HELPING COMMUNITIES ADDRESS SUICIDE AND VIOLENCE: THE SPECIAL INITIATIVES TEAM OF THE INDIAN HEALTH SERVICE

LEMYRA M. DeBRUYN, PhD, KAREN HYMBAUGH, MA, and NORMA VALDEZ, MSW

ABSTRACT. The Special Initiatives Team of the Mental Health Programs Branch, Indian Health Service, was formed to provide crisis and prevention consultation to American Indian/Alaska Native communities in response to violent behaviors: suicide, homicide, domestic violence, child abuse, child sexual abuse, elder abuse, and other forms of family and community violence. The team incorporates cultural and historical factors in assisting communities to develop programs to combat violent behaviors, and encourages community-based, community-controlled efforts.

Violent behaviors in the United States, recognized as major public health problems, include suicide, homicide, injuries inflicted by self or others, spouse abuse, rape, child abuse, child sexual abuse, and elder abuse (Rosenberg, Starke, & Zahn, 1986). Among American Indians and Alaska Natives, violent behavior constitutes a serious array of problems affecting individuals, families, and communities. Although rates fluctuate across communities, between 1981 and 1983, age-adjusted suicide and homicide rates for all American Indians were 1.5 and 2 times higher, respectively, than for the United States, all populations (National Center for Health Statistics [NCHS], 1985). Concerning child abuse and neglect, there is a wide variation in incidence from one tribe to the next. Like many social variables, child abuse and neglect are difficult to measure. However, available statistics indicate that off-reservation American Indian cases are reported at a rate of 5.7 per 1,000 children (Fischler, 1985). Two reservation studies, Navajo and Cheyenne River Sioux, have yielded rates of 13.5 and 26 per 1,000 children, respectively (White, 1977; Wischlacaz, Lane, & Kempe, 1978).

Most forms of violent behavior among American Indians and Alaska Natives have not been adequately measured. It is clear, however, that these forms of violent behaviors, either through increasing numbers and/or reporting of cases, have grown visibly and have become significantly more common among American Indian communities over the past 2 decades. When studied systematically, violence in all its forms is likely to reflect intergenerational patterns associated with alcoholism, poverty, low self-esteem, and/or family history of violent behaviors (Berlin, 1986).

Where violent behaviors hurt but do not destroy life, an American Indian community may deny that such problems exist or, when recognized, may feel helpless to address them effectively. These communities often experience chronic or endemic crises as expected, normative behaviors; the crises have lost their shock value because the community is in continuous mourning. Aware of

AMERICAN INDIAN AND ALASKA NATIVE MENTAL HEALTH RESEARCH
1(3), MARCH, 1988, pp. 56-65.

these individual violent episodes, the community may be so desensitized to violent acts that they are unable to perceive the patterns of violence across families and generations, or the inherent strengths in the community itself that can be mobilized to counter such violent behaviors.

The Special Initiatives Team (SIT) of the Mental Health Programs Branch, Indian Health Service, was formed to provide assistance to tribes and American Indian/Alaska Native communities--reservation, rural, and urban--which are concerned about violence issues and wish to address them. This paper outlines the philosophy which created SIT, explains the method of operation, and describes some of the projects with which SIT has been involved since its inception in 1987. It also emphasizes the team's commitment to community-based and community-controlled programs which reflect local positive values, cultural strengths, and the belief that individuals, families, and communities can effect positive change.

History of the Special Initiatives Team

The SIT concept grew out of widespread concern by American Indian/Alaska Native tribes and communities and the Indian Health Service (IHS) for suicide epidemics and suicide clusters, which brought national media attention to one tribal community in 1986. In August of that year, the Director of IHS, Dr. Everett Rhoades, called together a Task Force on American Indian/Alaska Native Suicide. The charge to the task force was to develop goals, objectives, and recommendations that would effectively address and help prevent suicide among American Indians and Alaska Natives. The task force recognized the need to consider all forms of violent behavior because, in their opinion, suicide per se cannot be separated from other violent behaviors. The goal of the task force was to assist local communities in addressing the problems of morbidity, mortality, and dysfunction resulting from violent and self-destructive behavior. The specific objectives were (a) to assist all IHS and tribally served communities in assessing the magnitude of the problem, (b) to decrease the perception of violence being an acceptable behavior, (c) to redirect (in an appropriate manner) the IHS commitment and resources toward dealing with violent and destructive behavior in the communities, and (d) to monitor key indicators in an ongoing evaluation process.

