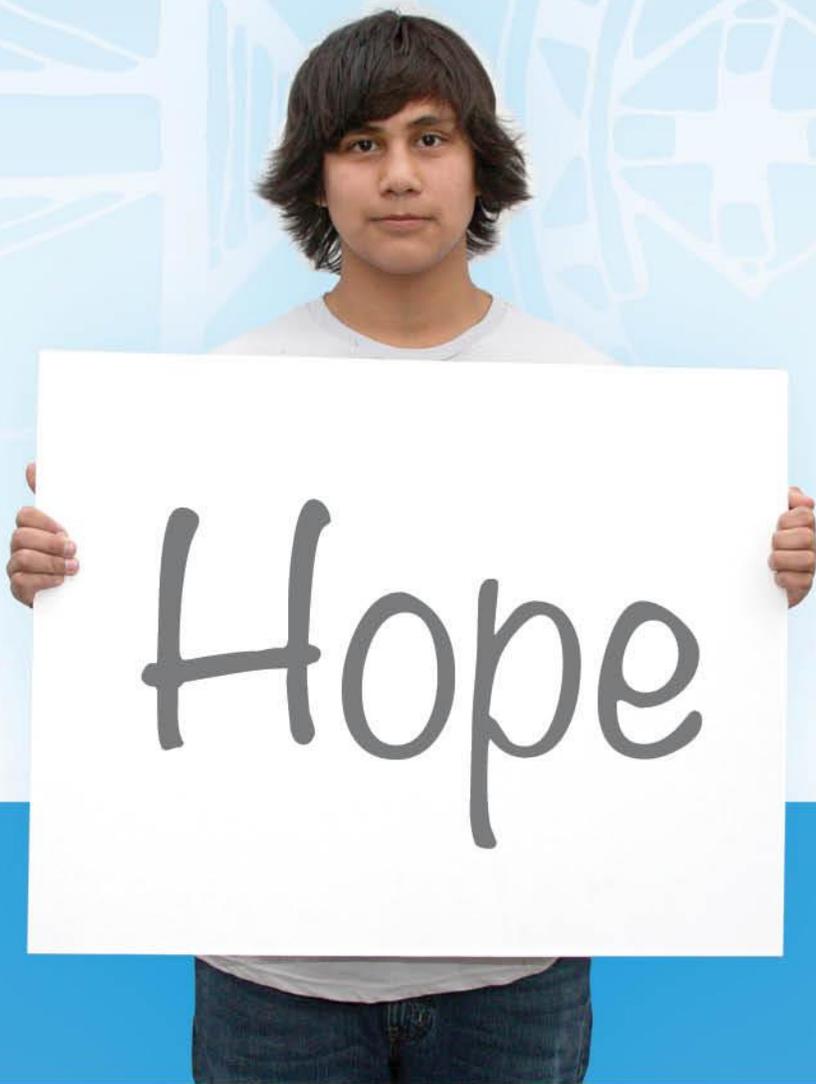


# Montana Native Youth Suicide Reduction Strategic Plan

January 2017



Updated for 2018



## Acknowledgements

### **Montana Native Youth Suicide Reduction Coalition (Advisory Council)**

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**“Our vision is to reclaim our sacred responsibility to care for each other as relatives...”**

## **Kauffman & Associates, Inc.**

Kauffman & Associates, Inc., is an American Indian-owned management firm dedicated to improving the lives of vulnerable populations and enhancing the reach and effectiveness of caring organizations.

At KAI, we do work that matters.

Jo Ann Kauffman, President  
Dr. Iris PrettyPaint, Subject Matter Expert  
Anna Whiting Sorrell, Consultant  
Julie Cahoon, Project Manager



## **Montana Department of Health and Human Services**

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**“Our vision is to reclaim our sacred responsibility to care for each other as relatives and embrace our cultural values to create welcoming, safe, and healing families and communities where our youth feel their worth, have hope for their future, are cared for when in pain, and live to realize their dreams.”**

*– Vision Statement, Montana Native Youth Suicide Reduction Strategic Plan*



Coalition of Montana Tribes and Urban Indians with Lt. Governor Mike Cooney (front, center) in Boulder, MT, November 1, 2016

Front: Mike Jetty, Julie Cahoon, Jo Ann Kauffman, Janelle Timber-Jones, Rosella Holds, Lt. Governor Mike Cooney, Patty Boggs, Shanell Lavallie, Anna Whiting Sorrell

Back: Quincy Bjornberg, Ben Horn, Ivan MacDonald, Loren Bird Rattler, Lonnie Headdress, Brandi King, Ernie Bighorn, Dr. Iris PrettyPaint

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## Executive Summary

In January 2017, the Montana Department of Public Health and Human Services (MT DPHHS), in partnership with a Coalition of tribes and urban Indian health organizations (UIHO) across the state, published the *Montana Native Youth Suicide Reduction Strategic Plan* to address the suicide rate among Native youth. Montana’s Native youth suicide deaths for ages 11 to 24 occur at a rate that is five times greater, at 42.82 per 100,000 deaths, than the statewide suicide death rate of the same age group, at 8.01 per 100,000 deaths.<sup>1</sup> This plan targets suicide reduction through the adoption of Zero Suicide, a prevention model developed to address a systems approach to suicide care within health and behavioral health organizations.

## Accomplishments

During 2017, the MT DPHHS and the newly established Montana Native Youth Suicide Reduction Advisory Council successfully completed priority action steps as identified in the inaugural version of this strategic plan. Table 1 outlines these accomplishments. From these efforts, each tribe and UIHO now has an established and trained group of individuals within their community health and behavioral health organizations to support and lead Zero Suicide implementation.

Table 1. Priority Action Step Accomplishments, 2017

Priority Action Step	Accomplishment
1.1. Montana Governor establishes the Native Zero Suicide Coalition	Governor Steve Bullock created the Native Youth Suicide Reduction Advisory Council with appointments made by MT DPHHS Director Sheila Hogan. The Advisory Council consists of 26 representatives from each tribe and UIHO. The Advisory Council met three times in-person during 2017.
1.2. Conduct a state-wide Zero Suicide Academy for providers, counselors, and workforce	MT DPHHS contracted with the Suicide Prevention Resource Center (SPRC), to host a Zero Suicide Academy, 2-day training orienting participants to the Zero Suicide model. The training was held October 11–12, 2017, in Helena, MT, and it was attended by 75 participants representing tribes, UIHOs, Indian Health Service (IHS) and MT DPHHS staff.
2.1. Support local planning and implementation of Zero Suicide	MT DPHHS secured task orders and contracts with each UIHO and tribe to provide funding to support the implementation of Zero Suicide by sending four representatives from each tribe and staff from UIHOs to the Zero Suicide Academy training.

<sup>1</sup> Montana DPHHS. (2016). *Montana 2016 Suicide Mortality Review Team Report* (p. 37). Retrieved from <http://www.sprc.org/sites/default/files/resource-program/2016%20Montana%20Suicide%20Mortality%20Review%20Report.pdf>

## Next Steps

Moving into 2018, funding from HB 118 supports further implementation of the plan. The Advisory Council identified priority action steps to accomplish through the end of the state 2019 fiscal year. Table 2 outlines these priority action steps. Each priority action step supports the plan’s strategic pillars and goals. The outcome from accomplishing these priority action steps will be continued implementation of Zero Suicide across tribal and UIHO health and behavioral health programs; building suicide care competency among health staff and community members; building youth leadership and establishing their voice at the planning table; and partnering local resources to support frontline healers.

Table 2. Priority Action Steps, 2018–2019

Priority Action Step	Goal
1.1. Montana Governor establishes the Native Youth Suicide Reduction Advisory Council	The MT Governor will renew the Advisory Council with appointments made by MT DPHHS Director Sheila Hogan. The Advisory Council will advise the state in the implementation of this plan and Zero Suicide across the state.
1.6. Montana tribes and UIHOs adopt Zero Suicide Policies, Practices, and Response Plans	Advisory Council members and MT DPHHS will secure commitment from tribal councils, IHS, and organizational leadership to adopt Zero Suicide policies and practices.
2.1. Support local planning and implementation of Zero Suicide	The state will provide direct funding to each tribe and urban Indian program to continue Zero Suicide implementation within health and behavioral health organizations.
2.4. Create a Zero Suicide and Native Youth Suicide Reduction listserv	MT DPHHS will create a listserv of interested parties for suicide reduction with whom the state of Montana may share information.
2.5. Create a newsletter about Native youth suicide reduction and Zero Suicide	MT DPHHS will establish a quarterly electronic newsletter that shares information about tools, resources, or local stories about Zero Suicide implementation.
2.6. Establish monthly technical assistance calls or webinars	MT DPHHS will establish monthly calls or webinars to provide updates, share ideas, and conduct mini-trainings, etc.; initial webinars will focus on the Zero Suicide initiative.
3.1. MT Governor establishes the Native Youth Suicide Reduction Council	The MT Governor will establish the Native youth component of the Advisory Council. Each tribe and UIHO will nominate two youth from each community to serve on the Advisory Council.
4.2. Provide training in self-care best practices	The state will provide direct funding to each tribe and urban Indian program to seek training for frontline health and behavioral health staff and community members in self-care practices.

## Introduction and Background

A Report on the Health of Montanans from 2013, showed that American Indians in Montana led significantly shorter lives than their White counterparts with White men living 19 years longer than American Indian men, and White women living 20 years longer than American Indian women.<sup>2</sup> A closer look into specific health issues exposed an alarming disparity of suicide rates among Native youth. Suicide is a public health concern in the state of Montana for all populations, but within the broad category of suicide risk, Native youth in Montana’s tribes and urban Indian communities face a suicide rate that is significantly higher than other races and age groups in the state and nationally. Urban Indian health organizations, tribal governments, Montana’s policy leaders, and other concerned stakeholders find the suicide risk for Montana’s Native youth unacceptably high.

In 2015, Governor Steve Bullock developed an initiative to reduce suicide among Native American youth in Montana and successfully secured \$250,000 through the 64th Montana Legislative session. Montana Department of Public Health and Human Services (MT DPHHS) spearheaded activities under the Governors’ 2015 initiative, which began with a formal tribal consultation where the need for a statewide approach was identified. DPHHS made the decision to seek a contractor to assist in convening a statewide coalition and to develop a strategic plan.



Former DPHHS Director Richard Opper, welcomes Coalition members to the initial convening in November 2016 held at the Helena Indian Alliance gymnasium.

Kauffman & Associates, Inc., (KAI), an American Indian-owned firm with 26-years of experience in the behavioral health and public health fields, was awarded a contract under the State of Montana procurement processes. The firm has worked on Native youth suicide and substance misuse prevention since 1990. KAI was charged with convening the Montana Native Youth Suicide Reduction Coalition (Coalition) and developing a statewide strategic plan on Native youth suicide reduction. The plan identifies the following shared vision and strategic pillars.

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<sup>2</sup> Montana Department of Health and Human Services. (2013). *The State of the State’s Health, A Report on the Health of Montanans*. Retrieved from Montana Department of Health and Human Services website: [dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/StateOfTheStatesHealth.pdf](http://dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/StateOfTheStatesHealth.pdf)

## Shared Vision

**“Our vision is to reclaim our sacred responsibility to care for each other as relatives and embrace our cultural values to create welcoming, safe, and healing families and communities where our youth feel their worth, have hope for their future, are cared for when in pain, and live to realize their dreams.”**

## 4 Strategic Pillars

- **Launch a statewide Zero Suicide Initiative**
- **Support local community healing and transformation**
- **Empower Native youth**
- **Reinforce frontline healers**



Quincy Bjornberg, Coalition member, listens intently to a fellow member speak.

This strategic plan provides a roadmap for tribal, federal, state, local, and organizational efforts to make significant inroads to reduce suicide among Native youth in the state of Montana. In addition, the strategic plan provides priorities for funds remaining under the Governors’ 2015 initiative and identifies action steps for continued implementation over the next 2 and a half years. The Coalition presented this strategic plan to state officials in January 2017.

Following the submission of the strategic plan in January 2017, Governor Steve Bullock established the Montana Native Youth Suicide Reduction Advisory Council (Advisory Council) with member appointments made by MT DPHHS Director Sheila Hogan. The Advisory Council consists of the same members that formed the Coalition to serve in an advisory capacity to the department for implementation of this strategic plan. Guided by the priority action steps identified by the Coalition listed in the initial plan published in 2017, the DPHHS committed to host a Zero Suicide Academy (Academy). The Academy is a 2-day training on the Zero Suicide approach for tribal, urban Indian health organization (UIHO), and Indian Health Service (IHS) representatives across the state.

The Advisory Council met in April 2017 for an introduction to the Zero Suicide model and set the pace for members to be community champions for the initiative. KAI worked with the department and Advisory Council members to recruit participants for the Academy to include at least four representatives from each tribe, UIHO, and IHS health or behavioral health program. The

Academy, presented by SPRC, was held in October 2017 in Helena, MT. The Academy hosted over 75 participants, including trainees from six tribes, four UIHOs, five IHS service units and the IHS Billings Area Office, and MT DPHHS. This historic event spearheaded the implementation of Zero Suicide across the state of Montana within tribal and urban Indian communities.

Governor Steve Bullock showed continued support for the strategic plan and its vision by including \$1 million dollars in the Governor’s fiscal year 2018-2019 budget for statewide suicide prevention efforts. During the 65th State of Montana Legislative session, after passionate testimony from Coalition members, support from tribal leaders across the state for the strategic plan, and Governor Bullock’s prioritization of this initiative, the state legislature passed House Bill 118, a suicide reduction bill. The bill allocates \$250,000 for the continued implementation of action steps within this plan.

Building on momentum from the Academy and the allocated state funding, Advisory Council members met in Helena, MT, in December 2017 to update the strategic plan and make recommendations to MT DPHHS on funding priorities. This strategic plan has been amended (January 2018) to reflect the Advisory Council’s advice and recommendations. The Advisory Council reaffirmed their commitment to the vision statement, recognized an additional challenge to the work, and updated the four strategic pillars. Table 9 lists the priority funding recommendations for MT DPHHS to propel efforts forward into 2018.

## An Environmental Scan of Native Youth Suicide in Montana

This environmental scan looks at Native youth suicide throughout Indian Country compared to all races and throughout the state of Montana.

### Native Youth Suicide in Indian Country

According to the Centers for Disease Control and Prevention (CDC), suicide is the second-leading cause of death among Native adolescents and young adults at a rate 2.5 times higher than the



Governor Steve Bullock is welcoming Academy attendees, becoming the first governor to ever speak at a Zero Suicide Academy, which was held October 2017 in Helena, MT.

national average.<sup>3</sup> Rates for death by suicide among non-Native populations peak in older adulthood, whereas rates of death by suicide among Native populations peak during adolescence and young adulthood.<sup>4</sup> Table 3 illustrates the contrast between national and Native-specific rates of death due to suicide among youth, as reported by the Indian Health Service (IHS) in 2014.<sup>5</sup>

Table 3. Percentage of suicide-related death rates among youth: 2007–2009 (by age, sex, and race)

Age Range	U.S. Youth of All Races			Native Youth, IHS Service Area		
	Both Sexes	Male	Female	Both Sexes	Male	Female
<b>5–14</b>	0.5	0.7	0.3	3.3	3.6	3.1
<b>15–24</b>	9.9	16.0	3.5	39.7	58.7	20.2

The Best Practices in Native Youth Suicide Reduction in Appendix E further identifies that Native Youth experience suicide at disproportionate rates, as shown by the following examples.

- Suicide-related death rates have remained unchanged, while other death rates, like drowning and fire-related accidents, etc., have declined.<sup>6</sup>
- Among 10- to 25-year-olds, the suicide rate is 62% above the national average, making it the leading cause of death in this age group.<sup>7</sup>
- Of Native youth ages of 15 and 24, 14% to 30% attempt suicide, and the rate of suicide completion in this age group is 3.5 times higher than the rate experienced by non-Native youth.<sup>8, 9</sup>

<sup>3</sup> Wexler, L., Chandler, M., Gone, J. P., Cwik, M., Kirmayer, L., LaFromboise, T., ... & Allen, J. (2015). Advancing suicide prevention research with rural American Indian and Alaska Native populations. *American Journal of Public Health, 105*(5), 891-899. doi:10.2105/AJPH.2014.302517

<sup>4</sup> Ballard, E., Musci, R., Tingey, L., Goklish, N., Larzelere-Hinton, F., Barlow, A., & Cwik, M. (2015). Latent class analysis of substance use and aggressive behavior in reservation-based American Indian youth who attempted suicide. *American Indian and Alaska Native Mental Health Research, 22*(1), 77-94. doi:10.5820/aian.2201.2015.77

<sup>5</sup> Indian Health Service. (2014). *Trends in Indian Health: 2014 Edition*. Retrieved from [ihs.gov/dps/includes/themes/newihstheme/display\\_objects/documents/Trends2014Book508.pdf](https://www.ihs.gov/dps/includes/themes/newihstheme/display_objects/documents/Trends2014Book508.pdf)

<sup>6</sup> Goodkind, J. R., Gorman, B., Hess, J. M., Parker, D. P., & Hough, R. L. (2015). Reconsidering culturally competent approaches to American Indian healing and well-being. *Qualitative Health Research, 25*(4), 486-499. doi:10.1177/1049732314551056

<sup>7</sup> Burrage, R., Gone, J., & Momper, S. (2016). Urban American Indian community perspectives on resources and challenges for youth suicide prevention. *American Journal of Community Psychology, 58*(1-2), 136-149. doi:10.1002/ajcp.12080

<sup>8</sup> Bolton, S., Elias, B., Enns, M., Sareen, J., Beals, J., Novins, D., the Swampy Cree Suicide Prevention Team, & AI-SUPERPFP Team. (2013). A comparison of the prevalence and risk factors of suicidal ideation and suicide attempts in two American Indian and a general population sample. *Transcultural Psychiatry, 51*(1), 3-22. doi:10.1177/1363461513502574

<sup>9</sup> LaFromboise, T., & Malik, S. (2016). A culturally informed approach to American Indian/Alaska Native youth suicide prevention. In N. Zane, G. Bernal, & F. Leong (Eds.), *Evidence-based Psychological Practice with Ethnic*

- CDC data shows that Native boys and young men, ages 10 to 24, have the highest suicide rate of any ethnic or racial group in the country.<sup>10</sup>

## Native Youth Suicide in Montana

Native youth are at the highest risk for suicide among all population groups within the State of Montana. The *2017 Montana Youth Risk Behavior Survey Suicide Report* found that 18.5% of Native students had attempted suicide compared to 8% of their White student counterparts.<sup>11</sup> This risk is well documented in the DPHHS’ *Montana 2016 Suicide Mortality Review Team Report*. Montana had the highest suicide rate of all U.S. states in 2014 (the latest year for which national data was available) and has been in the top five of this ranking for nearly 40 years.<sup>12</sup> Measured by race from 2005 to 2014, American Indians in Montana have the highest rate of suicide (28.16 per 100,000) followed by Whites (21.07 per 100,000), compared to an overall statewide suicide rate of 21.70 per 100,000 deaths.<sup>13</sup> Suicide among youth and young adults in Montana is also higher than the national average.<sup>14</sup> The national suicide rate for youth ages 11 to 17 is 3.59 per 100,000, while the rate is 8.9 per 100,000 in Montana, which is more than twice the national average. When measured according to race, Native youth and young adults again show substantially higher rates of suicide than Montana’s general youth population. Suicide deaths by American Indians ages 11 to 24 occur at the rate of 42.82 per 100,000 deaths. Compared to the statewide suicide rate of 8.01 per 100,000 for ages 11 to 24, the American Indian rate is more than five times as high. Information gathered from CDC’s WISQARS™ shows Montana AI/AN suicide death rates between 2005 and 2014, as shown in Table 4, which summarizes the age-adjusted, state-specific percentages.<sup>15</sup>



Ernie Bighorn, Coalition member, speaks about his community.

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*Minorities: Culturally Informed Research and Clinical Strategies*, (pp. 223-245). Washington, DC, US: American Psychological Association.

<sup>10</sup> See Footnote 3

<sup>11</sup> Montana Office of Public Instruction. (2017). *2017 Montana Youth Risk Behavior Survey Suicide Report* (p.2). Retrieved from [opi.mt.gov/Portals/182/Page%20Files/YRBS/17Suicide.pdf](http://opi.mt.gov/Portals/182/Page%20Files/YRBS/17Suicide.pdf)

<sup>12</sup> Montana DPHHS. (2016). *Montana 2016 Suicide Mortality Review Team Report* (p. 5). Retrieved from <http://www.sprc.org/sites/default/files/resource-program/2016%20Montana%20Suicide%20Mortality%20Review%20Report.pdf>

<sup>13</sup> These rates are age-adjusted. Suicide rates per race in Montana are from the *Montana 2016 Suicide Mortality Review Team Report* (p. 35). See Footnote 12.

<sup>14</sup> All data on youth suicide in Montana and nationally, including overall rates and rates by race, are reported in the *Montana 2016 Suicide Mortality Review Team Report* (p. 22–24, 37–38). See Footnote 12.

<sup>15</sup> CDC Web-based Injury Statistics Query and Reporting System (WISQARS), <https://www.cdc.gov/injury/wisqars/>; Also see Footnote 12.

Table 4. Percentage of suicide-related death rates in Montana: 2005–2014 (by age and race)

Rate of Death by Suicide by Age	Montana All Races	Montana AI/AN
All ages	21.70%	28.16%
Ages 11–24	8.01%	42.82%

Montana’s tribes are taking significant actions to address Native youth suicide at local, tribal, intertribal, and organizational levels. The Montana Native Youth Suicide Reduction Inventory in Appendix G further details these programs. The programs listed in the inventory represent activities for suicide prevention and youth wellness that are available through tribal health departments, UHIOs, the Montana Office of Public Instruction, the MT DPHHS Addictive and Mental Disorders Division, and the University of Montana’s National Native Children’s Trauma Center. This inventory was created to document current Native youth suicide reduction programs that may serve as resources and partners for the action steps proposed in this plan.



Shanell Lavallie, Coalition youth member, participates in a group discussion.

KAI also conducted a thorough analysis of Best Practices in Native Youth Suicide Reduction (Appendix E), which examined the myriad of models and intervention approaches recognized across the Nation as being effective or promising. These models were reviewed with the Coalition at the beginning of their planning workshop. Among the models examined, the Zero Suicide model, developed by the Suicide Prevention Resource Center and currently being implemented by IHS, offered promise as a model to bind together the many providers in Native communities around a common approach. The Zero Suicide approach assumes everyone is at risk and implements universal screenings, risk assessments, and support systems community wide.

## Calling Together a Coalition of Montana Tribes and Urban Indians

KAI reached out to urban Indian health organizations and tribes requesting nominations for members to join the Montana Native Youth Suicide Reduction Coalition. The Coalition has driven the development of this strategic plan to reduce suicide among Native youth in Montana. The Coalition was representative of the eight tribal communities and five urban Indian communities in the state. It included the seven Indian reservations with federally recognized tribes and the one state-recognized tribe, as listed here.

- Blackfeet Tribe of the Blackfeet Reservation
- Chippewa Cree Tribe of Rocky Boy’s Reservation
- Confederated Salish and Kootenai Tribes of the Flathead Reservation
- Crow Tribe of the Crow Reservation
- Fort Belknap Tribes of the Fort Belknap Reservation
- Fort Peck Tribes of the Fort Peck Reservation
- Little Shell Chippewa Tribe (a state-recognized tribe)
- Northern Cheyenne Tribe of the Northern Cheyenne Reservation



Erin Irvine and Patty Boggs, Coalition members, present ideas to the group.

In addition, the Coalition included the five UIHOs that serve Native Americans in Montana’s cities and provide health care to all qualifying individuals, as listed here.

- Helena Indian Alliance in Helena, MT
- Indian Family Health Clinic in Great Falls, MT
- Indian Health Board of Billings in Billings, MT
- Missoula Urban Indian Health Center in Missoula, MT
- North American Indian Alliance in Butte, MT

Each tribe and urban Indian health organization nominated two individuals to join the Coalition—one to represent leadership and one to represent youth. The selection process encouraged diversity in nominations to represent as many Native voices as possible, including gender balance, youth, elders, community leaders, veterans, LGBTQ or Two-Spirit individuals, and others.

The Coalition gathered for the initial convening in Helena, MT, November 2 and 3, 2016. This strategic plan was created from the sharing, discussion, and insights that occurred during and following that meeting. The plan was developed and reviewed by Coalition members, and a final plan was submitted to MT DPHHS in January 2017.

