

WHEN COMMUNITIES ARE IN CRISIS: PLANNING FOR RESPONSE TO SUICIDES AND SUICIDE ATTEMPTS AMONG AMERICAN INDIAN TRIBES

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Suicides and suicide attempts among American Indians and Alaska Natives have received periodic national media attention. Such coverage has been viewed by Indian/Native communities as a negative portrayal (Tower, 1989). Research on American Indian suicide to date primarily addresses completed suicides, which occur at a rate almost twice the national U.S. average. Some efforts have been made at outlining community intervention and prevention responses that can be planned and practically implemented (May, 1987, 1991).

This paper outlines a system of community planning strategies that can be utilized to address suicide and other behavioral crises when they arise in Indian and Native communities. It also includes steps for developing plans that may be particularly useful for small, tightly knit reservation-based populations. A basic principle underlying all such planning is that it should include and respect the particular history and culture of the tribe to ensure culturally sensitive programming.

The planning components discussed in this paper include

1. A suicide surveillance system for data collection and analysis to identify community-specific epidemiological trends, patterns, and high-risk individuals
2. Development of crisis response teams (CRTs) for possible suicide clusters, including
 - a. Determination and use of appropriate community and agency resources, as well as identification of gaps in resources
 - b. Ongoing community education efforts and information dissemination before, during, and after crisis
3. Consistent education for community members as well as ongoing education of local tribal officials and natural leaders in the community

The opinions expressed in this paper are the authors and do not necessarily reflect those of the Indian Health Service.

The approaches suggested here are based on the technical assistance and community analysis efforts of the Special Initiatives Team, Mental Health Programs Branch, Indian Health Service. This national community crisis response team has been operational since early 1987 (DeBruyn, Hymbaugh, & Valdez, 1988).

Suicide Surveillance and Community-Specific Data Collection

Although aggregate suicide completion data may be useful to cite general trends among American Indians and Alaska Natives, such data have little utility when determining community-specific patterns for program planning and intervention efforts. Rather, we suggest the implementation of a local suicide surveillance system (a community-based suicide register) that keeps records of completions and attempts in order to determine the community-specific, at-risk population and suicide behavior trends (Hymbaugh, 1988b; Yufit, 1989).

A suicide surveillance system is only part of a comprehensive community planning strategy to screen high-risk individuals and develop appropriate intervention and prevention measures. However, numerous communities have found such a register useful for determining the behavioral and demographic patterns of suicidal individuals, particularly regarding both location and degree of lethality of attempts. Specifically, a suicide surveillance system can provide:

1. A list of high-risk persons who need referral and follow-up
2. A mechanism for identification of high-risk families
3. The ability to assess degrees of lethality, possibly indicating the potential for a suicide crisis (e.g., a suicide cluster)
4. Epidemiological data for prevention and intervention program planning and development
5. A data base for analysis of local suicide rates and trends
6. A data base for the development of proposals to secure outside funding for prevention and intervention programs

The Special Initiatives Team has developed an example of a suicide surveillance instrument that collects the minimum amount of data needed to assess community patterns (see Appendix A). The amount and types of data to be collected probably depend on a community's perceived needs and resources available to meet those needs. For example, a community may want more information on family history, such as presence of child abuse, domestic violence, or substance abuse. The surveillance system would have an expanded data set to include more questions concerning family issues.

The team has focused on a history of family violence as being potentially important in determining familial risk. Although the suicide literature has not examined this particular potential risk factor, we encourage communities to collect these data to determine whether or not overall violence is a significant risk factor for suicide.

The surveillance system can be tallied by hand or entered and analyzed by computer. We have implemented the use of the Epi-Info software program for maintaining the suicide register, and we are developing a program that communities can use to analyze their own data trends.

Development of Crisis Response Teams (CRTs)

In an era when the community team approach is promoted as "This'll fix it," and most local service providers know better, why urge the development of yet another team? No community is immune to the possibility of finding itself in the midst of a suicide cluster or other widespread crisis; i.e., discovering that many of the local children have been sexually abused by one or more perpetrators. While the team described here is based primarily on response to suicide crises, the tenets are general enough to be applied to any widespread social crisis at the community level. The basic premise is that a multidisciplinary approach through a team effort will be the most effective method of responding to a community crisis.

The development of a CRT has utility in three areas: pre-crisis planning, crisis management, and post-crisis programming (Hymbaugh, 1988a; see also Comstock, Simmons, & Franklin, 1989; O'Carroll, Mercy, & Steward, 1988).

Pre-crisis Planning

Ideally, a plan should be developed before a crisis occurs. Planning during a crisis is difficult because judgments and decisions may be affected by an emotionally charged atmosphere. However, our experience has shown that most communities develop crisis response efforts only during a crisis and that continued planning efforts are difficult to maintain once the crisis is perceived to have passed. People are more motivated during a crisis to do something that will have positive effects in the community and end the crisis immediately.

