Suicide rates among non-Hispanic AI/AN persons increased nearly 20% from 2015 (20.0 per 100,000) to 2020 (23.9), compared with a < 1% increase among the overall US population.
• Suicide Prevention in Indian Country.
• The fight to prevent suicide-reframing to healing

AI/AN suicide deaths had higher odds of having a substance use problem
Suicide is the second leading cause of death for AI/AN youth between the ages of 5 and 24 years old (The IHS Trends in Indian Health report (2014))

The data in the report underscores the vulnerability of 15-24 year old AI/AN males, whose adjusted suicide rate of 58.7/100,000 was more than three and a half times the suicide rate for males of all races in that age group (16.0/100,000). While the adjusted suicide rate for AI/AN females in that age group was lower than males (20.2/100,000), it was still nearly six times the rate for females of all races (3.5/100,000), (The IHS Trends in Indian Health report (2014))
A study that linked death certificate data (1999-2009) to IHS patient registration data identified geographic differences, with the highest suicide rates occurring in Alaska (42.5/100,000) and the Northern Plains (26.2/100,000) (Herne, Bartholomew & Weahkee, 2014). The lowest suicide rates were in the East (11.6/100,000) and Southwest (19.7/100,000). Males had higher rates of suicide than females, which is consistent with rates for the overall U.S. population.

American Indians serve in the Armed Forces 5 times above the national average.

A veteran dies by suicide every 71 minutes.
Suicide and Primary Care

- Up to 45% of individuals who die by suicide visit their primary care provider for presenting physical health problems within a month of their death, with 20% of those having visited their primary care provider within 24 hours of their death.

- Elders who die by suicide:
  - 73% have contact with primary care physician within a month of their suicide, with nearly half visiting in the preceding week.

- There is a strong correlation between chronic pain and suicide.
  - 20-30% of those who die by suicide have issues of chronic illness or pain.
  - A person with chronic pain is 3 times at risk of suicide

Keys things to remember in assessing the degree of risk

Don’t hesitate to bring up the word “suicide”.

- Many fear that asking people if they are suicidal will plant the idea in their mind. This is a myth! There is no research to support this. Being direct validates their pain and gives them the opportunity to talk.
What We Hear Sometimes...

- “I don’t have the knowledge to assess or intervene.”
- “With such a short amount of time, I don’t have time to ask or address suicide risk.”

Language Matters
Choosing Compassionate & Accurate Language

Died of/by Suicide vs. Committed Suicide
Suicide vs. Successful Attempt
Suicide Attempt vs. Unsuccessful Attempt
Describe Behavior vs. Manipulative/Attention-Seeking
Describe Behavior vs. Suicidal Gesture/Cry for Help
Diagnosed with vs. they’re Borderline/Schizophrenic
Working with vs. Dealing with Suicidal Patients
Patient Safety and Error Reduction

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
Columbia Suicide Severity Rating Scale
(C-SSRS)

Instructions:
1. Ask the questions in order.
2. Mark “YES” or “NO” for each response.
3. If “YES,” ask the follow-up questions.
4. Use the provided scoring guidelines.
5. Follow the suggested procedures.

Ask the questions in order.

Columbia Suicide Severity Rating Scale
Columbia-Suicide Severity Rating Scale
Screen with Trauma History for Primary Care

Ask questions that are true and understood.

1) Have you wished you were dead or wished you could go to sleep and not wake up?

2) Have you had any thoughts of killing yourself?

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 3, go directly to question 6.

3) Have you been thinking about how you might do this?

4) Have you had thoughts, and had some intention of acting on them?

5) Have you started to work out or worked out the details of how to kill yourself?

6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?

Scores:
0 = Safe
1 = Moderate
2 = High

Supportive Procedure: C-SSRS Screening

1. Screen all patients for suicide risk.
2. If screening positive, refer to mental health services.
3. If screening negative, continue as usual.

For more information, visit: National Institute of Mental Health

Presented by: Megan Bailey, LCSW, LMFT, LAC
Approximately 1/3 had experienced a crisis within the preceding 2 weeks or anticipated that a crisis would occur in the coming 2 weeks.