The evening prior to the planning workshop, the Coalition gathered to begin its work in a good way, with prayer, song, and personal sharing about the impact suicide is having in Native families and communities. The Coalition met in Boulder, MT, a place where tribes historically went to heal in Peace Valley. Lieutenant Governor Mike Cooney attended the opening night and shared the state’s vision for the future of Native youth in the



Ivan MacDonald, Coalition member, explains strategy.

state of Montana and tribal communities within the state. Coalition members developed a deep connection that evening as they shared personal stories concerning the effect suicide has on survivors, families, and communities. Members recognized that their mission to develop this strategic plan would be challenging, but critical. For the Coalition, reducing Native suicide is not only a professional challenge, but also a very personal commitment.

The power of beginning this work in ceremony provided a strong foundation and permeated a sacredness to this work throughout the Coalition’s discussions. Beginning this work in a good way also allowed members of the public, state officials, and visitors to join coalition members in discussing painful challenges of addressing Native youth suicide prevention. It also allowed them to share stories of success, cultural revitalization, and resilience. The Coalition members found that they shared many common experiences and cared deeply about Native youth suicide reduction.

## Insights to Inform the Strategic Plan

The following insights were gathered from the 2-day planning workshop, which set the foundation for creating this suicide reduction plan.

- Ceremony is important and can help frame and facilitate difficult conversations.
- Spirituality and the power of prayer will sustain the Coalition’s efforts.
- People are passionate about and personally affected by suicide.
- Youth voices are insightful and powerful and must be welcomed into the circle.
- Native culture is important and can underlie many different efforts, and efforts must be engaged to welcome youth into cultural activities, events, and rituals.
- Many resources exist, but people do not always know how to access them.
- There are innovative and culture-based efforts with Native youth now, but people do not know about these promising practices.
- Intertribal efforts have been successful (such as horse journeys and Native Hope).



Coalition members support each other during discussion.

## The Coalition’s Shared Vision of Hope

The Coalition articulated their shared vision for Native youth suicide reduction in Montana.

**“Our vision is to reclaim our sacred responsibility to care for each other as relatives and embrace our cultural values to create welcoming, safe, and healing families and communities where our youth feel their worth, have hope for their future, are cared for when in pain, and live to realize their dreams.”**

## Obstacles and Challenges

The 2015 Montana Strategic Suicide Prevention Plan notes that, according to the 2013 Youth Risk Behavioral Survey, 15.1% of American Indian students living on reservations and 20.6% of American Indian students living in urban settings reported they had attempted suicide one or more times in the prior 12 months. The challenges facing a state-wide effort to reduce Native youth suicide in the state of Montana are real. When asked, “What stands between us and the shared vision we have articulated?” the Coalition identified the following root challenges: (1) denial and empty promises; (2) breakdown in traditional values, practices, and cultures; (3) dysfunctional systems that undermine unity; (4) burnout of local champions; (5) a state-wide infrastructure dependent on political will; and (6) addressing vulnerability and creating safe spaces for youth and adults to share their story.



Coalition members express their commitment to reducing Native youth suicide across the state.

The Coalition understands that it needs to surpass each of these challenges to create an environment where Zero Suicide is the norm in tribal and urban Indian communities. The Coalition acknowledges the profound impact of historical trauma and indigenous resilience. It also recognizes that Native youth face tremendous peer pressure in contemporary cultures that may not always support healthy choices.

Suicide reduction efforts must be supported by a network of tribal, federal, state, local, and organizational efforts. To achieve this level of integrated organization, the Coalition must work together to confront these challenges. The Coalition is optimistic that, with the strong commitment from tribes, urban Indian programs, the federal government, the state, and other key players, it can accomplish the integrated network to sustain a Zero Suicide system. The Coalition



## **1. Launch a statewide Zero Suicide initiative**

Following are the Advisory Council’s 2018 goals for a statewide Zero Suicide initiative.

- Train staff and community in Zero Suicide and implement 90-day plans in each location.
- Establish and formalize tribal council and IHS leadership support.
- Provide Zero Suicide implementation technical assistance.
- Establish tribal, state, and IHS data and surveillance capacity.

## **2. Support local community healing and transformation**

Following are the Advisory Council’s 2018 goals for community healing and transformation.

- Target resources to train local staff and community in best practices.
- Initiate community partnerships.
- Establish community safe spaces.
- Implement trauma-informed approaches in local settings.

## **3. Empower Native youth**

Following are the Advisory Council’s 2018 goals for empowering Native youth.

- Establish local youth councils and a statewide youth council.
- Train youth on evidence-based practices.
- Invite Native youth state-wide to provide input and leadership on the Suicide Reduction Plan.

## **4. Reinforce frontline healers**

Following are the Advisory Council’s 2018 goals for reinforcing frontline healers.

- Train staff and community on self-care evidence-based practices.
- Initiate community partnerships.
- Identify evidence-based education resources and venues where frontline healers gather.

## **Actions Steps and Implementation Plan**

Table 5 through Table 8 in this section discuss each strategic pillar and their intended goals. Under each pillar, action steps are listed with brief descriptions, parties responsible, completion timelines, and the estimated costs required for each step. Budget estimates for each step will help determine how the designated funding under HB 118 could be allocated, and steps that could be funded using other sources.

## 1. Launch a state-wide Zero Suicide initiative

Table 5. Steps to launch a state-wide Zero Suicide Initiative

Action Steps	Description	Implementation Timeline January 2018–June 2019
1.1. Montana (MT) Governor establishes the Montana Native Youth Suicide Reduction Advisory Council	The MT Governor will appoint community members to sit on the Advisory Council to advise the state in the implementation of this plan and Zero Suicide across the state. Each tribe and UIHO nominates two individuals, and includes the youth council members. The Advisory Council will meet in-person twice a year, and specific time will be set aside for the youth council to address the Advisory Council for each meeting.	Hold Advisory Council in-person meeting with conference calls as needed  Estimated cost \$20,000
1.2. Conduct a state-wide Zero Suicide Academy for providers, counselors, and the workforce	MT DPHHS will contract with the Suicide Prevention Resource Center to conduct a 2-and-a-half-day Zero Suicide Academy for tribal and urban Indian organizations.	Conduct Zero Suicide Academy refresher courses as needed  Estimated cost \$20,000
1.3. Develop Native Zero Suicide Initiative materials	Develop a two-part media campaign to (1) create awareness about Native Zero Suicide and (2) help reduce the stigma around suicide. The campaign will focus on Native youth suicide and feature Native youth. Outlets will include TV, online, radio, billboard, and other media that appeal to the target audience.	Develop a media campaign as recommended by the Advisory Council  Have the Part 1 media campaign go live by Summer 2019; have the Part 2 media campaign go live by Autumn 2019  Estimated cost \$35,000
1.4. Develop a centralized clearinghouse on Native youth suicide surveillance and reporting	MT DPHHS will host annual meetings on MT Native youth suicide surveillance, share current reporting processes, and make recommendations for improvements until the Governor’s Office designates a lead agency to coordinate the effort. The	The MT Governor will invite representatives to the initial planning meeting and hold the inaugural meeting by Autumn 2018

Action Steps	Description	Implementation Timeline January 2018–June 2019
	meetings will include MT DPHHS, IHS, MT Department of Vital Statistics, MT Suicide Mortality Review Team, and Zero Suicide Coalition representation. The MT Governor’s Office will issue the annual report, <i>State of Native Youth Health in Montana</i> , regarding suicide with rates, resources, programs, and recommendations to address suicide.	<p>The lead agency will coordinate efforts to develop the clearinghouse and hold an annual meeting by Autumn of each year</p> <p>Make the clearinghouse active by Spring 2019</p> <p>Issue an annual report by the close of each fiscal year</p> <p>Estimated cost \$25,000</p>
1.5. Establish a Native youth Zero Suicide agreement with education partners	Establish a 3-year commitment from MT DPHHS, MT Office of Public Instruction, and the MT Office of Commissioner of Higher Education to partner and address Native youth suicide in the state through supporting the Montana Native Youth Suicide Reduction Strategic Plan and advocating for collaborative efforts.	<p>The MT Governor will invite key education stakeholders to planning meetings and secure a 3-year commitment to coordinate with the Montana Education sector by Autumn 2018</p> <p>No cost</p>
1.6. Montana tribes and UIHOs adopt Zero Suicide policies, practices, and response plans	Advisory Council members and MT DPHHS will secure commitment from tribal councils, IHS, and organizational leadership to adopt Zero Suicide policies, practices, and response plans, including universal screenings, risk assessments, and referrals for care plans.	<p>All eight tribes, IHS and UIHOs should adopt Zero Suicide policies, practices, and response plans by Autumn 2018</p> <p>MT DPHHS and Advisory Council review plans annually</p> <p>No cost</p>

## 2. Support local community healing and transformation

Table 6. Steps to encourage and support local communities

Action Steps	Description	Implementation Timeline January 2018–June 2019
2.1 Support local planning and implementation of Zero Suicide	<p>The state will provide direct funding to each tribe and UIHO program to begin Zero Suicide planning and preparations, to include the following activities.</p> <ul style="list-style-type: none"> <li>• Read the online Zero Suicide Toolkit.</li> <li>• Adopt Zero Suicide policies and practices.</li> <li>• Convene a Zero Suicide implementation team.</li> <li>• Discuss and complete the Zero Suicide Organizational Self-Study.</li> <li>• Create a work plan and set priorities using the Zero Suicide Work Plan template.</li> <li>• Formulate a plan to collect data to support evaluation using the Zero Suicide Data Elements worksheet.</li> <li>• Make an announcement to staff about the adoption of Zero Suicide.</li> <li>• Administer the Zero Suicide Workforce Survey to all clinical and non-clinical staff to learn about their comfort in caring for those at risk for suicide.</li> <li>• Review and develop processes and policies for screening, assessment, risk formulation, treatment, and care transitions.</li> <li>• Annually evaluate progress and measure results, revisit the organizational self-study, and collect data.</li> </ul>	<p>Host planning meetings to begin Zero Suicide preparation to analyze current policies, resources, and capacity by Spring 2018</p> <p>Finalize 90-day work plans by the end of fiscal year 2018</p> <p>Estimated cost \$170,000</p>

Action Steps	Description	Implementation Timeline January 2018–June 2019
2.2. Identify and distribute Zero Suicide resource materials to tribes and UIHOs	<p>Ensure tribal programs and UIHOs are provided electronic access to currently available, effective materials and any developed materials in the future.</p> <p>Redesign the MT.gov Suicide Prevention Information and Resources page to be user friendly, act as a centralized resource portal, and include a Native American resource section.</p>	<p>Advisory Council members and stakeholder’s sign-up for the Zero Suicide listserv</p> <p>Publish the redesigned site by Autumn 2018</p> <p>Estimated cost \$10,000</p>
2.3. Host an annual Zero Suicide Summit	<p>Host an annual Zero Suicide Summit or plenary track in conjunction with another conference, inviting key stakeholders from the state, local, tribal, law enforcement, school, and community programs, etc., to share stories, technology, data, and successes.</p>	<p>Begin planning the inaugural Summit for Autumn 2019</p> <p>Estimated cost \$5,000</p>
2.4. Create a Zero Suicide and Native Youth Suicide Reduction listserv	<p>DPHHS will create a listserv of interested parties for suicide reduction with whom the state of Montana may share information.</p>	<p>No cost</p>
2.5. Create a newsletter about Native youth suicide reduction and Zero Suicide	<p>Establish a quarterly electronic newsletter that shares information about tools, resources, etc., that address suicide. (e.g., intervention, crisis, bereavement, research, technology)</p>	<p>Submit inaugural newsletter by Summer 2018 and quarterly thereafter</p> <p>Estimated cost \$5,000</p>
2.6. Establish monthly technical assistance calls or webinars	<p>MT DPHHS will establish monthly calls or webinars to provide updates, share ideas, and conduct mini-trainings, etc.; initial webinars will focus on the Zero Suicide initiative.</p>	<p>Hold monthly technical assistance webinars</p> <p>Estimated cost \$15,000</p>

### 3. Empower Native youth

Table 7. Steps to cultivate prevention activities in schools and empower youth leadership

Action Plan	Description	Implementation Timeline January 2018–June 2019
3.1. MT Governor establishes youth component to the Native Youth Suicide Reduction Advisory Council	The MT Governor annually appoints Native youth to sit on the Advisory Council to discuss Native youth suicide issues. Each MT tribe and UIHO nominates one male and one female youth from each community to serve on the Advisory Council.	Hold Advisory Council in-person meetings, with conference calls during the interim as needed  Estimated cost \$20,000
3.2. Cultivate existing K-12 school programs to be active in prevention activities, and recognize school staff as stakeholders in addressing youth suicide	Review existing Johnson-O’Malley (JOM) Act programs and Title 7 school programs across the state to ensure they include prevention activities, such as youth mentorship programs and culture-based approaches.	Begin review of JOM Act and Title 7 programs for suicide prevention activities  Estimated cost \$80,000
3.3. Certify all K-12 school and tribal college staff to be first responders in suicide crisis and bereavement	Provide mandatory training and certification of preferred training, like ASIST, STAR, etc., so all school staff can be first responders to a suicide crisis or bereavement.	Initiate outreach with the Office of Public Instruction Division of Indian Education to identify a training strategy for academic year 2019-2020  Certify all school staff and provide annual trainings for new school staff by Summer 2019  Estimated cost \$75,000
3.4. Support Native youth-planned programming	The MT Governor will send a letter to all MT public schools urging schools to support Native youth-based programs and routinely incorporate Native youth-planned programming throughout the school year.	The MT Governor will send the letter by start of the 2019-2020 school year, and will then issue the letter annually

Action Plan	Description	Implementation Timeline January 2018–June 2019
		No cost

#### 4. Reinforce frontline healers

Table 8. Steps to reinforce frontline champions and advocates

Action Plan	Description	Implementation Timeline January 2018–June 2019
4.1. Convene frontline healers annually	Host a plenary track for healers during the annual Zero Suicide Summit (Action Step 2.3) or in conjunction with a scheduled conference.	Host a heal-the-healers track at the Summit or at a scheduled conference by Autumn 2018  Included in Action Step 2.3
4.2. Seek training in self-care best practices	Seek training for behavioral health champions and community health program frontline staff in self-care practices. The recommended focus areas are: (1) self-care, (2) secondary traumatic stress training, and (3) vicarious trauma prevention.	Develop a virtual learning community for frontline staff and identify opportunities for in-person trainings  Estimated cost \$20,000

### Priority Action Steps for 2018

The Advisory Council identified three priority funding recommendations to allocate HB 118 budgetary support in the amount of \$250,000 to implement action steps from this strategic plan. Table 9 lists the priority funding recommendations and corresponding action steps with the associated budget allocation. Continuing the Native Youth Suicide Reduction Advisory Council and including two youth members are important steps to coordinate between tribes and UIHOs; show accountability to the plan by tribes, UIHOs, and the MT DPHHS; and include Native youth.

The Zero Suicide Academy was the first step toward introducing the Zero Suicide initiative across the state, and identifying key local players. Zero Suicide is a long-term strategy that requires continued commitment and support by local planners and maintained momentum for further implementation at the local level, including leadership buy-in from tribes, UIHO, IHS, and the state. Training on evidence-based practices will contribute to staff and community competency to recognize, engage, and treat youth at risk for suicide. Additionally, funding will support training of front-line healers on self-care best practices.

Table 9. Priority funding recommendations, 2018-2019

Priority Funding Recommendations	Action Step	Estimated Cost
Native Youth Suicide Reduction Advisory Council, reappoint members and include two youth from each tribe and UIHO	1.1. MT Governor establishes the Native Youth Suicide Reduction Advisory Council	\$20,000
	3.1. MT Governor establishes the Native Youth Suicide Reduction Council	\$20,000
Local implementation of Zero Suicide and best practices	1.6. Montana tribes and UIHOs adopt Zero Suicide policies, practices, and response plans	No cost
	2.1. Support local planning and implementation of Zero Suicide	\$170,000
	4.2. Provide training in self-care best practices	\$20,000
Statewide coordination and support	2.4. Create a Zero Suicide and Native Youth Suicide Reduction listserv	No cost
	2.5. Create an electronic newsletter about Native youth suicide reduction and Zero Suicide	\$5,000
	2.6. Establish monthly technical assistance calls or webinars	\$15,000
	<b>Total</b>	<b>\$250,000</b>

## **Appendix A. Members of the Montana Native Youth Suicide Reduction Coalition and Advisory Council**

## Members of the Montana Native Youth Suicide Reduction Coalition

(\*Attended the 2-day convening in November 2016 in Helena, MT)

Area of Representation	Nominee	Youth Nominee
Blackfeet Tribe of the Blackfeet Reservation	<b>Mary Ellen LaFromboise</b> Director Blackfeet Family Services Phone: (406) 338-5171 Email: <a href="mailto:melafynboyz@gmail.com">melafynboyz@gmail.com</a>	<b>Loren Bird Rattler*</b> Project Manager Blackfeet Resource Management Plan Phone: (406) 338-7521 Email: <a href="mailto:lbirdrattler@blackfeetnation.com">lbirdrattler@blackfeetnation.com</a>
Chippewa Cree Tribe of Rocky Boy's Reservation	<b>Calvin Jilot</b> Phone: (406) 395-5705 ext. 226 Email: <a href="mailto:calvin@cct.rockyboy.org">calvin@cct.rockyboy.org</a>	<b>Tierra Pullin-Houle</b> Phone: (406) 395-4995 Email: <a href="mailto:tierralynn15@gmail.com">tierralynn15@gmail.com</a>
Confederated Salish & Kootenai Tribes of the Flathead Reservation	<b>Jennifer Finley*</b> Program Manager Circle of Trust Phone: (406) 745-3525 ext. 5071 Email: <a href="mailto:jennifer.finley@cskthealth.org">jennifer.finley@cskthealth.org</a>	<b>Erin Irvine*</b> ECS Parent Mentor Phone: (406) 203-2324 Email: <a href="mailto:erinirvine09@gmail.com">erinirvine09@gmail.com</a>
Crow Tribe of the Crow Reservation	<b>Todd Wilson*</b> Executive Director Crow Tribal Health Phone: (406) 679-3727 Email: <a href="mailto:Todd.Wilson@crow-nsn.gov">Todd.Wilson@crow-nsn.gov</a>	<b>Rosella Holds*</b> Phone: (406) 679-3727 Email: <a href="mailto:rosella.holds@crow-nsn.gov">rosella.holds@crow-nsn.gov</a>
Fort Belknap Tribes of the Fort Belknap Reservation	<b>Brandi King*</b> Phone: (406) 353-7248 Email: <a href="mailto:brandiking5050@gmail.com">brandiking5050@gmail.com</a>	<b>Lynn Cliff, Jr.*</b> Councilman Chair, Tribal Health Committee Phone: (406) 353-8344 Email: <a href="mailto:lynn.cliff@ftbelknap.org">lynn.cliff@ftbelknap.org</a>
Fort Peck Tribes of the Fort Peck Reservation	<b>Roxanne Gourneau</b> Tribal Executive Board Member Phone: (406) 630-2448 (cell) Email: <a href="mailto:rgourneau@fortpecktribes.net">rgourneau@fortpecktribes.net</a>  Alternate: <b>Lonnie Headdress*</b> Phone: (406) 768-2300 Email: <a href="mailto:lheaddress@fortpecktribes.net">lheaddress@fortpecktribes.net</a>	<b>Ernie Bighorn*</b> TAP Coordinator Phone: (406) 853-6631 Email: <a href="mailto:ugotanidea@yahoo.com">ugotanidea@yahoo.com</a>

Area of Representation	Nominee	Youth Nominee
Helena Indian Alliance in Helena, MT	<b>Ben Horn*</b> Licensed Addiction Counselor Phone: (406) 442-5796 Email: <a href="mailto:bhorn@helenaindianalliance.com">bhorn@helenaindianalliance.com</a>	<b>Quincy Bjornberg*</b> Tobacco Prevention Program Coordinator Phone: (406) 442-9244 ext. 107 Email: <a href="mailto:gbjornberg@helenaindianalliance.com">gbjornberg@helenaindianalliance.com</a>
Indian Family Health Clinic in Great Falls, MT	<b>Linda Blackbird Short*</b> Case Manager, Substance Abuse Program Phone: (406) 268-1587 ext. 113 Email: <a href="mailto:lblackbirdshort@indianfamilyhealth.org">lblackbirdshort@indianfamilyhealth.org</a>	<b>Naomi Mendibles</b> Phone: (406) 836-2030 Email: <a href="mailto:aurora_jones77@yahoo.com">aurora_jones77@yahoo.com</a>  Alternate: <b>Shanell Lavallie*</b> Phone: (406) 799-2062 Email: <a href="mailto:justshanell1998@gmail.com">justshanell1998@gmail.com</a>
Indian Health Board of Billings in Billings, MT	<b>Marjorie Bear Don't Walk</b> Executive Director Phone: (406) 245-7318 Email: <a href="mailto:mbdwalk@yahoo.com">mbdwalk@yahoo.com</a>	<b>Robert Ironmaker</b> Health Site Manager Email: <a href="mailto:ronmaker@ihbbillings.org">ronmaker@ihbbillings.org</a>  Alternate: <b>Dana LeClair*</b> Addictions Counselor Email: <a href="mailto:danaleclair@yahoo.com">danaleclair@yahoo.com</a>
Little Shell Chippewa Tribe	<b>Gerald Gray*</b> Chairman Phone: (406) 690-9757 Email: <a href="mailto:ggray@gng.net">ggray@gng.net</a>	<b>Clarence Sivertsen*</b> Vice Chairman Email: <a href="mailto:clancy@3rivers.net">clancy@3rivers.net</a>
Missoula Urban Indian Health Center in Missoula, MT	<b>Kevin Kickingwoman</b> Phone: (406) 360-1286 Email: <a href="mailto:kevinkickingwoman@yahoo.com">kevinkickingwoman@yahoo.com</a>	<b>Marley Tanner</b> Phone: (406) 270-5101 Email: <a href="mailto:marley.tanner@hotmail.com">marley.tanner@hotmail.com</a>  Alternate: <b>Ivan MacDonald*</b> Phone: (406) 281-2257 Email: <a href="mailto:ivanmacdonald54@yahoo.com">ivanmacdonald54@yahoo.com</a>
North American Indian Alliance in Butte, MT	<b>Patty Boggs*</b> Health Coordinator Phone: (406) 782-0461 Email: <a href="mailto:pboggs@naia-butte.org">pboggs@naia-butte.org</a>	<b>Alta Boggs-Longfox</b> Youth Facilitator Phone: (406) 782-0461 ext. 113 Email: <a href="mailto:aboggs@naia-butte.org">aboggs@naia-butte.org</a>

Area of Representation	Nominee	Youth Nominee
Northern Cheyenne Tribe of the Northern Cheyenne Reservation	<b>Clyde Joel Brady II</b> Veterans Coordinator Phone: (406) 477-4548 Email: <a href="mailto:joel.brady@ihs.gov">joel.brady@ihs.gov</a>	<b>Janelle Timber-Jones*</b> MSPI Dragonfly Coordinator Phone: (406) 477-4944 Email: <a href="mailto:janelle.timberjones@nctribalhealth.org">janelle.timberjones@nctribalhealth.org</a>

## Members of the Montana Native Youth Suicide Reduction Advisory Council

(\*Attended the 1-day Advisory Council meeting in December 2017 in Helena, MT)

Area of Representation	Leadership Appointee	Youth Appointee
Blackfeet Tribe of the Blackfeet Reservation	<b>Mary Ellen LaFromboise</b> Director Blackfeet Family Services Phone: (406) 338-5171 Email: <a href="mailto:melafynboyz@gmail.com">melafynboyz@gmail.com</a>	<b>Loren Bird Rattler</b> Project Manager Blackfeet Resource Management Plan Phone: (406) 338-7521 Email: <a href="mailto:lbirdrattler@blackfeetnation.com">lbirdrattler@blackfeetnation.com</a>  <b>Alternate: Kim Paul</b> Director Piikani Lodge Institute Phone: (406) 370-6311 Email: <a href="mailto:kim.paul777@gmail.com">kim.paul777@gmail.com</a>
Chippewa Cree Tribe of Rocky Boy's Reservation	<b>Calvin Jilot</b> Tribal Council Member Phone: (406) 395-5705 ext. 226 Email: <a href="mailto:calvin@cct.rockyboy.org">calvin@cct.rockyboy.org</a>  <b>Alternate: Richard Sangrey*</b> Chief of Staff Chippewa Cree Tribe Phone: (406) 395-5705 Email: <a href="mailto:richard@cct.rockyboy.org">richard@cct.rockyboy.org</a>	<b>Vacant</b>