Whenever a plan is developed, excessive public focus on developing a suicide response plan should be avoided so as not to cause alarm; we should say *why*, however, key agencies and resources need to be involved in the planning process. A suicide cluster response plan should be part of an overall community suicide prevention plan. This is particularly the case in small communities, where news of a completed suicide spreads quickly and the individual who has died is known and/or

related to many others. Preventive action also should be taken when a dramatic suicide has occurred; a dramatic death creates the potential for emotionally traumatizing a large number of people in the community.

The agencies and/or resources that take the lead in coordinating the response to a suicide cluster may vary depending on the nature and location of the suicides as well as the immediate availability of those resources. We encourage tribal government involvement in the decision-making efforts for community crisis response. One person should be identified to act as the spokesperson for the tribe or community. Most often, this person is the tribal chairperson or tribal administrator. Each agency needs to identify a lead person to work with the tribal spokesperson to ensure that planning tasks are carried out.

Part of the planning process should include training and education for CRT members, especially in regard to how to determine who high-risk individuals might be during a suicide crisis. Ideally, this education should take place before a crisis occurs.

A CRT needs to be informed about screening techniques and develop the most effective screening method for high-risk individuals in that particular community. Screening procedures can take the form of written questionnaires, interviews, phone-in or drop-in centers, hotlines, school counselor sessions, or other methods where individuals can be questioned about and feel free to express their feelings about suicide or a suicide victim.

High-risk individuals include relatives of a suicide victim, close friends, a girlfriend or boyfriend, pallbearers of the victim, those who have attempted suicide in the past, persons with depression, and other troubled individuals. Those in the community whose social support system may be the weakest should also be screened.

Screening should be carried out by trained mental health professionals, if possible, but each community may want to develop its own structure for the screening process and for obtaining informal referrals of potentially suicidal persons from concerned community members.

A team needs to know that unintentional deaths or homicides, in addition to suicides, may precipitate suicide clusters or suicide cluster attempts. Health care providers will need to be alert to potential suicide clusters during periods of emotional stress or other crises in a community.

Environmental modifications should also be addressed by the CRT. There may be both direct and indirect environmental modifications that could decrease the likelihood of a completed suicide. Direct actions can be taken, such as removing lethal quantities of prescription drugs from the homes of high-risk persons, placing screens over bridges, or removing weapons — particularly guns and knives — from the immediate environment. Indirect actions may include developing youth or community activities programs, education programs, or community meetings and education sessions to increase awareness about suicide risk factors

and symptoms of potentially suicidal individuals. Indirect actions also may involve utilizing foster grandparents or other concerned community members to sit with troubled, high-risk individuals in jails, homes, or schools.

The CRT will need to make decisions as to the most effective community educators — service persons from outside the community, service providers working in the community, or a combination of both. These decisions should probably be made on a case-by-case basis, depending on the climate of the community and the widespread nature of the crisis.

Certain tasks need to be completed by the CRT before a period of crisis occurs. In brief, they are as follows:

1. Designate the CRT, which should include at least one person from the tribal government, local schools, law enforcement, mental health and social services, churches, youth groups, and others who may be appropriate. The team should especially include persons known in the community whom young people and adults respect and look to for advice and support; that is, natural community leaders.
2. Develop procedures for contacting survivors, including family, friends, schoolmates, and others.
3. Establish CRT operating procedures; i.e., who should do what task in response to the crisis.
 - a. Identify a method for notifying CRT members in the event of a suicide or other crisis.
 - b. Develop an operational plan with protocols for handling media statements, scheduling public community meetings, and scheduling private meetings with appropriate persons as necessary.
4. Identify the at-risk population (discussed briefly earlier).
5. Develop a plan before a crisis occurs to address the media. Press kits with important relevant facts about the community should be prepared ahead of time so they are ready for immediate dissemination if a crisis should occur. The media can be part of the problem in suicide situations for two reasons. First, the “contagion” of suicides clusters may be intensified and spread by media coverage. Second, much time is spent responding to media requests. Hence, a media plan should stress positive strengths in the community, such as the coordinated community response to the crisis, and provide accurate information that is not embellished.
6. Discuss beforehand potential healing events for the particular community, based on traditional healing customs, the utilization of church leaders (where appropriate), cultural expectations, and belief systems about healing. Involve individuals who can assist

with this process in pre-crisis planning, making sure these individuals have the respect of the majority of community members.