Interpersonal problems were more likely to be cited than physical health, occupational, or financial problems as contributing to AI/AN suicide deaths—the opposite of the non-tribal cohort.
Having a friend or family member who attempted suicide increases the risk for suicidal behavior among young adults (Mueller, Abrutyn, & Stockton, 2012). The risk of a suicide after a friend or family member’s suicide is 2–4 times higher for adolescents between the ages of 15 and 19 years old (Gould, 1990).

AI/AN were more likely than non AI/AN to disclose suicidal intent before death as well as more likely to have previous suicidal thoughts or plans.
• At the individual level, school completion, a commitment to tribal spirituality, and a sense of cultural belonging are associated with reduced suicide attempts (Freedenthal & Stiffman, 2004; SPRC, 2013; Wexler et al., 2015).

• Reservation youth who had never attempted suicide were found to have higher levels of family satisfaction (Freedenthal & Stiffman, 2004).
• Communities that had embarked on cultural reclamation efforts reported lower suicide rates among their youth (Chandler & Lalonde, 1998). These cultural efforts included the use of traditional language, the incorporation of a strong spiritual orientation, and the presence of cultural centers.

• Recognize/Acknowledge Tribal Differences
  • Rates of suicide and suicidal behavior vary among AI/AN communities.
  • Some tribes have established suicide surveillance tracking systems that can aid identification of risk factors and suicidal behavior patterns and inform intervention strategies.
  • Belief systems on death and suicide may differ among tribes. In some AI/AN communities, it is not appropriate to talk about death and/or suicide. This silence can hamper efforts to better understand the formation of a suicide cluster, to determine the mechanisms behind contagion, and to identify at-risk youth.
  • Healing and spiritual practices may vary among tribes. Native traditions and spiritual beliefs may coexist with other faith-based practices. Many AI/AN communities have followers of native spiritual traditions and western faith-based practices. Some community members practice both.
Zero Suicide
Great free resources
Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:
1. 
2. 
3. 

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity):
1. 
2. 
3. 

Step 3: People and social settings that provide distraction:
1. Name: _____________________________________________ Phone: ______
2. Name: _____________________________________________ Phone: ______
3. Place: _____________________________________________ 

Step 4: People whom I can ask for help:
1. Name: _____________________________________________ Phone: ______
2. Name: _____________________________________________ Phone: ______
3. Name: _____________________________________________ Phone: ______

Step 5: Professionals or agencies I can contact during a crisis:
1. Clinician Name: ______________________________________ Phone: ______
   Clinician Pager or Emergency Contact #: __________________________
2. Clinician Name: ______________________________________ Phone: ______
   Clinician Pager or Emergency Contact #: __________________________
3. Local Urgent Care Services: ____________________________
   Urgent Care Services Address: _______________________________
   Urgent Care Services Phone: _______________________________
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safer:
1. 

The one thing that is most important to me and worth living for is ____________________________
"How will you know when the safety plan should be used?” Be specific!

“What do you experience when you start to think about suicide or feel extremely distressed?”

“What can you do, on your own, if you become suicidal again, to help yourself not act on your thoughts or urges?”

“Who helps you take your mind off your problems—at least for a little while?”

“Who do you enjoy socializing with?”

“Where do you think you could go that is a healthy environment to have some social interaction?”

“Are there places or groups that you can go to that can help take your mind off your problems...even for a little while?”

“How likely would you be willing to contact these individuals?”

“Which clinicians (if any) should be on your safety plan?”
https://www.cdc.gov/opioids/naloxone/training/index.html

Naloxone training is offered as self-paced modules or as separate mini-modules and patient cases. Choose one or more of the mini-modules or patient cases; you will receive a quick training to focus on a specific topic or to improve a skill. Earn continuing education credits (CE) after completing the full modules.

Mini-Modules

- **Assessment: Do You Know the Risk Factors for an Opioid Overdose?**
  - Test your knowledge of the factors that indicate whether a patient is at risk for an opioid overdose. Understanding these risk factors will help you know when to prescribe or offer naloxone.

- **Engaging Patients in a Conversation**
  - Learn how to start a conversation with patients about naloxone and educate them about the risk of overdose and the role naloxone can have in preventing overdose.