Area of Representation	Leadership Appointee	Youth Appointee
Confederated Salish & Kootenai Tribes of the Flathead Reservation	<p><b><u>Alternate: Brenda Bodnar*</u></b> Health and Wellness Division Director Phone: (406) 745-3525 ext. 5020 Email: <a href="mailto:brenda.bodnar@cskthealth.org">brenda.bodnar@cskthealth.org</a></p>	<p><b>Erin Irvine*</b> ECS Parent Mentor Phone: (406) 203-2324 Email: <a href="mailto:erinirvine09@gmail.com">erinirvine09@gmail.com</a></p>
Crow Tribe of the Crow Reservation	<p><b>Henry Pretty On Top</b> Health and Human Services Cabinet Head Phone: (406) 679-3727 Email: <a href="mailto:Henry.Prettyontop.III@crow-nsn.gov">Henry.Prettyontop.III@crow-nsn.gov</a></p> <p><b><u>Alternate: Dee Pretty On Top</u></b> Executive Director Crow Tribal Health Phone: (406) 679-3731 Email: <a href="mailto:dee.prettyontop@crow-nsn.gov">dee.prettyontop@crow-nsn.gov</a></p>	<p><b><u>Alternate: Shannon Bradley*</u></b> Assistant Health Director/MSPI Program Director Phone: (406) 679-5028 Email: <a href="mailto:Shannon.bradley@crow-nsn.gov">Shannon.bradley@crow-nsn.gov</a></p>
Fort Belknap Tribes of the Fort Belknap Reservation	<p><b>Brandi King*</b> Tribal Council Member Phone: (406) 353-7248 Email: <a href="mailto:brandi.king@ftbelknap.org">brandi.king@ftbelknap.org</a></p>	<p><b>Lynn Cliff, Jr.*</b> Tribal Council Member Phone: (406) 353-8344 Email: <a href="mailto:lynn.cliff@ftbelknap.org">lynn.cliff@ftbelknap.org</a></p>
Fort Peck Tribes of the Fort Peck Reservation	<p><b><u>Alternate: Lonnie Headdress*</u></b> Tribal Executive Board Member Phone: (406) 768-2300 Email: <a href="mailto:lheaddress@fortpecktribes.net">lheaddress@fortpecktribes.net</a></p>	<p><b>Ernie Bighorn*</b> TAP Coordinator Phone: (406) 853-6631 Email: <a href="mailto:ugotanidea@yahoo.com">ugotanidea@yahoo.com</a></p>
Helena Indian Alliance in Helena, MT	<p><b>Ben Horn</b> Licensed Addiction Counselor Phone: (406) 442-5796 Email: <a href="mailto:bhorn@helenaindianalliance.com">bhorn@helenaindianalliance.com</a></p>	<p><b>Quincy Bjornberg*</b> Tobacco Prevention Program Coordinator Phone: (406) 442-9244 ext. 107 Email: <a href="mailto:qbjornberg@helenaindianalliance.com">qbjornberg@helenaindianalliance.com</a></p>
Indian Family Health Clinic in Great Falls, MT	<p><b>Linda Blackbird Short*</b> Case Manager, Substance Abuse Program Phone: (406) 268-1587 ext. 113</p>	<p><b>Vacant</b></p>

Area of Representation	Leadership Appointee	Youth Appointee
	Email: <a href="mailto:lblackbirdshort@indianfamilyhealth.org">lblackbirdshort@indianfamilyhealth.org</a>	
Indian Health Board of Billings in Billings, MT	<b>Vacant—Organization closed indefinitely</b>	<b>Vacant—Organization closed indefinitely</b>
Little Shell Chippewa Tribe	<p><b>Gerald Gray</b> Tribal Chairman Phone: (406) 690-9757 Email: <a href="mailto:ggray@gng.net">ggray@gng.net</a></p> <p>Alternate: <b>Kim McKeehan*</b> Tribal Council Member Phone: (406) 768-2300 Email: <a href="mailto:heartforward@gmail.com">heartforward@gmail.com</a></p>	<p><b>Clarence Sivertsen*</b> Tribal Vice Chairman Phone: (406) 315-2400 Email: <a href="mailto:clancy@3rivers.net">clancy@3rivers.net</a></p>
Missoula Urban Indian Health Center in Missoula, MT	<p>Alternate: <b>Dana Kingfisher*</b> ASAP/Tobacco Coordinator Phone: (406) 829-9515 Email: <a href="mailto:dkingfisher@muihc.org">dkingfisher@muihc.org</a></p>	<p>Alternate: <b>Ivan MacDonald*</b> MSW Intern Phone: (406) 281-2257 Email: <a href="mailto:imacdonald@muihc.org">imacdonald@muihc.org</a></p>
North American Indian Alliance in Butte, MT	<p><b>Patty Boggs*</b> Health Coordinator Phone: (406) 782-0461 Email: <a href="mailto:pboggs@naia-butte.org">pboggs@naia-butte.org</a></p>	<p>Alternate: <b>Dale Good Gun*</b> Executive Director Phone: (406) 782-0461 Email: <a href="mailto:dgoodgun@naia-butte.org">dgoodgun@naia-butte.org</a></p>
Northern Cheyenne Tribe of the Northern Cheyenne Reservation	<p>Alternate: <b>Bertha Brown*</b> MSPI Dragonfly Project Co-Facilitator Phone: (406) 477-4948 Email: <a href="mailto:bertie.b@nctribalhealth.org">bertie.b@nctribalhealth.org</a></p>	<p><b>Janelle Timber-Jones*</b> MSPI Dragonfly Coordinator Phone: (406) 477-4944 Email: <a href="mailto:janelle.timberjones@nctribalhealth.org">janelle.timberjones@nctribalhealth.org</a></p>

## **Appendix B. Coalition Member Letter of Invitation and Appointment Letter**

## Letter of Invitation

August 9, 2016

[Insert address]

Dear [Insert Contact Name],

On behalf of Kauffman & Associates, Inc., (KAI) I am pleased to announce that we will be assisting the Montana Department of Public Health and Human Services (DPHHS) American Indian Youth Suicide Prevention Initiative. As you know, the goal of this initiative is to collaborate with tribal and urban Indian representatives to develop a strategic plan to reduce suicide among Native youth in Montana. The plan will be completed and presented to state, tribal, and urban Indian health center stakeholders in February 2017.

An important part of this work is to form a Coalition of Montana Tribes and Urban Indians. The Coalition will serve a central role in developing a strategic plan for reducing Native youth suicide in the state. Coalition membership will consist of community and youth leaders from across all tribal government systems and urban Indian health organizations.

Coalition members will participate in a 2-day planning workshop to take place in October 2016 in Helena. Expenses for participation in the planning workshop, including travel and accommodation costs, will be covered by DPHHS. During this gathering, Coalition members will review current suicide prevention efforts in the state; discuss trends, challenges, and best practices in suicide prevention; and develop a shared vision, strategies, and implementation steps for this strategic plan. There will also be two to three teleconferences for Coalition members to help gather information about suicide prevention and plan prevention strategies.

Each tribe and urban Indian health organization is asked to nominate two individuals to participate in the Coalition: one nominee to represent leadership (which can include an elected leader, health director, or a community member with experience in the area of youth suicide) and a youth representative (18 years or older). We encourage diversity in nomination selections (e.g., male, female, veteran, LGBTQ-Two Spirit) to reflect as many Native voices in the state as possible. Please submit your nominations no later than **August 31**, to Adrienne Wiley, KAI Research Associate, at [Adrienne.wiley@kauffmaninc.com](mailto:Adrienne.wiley@kauffmaninc.com) or at (301) 943-1069.

Your voice is key to developing a shared vision for a safe, healthy, and nurturing future for our Native youth in Montana. Thank you for your consideration of this request.

Sincerely,

Jo Ann Kauffman, M.P.H., President

CC: Zoe Barnard, Chief, Children's Mental Health Bureau

## Letter of Appointment

March 21, 2017

Dear [insert Coalition member name]:

Congratulations!

I am pleased to appoint you to the Montana Native Youth Suicide Reduction Advisory Council (Coalition) as the Leadership representative for the [insert Montana tribe/UIHO]. Your appointment is effective March 15, 2017 and will expire December 31, 2017.

This Coalition is comprised of members representing Tribes and Urban Organizations who will serve in an advisory capacity to the Montana Department of Public Health and Human Services.

Reducing youth suicides across the state of Montana, particularly in Indian Country, is a priority for Governor Bullock, Lt. Governor Cooney, and I. We look forward to your participation and advice on the Implementation of Zero Suicide as recommended in the Montana Native Youth Suicide Reduction Strategic Plan.

Kauffman and Associates, Inc. (KAI) have agreed to continue to assist us with this important Governor's Initiative. You can expect to hear from them in the very near future as we work together to plan the initial meeting ahead of the Zero Suicide Academy which we expect to occur in the fall of 2017.

I appreciate your willingness to serve and thank you for the investment of time and energy that is necessary to make this Coalition effective.

Sincerely,

Sheila Hogan, Director

Montana DPHHS

## **Appendix C. Montana Suicide Reduction Survey Interview Script**

## Interview Script

Good morning/afternoon. How are you today?

My name is \_\_\_\_\_, and I'm calling from Kauffman & Associates, a Native American-owned company, on behalf of the Montana Department of Public Health and Human Services. How are you today? We are helping the Montana DPHHS put together a Coalition of Montana Tribes and Urban Indian representatives to develop a strategic plan for American Indian youth suicide reduction in Montana. Is **[Point of Contact]** available?

**If no:** In that case, would you or someone else be willing to take a few minutes to discuss any suicide prevention programs that you may run?

**If yes:** May I speak with them, please?

**Once you have established a Point of Contact:** Thank you for taking the time to speak with me. I know this is a sensitive topic, and I appreciate your willingness to discuss it. I'd first like to verify the contact information that we have for your health center. **[Verify their address, phone, and email if available.]**

Next, I'd like to know of any youth suicide prevention programs that your organization runs. Does your tribe/health center offer any programs geared towards Native youth suicide prevention? For reference, this includes people 24 years old and younger. **[Be aware that program availabilities and details may vary quite a bit. Always stay open-minded and get any relevant information that is available.]**

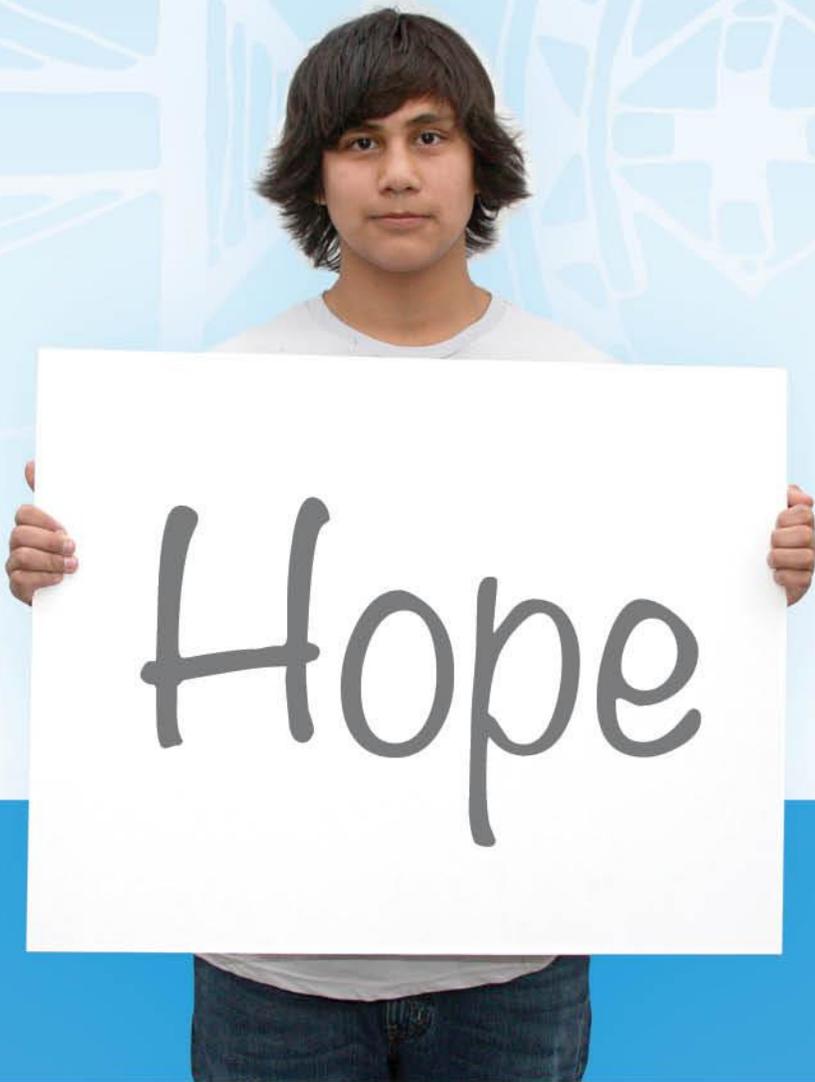
**If they have a suicide prevention program, follow up with these questions:**

1. Are you a tribally affiliated or an independent program/health center?
2. Is your program tribally, state, or grant funded? **[If they do not know, ask if they know someone who might.]**
3. Do you know the date of establishment of your program?
4. Are you aware of any other youth suicide prevention programs in the state of Montana? **[If they know other people or programs in Montana, take notes on that information and ask if it is OK if we use the contact's name when we reach out to the new person/program.]**

Thank you for taking the time to speak with me.

## Appendix D. Montana Suicide Reduction Survey

# Montana Suicide Reduction Survey



## Executive Summary

The Montana Suicide Reduction Survey provides a point-in-time collection of information from tribes, urban Indian centers, and other state and local programs across the state. The survey presents program contact information, along with a brief description of activities focused on reducing and preventing suicide among Native youth in Montana. It also provides a general description of program activities that seek to improve or promote Native youth wellness and development.

Survey findings were obtained from telephone and email discussions with tribal, urban Indian organizations, and program representatives and is supplemented with information gathered from online research.

### Program Contact Information

Organization and Program Name	Main Phone	Fax	Address	Web Address
<b>Blackfeet Nation Tribal Health Department</b>	(406) 338-6326	(406) 338-6311	807 N. Piegan St., Hospital Hill PO Box 866 Browning, MT 59417	<a href="https://www.facebook.com/Blackfeet-Tribal-Health-Dept-620084218061752/?ref=page_internal">https://www.facebook.com/Blackfeet-Tribal-Health-Dept-620084218061752/?ref=page_internal</a>
<b>The Chippewa Cree Tribe of Rocky Boy Montana Rocky Boy Health Board</b>	(406) 395-4486	(406) 395-4408	96 Clinic Rd. Box Elder, MT 59521	<a href="https://www.rbclinic.org">https://www.rbclinic.org</a>
<b>Confederated Salish &amp; Kootenai Tribes of the Flathead Reservation Tribal Health &amp; Human Services Department</b>	(406) 675-2700	(406) 745-4231	35401 Mission Dr. PO Box 880 St. Ignatius, MT 59865	<a href="http://www.cskthealth.org/">http://www.cskthealth.org/</a>
<b>Crow Tribe of Montana Tribal Health Department</b>	(406) 679-3727	(406) 638-3959	10006 Heritage Rd. PO Box 159 Crow Agency, MT 59022	
<b>Fort Belknap Indian Community Tribal Health Department</b>	(406) 353-8486	(406) 353-2884	656 Agency Main St. Harlem, MT 59526	
<b>Fort Peck Assiniboine &amp; Sioux Tribes Tribal Health Department</b>	(406) 768-2200	(406) 768-5780	107 H St. East PO Box 1027 Poplar, MT 59255	<a href="http://www.fortpecktribes.org/fpth/">http://www.fortpecktribes.org/fpth/</a>

Organization and Program Name	Main Phone	Fax	Address	Web Address
<b>Helena Indian Alliance</b>	(406) 442-9244	(406) 449-5797	501 Euclid Ave. Helena, MT 59601	<a href="http://www.helenaindianalliance.com/">http://www.helenaindianalliance.com/</a>
<b>Indian Family Health Clinic</b>	(406) 268-1510	(406) 268-1572	1220 Central Ave., Ste. 2B Great Falls, MT 59401	<a href="http://indianfamilyhealth.org">indianfamilyhealth.org</a>
<b>Indian Health Board of Billings</b>	(406) 245-7318	(406) 245-8872	1127 Alderson Ave., #1 Billings, MT 59102	<a href="http://www.uihi.org/urban-indian-health-organization-profiles/billings/">http://www.uihi.org/urban-indian-health-organization-profiles/billings/</a>
<b>Little Shell Chippewa Tribe</b>	(406) 315-2400	(406) 315-2401	625 Central Ave. West Great Falls, MT 59401	<a href="http://www.montanalittleshelltribe.org/">http://www.montanalittleshelltribe.org/</a>
<b>Missoula Urban Indian Health Center</b>	(406) 829-9515 ext.112	(406) 829-9519	830 W. Central Missoula, MT 59808	<a href="http://muihc.org/welcome/">http://muihc.org/welcome/</a>
<b>Montana Department of Public Health and Human Services Addictive and Mental Disorders Division</b>	(406) 444-3964	(406) 444-4435	100 N. Park, Ste. 300 PO Box 202905 Helena, MT 59620	<a href="http://dphhs.mt.gov/amdd/Suicide.aspx">http://dphhs.mt.gov/amdd/Suicide.aspx</a>
<b>Montana Office of Public Instruction</b>	(406) 444-3095	(406) 444-2893	1227 11th Ave., 2nd Fl. PO Box 202501 Helena, MT 59620	<a href="http://opi.mt.gov/">http://opi.mt.gov/</a>
<b>North American Indian Alliance</b>	(406) 782-0461	(406) 782-7435	55 E. Galena St. Butte, MT 59701	<a href="http://www.uihi.org/urban-indian-health-organization-profiles/butte/">http://www.uihi.org/urban-indian-health-organization-profiles/butte/</a>

Organization and Program Name	Main Phone	Fax	Address	Web Address
<b>Northern Cheyenne Tribe Northern Cheyenne Board of Health</b>	(406) 477-6722	(406) 477-6829	100 Eagle Feather St. PO Box 70 Lame Deer, MT 59043	<a href="http://www.nctribalhealth.org">http://www.nctribalhealth.org</a>
<b>Rocky Mountain Tribal Leadership Council</b>	(406) 252-2550	(406) 254-6355	711 Central Ave., Ste. 220 Billings, MT 59102	<a href="http://www.rmtlc.org/">http://www.rmtlc.org/</a>
<b>University of Montana Institute for Educational Research and Service National Native Children's Trauma Center</b>	(406) 243-2644	(406) 243-6376	The University of Montana College of Education McGill Hall 027 Missoula, MT 59812	<a href="http://coehs.umt.edu/about/People/iers1.php">http://coehs.umt.edu/about/People/iers1.php</a>

## Program Activity Information

Organization and Program Name	Summary of Activities
<p><b>Blackfeet Nation Tribal Health Department</b></p>	<p><b>Suicide Prevention Activities:</b>            The tribe utilizes Methamphetamine and Suicide Prevention Initiative (MSPI) funds to engage in trainings, prevention activities, and a public media campaign. Trainings include Question, Persuade, and Referral (QPR); safeTALK; Applied, Suicide, Intervention, and Training (ASIST); Active Parenting; and Grief Recovery. Prevention activities include street dances, powwows, Blackfeet Language and Runs, and presentations by the Buffalo Soup Troupe Theater Group in schools. Media campaign and public awareness efforts include the use and promotion of 1 (800) 273-TALK (a toll-free prevention support hotline); the promotion of protective factors and traditional methods of healing and help-seeking; radio, television, and newspaper ads; and awareness walks and marches. Behavioral health staff at the tribal IHS community hospital are on call 24-7 for screening, evaluation, and referral services.</p> <p><b>Youth Development/Youth Wellness Activities:</b>            Tribal college student mentors work with youth ages 14 through 16 years old. Tribal Youth Healing to Wellness Project activities (as part of the larger Honor Your Life Program) prevent and respond to juvenile delinquency and victimization. The tribe offers school staff and children outreach and training on bullying prevention and intervention skills.</p>
<p><b>Chippewa Cree Tribe of Rocky Boy Montana Rocky Boy Health Board</b></p>	<p><b>Suicide Prevention Activities:</b>            The tribe has received QPR, ASIST, and Second Step trainings through the state and continues to provide community trainings for suicide awareness and intervention. The tribe also received MSPI funding for suicide and substance misuse prevention activities. The tribe also increased outreach and awareness efforts using social media platforms (e.g., Facebook). The tribe has utilized the American Indian Life Skills Curriculum in its schools in the past.</p>

Organization and Program Name	Summary of Activities
	<p><b>Youth Development/Youth Wellness Activities:</b></p> <p>The Tribal Cultural Support Services Department collaborates with other tribal organizations/departments to host community activities, such as walks, family fun nights, basketball tournaments, bon fires, school activities, etc. The tribe also involves community elders as their Professionals in Cultural Education and Preservation, working with youth and the larger community in school, office, and community settings.</p>
<p><b>Confederated Salish &amp; Kootenai Tribes of the Flathead Reservation Tribal Health &amp; Human Services Department</b></p>	<p><b>Suicide Prevention Activities:</b></p> <p>The tribe operates seven clinics located in communities across the reservation utilizing prevention, intervention, and postvention services, as well as other behavioral health services. The department has also implemented a Circles of Trust program in the community and engages, where possible, with local schools. The tribe provides therapy, counseling, and other behavioral health services. Center staff are undergoing QPR training, and is exploring additional outreach to schools to provide similar trainings to school staff. The tribe is also working with a new grant to integrate behavioral health into primary care.</p> <p><b>Youth Development/Youth Wellness Activities:</b></p> <p>The tribe has a Health and Wellness Committee that discusses and sets programmatic priorities, such as youth wellness development and other prevention programs, for the tribal community. The tribe also engages with the UNITY program to develop personal development, citizenship, and leadership among Native youth.</p>
<p><b>Crow Tribe of Montana Tribal Health Department</b></p>	<p><b>Suicide Prevention Activities:</b></p> <p>The tribe oversees multiple social media campaigns that include the distribution of informational pamphlets, brochures, etc., along with outreach and educational presentations at community events, such as basketball tournaments, powwows, and other cultural events. The tribe also works with schools to mentor at-risk youth and intervene and respond (as requested</p>

Organization and Program Name	Summary of Activities
	<p>by schools and parents) to crisis events. The tribal wellness center offers substance misuse treatment services, including services specifically for adolescents and persons with co-occurring mental and substance misuse disorders.</p> <p><b>Youth Development/Youth Wellness Activities:</b></p> <p>The tribe provides financial assistance to eligible students attending institutions, apprenticeship programs, and on-the-job training courses, and scholarship assistance to students attending 2- or 4- year accredited institutions.</p>
<p><b>Fort Belknap Indian Community Tribal Health Department</b></p>	<p><b>Suicide Prevention Activities:</b></p> <p>No targeted activities are happening at this time, although the tribe has access to behavioral health resources through the local IHS clinic. (The tribe is currently working with IHS Behavioral Health to examine the feasibility of developing a tribally operated integrated behavioral health program.)</p> <p><b>Youth Development/Youth Wellness Activities:</b></p> <p>The tribe provides Community Health Recreational Aides to assist with youth activities. Tribal health department programs are also involved with youth activities. The tribe also works with local schools to develop and sustain community gardens to teach youth about growing vegetables and the values of medicinal plants.</p>
<p><b>Fort Peck Assiniboine &amp; Sioux Tribes Tribal Health Department</b></p>	<p><b>Suicide Prevention Activities:</b></p> <p>The tribes provide suicide awareness outreach with students at local schools. The tribes also received an MSPI grant and a grant to work in concert with Missoula Indian Health Center. The tribe is also in the process of applying for Systems of Care funding. Limited behavioral health services are also provided.</p> <p><b>Youth Development/Youth Wellness Activities:</b></p> <p>The tribe offers youth activities that encourage healthy sports, arts and crafts, engagement with tribal programming, and social gatherings (such as the community-wide Creator’s Games). The tribe also has a Department of Languages and Cultures that is</p>