7. Discuss beforehand who and what kinds of persons should be brought in from the “outside,” if any; how they should come into the community; and how they should be utilized. Often, it is wise to keep outside intervention to a minimum, with only a few such persons in the community at any given time, to prevent a visible “entourage” of outsiders. Too much visibility of many outside “experts” may give community members the message that they do not have the internal resources to make appropriate decisions for managing the crisis.

Crisis Management

During pre-crisis planning, what constitutes a crisis should be determined by community members and service providers, with input from the tribal council. When a crisis occurs, the following activities and tasks will need to be carried out:

1. Implement the CRT plan by contacting the CRT members to determine the level and scope of needed response. The designated leader or backup person will contact CRT members through previously agreed methods.
2. Maintain a business-as-usual atmosphere while implementing the emergency response procedures, particularly in the schools, tribal facilities, and other highly visible agencies. Discourage the development of memorials or public displays that glamorize or elevate the suicide victim. Such eulogizing may encourage other high-risk individuals to attempt suicide.
3. Aggressively search for at-risk individuals. All agencies should coordinate efforts with the CRT to identify and locate these persons. Certain family members may notify the appropriate persons about high-risk individuals. In addition, ensure that local school personnel are aware of the CRT activities and are active in searching for at-risk youth. People in daily contact with at-risk individuals (teachers, mental health counselors, parents, relatives, friends) should be notified and advised to maintain an attentive watch. Procedures for evaluating and screening these at-risk individuals must be coordinated with local health care providers. Some at-risk individuals should be referred for counseling. Issues of grieving, loss, and survivorship need to be addressed in such counseling sessions (Simpson, 1991). If at-risk people refuse to cooperate, try to

- alert and work with other significant persons who have daily contact with them.
4. Provide accurate public information. Have the spokesperson for each agency provide specific information about his or her agency's activities to the CRT in a coordinated manner. Provide agency staff members with a complete briefing of positions to be taken before public statements concerning policy are made.
 5. Provide support for the staffs of various agencies directly involved with suicidal persons, grieving families, etc. In a crisis of large proportions, staff members can easily burn out from the enormity of the responsibilities assigned to them. It is important to monitor staff for signs of fatigue, depression, or emotional problems and provide appropriate support. Periodic meetings with "frontline" staff should be held to discuss concerns and to keep the team updated with accurate information.
 6. Individual community leaders who have been identified and have agreed to assist in community healing and educational activities should be involved immediately. With the CRT, they should determine the timing for such activities to occur.

Post-Crisis Operations

Post-crisis operations are extremely important to assess the effectiveness of the crisis response plan and to continue with effective intervention, prevention, and educational efforts.

At some point, the CRT plan should be reviewed to identify unforeseen problems that may have arisen during the height of the crisis. However, it is vital to avoid dramatic and sudden changes in policies or procedures, "quick-fix" solutions, or other activities that may be responses to charged emotions. Identify the strengths in the plan as well as the weaknesses.

The surveillance of high-risk individuals should be a routine part of mental health service policy, not just an activity conducted during the immediate aftermath of a suicide cluster. Surveillance should always be on service providers' minds, particularly on anniversary dates of a victim's death or birthday.

Continue to disseminate information about the CRT efforts following the crisis and suicide prevention activities in a coordinated manner. Community education sessions and public discussion should continue after a crisis has passed and should become a part of regular community meetings.

Consistent Community Education and Solicitation of Support

To change some of the underlying issues that lead to suicide and other forms of violence, Indian/Natives must address two matters: (a) consistent and coordinated community education efforts on a variety of topics related to issues of violence and self-esteem and (b) continued support and advocacy on the part of tribal and natural community leaders. These are two arenas where local community people may demonstrate immediate control over their lives, unlike other issues such as economic hardship, racism and oppression, and lack of adequate service resources.

Consistent Community Education

The timing of educational sessions and topics prior to, during, and following crisis response efforts is important. Consistent educational and information sessions can help alleviate the emotional stress of community members who may be wondering what is being done and why the crisis occurred in the first place. Community education and information sessions conducted during a crisis must avoid presenting alarmist, blaming, and/or sensationalistic information. Facilitators of these sessions — whether from outside or inside the community — should be chosen with this concern, as well as their ability to relate in sensitive ways to the tribe's traditions and customs, kept in mind.

Depending on the nature of the crisis, the CRT should determine the kind of topics that will be most effective for community education efforts. Information sessions are of particular importance during the initial stages of the crisis to assure the community that local resources are managing the situation and that there is a constructive plan to mobilize and coordinate additional resources if needed. The resources and their coordination should have already been identified in the crisis response plan.

Educational topics for community education efforts should address suicide and why it happens; suicide prevention issues; grieving and loss; other issues of community violence such as child abuse, child sexual abuse, and domestic violence; substance abuse and why it happens; self-esteem; historical trauma and cultural strengths in American Indian communities; and other similar topics. As noted above, the timing and ordering of such educational sessions should be determined by the CRT.

