.

In order to answer the question, "What are recommendations for developing a community approach to suicide prevention?" the team followed published qualitative research guidelines appropriate for the population (Denzin, 2008; Denzin and Lincoln, 2005). A grounded theory analysis approach was used because the team was interested in developing recommendations based on an iterative process that compared perspectives, experiences, and multiple data sources. Following the recommendations of Corbin and Strauss (1990), the initial step in the analysis was deciding the research question. Next, the team worked toward understanding what they wanted to know and what it meant, and then the team reviewed information about what they wanted to know. Last the team reviewed information and talked about what it meant through an iterative process. This analysis process resulted in recommendations about community approaches to suicide prevention.

*Grounded theory data analysis*

The lead author used a constant comparative method to analyze data. This process began with the research question:

> RQ1. What are some recommendations for developing an American Indian reservation community approach to suicide prevention?

This question led to the first iteration of theoretical sampling where four key informants were interviewed and their responses were transcribed and analyzed by the lead author. After the transcripts were analyzed, the lead author began to develop recommendations. Next, program data in the form of monthly progress reports, minutes from team conference calls, activity reports were examined. Then based on the emerging recommendations, the lead author conducted two additional key informant interviews. Saturation was reached after the sixth interview and no new ideas or insights emerged from the data that would answer the research question. A thematic network analysis approach (Attride-Stirling, 2001) was selected because the team was most interested in a visual representation of themes and the relationships between them. All data were uploaded into Atlas ti by the lead author (Muhr and Friese, 2004) to ensure the themes illustrated were supported by the text and to see how they were related (Attride-Stirling, 2001). Themes were then reviewed by the authors, community members, and program personnel to ensure they represented the actual activities, experiences, and perceptions of the previous 12 months.

This analysis process required several steps. The first step was to devise a coding framework and then to open code text. Next, themes were abstracted from coded text segments and refined. Thematic networks were created by arranging basic and organizing themes and extrapolating Global themes. These networks were then illustrated and refined based on consensus and review of the program team. Networks were then examined to find meaning between themes and patterns that emerged from the process.

In the last step of the analytic process the team organized the themes as recommendations for community-based approaches to suicide prevention in an American Indian reservation community. These recommendations reflect generations of knowledge, extensive time spent in the community, and a participatory paradigm influenced by indigenous ways of knowing and sovereignty (Denzin, 2008).