Organization and Program Name	Summary of Activities
	<p>committed to the restoration and revitalization of the tribes’ languages and cultures among the people and youth. Community schools have active youth groups to encourage positive behavior among area youth and families.</p>
<p><b>Helena Indian Alliance</b></p>	<p><b>Suicide Prevention Activities:</b></p> <p>The clinic offers behavioral health services, including a substance misuse treatment and counseling program and mental health services, but it does not have a dedicated suicide prevention program at this time.</p> <p><b>Youth Development/Youth Wellness Activities:</b></p> <p>The clinic provides a culture-based youth development and support program through its tobacco prevention activities. Mental health services offered by the clinic also include family therapy and treatment for co-occurring disorders, grief, and sexual trauma.</p>
<p><b>Indian Family Health Clinic</b></p>	<p><b>Suicide Prevention Activities:</b></p> <p>The clinic offers behavioral health services, including individual and group counseling for substance misuse, but it does not have any suicide prevention programs at this time.</p> <p><b>Youth Development/Youth Wellness Activities:</b></p> <p>The clinic outpatient services include family therapy, educational groups, and youth- and family-focused cultural activities. It also operates a Fitness and Wellness Center that offers education and wellness instruction, as well as physical fitness support.</p>
<p><b>Indian Health Board of Billings</b></p>	<p><b>Suicide Prevention Activities:</b></p> <p>The clinic offers general substance misuse and mental health services and has licensed abuse counselors on staff. The clinic creates and airs a weekly television program that presents information and outreach on various health topics. The clinic also offers transportation to the Crow/Northern Cheyenne Service Unit several days a week.</p>

Organization and Program Name	Summary of Activities
	<p><b>Youth Development/Youth Wellness Activities:</b></p> <p>No additional wellness or development services are offered at this time. (However, the clinic is currently exploring the feasibility of providing a support group for at-risk youth.)</p>
<p><b>Little Shell Chippewa Tribe</b></p>	<p><b>Suicide Prevention Activities:</b></p> <p>No targeted activities are happening at this time.</p> <p><b>Youth Development/Youth Wellness Activities:</b></p> <p>The tribe operates a wellness program to tribal youth. Youth engage in cultural and traditional games and activities on weekends and after school. The tribe also operates a tobacco awareness and prevention program that targets youth.</p>
<p><b>Missoula Urban Indian Health Center</b></p>	<p><b>Suicide Prevention Activities:</b></p> <p>The Center provides behavioral health services, including culturally sensitive individual and group counseling services. Clinical staff have also received training in the Trauma Resilience Model to use in the Center’s clinical services as a trauma-informed organization. The Center also incorporates equine therapy as part of some of its behavioral health services.</p> <p><b>Youth Development/Youth Wellness Activities:</b></p> <p>The Center uses the Community Resilience Model to look into and design activities aimed at addressing issues experienced by youth related to lingering current, personal, intergenerational, and historical trauma. The Center also offers Circles of Security counseling to provide outreach and training to Native parents to support the development of positive parenting practices.</p>

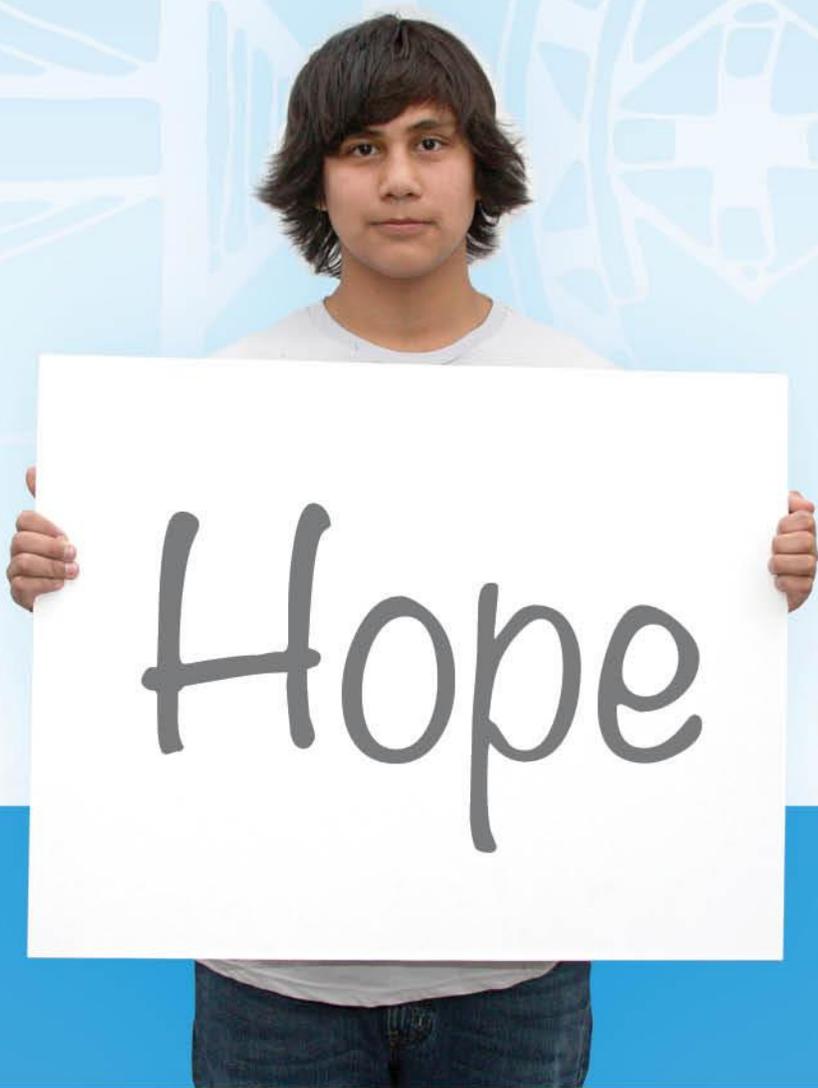
Organization and Program Name	Summary of Activities
<p><b>Montana Office of Public Instruction</b></p>	<p><b>Suicide Prevention Activities:</b>            The office provides universal, targeted, and intensive program training and technical assistance to schools about youth suicide awareness and prevention; provides a youth suicide prevention seminar specifically designed for parents; provides additional resources for parents, teachers, and school administrators; and offers a Child Trauma Toolkit for Educators through its website.</p> <p><b>Youth Development/Youth Wellness Activities:</b>            The office operates a youth leadership development program that uses traditional values to build up students and improve support services in reservation schools.</p>
<p><b>Montana Department of Public Health and Human Services Addictive and Mental Disorders Division</b></p>	<p><b>Suicide Prevention Activities:</b>            The department provides a range of training programs, including the indigenous version of the Pax Good Behavior Game (for elementary school-age youth), QPR (for all school staff), ASIST (most frequently used with reservation-based communities), and SOS (a mental health screening program). The department has also partnered with the National Crisis Text Line and engages in a statewide advertising campaign to promote this resource. The department also provides training in suicide screening and intervention for primary care nurses and college nursing programs, supports LifeLine (a toll-free support line) and the Voices of Hope resources across the state, and provides gun locks for primary care providers to distribute to patients.</p> <p><b>Youth Development/Youth Wellness Activities:</b>            The department is not offering specific activities in this area at this time.</p>

Organization and Program Name	Summary of Activities
<p><b>Montana Suicide Mortality Review Team (SMR Team)</b></p>	<p><b>Suicide Prevention Activities:</b></p> <p>The SMR team is a statewide effort to identify factors associated with suicide to develop prevention strategies. SMR Team is composed of mental health staff, social service staff, law enforcement, coroners, and other experts to review de-identified, suicide deaths. The purpose of the SMR Team is to determine if a suicide was preventable and what factors were associated with the suicide. The SMR Team’s program works to reduce the inequalities that impact the number of deaths through local community and state collaboration.</p>
<p><b>North American Indian Alliance</b></p>	<p><b>Suicide Prevention Activities:</b></p> <p>The clinic offers behavioral health services, including individual and family counseling on substance misuse and mental health issues.</p> <p><b>Youth Development/Youth Wellness Activities:</b></p> <p>The clinic provides prevention activities, such as talking circles, Native games, diabetes education, and YMCA membership. The clinic performs outreach by attending powwows and community Native dance activities.</p>
<p><b>Northern Cheyenne Tribe Northern Cheyenne Board of Health</b></p>	<p><b>Suicide Prevention Activities:</b></p> <p>The tribe operates the Honor Your Life program on the reservation and an MSPI program; both programs perform outreach activities in the community and area schools, including suicide prevention trainings and other collaborative events, such as Sobriety Camp, basketball camps, a block party, Child Service's Field Day, powwows, and Ride to the Battle of Little Big Horn.</p> <p><b>Youth Development/Youth Wellness Activities:</b></p> <p>The Tribal Board of Health offers parenting classes through its outpatient treatment program, the Northern Cheyenne Recovery Center. The tribe also operates a Tobacco Prevention Office that provides education and awareness outreach to local schools and the community.</p>

Organization and Program Name	Summary of Activities
<p><b>Rocky Mountain Tribal Leadership Council</b></p>	<p><b>Suicide Prevention Activities:</b></p> <p>The Council’s Tribal Prevention Initiative program focuses on substance misuse prevention among youth, ages 12 to 20 years, and their families. The Council utilizes the following strategies in this effort: alcohol- and drug-free activities (e.g., dances and sports clinics); prevention messages, trainings, and education (e.g., training in increasing protective factors in youth); a traditional values curriculum (e.g., drum making and beading classes); involvement of tribal leadership; promoting collaboration between tribes; broadening community participation; and consistently using social, print, and radio media. The Council’s Transitional Recovery &amp; Culture project provides substance misuse recovery support to peers via peer recovery support mentorship.</p> <p><b>Youth Development/Youth Wellness Activities:</b></p> <p>The Council’s Good Health and Wellness in Indian Country project promotes a holistic approach to chronic disease management and prevention. The program uses several different strategies in this effort, including the implementation of the American Indian Life Skills Curriculum, traditional Native games, and tobacco use prevention and cessation.</p>
<p><b>University of Montana Institute for Educational Research and Service National Native Children's Trauma Center</b></p>	<p><b>Suicide Prevention Activities:</b></p> <p>The Center teams with partner entities to operate a surveillance system. It also provides gatekeeper trainings, including ASIT, QPR, mental health awareness and support, and first aid, to clinicians and emergency department staff. The Center also hosts an elder and a youth group to gather community input on outreach and activity content and design. The Center works with schools to facilitate suicide awareness trainings, such as safeTALK. The Center also provides transportation services to youth in crisis or in need of in-patient treatment services.</p> <p><b>Youth Development/Youth Wellness Activities:</b></p> <p>The Center provides trainings to schools on bullying prevention.</p>

## Appendix E. Best Practices in Native Youth Suicide Reduction

# Best Practices in Native Youth Suicide Reduction



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## Introduction

This report highlights findings from the literature regarding the rates of suicide affecting Native youth across Indian Country, elements that seem to place Native youth at greater risk for suicide compared to non-Native populations, and the challenges often encountered by tribal communities and programs attempting to address this issue. However, it also highlights research into the promising characteristics and best practices of programs and interventions focused on preventing suicide among American Indian and Alaska Native (AI/AN) youth. Specifically, this report aims to:

- Provide a general overview of rates of suicide among Native youth, nationally and within Montana;
- Examine the risk factors contributing to these rates and the subsequent implications for tribal communities, programs, and services attempting to address this issue; and
- Review and discuss findings from the literature and examples from the field regarding the elements, strategies, and best practices that hold promise for establishing effective strategies to address and prevent suicide amongst AI/AN youth.

Findings in this document pull from several academic journals, professional presentations, and federal and nonfederal organization reports. A review of this data supports the targeted discussion and development of a strategic plan to address and prevent suicide among Native youth in Montana.

## Background

### Summary

Studies and research uniformly show that suicide rates are very high among Native youth—much higher than the rates of other races. While this is true across the United States, suicide rates for American Indians in Montana are three times higher than the national rates for other AI/ANs. The national statistics all show that Montana’s Native youth are at a particularly high risk.

### Suicide and Its Impact on Youth in Indian Country

Findings from the literature suggest that, across Indian Country, rates of completed and attempted suicide among Native youth have reached epidemic proportions. According to the Centers for Disease Control and Prevention (CDC), suicide ranks as the second leading cause of death among Native adolescents and young adults, at a rate 2.5 times higher than the national average.<sup>i</sup> In fact, where rates of death by suicide among non-Native populations peak in older adulthood, rates of death by suicide among Native populations peak during adolescence and young adulthood.<sup>ii</sup> Table 10 illustrates the contrast between national and Native-specific rates of death due to suicide reported by the Indian Health Service (IHS) in 2014.<sup>iii</sup>

Table 10. Percentage of suicide-related death rates among youth: 2007–2009 (by Age, Sex, and Race)

Age Range	U.S. All Races			AI/ANs, IHS Service Area		
	Both Sexes	Male	Female	Both Sexes	Male	Female
5–14	0.5	0.7	0.3	3.3	3.6	3.1
15–24	9.9	16.0	3.5	39.7	58.7	20.2

Additional evidence of the disproportionate rate at which Native youth experience suicide can be found throughout the literature:

- While rates of death among Native children have declined over the years for some causes (e.g., drowning and fire-related accidents), suicide-related death rates have remained unchanged.<sup>iv</sup>
- Among 10- to 25-year-olds, Native youth experience the highest rates of suicide in the United States, at rates 62% above the national average. These rates make suicide the leading cause of nonaccidental death among Native youth in this age group.<sup>v</sup>
- Research estimates that 14% to 30% of Native adolescents between the ages of 15 and 24 years attempt suicide; the rate of suicide completion in this age group is 3.5 times higher than the rate experienced by non-Native youth.<sup>vi, vii</sup>
- Among Native youth ages 10 to 14 years, suicide accounts for over 13% of all deaths.
- Among Native 15- to 19-year-olds, this rate increases to 26.5%.<sup>viii</sup>
- Urban Indian Health Institute data suggests that urban Indian youth attempt suicide nearly three times more often than their White peers.<sup>ix</sup>
- Similarly, Native high school students are more than three times as likely to report suicide attempts requiring medical treatment, and 70% more likely to report suicidal ideation than their White peers.<sup>x</sup>
- CDC data found that Native boys and young men ages 10 to 24 years have the highest suicide rates of any ethnic or racial group in the country.<sup>xi</sup>

Research specific to tribal and urban Indian communities in the Northern Plains has uncovered similar findings.

- A comparison of National Comorbidity Survey baseline data with results from surveys and interviews with Northern Plains tribes found that tribal participants were less likely to report suicidal ideation than the general population.<sup>xii</sup>
- Montana has ranked among the top five states with the highest national suicide rates for the past 40 years and has reported the highest national suicide rate (24.5%) in 2014.
- Among youth ages 15 to 24 years, suicide serves as the second leading cause of death, at a rate that increased between 2013 and 2014.<sup>xiii</sup>

Much like nationally reported figures, Native youth in Montana experience substantially higher rates of suicide compared to their non-Native counterparts. Between 2005 and 2014, AI/ANs in Montana experienced death by suicide at a rate more than three times the national Native population (14.17 vs 43.28).<sup>xiv</sup> Table 11 summarizes age-adjusted, state-specific information gathered from CDC’s WISQARS™.<sup>xv</sup>

Table 11. Percentage of Suicide-Related Death Rate in Montana: 2005–2014 (By Age and Race)

Rate of Death by Suicide by Age	Montana All Races	Montana AI/AN
All ages	21.70%	28.16%
Ages 11–24	8.01%	42.82%

It is important to note that reported rates of Native deaths due to suicide for youth and adults are likely underestimated due to issues related to racial misclassification or the inaccurate recording of the cause of death. A 2015 CDC report on racial and gender disparities in suicide among young adults found that Native deaths were underreported by 30%.<sup>xvi</sup>

## Factors Placing Native Youth at Risk

### Summary

Factors at the individual, family, peer, school, and community levels place Native youth at an increased risk for suicide. Two factors are of special importance: **exposure to violence** and **exposure to trauma**. Native youth experience higher rates of exposure to suicide and other violence, with exposure to suicide or traumatic death, in turn, serving as serious risk factors for suicide. Exposure to trauma also increases the risk of suicide. In additional individual trauma, such as personal experiences of violence or racism, Native youth experience increased rates of family, community, intergenerational, and historical trauma that have long-lasting impacts on Native youth’s health and wellbeing.

The development of effective strategies to address suicide among Native youth must consider the factors that place Native youth at an elevated risk for experiencing suicide. Table 12 summarizes the most frequently cited factors associated with Native youth suicide or suicide ideation divided into attributes at the individual, family, peer, school, and community levels.<sup>xvii</sup>

Table 12. Frequently Cited Factors Associated with Native Youth Suicide/Suicide Ideation

Attribute Level	Factors
Individual	Tobacco use Exposure to violent trauma (victim and/or perpetration) Early or high-risk sexual activity Mental health disorder/poor emotional health

Attribute Level	Factors
	Access to weapons or firearms Poor physical health
<b>Family</b>	Attempted or completed suicide within family or social circle Family violence Presence of substance or alcohol misuse within the family
<b>Peer</b>	Lack of friends or supportive peer group Bullying Gang involvement
<b>School</b>	Poor academic performance/academic problems
<b>Community</b>	Lack of accessible services Impoverished community High crime rate

Both Native and non-Native youth share many risk factors for suicide.<sup>xviii</sup> However, while these factors are not exclusive to Native populations, they are frequently more prevalent for them, despite variations in rates and estimates across regions, tribes, and urban communities.

- *Poverty and unemployment:* Native populations experience the highest rate of poverty of any race group in the United States.<sup>xix, xx</sup> In 2014, the unemployment rate among Native populations was nearly twice the national rate and second only to the rate experienced by African Americans.<sup>xxi</sup> The average median income for Native-only households for this time period was well below the national average (\$37,227 vs. \$53,657).<sup>xxii</sup>
- *Exposure to violence:* Research indicates that the presence of one form of violence (either as the victim or the perpetrator) increases the likelihood of more violence exposure. In other words, evidence suggests that violence begets more violence.<sup>xxiii–xxiv</sup> For example, a study of urban American Indian youth found a strong link between involvement in committing a violent act with increased suicide risk.<sup>xxv</sup>
- *Academic problems:* Native high school students have the lowest graduation rate of any race group.<sup>xxvi</sup> A growing amount of evidence suggests that one factor possibly contributing to this rate may be the disproportionate rate at which Native students, particularly kindergartners, are held back in school.<sup>xxvii</sup> Research indicates that this type of retention may reduce the likelihood of high school completion.<sup>xxviii, xxix</sup>
- *Inability to physically access services:* For the estimated 22% of Native peoples living in tribal areas, many specialized medical care and social service options are located some distance away in major metropolitan areas.<sup>xxx</sup> Transportation and infrastructure issues in these areas also limit access to services. According to reports, only 17% of Bureau of Indian Affairs (BIA) and tribally operated roads are in acceptable conditions, while 15% of BIA-owned bridges and 70% of all tribally owned bridges are classified as deficient or functionally obsolete.<sup>xxxj, xxxk</sup>

- For many urban Native youth, access limitations stem from a lack of federally funded health care services available off-reservation. In these instances, barriers to needed social, behavioral, or mental health services include time constraints, lack of transportation options, and costs associated with travel costs. Cost serves as an additional barrier to accessible services, as Medicaid only partially covers urban clinic service costs, leaving a balance that is often too expensive for many urban Native consumers.<sup>xxxiii, xxxiv</sup>
- *Substance misuse*: National survey results indicate that Native people ages 12 years and older have the highest substance misuse rates in the nation.<sup>xxxv</sup> The reported rate of methamphetamine use among Native people in the same age group are more than three times the rate for the general population.<sup>xxxvi, xxxvii</sup> In a study examining suicide among urban Indian youth ages 9 to 15 years, researchers found a significant association between substance use and increased risk for attempting suicide.<sup>xxxviii</sup> Research with reservation-based Native youth found similar evidence: over half of one study population sample was intoxicated at the time of suicide attempt or death.<sup>xxxix</sup>

### Exposure to Violence: Suicide Exposure and Contagion

Findings that highlight the link between increased suicide risk and exposure to violence underscore a parallel risk often faced by Native youth—specifically, exposure to suicide itself. Suicide exposure (or exposure to suicidal behavior) appears to influence an individual’s level of suicide ideation, attempt, or completion.<sup>xl, xli, xlii</sup> Most research refers to this type of localized exposure and its subsequent impact on a person’s behavior as suicide contagion. Exposure to a traumatic death, be it a result of intentional or unintentional injury, may result in an individual expressing grief, despair, or hopelessness by taking his or her own life.<sup>xliii</sup>

This specific risk is of particular concern for Native youth. While adolescents and young adults seem vulnerable to suicide contagion nationally, data suggest that Native youth have the highest risk of experiencing it.<sup>xliv</sup> Findings from the literature indicate that many Native youth, particularly reservation-based youth, have one or more members of their social network who attempt or complete suicide.<sup>xlv</sup> Exposure to suicide within a family network served as the predominant factor contributing to youth suicide in the community in one study, with researchers noting that 70% of the community members who completed suicide had a family member who had also died by suicide.<sup>xlvi</sup>

### Trauma Past and Present

In addition to the risks already discussed, trauma serves as a significant risk factor for Native youth suicide. This risk factor includes experiences of individual, family, community, intergenerational, and historical trauma, which impact Native youth on multiple levels. For example, a study conducted with Southwest and Northern Plains tribes found a significant association between accident and other unexpected trauma, demonstrated suicide ideation, and suicide attempts

among the Northern Plains study participants.<sup>xlvii</sup> The cumulative negative effect of these experiences ultimately impaired the ability of Native youth to effectively prepare for successful and independent futures.<sup>xlviii</sup>

#### *Historical, Intergenerational, and Current Trauma*

The history of Native peoples following the colonization of the Americas is marked by repeated instances of racism, attempted genocide, and oppression. *Historical trauma* describes the response to past traumatic experiences and the ongoing negative influence on a community's or a population's social and psychological well-being, manifesting outwardly as poor mental, physical, or emotional health (e.g., depression or posttraumatic stress disorder (PTSD)) or self-destructive behavior (e.g., substance abuse and suicide).<sup>xlix, l</sup> Research has identified a correlation between historical trauma and conditions, such as PTSD and depression, as well as behavioral health issues, such as suicide and substance abuse.<sup>li</sup>

Because of the intrinsic connections between individuals, families, and communities, historical trauma and related responses to these traumas continually influence and reinforce each other across multiple generations.<sup>lii, liii</sup> The traumatic experiences of one generation influence the development of the generations that follow. For example, forced boarding school placement and the subsequent assimilation and acculturation policies forced on Native youth and families severely fractured the connections and relationships that served as protective factors for youth's cultural knowledge and Native self-identity.<sup>liv</sup> In a present-day context, this trauma perpetuates distrust of formal service providers, which may dissuade youth from accessing available services.<sup>lv</sup>

The cumulative impact of traumatic experiences (occurring in historic and present-day settings) also contributes to experiences of trauma within family and community networks. This impact often manifests as negative parenting practices or interparental violence at the family level and as high rates of suicide at the community level.<sup>lvi</sup> Family and community trauma also embeds itself in a population's collective social memory. As a result, children and youth learn to share in the ancestral pain of their community. This can lead to experiences of unresolved grief, persecution, and distrust, as well as a loss of culture or language. This shared knowledge and understanding of the historical trauma is subsequently validated and even reinforced as these younger generations experience trauma first-hand in the form of discrimination, injustice, or inequity.<sup>lvii</sup> In this way, exposure to historical trauma is intergenerational, thus perpetuating the negative, combined impact of past and present trauma within a Native community.

Finally, many Natives, including youth, continue to experience individual-level trauma within a present-day context in the form of discrimination or institutionalized racism, along with personal encounters with violence or abuse. These contemporary stressors have a significant negative impact on the health and well-being of Native youth that spreads over time and across their lifespans. This impact leads to a wide range of more significant negative health and social

outcomes, particularly in Native populations, such as memory suppression, depression, or violent or abusive behavior. Existing longitudinal research, such as the Adverse Childhood Experiences (ACE) Study, has uncovered strong associations between exposure to various types of adverse childhood experiences (e.g., abuse, neglect, household dysfunction) and increased risk for suicide.<sup>lviii</sup> Additional research indicates that Native youth exposed to adverse childhood experiences often undergo severe emotional problems that may increase their likelihood of engaging in substance use.<sup>lix</sup> Given the current rates of AI/AN exposure to the types of adverse experiences categorized by the study, one could safely conclude that historic and current trauma have a continued, calamitous impact on the health and well-being of Native youth throughout Indian Country.