Community education sessions should be a consistent part of community health education activities. During a crisis, however, educational sessions are particularly important to inform the community about what is being done to address the crisis.

Support of Tribal and Natural Community Leaders

The Indian Health Service in the past has not sought specifically to educate, elucidate, and support the role of tribal leaders in responding to and advocating human development issues in their communities. Most tribal councils, in our experience, are focused on economic development as the force that will most effectively change destructive behaviors related to widespread social problems. Many councils have been surprised to learn that economic improvement alone does not lead necessarily to better lives for their community members. We advocate a balance between economic enterprises and human service programs fully supported by tribal councils. Where community service providers have the informed support of the tribal council, their efforts have met with greater success. Unfortunately, many community members find it necessary to avoid their tribal councils in their efforts to address necessary social change. However, there is no substitute for positive role models on the part of tribal and natural community leaders in helping to create positive social change in Indian/Native communities. Hence, although change most often occurs due to the committed grassroots efforts of community members and service providers, the support of local leadership makes any path to change violent behaviors far less cumbersome and difficult. The best way to generate support of tribal leaders is to provide them with specific on-site education sessions on family violence.

Conclusions

This paper outlines a community response planning and implementation process to address suicide and other crises that American Indian and Alaska Native communities may experience. Special attention is given to the development of crisis response teams, suicide surveillance efforts, community education, and the need for advocacy on the part of tribal leadership. The strategies presented here have been the result of the wisdom, courage, and dedication of the many Indian/Native communities and individuals with whom we have worked over the past 4 years. It is their commitment to positive social change in addressing suicide and other forms of violence that has made possible future healthier Indian/Native communities.

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Discussion

Dr. Bechtold: The authors propose a system of planning for crisis intervention in response to suicide and suicide attempts for use in American Indian communities. Their proposal derives from their substantial collective experience in providing crisis intervention and consultation to tribes across the United States on issues such as suicide, domestic violence, child abuse, and involves a system with three main components. These components relate to the development of (a) suicide surveillance systems, (b) clinically trained and culturally sensitive crisis response teams, and (c) ongoing community education programs about risk factors for suicide and other violent behaviors.

The authors appropriately document the need for suicide surveillance systems, as well as emphasize the attendant difficulties in identifying

those individuals who are truly at highest risk. Toward this end, the paper makes an important contribution to the existing literature. That is, current technology recognizes that variables such as male gender, prior exposure to suicide and suicidal behaviors, impulsivity, academic disorders, substance use and abuse disorders, conduct disorders, and affective disorders are among the most powerful risk factors for suicide and related behaviors that have been elucidated to date. To this list the authors add the variable of a history of family violence as a potential risk factor. Intuitively, this makes sense, as suicide rates commonly parallel homicide rates as a reflection of a community's attitude toward violence. Clearly, further research is needed to evaluate this potential risk factor which could prove to be a strong one in terms of its ability to predict suicide and suicidal behaviors.

Regarding the development of crisis response teams, the authors discuss three distinct roles for such a team: pre-crisis planning, crisis management and intervention, and post-crisis programming. While there is consensus in the literature of the need for pre-crisis planning, there remains some debate particularly with regard to the specific focus of such planning. There is little controversy about the appropriateness of primary prevention and health promotion activities which prevent the emergence of risk factors for suicide and suicidal behaviors. The controversy arises around the questions of specifically placing focus on suicide in a community which has not yet been touched by suicide among its young people. The authors appropriately argue that this and other key decisions need to be made with input from the community, multidisciplinary clinical input, and essential input from the tribes themselves.

The paper nicely outlines the essential elements of a system for crisis management and intervention. These elements include mechanisms for multiagency coordination, avoidance of atmospheres of panic and disorganization, media containment and management, case finding, and for intervention, which includes supportive clinical and educational dimensions.

Post-crisis intervention, which is commonly referred to as "postvention," is a growing area in the scientific literature. While specific technologies are still poorly defined, preliminary data offers hope that postvention activities have some utility at both the individual and community level.

The authors close with an imperative admonition regarding community education. This is that the solution to a community's problem lies more within the power of its indigenous members than in the contribution of outside "experts." Clearly, this does not preclude utilization of carefully selected, culturally sensitive clinical and systems consultants, but it does maintain the necessary perspective in Indian and Native communities that the tribes themselves are absolutely central to all community processes. The authors appropriately advocate for prioritization of human service

programs when tribal councils are faced with competing pressures from multiple agendas. Education that focuses on the individual and collective needs of the community, and which begins centrally within the tribal structure and extends outward into the periphery of the community, is what the authors suggest. A person would be hard-pressed to argue with the logic of such an approach.