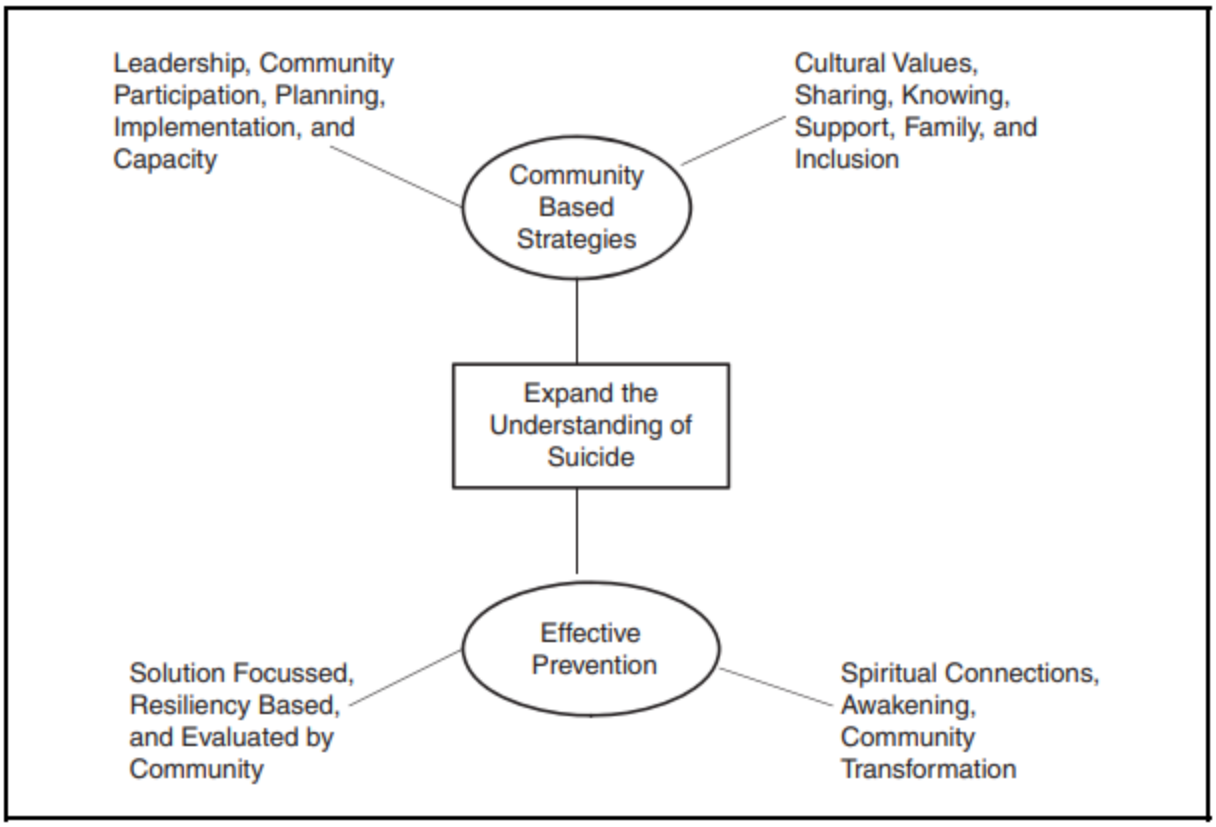
## Results

The Global theme that emerged was expanding the understanding of suicide. This was linked with other organizing themes including community based prevention strategies and effective prevention efforts (Figure 1).

Themes related to community-based strategies include leadership, community participation, planning, implementation, and capacity building. In addition, these community-based strategies were linked to cultural values, sharing, knowing, support, family and inclusion. Community-based strategies combined with effective prevention efforts lead to an expanded understanding of suicide, both within the community and among non-community based institutions.

Effective prevention was related to several themes including: solution focused, resiliency based, and evaluated based on community standards and norms. Also, the spiritual aspects of prevention included connections with others and with culture, an awakening process that leads to community transformation – all of which are difficult to measure, or even describe based on Western dominated approaches (Wexler and Gone, 2012). These themes form the basis of recommendations for an American Indian reservation community-based suicide prevention approach.

Figure 1 Themes from an American-Indian community on community-based suicide prevention




**Discussion**

Seven recommendations for community-based suicide prevention emerged from the analysis process and were supported by significant statements made by key informants and program data. These recommendations complement a public health approach to suicide prevention mentioned previously, but also provide context for communities, policy makers, and funding agencies to consider when working with American Indian reservation communities. The experiences and recommendations reported in this paper are consistent with previous publications related to American Indian community-based suicide prevention; however, this paper extends understanding and adds the unique perspectives of a culturally based American Indian reservation community. Recommendations reinforce the need for community approaches to suicide prevention that use American Indian traditional knowledge, cultural teachings, holistic approaches to health and wellness, reinforce the cultural identity of individuals and communities, and the importance of family and community values:

> Recommendation 1. Expand understanding of suicide, not limit the definition to what is technical or standard practice.
>
> Until now people viewed suicide as the solution to address their spiritual pain. The spirit comes to the community because it is being called [...]. Because it feels the pain, and wants to help [...].

> This new understanding is about what the spirit is and how it can be used as a way to help our people, the program is working to help others to understand, so they can start healing their own pain and listen better to the spirit being called to our community
>
> [...]. trying to get tribal identity restored where it has been lost [...]. I have found that if identity is missing it makes it easier to commit suicide [...] if there is no one to kill then one is not killing anyone in the act of suicide [...].