## Challenges to Effective Prevention and Intervention

### Summary

Significant challenges must be addressed to create effective prevention and intervention efforts. Native tribes, communities, and individuals are very different from one another, and **standardized, one-size-fits-all approaches are inappropriate**. Differences between living on reservations or in urban areas are also significant and are largely overlooked in research and program planning. **Fear and stigma about suicide** prevent communities and at-risk individuals from talking about it. **Risk behaviors are not the same** among Native youth as in other populations, and providers and standard screening tools may not accurately recognize at-risk youth. Providers and others **may not understand or acknowledge the impact of current and historical trauma** for Native youth and may not have the tools to address trauma effectively. Finally, while Native populations have higher rates of mental health disorders, **there are few mental health services, a lack of research, and a lack of established practice for effective indigenous mental health treatment**.

Efforts to strategically prevent suicide among Native youth must first uncover the issues and challenges to addressing suicide in the community. Identification and discussion allows for a more comprehensive understanding of—and the development of solutions to—the complexities inherent in effective suicide prevention and intervention with Native youth. Findings from the literature highlight the following challenges and barriers:

- The heterogeneity of the Native population,
- Fear and stigma surrounding suicide and formal prevention or intervention services,
- Effective recognition of at-risk behavior in Native youth,
- Acknowledging current and historical trauma, and
- Issues related to Native youth mental health.

Though by no means an exhaustive list, this section serves as the foundation for a detailed, in-depth discussion of the barriers that must be addressed for any potential strategies or plans to succeed.

## Heterogeneity of the Native Population

Indian Country consists of 567 federally recognized sovereign nations. Montana alone is home to seven federally recognized tribes, one state-recognized tribe, and five urban Indian centers serving individuals from a variety of Native communities. This diversity is reflective of the heterogeneity of the Native population and those in need of suicide prevention and intervention services.

Consequently, an effective and comprehensive prevention or intervention plan must consider the range of different factors that lead a Native youth to contemplate suicide, as specific implications for treatment and prevention efforts accompany each factor.<sup>lx</sup> For example, many evidence-based interventions utilize a strict experimental approach that may be designed for non-Native communities or include implementation plans that cannot be significantly modified. For many Native communities, such a one-size-fits-all approach is ineffective and inappropriate.<sup>lxi</sup>

### *Urban Native Youth*

Though the majority of individuals who identify as Native live in urban areas, little research focuses on the particular needs and issues of urban Native youth; there is a similar lack of information with regards to urban Native youth suicide rates.<sup>lxii</sup> For example, IHS records and reports information on suicide rates for reservation-based youth, while urban Native youth suicide rates rely on hospitals, which—as previously noted—are prone to racial misclassification.<sup>lxiii</sup> Interviews with urban Native youth also uncovered a general consensus that urban Native populations, overlooked or disregarded by local and state governments, face greater difficulty accessing professional resources (e.g., grants) to address Native youth mental health needs.<sup>lxiv</sup>

## Fear and Stigma

As a challenge to effectively address Native youth suicide, fear takes multiple forms, including:

- Concern that disclosing suicide ideation or intent, particularly to a service provider, will lead to negative consequences, such as punishment, removal from one’s home, or involuntary hospitalization or commitment;<sup>lxv</sup> and
- Concern that an open discussion about suicide with someone at risk will drive that individual to contemplate or complete suicide.<sup>lxvi</sup>

Stigma has its roots in historical, community, and individual trauma. Family histories that may involve the forced removal or relocation combined with negative experiences with service providers in the past contribute to a person’s reluctance to seek out or use formal intervention services.<sup>lxvii</sup> Suicide and mental illness—or an open discussion of these issues—are also often surrounded by social stigma and community disapproval. This stigma may cause youth at risk of suicide to suffer in silence instead of seeking out support or intervention services.<sup>lxviii</sup>

### Effective Recognition of At-Risk Behavior in Native Youth

Most models for identifying youth at risk for suicide draw from research with non-Native populations. As a result, programs and services targeting Native youth lack accurate information to recognize at-risk or help-seeking behavior in an effective or timely manner. For example, research with Native youth in a Northern Plains tribe found that youth appeared more likely to attempt suicide, but less likely than the general U.S. population to have suicidal thoughts or ideation.<sup>lxxix</sup> A separate study found similar results for urban Native youth, who demonstrate lower rates of ideation than reservation-based youth.<sup>lxxx</sup> A traditional model of suicide risk continuum, however, looks for suicide ideation as a common precursor to attempted suicide.<sup>lxxxi</sup> A similar study found that a notable proportion of Native 13- to 18-year-olds in a specific tribe who recently attempted suicide engaged in few, if any, of the typical risk behaviors (e.g., substance use and aggression).<sup>lxxxii</sup>

Thus, at-risk behaviors or issues related to physical or mental health may be missed using standard screening tools and measures. Instead, these issues may manifest in Native youth in less discernable ways or may be identified by systems not trained to identify and intervene with youth at risk for suicide (e.g., juvenile justice or law enforcement, substance abuse treatment programs, or sexual health clinics).<sup>lxxxiii, lxxxiv</sup>

### Acknowledging Current and Historical Trauma

As discussed earlier, current, and historical trauma reveal themselves over time at individual, family, and community levels in the form of abusive or self-destructive behavior, mental health issues, or impaired physical health or functioning.<sup>lxxxv</sup> However, mainstream service providers often fail to consider the lingering impact and influence of current and historical trauma affecting Native youth. As previously discussed, past historical and personal trauma may lead to Native youth avoiding professional prevention or intervention services. Service providers unaware of this trauma or the specific trauma of a particular individual or community may fail to address the underlying social, community, or societal issues, factors, and disparities placing Native youth at an increased risk for suicide.<sup>lxxxvi</sup> Effective intervention requires recognition and exploration of the historical context of these issues.<sup>lxxxvii</sup>

### Issues Related to Mental Health

Despite growing research focused on mental health issue causes and treatment, Native populations (particularly children) continue to experience disproportionate rates of mental health disorders due to stigma, health disparities, and fragmented mental health care services.<sup>lxxxviii</sup> Research suggests that, among Native populations, the lifetime prevalence rates for any mental health disorder ranges from 35% to 54%. These rates have considerable implications for regarding, among other things, the risk factors for suicide, which may be compounded by a mental health disorder.<sup>lxxxix</sup> Researchers note that mental health issues in Native youth and adolescents run along a continuum ranging from more obvious (e.g., developmental delays, substance abuse, anxiety) to

more subliminal (e.g., school failure, running away, sexually acting out). The latter manifestations run the risk of being overlooked, leaving youth without much needed mental health support services.<sup>lxxx</sup>

A comprehensive understanding of this issue is also compromised by a lack of research regarding Native strategies for coping with mental health issues, indigenous definitions of healing and treatment, and locally developed efforts that build on the strengths of Native and non-Native healing traditions. This information is crucial for establishing successful partnerships between service providers or researchers and Native communities to develop and implement efforts that promote community-level healing.<sup>lxxxi</sup>

## Elements That Work: Findings from the Literature

### Summary

Research shows us what makes suicide prevention and intervention programs effective. Interventions should **start early and continue** through childhood and adolescence; should **include individuals, families, and communities**; and should **address co-occurring behaviors**, such as substance misuse or aggression. Interventions should take **strengths-based approaches** and build **resiliency** and **protective factors**, which are even more important than risk factors in determining suicide outcomes. Successful interventions are **deeply rooted in specific tribal cultures, histories, communities, and worldviews**, and they are developed through **respectful partnerships** between providers and tribal and urban Indian communities. Finally, interventions must effectively **address current and historical trauma** as a part of Native youth’s experience, encompassing grief, loss, mourning, healing, and connection to a broader community and history.

Characteristics of successful or promising suicide prevention and intervention strategies and programs can be found throughout the literature. Generally speaking, these traits fall into one of several categories:

- Early and continuous intervention at individual, family, school, and community levels;
- Interventions that address co-occurring issues (e.g., substance misuse or aggression);
- Utilization of a strengths-based approach with a focus on building resiliency through protective factors;
- Incorporation of Native cultures and traditional worldviews;
- Collaborative partnerships between researchers, service providers, and tribal and urban Indian communities; and
- Consideration of current and historical trauma in intervention design.

### Early and Continuous Intervention

Early interventions that continue throughout childhood and adolescence provide opportunities for programs to identify and target a wide range of factors that place Native youth at risk for suicide, such as substance misuse, aggression, or high risk sexual behavior.<sup>lxxxii</sup> Successful interventions also

target families and communities in addition to the individual. This broader focus provides a better understanding of the distinct current and historical context of the risks and issues with a particular family or community that can be used to tailor interventions to meet their unique needs while increasing community and individual health and well-being.<sup>lxxxiii</sup> It also provides an opportunity for programs to include family and community as protective factors that can contribute to efforts to build the strength and wellness of youth receiving services.<sup>lxxxiv</sup>

### Focus on Co-occurring Issues

As previously discussed, researchers have linked various individual attributes to increased risk for attempted or completed suicide among Native youth, including patterns of aggressive behavior, the presence of one or more mental health issues, and a history of substance misuse. Native youth, therefore, may demonstrate a need for suicide prevention or intervention services in ways that standard programs may fail to recognize.<sup>lxxxv</sup> Likewise, those who are identified may need more complex care or treatment to address co-occurring issues.<sup>lxxxvi</sup> Successful programs include a broad range of intervention and prevention strategies earlier that address Native youth's broader social environments and co-occurring issues and behaviors.<sup>lxxxvii</sup>

### Utilization of a Strengths-Based Approach

A strengths-based approach allows programs to provide youth, their families, and their communities with an opportunity to identify, develop, and maintain the internal and external resources needed to help youth reach their program or treatment goals while developing their relationships with the community.<sup>lxxxviii</sup> Research suggests that such strengths-based strategies positively influence the Native youth's behavioral outcomes and motivation to continue their development. They also force researchers and practitioners to examine and challenge their own biases regarding suicide risk and pathology while working with youth to identify, attain, and maintain formal and informal community resources, such as professional and paraprofessional services and health and supportive peer and family networks.<sup>lxxxix</sup>

#### *Protective Factors*

Growing evidence within the literature focuses on the strength and utilization of protective factors to decrease Native youth's suicide risk.<sup>xc</sup> Research suggests that developing and building protective factors may, in fact, have an even greater impact on addressing suicide among Native youth than attempts to solely reduce or treat commonly cited risk factors.<sup>xc1</sup> The literature most commonly highlights the following protective factors:

- Easily accessible services,
- Life satisfaction,
- Self-esteem and self-efficacy,
- Positive mood and emotional health,
- Family support and connectedness,

- Parental prosocial norms,
- Ability to communicate openly with family or peer networks,
- Training in problem-solving and/or conflict and dispute resolution,
- Academic achievement,
- Supportive peer group,
- Sense of connection to community,
- Spirituality or formal religion, and
- Enculturation/a sense of connection to culture.

### **Incorporation of Native Culture and Worldview**

Building on the idea that culture can serve as a protective factor, successful intervention and prevention programming for Native youth reflects an understanding of the needs and issues of youth as defined by youth and the community from which they come.<sup>xcii</sup> They also demonstrate an awareness of and respect for spiritual beliefs, Native perceptions, and experiences of the world or community and their connection to it.<sup>xciii</sup> For example, one study highlighted the frequent Native worldview that links healing, wellness, and treatment to one's physical place and space. In this way, strategies to address suicide must be framed within a detailed understanding of the tribal connection to the land and its impact on the processes through which healing can take place.<sup>xciv</sup> Therefore, suicide reduction strategies must be based on a comprehensive understanding of the unique history and cultural norms and values of the Native community being served.<sup>xcv</sup> Subsequently, strategy design, implementation, and evaluation must actively include community members.<sup>xcvi</sup>

### **Collaborative Researcher-Provider-Tribal/Urban Indian Partnerships**

Accurate identification of and efforts to address the unique needs of a particular tribal or urban Indian community over time indicate a successful collaborative relationship between researchers, providers, and tribal or urban Native communities. This relationship is based on a foundation of trust and an equal and open exchange of information, beliefs, and personal values. It is marked by respect for tribal history and diverse community customs, values, and practices where actions can take place without judgement or fear of betrayal. It also reflects a respect for indigenous research frameworks and ways of knowing where engagement with the community promotes productive, sustainable, community-based change.<sup>xcvii</sup>

### **Consideration of Current and Historical Trauma**

Finally, much of the literature emphasizes the necessity for the recognition and awareness of current and historical trauma when attempting to address suicide with Native populations, particularly with Native youth.<sup>xcviii</sup> Given the complex interaction between the social determinants of health and social and historical history of a given community, such understanding is critical when developing targeted health initiatives.<sup>xcix</sup> This understanding should encompass the trauma suffered, as well as traditional ways of experiencing and healing from such considerable grief and

loss.<sup>c</sup> For Native youth, this acknowledgement and inclusion provides an opportunity to understand their identities and personal experiences within a larger historical- and community-encompassing framework. This opportunity allows youth to connect their present and future identities to the past, which can build their abilities to overcome hardship and maintain their mental and emotional health.<sup>ci</sup>

## Recommended Strategies for Successful Programs and Interventions

### Summary

Just as research and practice have identified specific elements that work in suicide prevention and intervention for Native youth, research and practice also show **many examples of how these elements can be implemented**. This section takes each element that works from the previous section and gives concrete ways to implement the element with **program examples and citations** for each one.

This section provides an overview of the specific strategies highlighted in the literature for successful suicide prevention and intervention program design. These recommendations should be perceived as best practices to be considered when incorporating the previously discussed promising elements into a suicide prevention and intervention plan.

### Strategies for Early and Continuous Intervention

- Increase service availability by making treatment and intervention services available through other avenues, such as schools or telehealth networks and systems.<sup>cii</sup>
- Develop and implement community-wide plans and collaborative efforts to address suicide, identifying available and needed activities, outreach, and resources early in the process. This process should include input obtained from and collaboration with elected tribal leaders and various departments and organizations (e.g., police, schools, IHS, emergency medical services, religious leaders, tribal elders, spiritual and cultural leaders, and behavioral health systems).<sup>ciii, civ</sup>
- Provide training and education for law enforcement, schools, mental health professionals, and other community members to increase suicide awareness and skills in identifying and assisting at-risk youth.<sup>cv</sup>
- If possible, develop and implement a tribal mental health code that specifies the roles and responsibilities of different agencies responding to at-risk youth, or develop a centralized reporting system to accurately capture data on completed or attempted suicides.<sup>cvi</sup>
- When and where possible, restrict Native youth's access to lethal means, such as firearms, certain prescription drugs, etc.<sup>cvii</sup>

### Strategies for Identifying and Addressing Co-occurring Issues

- Utilize an integrated treatment approach that includes coordination between treatment philosophy, prevention and treatment services, and intervention timing.<sup>cviii</sup>
- Increase understanding of how suicide is viewed by community members and informed by traditional knowledge, rather than limiting definitions to technical or standard practice interpretations.<sup>cix</sup>

### Strategies for Supporting Tribal and Urban Indian Development of a Suicide Reduction Program

- Increase funding and technical support for tribal and urban Indian center-based suicide reduction programs, including evaluation resources and budget allowances for culture- and tradition-based activities.<sup>cx</sup>
- At the federal and state levels, increase financial resources for Native mental health services, particularly in urban areas. Consideration should also be given to federal, state, or private organizational funding to support community-based events and activities, like sponsoring food purchases for an event or supporting culturally based gift-giving traditions.<sup>cxii</sup>
- Increase funding available to areas with a demonstrated greater need, specifically by rates of completed or attempted suicide, rather than by population size alone.<sup>cxii</sup>

### Strategies for Utilizing a Strengths-Based Approach

- Train program staff to increase their awareness, understanding, and the use of a strengths-based approach.<sup>cxiii</sup>
- Develop and implement positive activities and centers for youth focused on building resilience and overcoming obstacles instead of focusing exclusively on suicide education.<sup>cxiv</sup> Allow youth who are seeking services to set their own treatment goals and encourage youth involvement in extra-curricular, community, and service-based activities as integral components of the program.<sup>cxv</sup>
- Utilize positive family relationships and social support as protective assets when working with Native youth. To this end, it is important to promote a culture of mutual support between youth in need of services and the community at large.<sup>cxvi</sup>

### Incorporate Native Culture and Traditional World Views

- Adapt mainstream intervention approaches to grieving and recovery by integrating traditional Native values and healing methods to ensure the development and implementation of culturally relevant and appropriate strategies. For example, the particular spiritual and cultural components of a given community must be included as program components.<sup>cxvii</sup>
- Utilize Indigenous perspectives and methodologies when researching or addressing mental health issues experienced by Native youth.<sup>cxviii</sup> Consider expanding the definition of suicide

prevention to include goals, objectives, and perspectives of health and wellbeing that extend beyond increased access to clinical services or community outreach.<sup>cxi</sup>

- Incorporate traditional healing models and ceremonies where appropriate. For example, consider using storytelling; talking circles; sweat lodges; ceremonies and rituals; or drumming, singing, or dancing ceremonies to engage youth and promote healing. Improve access to traditional healers and healing practices.<sup>cx</sup>

### Strategies for Developing Collaborative Relationships

- Actively include and engage community members in the design, implementation, and evaluation of all suicide prevention and intervention activities. Form an advisory group made up of community representatives—including elders, tribal or community leaders, natural helpers, and youth—to give the community a voice in every stage of the strategic planning or program development process.<sup>cxxi</sup>
- Improve collaboration and coordination between state and federal agencies, tribes, and urban Indian centers. These efforts have the potential to benefit Native communities by increasing awareness of available resources and how to access them and providing access to current technical assistance and prevention tools that could be used in the community.<sup>cxxii</sup>
- Increase collaborative efforts to develop services and collect data for tribal and urban Indian communities. These efforts include providing tribal and urban Indian partners with resources and training on effective evaluation, its purpose, how to develop and implement an evaluation plan, and how to use evaluation findings. These efforts would improve the quality and accuracy of data related to suicide and suicide-risk specific to Native populations and help tribes or urban Indian centers better evaluate their own suicide prevention programs.<sup>cxxiii</sup>
- Support the use of indigenous research methods and research approaches that engage and empower Native communities, such as community-based participatory research. Strong, collaborative research community partnerships can promote Native perceptions of mental health and wellbeing among mainstream research and funding circles.<sup>cxxiv</sup>

### Strategies for Building Awareness and Incorporating Current and Historical Trauma

- Increase knowledge and understanding of the historic experience of Native communities and subsequent impact this experience may have on their current health status and health-seeking behavior. Include education on current and historical trauma as a central component of staff training to improve cultural competency. Explore variations in the lingering negative impacts of colonization and its consequences across different local Native communities.<sup>cxxv</sup>
- Provide support specifically designed for suicide survivors. Include survivors in suicide prevention efforts, possibly allowing survivors to serve as mentors for identified at-risk youth.<sup>cxxvi</sup>
- Consider utilizing a trauma-informed approach when working with Native youth, which emphasizes provider and survivor safety on physical, psychological, and emotional levels with

the goal of providing survivors with opportunities to regain a sense of control and empowerment while avoiding re-experiencing trauma.<sup>cxxvii, cxxviii</sup>

## Examples in Practice: Profiles of Programs and Trainings

### Summary

Suicide prevention and intervention programs and trainings are already at work in the state of Montana. Some are specific to Native youth and communities, some can be tailored to fit specific communities, and some are designed for anyone and everyone. This section profiles **eight existing programs**, describing their distinct features and activities, identifying resources and technical assistance available, and asking questions to consider about how they might be implemented in community, tribal, or urban Indian settings in Montana.

To gain a sense of how these elements and strategies work in a real-life context, it is important to look at examples of programs, trainings, and intervention models currently at work. The profiles in this section offer a concise snapshot of Native youth suicide prevention and intervention efforts currently underway in the state of Montana. A brief overview of these efforts, including their distinct features and activities, provides a foundation for additional discussion about the potential for implementing these trainings and programs in different tribal and urban Indian communities; the possible impact (positive or negative) on attempted and completed suicide rates for Native youth; and any additional resources, modifications, or technical assistance that would be required to utilize these efforts in a given community.

## ASIST: Applied Suicide Intervention Skills Training

### Description

Applied Suicide Intervention Skills Training (ASIST) is designed for anyone age 16 years or older. The training targets everyday individuals, as family and friends are often the first to identify persons at risk for suicide, but lack the skills and knowledge to respond effectively.<sup>cxxix</sup> Consequently, ASIST is based on the principle that “everyone can make a difference in preventing suicide.”<sup>cxxx</sup> The program provides training in suicide first aid, focusing on identifying persons at risk, helping them stay safe, seeking further help, and following up. ASIST encourages participants to actively engage in community networks related to suicide prevention.

### Example Strategies and Activities

- ASIST training is provided during a 2-day session (15 hours total) by registered trainers.
- The learning process is highly participatory and includes lectures, facilitated discussions, group simulations, and role plays.
- An ASIST workshop includes networking, identifies local resources, and discusses resource availability in each community.
- ASIST is a more advanced training designed to complement the introductory safeTALK program.
- Training for trainers is also available to become a registered ASIST trainer.

### Cultural Components

- ASIST is a Western/mainstream intervention that is widely used in many settings.
- ASIST can be part of a broader, more culturally based intervention and has been used by Native communities (including grantees in tribal programs like Native Connections).

### Additional Considerations

- ASIST training can be provided to anyone (i.e., youth or adults).



### Applying It in Montana: Issues to Consider

- Are resources available to support the training (e.g., is space available and can participants take part in a 2-day process)?
- Will community perceptions of suicide dissuade individuals from taking part in the training?
- How will participant recruitment take place?
- Is follow-up training available if needed?
- Does the training curriculum reflect Native community perceptions of risk, health, and wellbeing?
- Does the training provide strategies and supports to evaluate the impact of the training on the community?

#### Visit the Website

<https://www.livingworks.net/programs/asist/>

## safeTALK

safeTALK trainings are designed for anyone age 15 years or older. It stresses suicide alertness and helps participants challenge the taboos that prevent people from talking openly about suicide.<sup>cxvxi</sup> safeTALK works to combat societal beliefs that can cause caring people to miss, dismiss, or avoid signs of suicide. “safe” stands for “suicide alertness for everyone,” while “TALK” stands for “Tell, Ask, Listen, and KeepSafe.” Trainers emphasize the importance of connecting people at risk for suicide with community resources.



### Example Strategies and Activities

- safeTALK training is offered in one half-day session (2 ½ to 3 ½ hours) by registered trainers and a community resource person who helps recommend local resources for persons at risk.
- safeTALK is an introductory program designed to complement the more advanced ASIST program.
- safeTALK training for trainers is available.

### Cultural Components

- safeTALK has been used worldwide in over 200 countries.
- safeTALK can be part of a broader, more culturally based intervention and has been used by Native communities (including grantees in tribal programs like Native Connections).

### Additional Considerations

- Training can be provided to youth or adults.
- safeTALK focuses on suicide awareness and talking openly about suicide, challenging the stigma around speaking about suicide directly.

### Applying It in Montana: Issues to Consider

- Does the community have access to the necessary resources to provide training (e.g., is space available)?
- How will participant recruitment (particularly youth) take place?
- Is follow-up training available if needed?
- Does the training curriculum reflect Native community perceptions of risk, health, and wellbeing?
- Does the training provide strategies and supports to evaluate the impact of the training on the community?

### Visit the Website

<https://www.livingworks.net/programs/safetalk/>

## QPR: Question Persuade Refer Gatekeeper Training

The Question, Persuade, Refer (QPR) intervention is designed for use by many people in a given community. QPR trains people to serve as gatekeepers to help them recognize the signs of suicide and direct someone in crisis to proper sources of care. While anyone can be a gatekeeper, specialized training is available for people in specific roles, like school health workers.



### Example Strategies and Activities

- QPR training is short and can be completed in as little as 1 hour. More in-depth trainings are also available.
- Training is available to become a certified QPR trainer to then provide training to others.
- Specialized trainings are available for law enforcement, emergency medical responders, firefighters, doctors, physician’s assistants, nurses, school health workers, student volunteers, veterans, and others.

### Cultural Components

- QPR is a Western/mainstream intervention that is used in many settings to provide gatekeeper training to individuals and organizations.
- Many tribes have used QPR as a training component of other culturally based suicide prevention grants, such as the Methamphetamine and Suicide Prevention Initiative or Native Connections.

### Additional Considerations

- QPR trainings can be specialized for targeted groups, like youth or adults in any role in the community.

### Applying It in Montana: Issues to Consider

- Does the community have access to the necessary resources to provide training (e.g., is space available)?
- Is the length of time enough to effectively educate and train gatekeepers for your particular community?
- How will participant recruitment take place?
- Is follow-up training available if needed?
- Does the training curriculum reflect Native community perceptions of risk, health, and wellbeing?
- Does the training provide strategies and supports to evaluate the impact of the training on the community?