- **Reducing Stigma Surrounding Naloxone**
  - Learn how to communicate about naloxone in a manner that is caring, compassionate, and non-stigmatizing.

https://www.ihs.gov/opioids/naloxone/naloxonetoolkit/

### Naloxone Community Distribution Models

In collaboration with the Northwest Portland Area Indian Health Board, the IHS HCPF Committee launched a virtual, on-demand naxolone training program that medical professionals, first responders, and community members may all use to become official naloxone trainers.

The course discusses the role in opioid-related deaths, how to identify an overdose, how to properly administer nasal and injectable naloxone, as well as sharing best practices related to harm reduction strategies.

### Naloxone Keeps the Circle Strong

Naloxone has become a standard first aid tool across the nation. Naloxone is a medication that reverses an overdose; it can be given at any time. As a result, it can be administered even if an opioid overdose is only suspected, not confirmed. Studies have shown that community access to naloxone can decrease overdose death rates.

- [Naloxone Keeps the Circle Strong PPT](PDF - 594 KB)
- [Naloxone Training for Community Members PPT - 8 MB]

### Pharmacist Mentors for Co-prescribing Naloxone

Please contact a pharmacist mentor in your jurisdiction for assistance with creating a naloxone co-prescribing initiative at your site. Mentors can provide an overview of the training materials, program best practices, and offer specific technical assistance.

Be a naloxone champion in your community: download and customize the naloxone standing order and presentations, created to provide partners with resources for promoting naloxone awareness and training based on the educational needs of various local audiences.

- Naloxone: **Community Standing Order Training (DOC) - 94 KB**
- Naloxone: **Self- Check Module Assessment**
- Naloxone: **Co-prescribing Naloxone PPT - 8 MB**
- Naloxone: **Naloxone Training for Community Members (PPT - 8 MB)**

---

Presented by: Megan Bailey, LCSW, LMFT, LAC
Lethal Means Restriction

- Temporary
- Matter of Fact
- Standard Practice
- Safety Approach (Public Health!)
- Preferred method is important to know and note

Lethal Means Counseling

**CALM – Counseling about Access to Lethal Means**

1. **Raise the issue.**
   
   **Behavioral Goal:** Motivate the family to reduce access to lethal means at home.

   **Behavioral Goal:** Assess how guns and medications are currently stored at home.

   **Sample Language:**
   
   • “Let’s also talk over what types of medications are in your home and how they’re stored.”

2. **Develop a plan**

   **Behavioral Goal:** Safely store firearms until the client recovers.

   **Considerations:**
   
   - Storing firearms away from the home temporarily is the safest choice. Here are some options:
     - Relative or friend, Self-storage rental unit, Gun shop or shooting range, Pawn shop, Law enforcement.
   
   Quick and easy access to a loaded firearm during a suicidal crisis adds a lot of risk. Here are some additional safety considerations:
   
   - A *locked* gun is safer than an unlocked gun.
   - An *unloaded* gun is a lower suicide risk than a loaded gun, especially if the ammunition is stored separately or away from the home.
   - Hiding guns is not recommended. Family members, especially children and teens, often know or can find the hiding places someone else uses.
   - If a loaded gun is needed for self-defense, discuss with the client and family the short-term comparative risk of suicide versus a home invasion.

3. **Document and Follow Up**

   **Behavioral Goal:** Agree on roles and timetable.

   **Behavioral Goal:** Document the plan and next steps.

   **Behavioral Goal:** Confirm that the plan was implemented.
Document collaborative contacts

- Help the patient do this in their safety plan if possible (scan a copy into the chart or put on file at the school)
- A faith leader
- An AA/NA/Wellbriety sponsor
- A safe friend or family member
- A coach
- A school counselor, teacher, or staff member

* Ask the patient if we can call these folks and explain that they have been identified as a resource for the patient who is struggling—provide them with 911, 988, and/or community resources for an emergency. Can we send them a copy of the safety plan?

HIPAA

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge
- See Handout
Document consultations.

- Did you talk to the patient’s therapist? Staff with their medical provider? Consult with colleague?
- Even if the contact amounted to no more than an exchange of voice mail messages, it's worth documenting.
- *show due diligence

Questions & Answers