Recommendations begin with expanding understanding of suicide. This may be different for each tribal or non-reservation based community and therefore prevention programs must seek to understand how suicide is viewed by community members and in this case by spiritual and/or culturally based traditional leaders and informed by traditional knowledge. In many communities, prevention programs use Western or biomedical approaches to assess and define suicide and risk factors. Most people in this community viewed suicide as a spirit that comes to help people in pain. However misunderstanding this spirit may lead people to think about suicide. This program helped support activities and outreach that reaffirmed native culture and positive identity of community members. These activities helped the community understand suicide from a traditional native perspective based on the Tribe's culture and teachings. Promoting new understanding of suicide reduced the likelihood that individuals would misinterpret the spirit and complete a suicide act. Some might view this recommendation as meaning an entirely new approach to suicide prevention is needed; however, this is not necessarily what the data or results suggests. Understanding differences in American Indian suicide prevention must occur first, then activities and outreach can follow based on a shared understanding:

> Recommendation 2. Plan activities, outreach, and identify resources needed early
>
> [...] arrange for mental health and behavioral health people to be present, they could be part of the team from beginning to end [...] it is difficult to get mental health workers into the community.
>
> [...] meeting the school leaders, teachers, administrators and other school personnel to bring awareness to the issues facing children in the community. Presently many of the teachers have little knowledge of the (reservation based tribal) culture and the issues that lead to children having difficulty in school.
>
> The community is in crisis and we need ongoing things with them in the future. We need to get into the schools and communicate with them.

Planning activities and outreach were common themes in the qualitative data, where resources were often needed, but due to administrative or organizational barriers, coordinated planning was limited. There was a common theme for more involvement and awareness of key partners and supports in the community. For example, there was a need for behavioral health providers and public school teachers to understand the culture and issues that may lead to suicide, but this required increased communication exchanges and coordinating and planning of activities well in advance and reaching out to these groups to encourage their input and involvement:

> Recommendation 3. Uphold the values of the tribal culture, community including trustworthiness, consistency, credibility, dependability, and humility.
>
> Our role is not necessarily defined by a title or a formal position, but the amount of time we have been in the community, doing sweats, and teaching others about the culture, humor, and ways.
>
> The people here really monitor you and if you are working this program they will see if they can trust you [...] especially in helping programs like this, the community takes a hard look at you and if you are not walking your talk, they lose faith.
>
> This work is good work [...] the help [team] we are all on the same page because we walk the talk. If we didn't we would still be somewhere else in an environment in a non-helping situation. We can be very forgiving

Tribal values emerged as a common theme for effective suicide prevention strategies. These values include the individual values and roles of the people involved in the program, community perceptions of these individuals and their ability to lead program efforts based on their reputation in the community, congruent values among team members, and forgiving:

> Recommendation 4. Build administrative and community capacity, infrastructure is critical.
>
> [...] It has been difficult to communicate with HYL staff via email or phone.
>
> [...] Get some of the societies [ traditional leaders] involved to build capacity [...].
>
> It is pretty exciting as all of this is playing out and what this means for the communities and how they are trying to build the capacity within.

Building administrative and community capacity to plan and implement suicide prevention programs require that capacity is built within. In this program, the training and outreach focussed on building knowledge and skills of community members to understand suicide, warning signs, resources available, and what to do in the event of a suicide which is standard practice. This recommendation builds on findings from a previous study where the authors found that when communities have control over suicide prevention activities they are effective (Kral et al., 2009). Yet, one cannot assume that communities have the inherent capacity to navigate a Western dominated suicide prevention model (Wexler and Gone, 2012). Community members have multiple roles (e.g. traditional/cultural leader, parent, educator, health provider) and reservation-based programs often provide multiple services and resources within the reservation-based community. The program staff along with the other programs functioned as the crisis response team as well as the traditional cultural-based helpers and healers. Non-American Indian community-based institutions must recognize the capacity level is different for every community and likely influenced by different factors at various times such as changes in tribal council,

program staffing, access to technology such as email, voicemail, and computers, department leadership and access to traditionally based cultural helpers and healers:

> Recommendation 5. Be prepared to respond to community needs and situations.
>
> [...] with the extreme shortage of mental health professionals in Indian Country, a peer-to-peer, youth helping youth and adults helping adults approach is effective.
>
> [...] we encouraged students to be there for one another and not be afraid to reach out to one another, we offer prayer, cedar smudging, Talking Circles during school hours, we met with individual students as needed, we identified and referred at risk students to the school staff, held debriefings, coordinated behavioral health visits and other supports.
>
> [...] the prevailing cynicism and negativity that exists within our communities is rooted in historical trauma, colonization and interventions are needed to redirect individuals, organizations, and leadership.