#### Visit the Website

<https://www.qprinstitute.com/>

### Circles of Care

Circles of Care (CoC) provides tribal and urban Indian communities with tools and resources to design holistic, community-based systems of care to support mental health and wellness in tribal and urban Indian communities.<sup>cxxxii, cxxxiii</sup>

CoC focuses on building mental health systems, and each 3-year grant must be designed to increase access to and capacity of mental health services for children, youth, and families.<sup>cxxxiv</sup> The program is funded by the Substance Abuse and Mental Health Service Administration (SAMHSA).



### Example Strategies and Activities

- CoC grantees must focus on planning and developing infrastructure and building local capacity for mental health, substance misuse prevention, and wellness services.
- Grantee approaches should emphasize cross-system collaboration, including family, youth, and community resources, and use culturally relevant approaches.
- Grant funds cannot be used to provide direct care.

### Cultural Components

- The CoC grant program and the Native Connections program are the only SAMHSA grant programs specifically designed for Native communities. There is no competition from states, counties, or cities for these funds.
- CoC strategies are designed to reduce stigma about mental health care and increase cultural competency throughout all of a community's systems.

### Additional Considerations

- CoC is a grant program, which requires a successful application.

### Applying It in Montana: Issues to Consider

- Are resources available to develop and submit a successful COC grant application?
- Would the proposed plan have the full support of and buy-in from the various tribal/urban Indian departments, agencies, and leadership?
- Is non-direct service mental health development a priority within the tribe or urban Indian community?
- Can crucial components of the proposed plan be sustained without grant funding?

#### Visit the Website

[https://www.samhsa.gov/  
tribal-ttac](https://www.samhsa.gov/tribal-ttac)

## Native Connections

Native Connections offers 5-year grants to Native communities that are funded by the Substance Abuse and Mental Health Service Administration (SAMHSA) to identify and address behavioral health needs using sustainable strategies. The



program seeks to prevent and reduce suicide and substance misuse with Native youth (up to the age of 24), promote mental health, and address the impact these issues have on Native communities. Native Connections uses a collaborative, inter-agency public health approach. As of 2016, there are 20 Native Connections grantees.<sup>CXXXV</sup>

## Example Strategies and Activities

- Native Connections allows grantees to address their community’s most urgent priorities, whether they are suicide prevention, substance misuse, mental health and wellness promotion, or a combination of the three.
- Grantees receive technical assistance on community readiness, strategic action planning, service delivery system mapping (identifying strengths and weaknesses in the current community infrastructure), postvention, and Native youth development.
- Native Connections focuses on collaboration across many sectors, including tribal government; youth, health, and behavioral health organizations; and more.

## Cultural Components

- Each Native Connections grantee can design their prevention efforts to incorporate their chosen cultural and community elements.
- Native Connections and Circles of Care are the only SAMHSA grant programs specifically for Native communities with no competition from states, counties, or cities.

## Additional Considerations

- Native Connections is a grant program, which requires a successful application.

### Applying It in Montana: Issues to Consider

- Are resources available to develop and submit a successful grant application?
- Can crucial components of the proposed plan be sustained without grant funding?
- Would the proposed plan have the full support of and buy-in from the various tribal or urban Indian departments, agencies, and leadership?

#### Visit the Website

<http://www.samhsa.gov/native-connections>

## MSPI: The Methamphetamine and Suicide Prevention Initiative

The Indian Health Service (IHS) has funded the Methamphetamine and Suicide Prevention Initiative (MSPI) grant program since 2009. MSPI offers grantees access to resources, including evaluation training, technical assistance on grant management, and information and guidance on best practices focused on culture, suicide prevention, and youth. Grantees apply for funding under one of four program areas: (1) community and organizational needs assessment and strategic planning; (2) suicide prevention, intervention, and postvention; (3) methamphetamine prevention, treatment, and aftercare; and (4) generation indigenous initiative support. As of 2016, IHS funds 156 MSPI grants across the country, with 10 in the Billings, MT, area alone.<sup>cxxxvi</sup>



### Example Strategies and Activities

- MSPI provides funding and support to IHS, tribal, and urban Indian grantees to implement their own prevention and treatment activities.
- MSPI focuses on the implementation of evidence-based and practice-based models.
- Grantees choose their areas of focus, strategies, and activities.

### Cultural Components

- Each MSPI grantee can design their prevention efforts to incorporate their chosen cultural and community elements.
- MSPI emphasizes culturally appropriate prevention and treatment approaches from a community-driven context.

### Additional Considerations

- MSPI is a grant program, which requires a successful application.

### Applying It in Montana: Issues to Consider

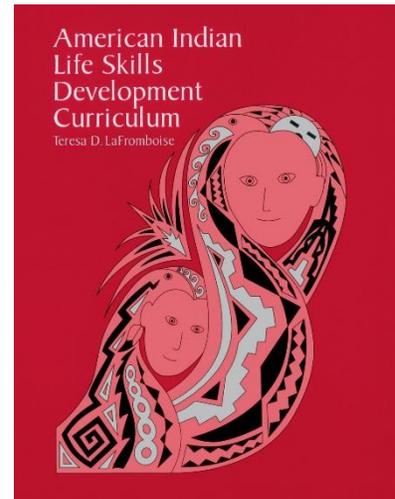
- Are resources available to develop and submit a successful MSPI grant application?
- Can crucial components of the proposed plan be sustained without grant funding?
- Would the proposed plan have the full support of and buy-in from various tribal or urban Indian departments, agencies, and leadership?
- What are the repercussions if circumstances force a grantee to significantly modify the originally proposed plan?

#### Visit the Website

<https://www.ihs.gov/mspi/>

## AILS: The American Indian Life Skills Development Curriculum

American Indian Life Skills (AILS) was developed from the Zuni Life Skills Development Program. The Zuni Tribe created this intervention program in the late 1980s in response to a sharp increase in Native youth suicide on the tribe’s reservation. The AILS framework focuses on seven main themes: (1) building self-esteem, (2) identifying emotions and stress, (3) increasing communication and problem-solving skills, (4) recognizing self-destructive behavior and finding ways to eliminate it, (5) learning information about suicide, (6) helping a suicidal friend get help, and (7) planning ahead for a great future.<sup>cxxxvii, cxxxviii, cxxxix</sup>



### Example Strategies and Activities

- AILS is designed to be taught in 28 to 56 lesson plans, the curriculum is typically delivered over 30 weeks in the school year.<sup>cxl</sup>
- The curriculum focuses on modeling and teaching youth social and problem-solving skills.
- AILS helps youth replace negative coping strategies with prosocial and problem-solving behaviors.
- AILS addresses risks and protective factors that are shared between suicide and substance misuse.

### Cultural Components

- The AILS curriculum is designed for tribes and communities to tailor it to their own cultures, needs, traditions, and values within the tribal context.<sup>cxli, cxlii</sup>

### Additional Considerations

- A curriculum can be purchased and potentially implemented at middle schools or high schools.

### Applying It in Montana: Issues to Consider

- Does the tribe have the necessary financial resources? Curriculum materials must be purchased to access training and support resources.
- Can the school system support the comprehensive implementation of the AILS curriculum (e.g., is there enough available staff and time in the school calendar to accommodate training)?

#### Visit the Website

<https://uwpress.wisc.edu/books/0129.htm>

#### Additional information

Suicide Prevention Resource Center:  
<http://www.sprc.org/resources-programs/american-indian-life-skills-developmentzuni-life-skills-development>

## Zero Suicide: In Health and Behavioral Health Care

Zero Suicide prescribes that suicide deaths are preventable within health and behavioral health systems. The Zero Suicide framework recognizes that suicide individuals are not adequately treated in available health care systems. Zero Suicide requires a systematic commitment to improve outcomes and close gaps.



Zero Suicide follows seven elements of suicide care: (1) Lead – leadership driven, (2) Train – develop workforce competency, (3) Identify – recognize at-risk individuals, (4) Engage – create pathways to care, (5) Treat – use evidence-based treatment, (6) Transition – provide continuous support, and (7) Improve – use data to improve processes.<sup>cxliii</sup>

### Example Strategies and Activities

- Zero Suicide recommends using the Zero Suicide Toolkit to assist in the implementation process.
- The 2-day Zero Suicide Academy trains leadership to incorporate best practices into organizations or develop action plans.
- Zero Suicide provides a work plan template, data worksheet, workforce survey, and organizational self-study documents.
- Zero Suicide asks for communities to review and develop processes and policies for screening, assessment, risk formulation, treatment, and care transition.<sup>cxliv</sup>

### Cultural Components

- Zero Suicide is designed for communities or organizations to adopt the approach as needed to provide suicide care.

### Additional Considerations

- Zero Suicide provides every resource needed for beginning implementation on their website and offers technical assistance through the Suicide Prevention Resource Center.

### Applying It in Montana: Issues to Consider

- Does the tribe have the necessary financial resources? Zero Suicide Academy training has fees and materials that will need to be purchased.
- Can the tribes garner enough leadership buy-in to implement Zero Suicide, as it is a system-wide model?
- Can the tribes gain health care system staff buy-in to carry out the new activities?
- Are there enough funds available to conduct the surveys and self-study documents linked to the Zero Suicide model?
- Can enough staff commit to being on the Zero Suicide Team for implementation?

#### Visit the Website

<http://zerosuicide.sprc.org/about>

## Conclusion

Suicide among Native youth has reached a crisis point. Findings from literature illustrate the staggering rate at which Native children, teens, and young adults—particularly youth in Montana—experience suicide ideation, attempts, and completion. These numbers are rooted in complex individual-, family-, school-, and community-level issues, as well as in the lingering deleterious effects of historical, intergenerational, and personal trauma. Efforts to address this issue face considerable hurdles. These barriers relate to meeting the wide and varied needs of heterogeneous tribal and urban Indian populations, fear and stigma surrounding the topic of suicide and mental health, the unique characteristics of Native youth that make it difficult to assess risk using standard measures, services that often fail to consider the impact of current and past trauma, and additional issues raised by co-occurring mental health disorders.

Yet, despite these findings, there is hope. Research points to a long list of factors that show great promise in helping tribal and urban Indian communities reduce and prevent suicide among their youth. These factors include early and continuous interventions that focus on individual, family, and community wellbeing and development; efforts to develop intervention and treatment strategies capable of addressing co-occurring issues; and increasing efforts to utilize a strengths-based approach to build a protective foundation for Native youth. Additional factors include recognizing the need to incorporate Native culture and traditional world views into suicide prevention and intervention strategies; focusing on reaching across the table to form successful collaborative partnerships between tribes and urban Indian communities, researchers, and program providers; and finally acknowledging the lingering effects of current and historical trauma and including consideration of these impacts in the design of suicide reduction strategies.

The literature also highlights numerous strategies that hold promising potential for addressing Native youth suicide in Montana and across Indian Country. While too numerous to list here, highlights of these findings include developing and implementing community-wide plans and collaborative efforts to address suicide; expanding definitions of suicide to encompass culturally and spiritually defined perspectives; engaging community members in the design, implementation, and evaluation of suicide treatment and intervention plans; and utilizing a trauma-informed approach to support and protect those in need of care. A range of training and grant programs in Montana currently utilize some of these elements in strategies, including the AILS Development Curriculum; ASIST, QPR, and safeTALK trainings and CoC, Native Connections, and MSPI grant funding. Zero Suicide is another model that is gaining momentum in approval and support across organizations, including the Indian Health Service. By examining the findings from the literature and the lessons from these examples currently in practice, it is possible for state, tribal, and urban Indian stakeholders to develop an effective strategic plan to target the rates of suicide currently experienced by Native youth in Montana.

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<sup>i</sup> Wexler, L., Chandler, M., Gone, J. P., Cwik, M., Kirmayer, L., LaFromboise, T., ... & Allen, J. (2015). Advancing suicide prevention research with rural American Indian and Alaska Native populations. *American Journal of Public Health, 105*(5), 891-899. doi:10.2105/AJPH.2014.302517

<sup>ii</sup> Ballard, E., Musci, R., Tingey, L., Goklish, N., Larzelere-Hinton, F., Barlow, A., & Cwik, M. (2015). Latent class analysis of substance use and aggressive behavior in reservation-based American Indian youth

- 
- who attempted suicide. *American Indian and Alaska Native Mental Health Research*, 22(1), 77-94. doi:10.5820/aian.2201.2015.77
- iii Indian Health Service. (2014). *Trends in Indian health: 2014 edition*. Washington, DC: Government Printing Office. Retrieved from the Indian Health Service, Division of Program Statistics website: [ihs.gov/dps/includes/themes/newihstheme/display\\_objects/documents/Trends2014Book508.pdf](https://www.ihs.gov/dps/includes/themes/newihstheme/display_objects/documents/Trends2014Book508.pdf)
- iv Goodkind, J. R., Gorman, B., Hess, J. M., Parker, D. P., & Hough, R. L. (2015). Reconsidering culturally competent approaches to American Indian Healing and well-being. *Qualitative Health Research*, 25(4), 486-499. doi:10.1177/1049732314551056
- v Burrage, R., Gone, J., & Momper, S. (2016). Urban American Indian community perspectives on resources and challenges for youth suicide prevention. *American Journal of Community Psychology*, 58(1-2), 136-149. doi:10.1002/ajcp.12080
- vi Bolton, S., Elias, B., Enns, M., Sareen, J., Beals, J., Novins, D., the Swampy Cree Suicide Prevention Team, & AI-SUPERPPF Team. (2013). A comparison of the prevalence and risk factors of suicidal ideation and suicide attempts in two American Indian and a general population sample. *Transcultural Psychiatry*, 51(1), 3-22. doi:10.1177/1363461513502574
- vii LaFromboise, T., & Malik, S. (2016). A culturally informed approach to American Indian/Alaska Native youth suicide prevention. In N. Zane, G. Bernal, & F. Leong (Eds.), *Evidence-Based Psychological Practice with Ethnic Minorities: Culturally Informed Research and Clinical Strategies* (p. 223-245). Washington, DC, US: American Psychological Association.
- viii LaFromboise & Malik, 2016.
- ix Friesen, B., Cross, T., Jivanjee, P., Thirstrup, A., Bandurraga, A., Gowen, L., & Rountree, J. (2015). Meeting the transition needs of urban American Indian/Alaska Native youth through culturally based services. *The Journal of Behavioral Health Services & Research*, 42(2), 191-205. doi:10.1007/s11414-014-9447-2
- x Burrage et al., 2016.
- xi Wexler et al., 2015.
- xii Bolton et al., 2013.
- xiii Montana Department of Public Health and Human Services (DPHHS). (2016). *Montana Strategic Suicide Prevention Plan 2017*. Retrieved from <https://dphhs.mt.gov/Portals/85/suicideprevention/StateSuicidePlan2019.pdf>
- xiv DPHHS, 2016.
- xv Centers for Disease Control and Prevention (CDC) Web-based Injury Statistics Query and Reporting System™ (WISQARS) (<https://www.cdc.gov/injury/wisqars/>); DPHHS, 2016.
- xvi Jiang, C., Mitran, A., Minino, A., & Ni, H. (2015). *Racial and Gender Disparities in suicide Among Young Adults Aged 18–24: United States, 2009–2013*. Retrieved from the CDC National Center for Health Statistics website: [http://www.cdc.gov/nchs/data/hestat/suicide/racial\\_and\\_gender\\_2009\\_2013.pdf](http://www.cdc.gov/nchs/data/hestat/suicide/racial_and_gender_2009_2013.pdf)
- xvii Burrage et al., 2016; Goodkind et al., 2015;

- 
- <sup>xviii</sup> Burrage et al., 2016
- <sup>xix</sup> U.S. Census Bureau. (2015). *American Indian and Alaska Native Heritage Month: November 2015* (Profile America Facts for Features: CB15-FF.22). Retrieved from [http://www.census.gov/content/dam/Census/newsroom/facts-for-features/2015/cb15-ff22\\_AIAN\\_month.pdf](http://www.census.gov/content/dam/Census/newsroom/facts-for-features/2015/cb15-ff22_AIAN_month.pdf)
- <sup>xx</sup> Gray, 2015. *Epidemic: Suicide in Indian Country* [PowerPoint Slides]. Retrieved from <https://ruralhealth.und.edu/assets/910-2962/100715-suicide-in-indian-country.pdf>
- <sup>xxi</sup> U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates
- <sup>xxii</sup> U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates
- <sup>xxiii</sup> Mackin, J., Perkins, T., & Furrer, C. (2012). The power of protection: A population-based comparison of Native and non-Native youth suicide attempters. *American Indian and Alaska Native Health Research*, 19(2), 20-54. doi:10.5820/aian.1902.2012.20.
- <sup>xxiv</sup> Burrage et al., 2016; Friesen et al., 2015; Goodkind et al., 2015; LaFromboise & Malik, 2016; Pettingell et al., 2008.
- <sup>xxv</sup> Pettingell et al., 2008.
- <sup>xxvi</sup> Executive Office of the President. (2014). *2014 Native Youth Report*. Retrieved from [https://obamawhitehouse.archives.gov/sites/default/files/docs/20141129nativeyouthreport\\_final.pdf](https://obamawhitehouse.archives.gov/sites/default/files/docs/20141129nativeyouthreport_final.pdf)
- <sup>xxvii</sup> Executive Office of the President, 2014.
- <sup>xxviii</sup> Andrew, M. (2014). The scarring effects of primary-grade retention? A study of cumulative advantage in the educational career. *Social Forces*, 93(2), 653–685. doi:10.1093/sf/sou074
- <sup>xxix</sup> U.S. Department of Education Office for Civil Rights. (2014). *Civil Rights Data Collection, Data Snapshot: College and Career Readiness* [Issue Brief No. 3]. Retrieved from the U.S. Department of Education website: <https://www2.ed.gov/about/offices/list/ocr/docs/crdc-college-and-career-readiness-snapshot.pdf>
- <sup>xxx</sup> Pettit, K., Kingsley, G. T., Biess, J., Bertumen, K., Pindus, N., Narducci, C., & Budde, A. (2014). *Continuity and change: Demographic, Socioeconomic, and Housing Conditions of American Indians and Alaska Natives*. Retrieved from the U.S. Department of Housing and Urban Development website: [https://www.huduser.gov/portal/publications/commdevl/housing\\_conditions.html](https://www.huduser.gov/portal/publications/commdevl/housing_conditions.html)
- <sup>xxxi</sup> Bureau of Indian Affairs. (2014). *BIA Tribal Transportation Program Update* [PowerPoint Slides]. Retrieved from <https://www.bia.gov/regional-offices/great-plains/indian-reservation-roads-program>
- <sup>xxxii</sup> U.S. Department of Transportation. (2013). *2013 Status of the Nation's Highways, Bridges, and Transit: Conditions & Performance*. Retrieved from the U.S. Department of Transportation, Federal Highway Administration's website: <http://www.fhwa.dot.gov/policy/2013cpr/pdfs/cp2013.pdf>

- xxxiii Salvador, J., Goodkind, J., & Ewing, S. (2016). Perceptions and use of community- and school-based behavioral health services among urban American Indian/Alaska Native youth and families. *American Indian and Alaska Native Mental Health Research*, 23(3):221-47. doi:10.5820/aian.2303.2016.221
- xxxiv Burrage et al., 2016.
- xxxv Substance Abuse and Mental Health Services Administration (SAMHSA). (2012). *The NSDUH Report: Need for and Receipt of Substance Use Treatment among American Indians or Alaska Natives*. Retrieved from <https://www.samhsa.gov/data/sites/default/files/NSDUH120/NSDUH120/SR120-treatment-need-AIAN.htm>
- xxxvi Dickerson, D., & Johnson, C. (2012). Mental health and substance abuse characteristics among a clinical sample of urban American Indian/Alaska Native youths in a large California metropolitan area: A descriptive study. *Community Mental Health Journal*, 48(1), 56–62. doi:10.1007/s10597-010-9368-3
- xxxvii Indian Health Service. (2011). *American Indian/Alaska Native Behavioral Health Briefing Book*. Washington, DC: U.S. Department of Health and Human Services. Retrieved from [ihs.gov/newsroom/includes/themes/newihstheme/display\\_objects/documents/2011\\_Letters/AIANBHBriefingBook.pdf](https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2011_Letters/AIANBHBriefingBook.pdf)
- xxxviii Pettingell, S., Bearinger, L., Skay, C., Resnick, M., Potthoff, S., & Eichhorn, J. (2008). Protecting urban American Indian young people from suicide. *American Journal of Health Behavior*, 32(5), 465–476. doi:10.5555/ajhb.2008.32.5.465
- xxxix Ballard et al., 2015.
- xl Erickson, J. (2013). *Practice Implications for Addressing Native American Youth Suicide: An integrative Review* (Master's thesis). Retrieved from <http://scholarworks.montana.edu/xmlui/bitstream/handle/1/2645/EricksonJ0513.pdf?sequence=1&isAllowed=y>
- xli Serna, P. (2011). *Adolescent Suicide Prevention Program Manual: A Public Health Model for Native Communities*. Newton, MA: Suicide Prevention Resource Center, Education Development Center, Inc. Retrieved from [sprc.org/sites/sprc.org/files/library/AdolescentSP\\_ProgramManuaPH\\_ModelNA\\_Communities.pdf](https://www.sprc.org/sites/sprc.org/files/library/AdolescentSP_ProgramManuaPH_ModelNA_Communities.pdf)
- xlii U.S. Department of Health and Human Services (HHS). (2010). *To Live to See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults*. Rockville, MD: Center for Mental Health Services, SAMHSA. Retrieved from [sprc.org/sites/sprc.org/files/library/Suicide\\_Prevention\\_Guide.pdf](https://www.sprc.org/sites/sprc.org/files/library/Suicide_Prevention_Guide.pdf)
- xliii HHS, 2010.
- xliv Erickson, 2013; HHS, 2010.
- xlv Ballard et al., 2015.
- xlvi Serna, 2011.
- xlvii Bolton, S., Elias, B., Enns, M., Sareen, J., Beals, J., Novins, D., the Swampy Cree Suicide Prevention Team, & AI-SUPERPPF Team. (2013). A comparison of the prevalence and risk factors of suicidal ideation and

---

suicide attempts in two American Indians and a general population sample. *Transcultural Psychiatry*, 51(1), 3-22. doi:10.1177/1363461513502574

xlviii Friesen et al., 2015

xliv Brave Heart, M., & DuBruyn, L. (1998). The American Indian holocaust: healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*, 8(2), 56–78. Retrieved from [ih.gov/telebehavioral/includes/themes/newihstheme/display\\_objects/documents/slides/historicaltrauma/historicaltraumaintro\\_011113.pdf](https://www.ih.gov/telebehavioral/includes/themes/newihstheme/display_objects/documents/slides/historicaltrauma/historicaltraumaintro_011113.pdf)

l Brave Heart, M., Elkins, J., Tafoya, G., Bird, D., & Salvador, M. (2012). Wicasa Was' aka: Restoring the traditional strength of American Indian boys and men. *American Journal of Public Health*, 102(S2), S177-S183. doi:10.2105/AJPH.2011.300511

li Grayshield, L., Rutherford, J., Salazar, S., Mihecoby, A., & Luna, L. (2015). Understanding and healing historical trauma: The perspectives of Native American elders. *Journal of Mental Health Counseling*, 37(4), 295-307. doi:10.17744/mehc.37.4.02

lii Ehlers, C., Gizer, I., Gilder, D., Ellingson, J., & Yehuda, R. (2013). Measuring historical trauma in an American Indian community sample: contributions of substance dependence, affective disorder, conduct disorder and PTSD. *Drug and Alcohol Dependence*, 133(1), 180–187. doi:10.1016/j.drugalcdep.2013.05.011

liii Walls, M. & Whitebeck, L. (2012). The intergenerational effects of relocation policies on indigenous families. *Journal of Family Issues*, 33(9), 1272–1293. doi:10.1177/0192513X12447178

liv LaFromboise & Malik, 2016; Walls & Whitebeck, 2012.

lv Burrage et al., 2016.

lvi Ehlers et al., 2013; LaFromboise & Malik, 2016.

lvii Sotero, M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. *Journal of Health Disparities Research and Practice*, 1(1), 93–108.

lviii CDC Injury Prevention & Control Division of Violence Prevention  
(<http://www.cdc.gov/violenceprevention/acestudy/index.html>)

lix LaFromboise & Malik, 2016.

lx Ballard et al., 2015.

lxi LaFromboise & Malik, 2016.

lxii Burrage et al., 2016.

lxiii Burrage et al., 2016; Jiang et al., 2015.

lxiv Burrage et al., 2016.

lxv Burrage et al., 2016.

lxvi HHS, 2010.

lxvii Burrage et al., 2016

lxviii HHS, 2010.

- 
- lxi Bolton et al., 2013.
  - lxx Burrage et al., 2016.
  - lxxi Bolton et al., 2013.
  - lxxii Ballard et al., 2015.
  - lxxiii Gary, F., Baker, M., & Grandbois, D. (2005). Perspectives on suicide prevention among American Indian and Alaska Native children and adolescents: A call for help. *Online Journal of Issues in Nursing, 10*(2), 6. doi:0.3912/OJIN.Vol19No02HirshPsy01
  - lxxiv Ballard et al., 2015.
  - lxxv Brave Heart, M. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs, 35*(1), 7–13. doi:10.1080/02791072.2003.10399988
  - lxxvi Burrage et al., 2016.
  - lxxvii Goodkind et al., 2015.
  - lxxviii Gary et al., 2005.
  - lxxix LaFromboise & Malik, 2016.
  - lxxx Gary et al., 2005.
  - lxxxi Goodkind et al., 2015.
  - lxxxii Ballard et al., 2015.
  - lxxxiii Wexler et al., 2015.
  - lxxxiv McMahan, T., Kenyon, D., & Carter, J. (2013). My culture, my family, my school, me: identifying strengths and challenges in the lives and communities of American Indian youth. *Journal of Child and Family Studies, 22*(5), 694-706. doi:10.1007/s10826-012-9623-z
  - lxxxv McMahan et al., 2013.
  - lxxxvi Ballard et al., 2015.
  - lxxxvii McMahan et al., 2013.
  - lxxxviii McMahan et al., 2013.
  - lxxxix Burrage et al., 2016; McMahan et al., 2013.
  - xc Pettingell et al., 2008; Mackin et al., 2012; LaFromboise & Malik, 2016; HHS, 2010; McMahan et al., 2013.
  - xcj Mackin et al., 2012.
  - xcii Salvador et al., (2016).
  - xciii Rink, E., Fourstar, K., Ricker, A., Runs-Above, W., & Meyers, A. (2016). Partnering with American Indian communities in strength-based collaborative health research: guiding principles from the Fort Peck ceremony of research project. *American Indian and Alaska Native Mental Health Research, 23*(3), 187-205. doi:10.5820/aian.2303.2016.187
  - xciv Goodkind et al., 2015.

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<sup>xcv</sup> LaFromboise & Malik, 2016.

<sup>xcvi</sup> Burrage et al., 2016; LaFromboise & Malik, 2016.

<sup>xcvii</sup> Rink et al., 2016; Wexler et al., 2015.

<sup>xcviii</sup> Brave Heart et al., 2012; Brave Heart & DuBruyn, 1998; Goodkind et al., 2015; LaFromboise & Malik, 2016; Rink et al., 2016; Friesen et al., 2015; HHS, 2010; Grayshield et al., 2015.

<sup>xcix</sup> Brave Heart et al., 2012.

<sup>c</sup> Brave Heart et al., 2012; Goodkind et al., 2015.

<sup>ci</sup> Friesen et al., 2015.

<sup>cii</sup> Salvador et al., 2016; Brave Heart et al., 2012.

<sup>ciii</sup> Kelley, A., BigFoot, D., Small, C., Mexicancheyenne, T., & Gondara, R. (2015). Recommendations from an American Indian reservation community-based suicide prevention program. *International Journal of Human Rights in Healthcare*, 8(1), 3-13. doi:10.1108/IJHRH-10-2013-0025

<sup>civ</sup> Sahota, P., & Kastelic, S. (2014). Tribally based suicide prevention programs: a review of current approaches. *Wicazo Sa Review*, 29(1), 77-99. doi:10.1353/wic.2014.0000

<sup>cv</sup> Sahota & Kastelic, 2014.

<sup>cvi</sup> Sahota & Kastelic, 2014.

<sup>cvi</sup> Sahota & Kastelic, 2014.

<sup>cviii</sup> Gray, 2015.

<sup>cix</sup> Kelley et al., 2015.

<sup>cx</sup> Sahota & Kastelic, 2014.

<sup>cx</sup> Burrage et al., 2016; Sahota & Kastelic, 2014.

<sup>cxii</sup> Sahota & Kastelic, 2014.

<sup>cxiii</sup> McMahan et al., 2013.

<sup>cxiv</sup> Sahota & Kastelic, 2014.

<sup>cxv</sup> McMahan et al., 2013.

<sup>cxvi</sup> Burrage et al., 2016.

<sup>cxvii</sup> Gary et al., 2005; Sahota & Kastelic, 2014.

<sup>cxviii</sup> Goodkind et al., 2015.

<sup>cxix</sup> Burrage et al., 2016.

<sup>cx</sup> Brave Heart et al., 2012; Burrage et al., 2016; Gray, 2015.

<sup>cx</sup> LaFromboise & Malik, 2016; Brave Heart et al., 2012; Kelley et al., 2015.

<sup>cxii</sup> Sahota & Kastelic, 2014.

<sup>cxiii</sup> Sahota & Kastelic, 2014.

<sup>cxiv</sup> Burrage et al., 2016; Sahota & Kastelic, 2014.

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- cxxv Brave Heart et al., 2012; Goodkind et al., 2015.
- cxxvi Sahota & Kastelic, 2014; HHS, 2010.
- cxxvii Clervil, R., & DeCandia, C. (2013). *Integrating and Sustaining Trauma-Informed Care across Diverse Service Systems*. Washington, DC: American Institutes for Research. Retrieved from [http://www.fredla.org/wp-content/uploads/2016/01/Tap-Trauma-informed-Systems-of-Care-Brief\\_092713\\_Ack.pdf](http://www.fredla.org/wp-content/uploads/2016/01/Tap-Trauma-informed-Systems-of-Care-Brief_092713_Ack.pdf)
- cxxviii DeCandia, C., Guarino, K., & Clervil, R. (2014). *Trauma-Informed Care and Trauma-Specific Services: A Comprehensive Approach to Trauma Intervention*. Washington, DC: American Institutes for Research. Retrieved from [http://www.air.org/sites/default/files/downloads/report/Trauma-Informed%20Care%20White%20Paper\\_October%202014.pdf](http://www.air.org/sites/default/files/downloads/report/Trauma-Informed%20Care%20White%20Paper_October%202014.pdf)
- cxxix Suicide Prevention Resource Center Applied Suicide Intervention Skills Training (<http://www.sprc.org/resources-programs/applied-suicide-intervention-skills-training-asist>)
- cxix LivingWorks Applied Suicide Intervention Skills Training (<https://www.livingworks.net/programs/asist/>)
- cxix safeTALK (<http://www.sprc.org/resources-programs/suicide-alertness-everyone-safetalk>)
- cxxii Garrett, et al., 2014.
- cxxiii Spicer, P., LaFramboise, T., Marstrom, C., Niles, M., West, A., Fehringer, K., & Sarche, M. (2012). Toward an applied developmental science for Native children, families, and communities. *Child Development Perspectives*, 6(1), 49-54. doi:10.1111/j.1750-8606.2011.00212.x
- cxxiv SAMHSA Circles of Care (<https://www.samhsa.gov/tribal-ttac>)
- cxxv SAMHSA Native Connections (<http://www.samhsa.gov/native-connections>)
- cxxvi Indian Health Service Methamphetamine and Suicide Prevention Initiative ([ihs.gov/mspi/includes/themes/newihstheme/display\\_objects/documents/mspiaward.pdf](https://www.ihs.gov/mspi/includes/themes/newihstheme/display_objects/documents/mspiaward.pdf))
- cxxvii *Demanding Results to End Native Youth Suicide: Hearing before the U.S. Senate Committee on Indian Affairs*, 114th Cong., 1 (2015).
- cxxviii Dickerson, D., & Johnson, C. (2012). Mental health and substance abuse characteristics among a clinical sample of urban American Indian/Alaska Native youths in a large California metropolitan area: A descriptive study. *Community Mental Health Journal*, 48(1), 56-62. doi:10.1007/s10597-010-9368-3
- cxxix LaFromboise, T., & Lewis, H. (2008). The Zuni Life Skills Development Program: A school/community-based suicide prevention intervention. *Suicide & Life-Threatening Behavior*, 38(3), 343-353. doi:10.1521/suli.2008.38.3.343
- cxl American Indian Life Skills Development/Zuni Life Skills Development (<https://www.sprc.org/resources-programs/american-indian-life-skills-developmentzuni-life-skills-development>)
- cxli Garrett, M., Parrish, M., Williams, C., Grayshield, L., Awe Agahe Portman, T., Torres Rivera, E., & Maynard, E. (2014). Invited commentary: Fostering resilience among Native American youth through therapeutic intervention. *Journal of Youth & Adolescence*, 43, 470-490. doi:10.1007/s10964-013-0020-8

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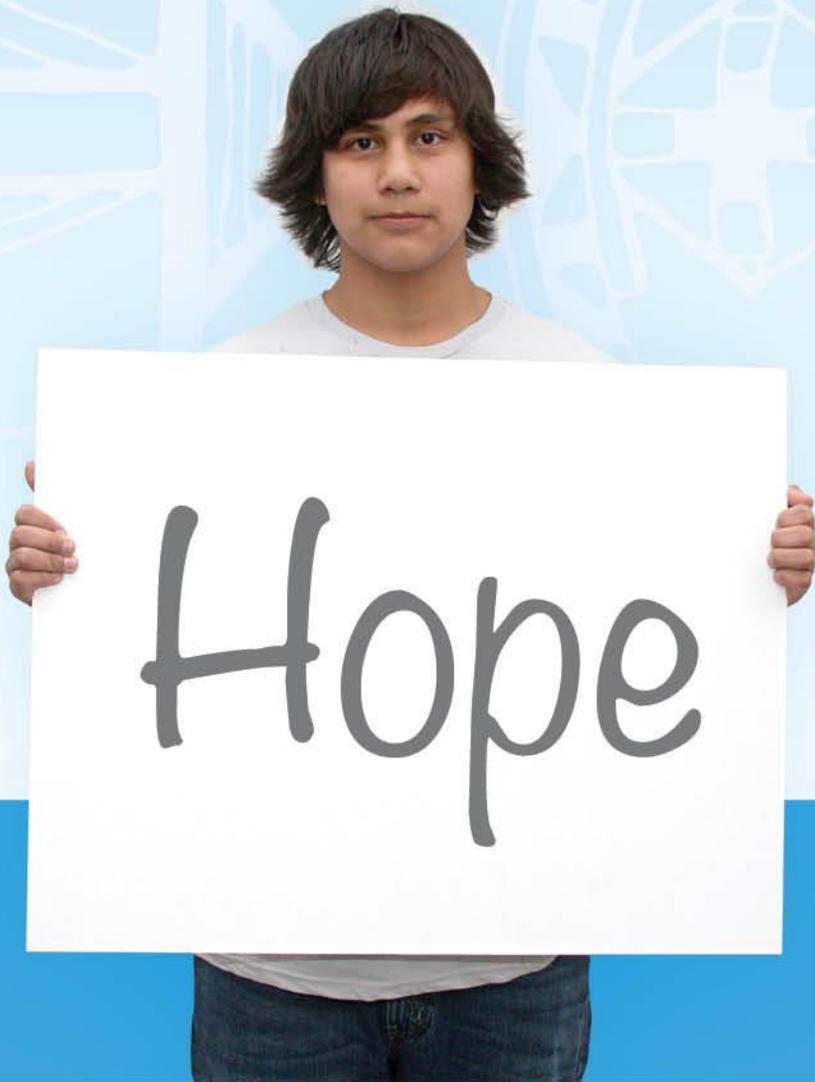
cxlii LaFromboise & Lewis, 2008.

cxliii Zero Suicide in Health and Behavioral Health Care (<http://zerosuicide.sprc.org>)

cxliv Quick Guide to Getting Started with Zero Suicide  
(<http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/Quick%20Guide%20to%20Getting%20Started%20with%20Zero%20Suicide.pdf>)

## **Appendix F. Insights Report on Native Youth Suicide Reduction**

# Insights Report on Native Youth Suicide Reduction



## Introduction

This report highlights the information learned about implementing an effective strategic plan to address Native youth suicide in Montana. Information was gleaned from meetings and key informant interviews with Montana Native Youth Suicide Prevention coalition (Coalition) members. Members include community members, Native youth, tribal leaders, and tribal health experts in Montana. Specifically, this report aims to:

- Identify critical elements of consideration for a strategic plan to reduce suicide, and
- Share insights provided by Native youth to address suicide among peers.

Findings in this document pull from meeting transcripts, written responses, and phone conversations with Coalition members. Information received from coalition members was used to develop a comprehensive strategic plan to address and prevent suicide among Native youth in Montana.

## Background

### Montana Native Youth Suicide Prevention Coalition

The Montana Department of Public Health and Human Services contracted with Kauffman & Associates, Inc., to form the Coalition in August 2016 to address the high Native youth suicide rate in Montana and develop a strategic plan. Each Montana tribe and urban Indian health organization nominated two members of the community—one at-large member and one Native youth representative. The Coalition consists of 26 members, and three alternate members.

The Coalition convened for a 2-day workshop in Helena, MT, November 2 through 3, 2016, to discuss and offer solutions to address Native youth suicide in the state. The workshop was open to the public, and several Montana organizations sent representatives. The Montana State Children’s Mental Health Bureau accepted the Coalition’s invitation to attend the workshop, as well. Given the nature of the meeting, non-coalition attendees were invited to participate in the strategic planning process, allowing for full participation from tribes, urban Indian health organizations, and the state.

### Helena Convening

The convening structure was designed to allow for members to have extensive and difficult discussions about suicide in Montana and share stories about their tribal communities. Given the sensitive nature of the topic, KAI hosted an opening gathering in Boulder, MT, to create an opportunity for members to meet each other. During the opening night, Lt. Governor Mike Cooney offered introductory words of encouragement to the members and stressed the importance of the work ahead in developing a much-needed strategic plan. He reiterated the Governor’s commitment to addressing and reducing suicide.

Lt. Governor Cooney’s remarks set the tone of inspiration and hope for the evening as KAI led members through dinner and icebreaker activities. A deep connectedness was developed during the first night as personal stories were shared of the extreme mark suicide leaves upon survivors, families, communities, and tribes. Coalition members recognized that their work was difficult, but critical.

The opening night’s break-through discussions allowed for an equally connective introduction session among Coalition members, members of the public, and state representatives on the first day of the convening. The powerful messages that each attendee brought to the meeting was present during the strategic planning sessions. The coalition members were able to champion the difficult task of brainstorming and identifying solutions that work for Montana tribes and bridge communications with Montana state and local communities to address suicide among Native youth.

## Addressing Native Youth Suicide in Montana

While Coalition members expressed doubt and skepticism about the State of Montana’s intent to sustain efforts in fulfilling the strategic plan, they were more hopeful that an effective plan is plausible if the right players are at the table during the plan’s development and implementation. The following insights were identified about effectively addressing Native youth suicide in Montana:

- Recognize culture- and practice-based interventions as being equal to evidence-based approaches. Coalition members cited that tribal traditions and practices are not necessarily documented within communities, labeled as treatment, or included in reports as tools used to address an issue.
- Implement Healing the Healer resources and support for program advocates. The level of pain and trauma in tribal communities is palpable and personal. People on the front lines who are personally connected to and invested in their work need Healing the Healer resources and support.
- Suicide prevention programs are often underfunded, and understaffed, which limits their reach to youth in need and their ability to network with programs outside of their communities. Moreover, programs offering the same services in different tribes and towns do not communicate with each other, creating a sense of isolation for the program leads. Connecting programs through a centralized portal will increase communication, prevent activity overlap, close outreach gaps to youth, and focus limited program funds.
- Coalition members identified several intervention programs that have been proven effective in their communities, including Question, Persuade, Refer (QPR); Training of Trainers (ToT) approaches; Applied Suicide Intervention Skills (ASIST); Services for Teens At Risk (STAR); safeTALK; Mental Health First Aid; and school-based programs like the Good Behavior Game.

- Data collection sources need to be developed to capture accurate records of suicide among youth. Many tribal programs do not have the tools to collect community data, nor do they have immediate access to available data sets. Coalition members stressed a need for a streamlined system to share information across organizations and develop tools for programs to begin collecting their own data.
- Coalition members discussed the influential role medical coroners have in categorizing the cause of death and race in official documents, which have led to the underreporting of Native youth suicide rates.
- Coalition members further agreed that spirituality is diverse and tied to all aspects of Native culture through dance, language, songs, and other traditional practices. Spirituality is too complicated to condense into a curriculum for youth. Instead, spirituality should be integrated into their daily activities to ensure that the youth are engaged and connected with their culture. For example, spirituality can be incorporated through blessings before activities begin. Tribal communities will need to commit to small gestures like this to provide more positive connections between youth and their culture.

### Including the Native Youth Voice

Coalition members unanimously agreed that the Native youth voice is imperative to successfully implement a strategic plan. Including Native youth is essential from the development stage, through to the planning and execution stages. Native youth need continual involvement well after a plan or program is in place, as well. During the Coalition’s convening, Native youth members voiced their opinions, recommendations, and visions for a strategic plan to provide hope for Native youth and provide them with a stronger sense of belonging to their culture:

- Create a safe space for Native youth in the schools and in the community. Youth require an environment where they can talk and share their stories with other youth or with an adult.
- Youth need to trust the schools. Tribes can train appropriate staff to respond to a diverse student body during emergencies or crises.
- Establish Native youth groups to allow youth to connect and engage with their peers during and after school.
- Increase Native youth’s access to cultural activities, like games, dances, and horses.
- Provide trauma education in public and tribal schools, like the STAR program.
- Create trauma-informed care centers in public and tribal schools and health facilities.
- Create an elder outreach campaign that welcomes youth to cultural activities or recognizes academic achievements.
- Establish youth-to-youth mentorship programs in public and tribal schools.

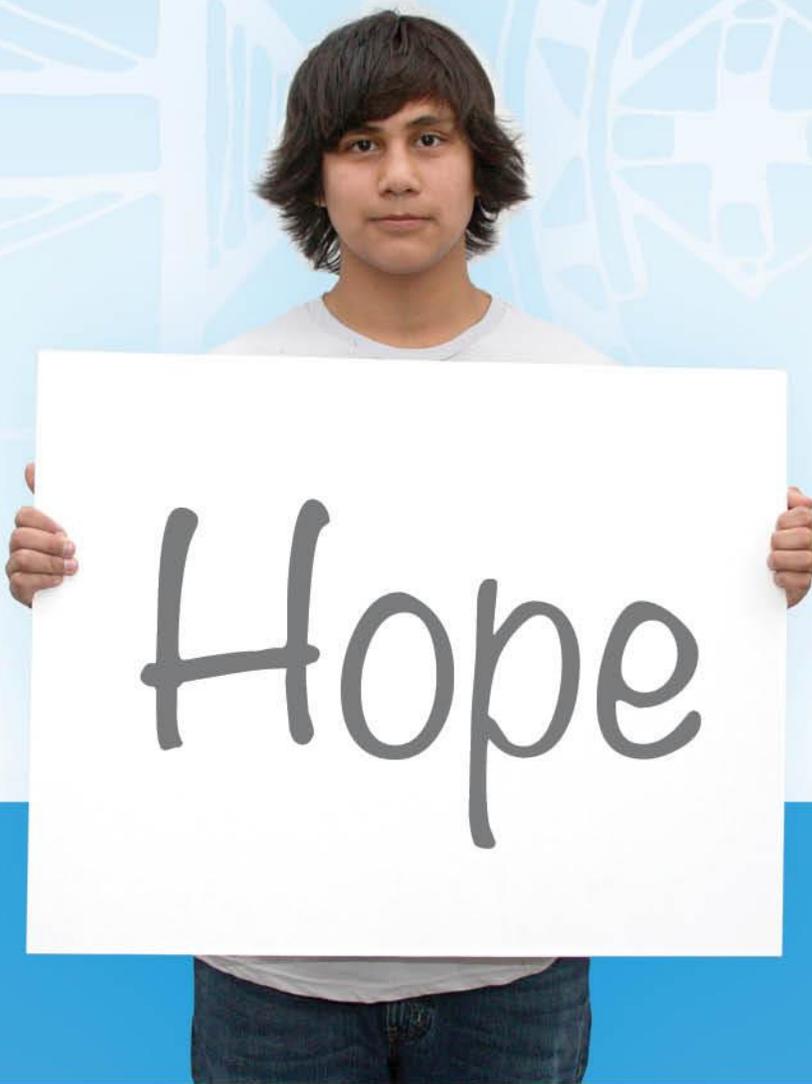
Youth coalition members stressed that youth need to feel wanted, valued, important, and supported by the community; when they feel welcomed it provides them with positive connections to their culture. Effective communication and engagement by the community will go a long way to reduce their feelings of isolation, pain, and hopelessness.

## Conclusion

These insights are inclusive of youth, family, community, tribal culture and spiritually, education, and key players. For this plan to have an impact, Coalition members emphasize the need to recognize, acknowledge, and honor Native culture and practices as being equally effective as western, mainstream academic approaches. The Coalition identified that Native youth have a role in reducing youth suicide among their peers and that youth need to be present during every phase of implementation from beginning to end. The Native youth voice is powerful and salient in calling out the challenges that thwart their peers most. These insights further call on all key players to commit to and genuinely fulfill their roles in implementing a strategic plan to effectively address the high Native youth suicide rate in the state of Montana.

## Appendix G. Native Youth Suicide Reduction Inventory of Funding Sources

# Native Youth Suicide Reduction Inventory of Funding Sources



## Introduction

The Native Youth Suicide Reduction Funding Sources Inventory provides collected information about federal, tribal, state, and private resources that offer grants, training and technical assistance, or other resources for youth suicide reduction. The inventory provides the program name, a brief description of the opportunity, and where to find more information (usually online contact information, such as a URL or an email address). Many funding sources are specifically offered for tribes and tribal programs. The sections below describe federal, state, and private sources for funding and technical assistance with a separate table for each. In addition to grants, tribal communities can use resources provided by federal, state, and private organizations to develop the infrastructure in their communities. Many resources are available to the public for free.

Identifying funding opportunities—particularly funding streams that are sustainable over time—is a challenge for many tribal programs. For many Montana tribes, grants are the bedrock support for programs that offer youth suicide reduction activities. Many Montana tribes receive federal grants to create suicide reduction programs, like the Methamphetamine and Suicide Prevention Initiative (MSPI) through the Indian Health Service (IHS). Currently, seven Montana tribes use an MSPI grant to sustain activities in their tribal communities to address substance use disorders and suicide reduction.

Despite the numerous sources for grant funding, even programs where funding is earmarked exclusively for tribal communities, grant funding does not provide a long-term or sustainable solution for supporting suicide reduction activities. The grant process itself has drawbacks that make it prohibitive and discouraging for tribes, including the limited award amounts available even when applications are successful, the strict time limits that grant funding places on programs, and application processes that create competition among tribes and communities for limited resources. Grant funding is also limited in utility when tribes are not aware of funding opportunities or lack the resources to devote to lengthy application and reporting requirements.

Federal, state, and private grant and training opportunities will continue to be offered to tribal communities to reduce suicide, as long as funding is available, and tribes should make use of these resources, as is practical for their communities. But long-term program sustainability will require tribal communities to identify opportunities to integrate suicide reduction activities into existing program structures and the ongoing daily efforts of tribal health programs and tribal community services. When existing tribal and urban Indian program structures can integrate suicide reduction activities into their current work routine, Montana tribes will be in a more sustainable position.

This inventory offers a limited solution to funding and sustainability issues that exist for Montana tribes in their suicide reduction efforts. It lists federal, state, and private funding and technical assistance sources to raise awareness about available resources. Tribes are encouraged to explore

how the resources, technical assistance, and funding streams can be integrated into their own larger efforts toward youth suicide reduction.