Responding to community needs and situations requires that programs proactively address situations where suicide may impact their community. Team members, support staffs, and funding agencies must be familiar with the community context, norms, cultures, and histories. This is particularly important because the correlates of suicide are often different between tribal communities (Novins *et al*., 1999). In this community, when a suicide occurred, program personnel and partners provided support to the school and family members impacted by the event. This extended several months after the event and the team provided cultural resources, traditional/cultural sources of healing, and in addition access to behavioral health providers for individuals and families in need:

> Recommendation 6. Anticipate challenges and develop strategies to address them.
>
> The missing link is the adults- this is a problematic area [y] we need to plan events that get families together.
>
> Working with both professional and local contracts was our biggest obstacle we faced [y] We need to be better prepared and ensure activities are identified in advance, and contracts, vendors, and purchase orders are in place.
>
> The evaluation is not clear cut so it is really hard because people have to scramble each time there is an event [...] shifting all the time to how to do next steps or what questions to ask [...] it is evolving [...] Trying to figure out how design something to ask that is not clear cut is problematic.

Community-based suicide prevention approaches will encounter challenges, and these challenges require that community members help identify solutions. For example, in this program, community members identified adult and parent involvement as a challenge. The program plans to revise some of the planned activities to include more parent and family events in the future. Another challenging aspect of this program was the evaluation, mainly because many of the

events were new and the constructs of spirituality and culture were difficult to measure. To evaluate the effectiveness of certain events, the team had to pilot instruments with the community, examine issues of reliability and validity for the population, and then ensure the instruments were administered and collected as designed. In the future, the team plans to describe the community-driven culturally based evaluation process and report on the effectiveness of prevention strategies. A differentiating aspect of effectiveness from an American Indian community evaluation standpoint is that it is not measured by a decrease in risk factors, increases in knowledge, or changes in behaviors – effectiveness is achieved when a community is physically, spiritually, emotionally, relationally, and psychologically well:

> Recommendation 7. Recognize the spiritual aspects of the program.
>
> Many of us today, lack that spiritual connection, faith, trust and cannot endure pain that is both physical and spiritual pain and loss. People seek an easier path because if they are not taught or fail to learn about their own spirituality, they will always seek an easier path or road.
>
> [...] Recognize the spiritual journey and the spiritual helpers that come for healing.
>
> [...] The process and the many helpers are being led on a spiritual awakening [...] a journey that is taking place today in our communities among our people both young and old.

A key distinction between this American Indian community approach to suicide prevention compared with a non-American Indian community-based approach is the emphasis on the culturally based spiritual aspect. Themes from qualitative data analyses reinforced the fact that this program was a spiritual journey for the community members as well as the team members. This approach was part of a program awakening process with the potential to transform the community and help people find spiritual solutions to their problems. The spiritual aspects are built on the strong tribal/traditionally based cultural teachings and beliefs of a tribally based community that has been challenged as they preserve and practice these teachings in the present generation. While Western dominated models of suicide prevention are abundant in the literature, they have less relevance within an American Indian community context. It has only been recently that Western models have acknowledged spirituality and cultural norms which is the foundational piece for most if not all American Indian communities. Community transformation or spiritual awakening has not been reported as an evidence-based strategy for suicide prevention, yet this community experienced prevention specifically in this way.

In a recent meta review of community-based suicide prevention interventions Fountoulakis et al. (2011) reported that most interventions result in changes in knowledge and attitudes but fail to reach those most in need. Increasing knowledge and changing attitudes about suicide is not enough – prevention may require a spiritual component, not described in the current body of literature.

*Concluding thoughts*

Through this process the team reflected and shared their community-based suicide prevention experiences. Recommendations draw from the first 12 months of a community-based suicide prevention program. The team describes some of the differences and challenges related to community based suicide prevention strategies in an American Indian reservation community. The task of implementing a suicide prevention program requires consideration of the issues most important to the community and often these are different than funding agency priorities. Flexibility is needed with regard to how communities and funding agencies (institutions) navigate their differences; however, this flexibility must be met with an understanding of health and spirituality from an American Indian community perspective. Communities possess knowledge and teachings from many healthy generations, they know what is needed and they know what works and what does not. The process of building effective community-based suicide prevention strategies begins first with understanding and leads to spiritual embracing and community transformation. Future work must focus on balancing the evidence required by Western standards and the reality of what works based on community context and experiences.

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**Further reading**

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