## Federal Resources and Funding

Agency	Summary of Program or Resource
<p><b>Centers for Disease Control and Prevention (CDC)</b></p>	<p><b>Division of Violence Prevention</b>            CDC's Division of Violence Prevention is committed to stopping violence, including suicide, before it begins. This program provides Training and Technical Assistance (TTA).  <a href="https://www.cdc.gov/violenceprevention/">https://www.cdc.gov/violenceprevention/</a></p> <hr/> <p><b>Youth Risk Behavior Surveillance System (YRBSS)</b>            CDC's YRBSS monitors health-risk behaviors, including suicidal behaviors, that contribute to the leading causes of death and disability among young people in the United States. This is a data resource.  <a href="http://www.cdc.gov/healthyouth/data/yrbs/index.htm">http://www.cdc.gov/healthyouth/data/yrbs/index.htm</a></p>
<p><b>U.S. Department of Health and Human Services (HHS), Administration for Children &amp; Families</b></p>	<p><b>Administration for Native Americans (ANA) Social and Economic Development Strategies (SEDS)</b>            ANA SEDS promotes social and economic self-sufficiency in communities. These competitive financial assistance grants support locally determined projects designed to reduce or eliminate community problems and achieve community goals.  <a href="https://www.acf.hhs.gov/ana/programs/seds">https://www.acf.hhs.gov/ana/programs/seds</a></p> <hr/> <p><b>ANA Native Youth Initiative for Leadership, Empowerment, and Development (I-LEAD)</b>            I-LEAD emphasizes a comprehensive, culturally appropriate approach to young Native peoples by fostering Native youth resilience, capacity building, and leadership. Native Youth I-LEAD specifically focuses on the implementation of community programs that foster protective factors, such as connections with Native languages and elders, positive peer groups, culturally responsive parenting resources, models of safe sanctuary, and reconnection with traditional healing. This program provides funding and training and technical assistance.  <a href="http://www.acf.hhs.gov/ana">http://www.acf.hhs.gov/ana</a></p>

Agency	Summary of Program or Resource
	<hr/> <p><b>ANA Language Preservation &amp; Maintenance (P&amp;M)</b> ANA believes preserving language will strengthen a community’s culture. Use of Native language builds identity and encourages communities to move toward social unity and self-sufficiency. P&amp;M provides funding and training and technical assistance. <a href="http://www.acf.hhs.gov/ana">http://www.acf.hhs.gov/ana</a></p> <hr/> <p><b>ANA Native American P&amp;M - Esther Martinez Immersion (EMI)</b> ANA P&amp;M EMI provides opportunities to assess, plan, develop, and implement projects that strengthen the vitality of Native languages. This grant was created after Congress passed the Esther Martinez Native American Languages Preservation Act to enact immersion and restoration programs. ANA want applicants to involve elders and other community members in project activities. <a href="http://www.acf.hhs.gov/ana">http://www.acf.hhs.gov/ana</a></p> <hr/> <p><b>ANA Sustainable Employment and Economic Development Strategies (SEEDS)</b> ANA supports economic development in Native communities through the provision of discretionary grants to tribal governments and Native-serving nonprofits to support the creation of employment opportunities, professional training and skill development, entrepreneurial activities, and the sustainability of tribal businesses. <a href="http://www.acf.hhs.gov/ana">http://www.acf.hhs.gov/ana</a></p> <hr/> <p><b>ANA Native Language Community Coordination Demonstration Project (NLCC)</b> The NLCC addresses key drivers of program effectiveness: strong community ties, integrated language and educational services, support services and interventions, collaborations, and leaders and champions. <a href="http://www.acf.hhs.gov/ana">http://www.acf.hhs.gov/ana</a></p> <hr/>

Agency	Summary of Program or Resource
	<p><b>Regional Partnership Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Substance Abuse in AI/AN Communities</b>            The goal of the program, services, and activities supported by these funds is to improve the well-being of children and families affected by parental substance misuse in AI/AN communities.  <a href="https://www.grants.gov/web/grants/view-opportunity.html?oppld=288214">https://www.grants.gov/web/grants/view-opportunity.html?oppld=288214</a></p> <hr/> <p><b>National Quality Improvement Center (QIC) for Preventive Services and Interventions in Indian Country</b>            The objectives of the QIC are to: (1) promote awareness and the use of culturally relevant child maltreatment prevention and interventions services supported by practice-based evidence in tribal child welfare systems, (2) improve holistic services for children and families who have experienced or are at risk of child abuse or neglect, and (3) disseminate findings and support knowledge transfer from the QIC projects to the field.  <a href="https://ami.grantsolutions.gov/index.cfm?switch=foa&amp;fon=HHS-2017-ACF-ACYF-CA-1234">https://ami.grantsolutions.gov/index.cfm?switch=foa&amp;fon=HHS-2017-ACF-ACYF-CA-1234</a></p>
<p><b>U.S. Department of Housing and Urban Development (HUD)</b></p>	<p><b>NAHASDA</b>            The Native American Housing Assistance and Self Determination Act of 1996 (NAHASDA) reorganized the system of housing assistance provided to Native Americans through HUD by eliminating several separate programs of assistance and replacing them with a block grant program.  <a href="http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/ih/codetalk/nahasda">http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/ih/codetalk/nahasda</a></p>
<p><b>U.S. Department of Justice (DOJ)</b></p>	<p><b>Coordinated Tribal Assistance Solicitation (CTAS)</b>            CTAS grants provide more than \$102 million to enhance law enforcement practices and sustain crime prevention and intervention efforts in nine areas, including public safety and community policing, justice systems planning, alcohol and substance abuse, corrections and correctional alternatives, violence against women, juvenile justice, and tribal youth programs. The funding under this grant is up to \$4,000,000.  <a href="mailto:tribalgrants@usdoj.gov">tribalgrants@usdoj.gov</a>  <a href="https://www.justice.gov/tribal/grants">https://www.justice.gov/tribal/grants</a></p>

Agency	Summary of Program or Resource
<p><b>HHS, Indian Health Service (IHS)</b></p>	<p><b>The Methamphetamine and Suicide Prevention Initiative (MSPI)</b>  MSPI offers evaluation training, technical assistance on grant management, and information and guidance on best practices focused on culture, suicide prevention, and youth.  <a href="https://www.ihs.gov/mspi">https://www.ihs.gov/mspi</a></p> <hr/> <p><b>safeTALK</b>  safeTALK is a training designed for anyone age 15 years or older. It stresses suicide alertness and helps participants challenge the taboos that prevent people from talking openly about suicide. safeTALK works to combat societal beliefs that can cause caring people to miss, dismiss, or avoid signs of suicide.  <a href="https://www.livingworks.net/programs/safetalk">https://www.livingworks.net/programs/safetalk</a></p>
<p><b>HHS, National Institutes of Health</b></p>	<p><b>Native American Research Centers of Health (NARCH)</b>  The NARCH program supports research and career enhancement to meet the health needs of AI/AN communities and the scientists conducting research on the health needs of these communities. Funding and training and technical assistance is available up to 4 years.  <a href="http://grants.nih.gov/grants/guide/pa-files/PAR-16-297.html">http://grants.nih.gov/grants/guide/pa-files/PAR-16-297.html</a></p>
<p><b>HHS, Substance Abuse and Mental Health Services Administration (SAMHSA)</b></p>	<p><b>Circles of Care</b>  The Circles of Care grant program provides tribal and urban Indian communities with tools and resources to design holistic, community-based systems of care to support mental health and wellness in tribal and urban Indian communities. Circles of Care focuses on building mental health systems. Each grant must be designed to increase access to and capacity of mental health services for children, youth, and families. Funding and training and technical assistance is available for up to \$418,000 for 3 years.  <a href="https://www.samhsa.gov/tribal-ttac">https://www.samhsa.gov/tribal-ttac</a></p> <hr/> <p><b>Native Connections</b>  Native Connections offers 5-year SAMHSA-funded grants to AI/AN communities to identify and address behavioral health needs using sustainable strategies. The program seeks to prevent and reduce</p>

Agency	Summary of Program or Resource
	<p>suicide and substance misuse with Native youth (up to the age of 24) while promoting mental health and addressing the impact these issues have on Native communities, using a collaborative, inter-agency public health approach. Funding and training and technical assistance is available up to 5 years.</p> <p><a href="http://www.samhsa.gov/native-connections">http://www.samhsa.gov/native-connections</a></p> <hr/> <p><b>Systems of Care (SOC)</b> SOC assists youth and families in developing healthy routines at home, school, and in the community. The program is aimed to address behavioral health outcomes for children and youth with critical emotional disturbances. SOC increase access to mental health services with systemic changes in policy, finance, support services, training and technical assistance and workforce development.</p> <p><a href="https://www.samhsa.gov/grants/grant-announcements/sm-16-009">https://www.samhsa.gov/grants/grant-announcements/sm-16-009</a></p> <hr/> <p><b>Garrett Lee Smith (GLS) State/Tribal Suicide Prevention Programs</b> The GLS grant was created to support states and tribes (including Alaska villages and urban Indian organizations) in developing and implementing statewide or tribal youth suicide prevention and early intervention strategies grounded in public or private collaboration.</p> <p><a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3107991/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3107991/</a></p> <hr/> <p><b>Strategic Prevention Framework Partnerships for Success (SPF-PFS)</b> SPF-PFS works to prevent underage drinking among 12- to 20-year-olds and prescription drug misuse and abuse for 12- to 25-year-olds.</p> <p><a href="https://www.samhsa.gov/grants/grant-announcements/sp-16-003">https://www.samhsa.gov/grants/grant-announcements/sp-16-003</a></p> <hr/> <p><b>Adult Tribal Healing to Wellness Courts and Juvenile Treatment Drug Courts Program</b> This program expands substance misuse treatment services for alcohol and drugs to defendants and/or offenders.</p> <p><a href="https://www.samhsa.gov/grants/grant-announcements/ti-16-009">https://www.samhsa.gov/grants/grant-announcements/ti-16-009</a></p> <hr/> <p><b>Residential Treatment for Pregnant and Postpartum Woman</b> This program expands access to residential substance misuse treatment, prevention, and recovery services for qualifying woman 18 years old and over.</p>

Agency	Summary of Program or Resource
	<p><a href="https://www.samhsa.gov/grants/grant-announcements/ti-14-005">https://www.samhsa.gov/grants/grant-announcements/ti-14-005</a></p> <hr/> <p><b>Drug-free Communities (DFC) Support Grant Program</b> An office partnership with SAMHSA and the Office of National Drug Control Policy (ONDCP), SAMHSA manages the DFC grant funds, while ONDCP provides the funding and oversight. The goal is to strengthen community collaboration, strengthen public and private agencies, and reduce substance abuse among youth.</p> <p><a href="https://www.samhsa.gov/grants/grant-announcements/sp-16-001">https://www.samhsa.gov/grants/grant-announcements/sp-16-001</a></p> <hr/> <p><b>Project Launch</b> Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health) promotes coordination across child-serving systems, builds infrastructure, and increases access to high-quality prevention and wellness for children and their families.</p> <p><a href="http://www.healthysafechildren.org/grantee/project-launch">http://www.healthysafechildren.org/grantee/project-launch</a></p> <hr/> <p><b>Campus Suicide Prevention Program</b> This program aims to prevent suicide in higher education institutions, and improve services for students with mental and substance use disorders.</p> <p><a href="https://www.samhsa.gov/grants/grant-announcements/sm-15-008">https://www.samhsa.gov/grants/grant-announcements/sm-15-008</a></p> <hr/> <p><b>Tribal Training and Technical Assistance Center (Tribal TTA Center)</b> The Tribal TTA Center provides TTA on mental and substance use disorders, suicide prevention, and mental health promotion.</p> <p><a href="http://www.samhsa.gov/tribal-ttac">http://www.samhsa.gov/tribal-ttac</a></p> <hr/> <p><b>Tribal TTA Center – Intensive TTA</b> The goal of Intensive TTA is to help communities build their capacity to address and prevent mental and substance use disorders and suicide, and to promote mental health. The Tribal TTA Center provides TTA that is easily accessible, culturally appropriate, and shows awareness of the complexities facing AI/AN communities.</p> <p><a href="http://www.samhsa.gov/tribal-ttac/training-technical-assistance/intensive">http://www.samhsa.gov/tribal-ttac/training-technical-assistance/intensive</a></p> <hr/> <p><b>Tribal TTA Center – Broad TTA</b></p>

Agency	Summary of Program or Resource
	<p>Broad TTA is available through the Tribal TTA Center for all federally recognized AI/AN tribes, other tribal nations, and rural and urban organizations that serve Native communities. The audience for Broad TTA also includes tribes developing Tribal Action Plans under the Indian Alcohol and Substance Abuse Act of the Tribal Law and Order Act Amendments of 2010.</p> <p><a href="http://www.samhsa.gov/tribal-ttac/training-technical-assistance/broad">http://www.samhsa.gov/tribal-ttac/training-technical-assistance/broad</a></p> <hr/> <p><b>Tribal TTA Center – Focused TTA</b>            The audience for Focused TTA are SAMHSA tribal grantees. TTA helps increase knowledge, build community capacity, and enhance systems. The Tribal TTA Center also coordinates with other TTA programs that serve SAMHSA tribal grantees.</p> <p><a href="http://www.samhsa.gov/tribal-ttac/training-technical-assistance/focused">http://www.samhsa.gov/tribal-ttac/training-technical-assistance/focused</a></p> <hr/> <p><b>Tribal Action Plan (TAP)</b>            The Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986, as amended by the Tribal Law and Order Act of 2010, requires the Office of Indian Alcohol and Substance Abuse to work with other federal agencies and offices that oversee federally recognized tribes in developing a TAP. The TAP coordinates resources and programs to help tribes achieve their goals for preventing and treating substance use disorders.</p> <p><a href="http://www.samhsa.gov/tloa/tap">http://www.samhsa.gov/tloa/tap</a></p> <hr/> <p><b>Treatment Improvement Protocols (TIPS)</b>            The TIPS series developed by the Center for Substance Abuse Treatment provides detailed guidelines on best practices aimed at preventing and treating substance misuse and mental health disorders.</p> <p><a href="https://www.ncbi.nlm.nih.gov/books/NBK82999/">https://www.ncbi.nlm.nih.gov/books/NBK82999/</a></p>
<p><b>Federal Emergency Management Agency (FEMA)</b></p>	<p><b>Crisis Counseling Assistance &amp; Training Program</b>            The CCP is a supplemental assistance program available to the United States and its territories. The Center for Mental Health Services, Emergency Mental Health and Traumatic Stress Services Branch</p>

Agency	Summary of Program or Resource
	<p>works with FEMA through an interagency agreement to provide technical assistance, consultation, and training for state and local mental health personnel; grant administration; and program oversight.</p> <p><a href="https://www.fema.gov/recovery-directorate/crisis-counseling-assistance-training-program#2">https://www.fema.gov/recovery-directorate/crisis-counseling-assistance-training-program#2</a></p>
<b>The White House</b>	<p><b>My Brother's Keeper Alliance</b></p> <p>President Obama launched the My Brother’s Keeper initiative to address persistent opportunity gaps faced by boys and young men of color and to ensure that all young people can reach their full potential. Through this initiative, the Administration is joining with cities and towns, businesses, and foundations that are taking important steps to connect young people to mentoring, support networks, and the skills they need to find a good job or go to college and work their way into the middle class.</p> <p><a href="https://www.whitehouse.gov/my-brothers-keeper#">https://www.whitehouse.gov/my-brothers-keeper#</a>  <a href="https://obamawhitehouse.archives.gov/my-brothers-keeper">https://obamawhitehouse.archives.gov/my-brothers-keeper</a></p>

## State Resources and Funding

Agency	Summary of Program or Resource
<b>Montana Office of Public Instruction</b>	<p><b>Montana Suicide Awareness and Prevention Training Act</b></p> <p>The Montana Office of Public Instruction provides vision, advocacy, support, and leadership for schools and communities to ensure that all students meet today's challenges and tomorrow's opportunities.</p> <p><a href="https://opi.mt.gov/Montana-Suicide-Awareness-and-Prevention-Training">https://opi.mt.gov/Montana-Suicide-Awareness-and-Prevention-Training</a></p>
<b>Montana State Department of Public Health and Human Service (DPHHS)</b>	<p><b>Montana DPHHS</b> provides suicide prevention information and resources on its website.</p> <p><a href="http://dphhs.mt.gov/amdd/Suicide">http://dphhs.mt.gov/amdd/Suicide</a></p>
<b>Montana State University</b>	<p>Suicide prevention is a major focus on the <b>Montana State University</b> campus. Suicide is the second leading cause of death among college students nationwide. MSU has a team of psychologists, counselors, faculty, staff, and student leaders working to protect the MSU community from the devastating impact of suicide. The MSU website</p>

Agency	Summary of Program or Resource
	<p>provides a summary of crisis and counseling resources, as well as training and prevention options.</p> <p><a href="http://www.montana.edu/suicide-prevention/">http://www.montana.edu/suicide-prevention/</a></p>
<p><b>University of Montana</b></p>	<p><b>National Native Children's Trauma Center (NNCTC)</b></p> <p>NNCTC collaborates with IHS and other providers in tribal communities across the country to use evidence-based, culturally appropriate, trauma-informed interventions for AI/AN children, youth, and military families who experience disproportionate violence, grief, and/or poverty and childhood, historical, and/or intergenerational trauma. NNCTC serves as a national leader in trauma intervention training and workforce development.</p> <p><a href="http://nctsn.org/about-us/network-members/national-native-childrens-trauma-center">http://nctsn.org/about-us/network-members/national-native-childrens-trauma-center</a></p>

### Private Resources and Funding

Organization	Summary of Program or Resource
<p><b>Action Alliance for Suicide Prevention (AASP)</b></p>	<p>The <b>AASP</b> works to advance the National Strategy for Suicide Prevention (NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high priority objectives of the NSSP, and cultivating the resources needed to sustain progress</p> <p><a href="http://actionallianceforsuicideprevention.org/home">http://actionallianceforsuicideprevention.org/home</a></p>
<p><b>The American Association of Suicidology</b></p>	<p>The <b>American Association of Suicidology</b> provides resources, including a Youth Suicide Fact Sheet and training for suicide prevention volunteers and professionals.</p> <p><a href="http://www.suicidology.org/">http://www.suicidology.org/</a></p>
<p><b>American Foundation for Suicide Prevention (AFSP)</b></p>	<p><b>AFSP Research Grants</b></p> <p>AFSP grants support studies that will increase our understanding of suicide or test treatments and other interventions that save lives. There are six categories of Innovation Grants and Focus Grants. Funding and training and technical assistance is available for up to \$500,000 per year for 3 years.</p> <p><a href="https://afsp.org/our-work/research/grant-information/">https://afsp.org/our-work/research/grant-information/</a></p> <hr/> <p><b>AFSP – Montana Chapter</b></p>

Organization	Summary of Program or Resource
	<p>The AFSP – Montana Chapter works to eliminate the loss of life from suicide by: delivering innovative prevention programs, educating the public about risk factors and warning signs, raising funds for suicide research and programs, and reaching out to those individuals who have lost someone to suicide.</p> <p><a href="https://afsp.org/chapter/afsp-montana/">https://afsp.org/chapter/afsp-montana/</a></p> <hr/> <p><b>American Indian Life Skills (AILS)</b>            Developed from the Zuni Life Skills Development Program, the AILS program framework focuses on seven main themes: (1) building self-esteem, (2) identifying emotions and stress, (3) increasing communication and problem-solving skills, (4) recognizing self-destructive behavior and finding ways to eliminate it, (5) learning information about suicide, (6) helping a suicidal friend go for help, and (7) planning ahead for a great future.</p> <p><a href="https://uwpress.wisc.edu/books/0129.htm">https://uwpress.wisc.edu/books/0129.htm</a>  <a href="http://www.sprc.org/resources-programs/american-indian-life-skills-developmentzuni-life-skills-development">http://www.sprc.org/resources-programs/american-indian-life-skills-developmentzuni-life-skills-development</a></p>
<p><b>Aspen Institute</b></p>	<p><b>Center for Native American Youth (CNAY)</b></p> <p>CNAY is dedicated to improving the health, safety, and overall well-being of Native American youth through communication, policy development, and advocacy.</p> <p><a href="http://www.cnay.org/">http://www.cnay.org/</a></p>
<p><b>The Jason Foundation (JFI)</b></p>	<p><b>JFI</b> is dedicated to the prevention of the “Silent Epidemic” of youth suicide through educational and awareness programs that equip young people, educators, youth workers, and parents with tools and resources to help identify and assist at-risk youth.</p> <p><a href="http://jasonfoundation.com/get-involved/parent/parent-and-community-seminar/">http://jasonfoundation.com/get-involved/parent/parent-and-community-seminar/</a></p>
<p><b>Living Works</b></p>	<p><b>Applied Suicide Intervention Skills Training (ASIST)</b></p> <p>ASIST is designed for anyone age 16 years or older. The 2-day training targets everyday individuals as family and friends are often the first to identify persons at risk for suicide. These first responders often lack the skills and knowledge to respond effectively. ASIST is based on the principle that “everyone can make a difference in preventing suicide.” The program provides training in suicide first aid, focusing</p>

Organization	Summary of Program or Resource
	<p>on identifying persons at risk, helping them stay safe, seeking further help, and following up.  <a href="https://www.livingworks.net/programs/asist/">https://www.livingworks.net/programs/asist/</a></p>
<b>National Alliance on Mental Illness (NAMI)</b>	<p><b>Montana Suicide Prevention Program</b>            The NAMI Montana chapter is part of the nation's largest grassroots organization for people with mental illnesses and their families.  <a href="http://www.namimt.org/stop-suicide-save-a-life.html">http://www.namimt.org/stop-suicide-save-a-life.html</a></p>
<b>One Sky Center</b>	<p><b>American Indian Community Suicide Prevention Assessment Tool</b>            This tool aims to improve the prevention and treatment of substance misuse and mental health disorders across Indian Country.  <a href="http://www.oneskycenter.org">http://www.oneskycenter.org</a></p>
<b>QPR Institute</b>	<p><b>Question. Persuade. Refer (QPR) Gatekeeper Training</b>            QPR is designed for use by many different types of people in a given community. QPR trains people to serve as gatekeepers to be able to recognize the signs of suicide and direct someone in crisis to proper sources of care. Anyone can be a gatekeeper, and specialized training is available for people in specific roles, like school health workers.  <a href="https://www.qprinstitute.com/">https://www.qprinstitute.com/</a></p>
<b>Rocky Mountain Tribal Leadership Council</b>	<p><b>Tribal Prevention Initiative (TiPI)</b>            The TiPI is a substance misuse prevention program for youth, ages 12 to 20, and their families. The TiPi expands current prevention activities to further reduce underage drinking and promote a holistic wellness movement. The TiPI further prevents underage drinking among reservation youth by strengthening the tradition of wellness through tribal-specific programs.  <a href="https://www.rmtlc.org/programs/tribal-prevention-initiative-tipi/">https://www.rmtlc.org/programs/tribal-prevention-initiative-tipi/</a></p>
<b>Suicide Prevention Resource Center</b>	<p>The <b>Suicide Prevention Resource Center (SPRC)</b> can be used to find articles, tools, fact sheets, and reports developed by SPRC and other suicide prevention organizations and experts.  <a href="http://www.sprc.org/resources-programs/building-evaluation-capacity-local-programs-serving-american-indianalaska-na">http://www.sprc.org/resources-programs/building-evaluation-capacity-local-programs-serving-american-indianalaska-na</a></p> <hr/> <p><b>Model Adolescent Suicide Prevention Program (MASPP)</b>            MASPP sought to reduce the number of suicides and suicide attempts by adolescents and young adults in one American Indian community, and increase community education and awareness about suicide and</p>

Organization	Summary of Program or Resource
	<p>related behavioral issues, such as trauma, family violence, intimate partner violence, and substance misuse.</p> <p><a href="http://www.sprc.org/sites/default/files/migrate/library/AdolescentSP_ProgramManuaPH_ModelNA_Communities.pdf">http://www.sprc.org/sites/default/files/migrate/library/AdolescentSP_ProgramManuaPH_ModelNA_Communities.pdf</a></p>
<p><b>Wellness Recovery Action Plan (WRAP)</b></p>	<p><b>WRAP</b> is a self-designed prevention and wellness tool.</p> <p><a href="http://mentalhealthrecovery.com/">http://mentalhealthrecovery.com/</a></p>
<p><b>Yellow Ribbon Suicide Prevention Program®</b></p>	<p>The <b>Yellow Ribbon Suicide Prevention Program®</b> is dedicated to preventing suicide and attempts by making suicide prevention accessible and removing barriers. The program helps empower individuals and communities through leadership, awareness, and education by collaborating and partnering with support networks to reduce stigma and help save lives. These resources require membership to access training materials.</p> <p><a href="http://www.yellowribbon.org/">http://www.yellowribbon.org/</a></p>
<p><b>Zero Suicide</b></p>	<p><b>Zero Suicide</b> approaches suicide prevention as a core responsibility of the health care system that requires the attention and direct effort of entire health systems, rather than relying on individual efforts to evoke change.</p> <p><a href="http://www.zerosuicide.com">www.zerosuicide.com</a></p>