The recommendation responsible for the formation of SIT called for a "national crisis response team" to help local communities address outbreaks of violent and self-destructive behaviors (Indian Health Service Task Force on Suicide, 1986). The first team member joined the Mental Health Programs Branch in November,

1986. Other members were recruited through March 1987. The team planned extensively for methods of field operation and response to requests to address violent behaviors, and began full field operation in June 1987.

Although SIT has the capacity to respond to community crises involving violent behaviors, the team has developed a community consultation approach through prevention modalities. Services offered by the team include assistance, consultation, and referral on (a) program planning, development, and evaluation; (b) mobilization of resources, such as consultants, materials, and programs, including assistance with the development of proposals for outside resources; (c) development of data collection methods and analysis to document incidence of violent behaviors, and assessment of the effectiveness of community programs/efforts against violence; and (d) analysis of local needs to assist in redesigning/developing programs against violence.

Crisis intervention services include assistance with the assembly of information about crisis and developing methods for addressing it. Emphasis is placed on recognition and utilization of community strengths and identification of potential resources to address the crisis and prevent its recurrence. It has been the experience of the team thus far, after less than a year of field operation, that requests for outside assistance in response to crisis intervention will occur only after the team has earned the trust of the community, based on previous exposure through program development and other prevention efforts. Such trust has developed in those communities where the team has provided assistance by making contact and/or site visits regularly and consistently as programs unfold.

Operating Philosophy of the Special Initiatives Team

The basic premise underlying the operating philosophy of the SIT is that the community contains the strengths and expertise to address violent behaviors effectively. Consultants from the outside can be catalysts and assistants but, when the community is willing to take action against violent behaviors and the values and conditions that underlie them, the community is the expert.

Taking responsibility to address these problematic social issues does not mean that the community is to blame for its violent situations. The difficult and painful treatment of American Indian populations historically has resulted in poverty, isolation, problems with alcoholism, low self-esteem, and a unique status in relation to the United States government (Berlin, 1986; Deloria & Lytle, 1984; Unger, 1977). All of these social issues are associated directly or indirectly with violent behaviors, and are antithetical to views which "blame the victim." Rather, communities which ask themselves to take responsibility for addressing their social problems acknowledge the strengths inherent in a common community history and cultural framework.

Before such acknowledgement occurs, community leaders and health providers may be so embroiled in a crisis that they do not see the strengths either in themselves or in the community which may be called upon to help. Outsiders may view community leaders and members as apathetic in relation to violent behaviors whereas, in actuality, the community may be stunned by chronic violent episodes. In this arena, outside consultation and creative tribal leadership can join forces to help community leaders and health providers reframe their views from one of hopelessness in dealing with these problems to a vision encompassing the ability to instigate positive social change.

Based on prior clinical and community education experience among American Indians, the SIT has found that communities, very much like individuals and families, may go through three basic stages when faced with crises or severe social problems. The first stage is one of denial, where such problems are not acknowledged. Such denial is extremely frustrating for local health providers who, called upon to treat these problems regularly, experience little support from tribal leadership and the community at large. In fact, local health providers, be they tribal, IHS, Bureau of Indian Affairs (BIA), or other service providers, are sometimes seen as part of the problem by the community rather than persons who can help to alleviate serious crises.

In the second stage, crises and severe social problems are gradually or quickly recognized, yet the underlying belief in community strengths is not realized. Rather, community members and leaders may experience anger, fear, a sense of helplessness and numbness, shame or guilt through fear of exposure to the outside world, and potentially, community splitting and fragmentation.

The third stage is the realization that such social problems must and can be addressed. Behavior becomes help-seeking both internally and externally to take action for resolution of the problems. Numerous communities have acted to address violent behaviors. The most successful are those which have strong backing by community leadership and/or where leadership has emerged from the community to develop these efforts (May, 1987).

An important aspect of the team's operating philosophy is its stance on confidentiality. Projects with which the SIT is involved are confidential, unless the community itself wishes recognition for its efforts to combat violence. Hence, when communities are discussed in other team projects, they are not mentioned by name unless the community has sought to publicize its antiviolence activities.

SIT is committed to long-term efforts to address violence, realizing that prevention and intervention programs, along with efforts to change a value that accepts violence as normative behavior, need time to take effect. Hence, the team does not advocate a "hit and run" consultative approach, but rather one that evolves over time through the development of community programs and

activities. Not all projects require long-term efforts. Where they do, however, the team is regularly in touch with community leaders and local tribal and IHS personnel concerning the progress of antiviolence program efforts, and is available for regular site visits to assist program development and to assess additional program needs.

Method of Operation

SIT regularly receives different types of requests from American Indian community health providers, tribal leaders, and local IHS providers. These requests have been generated in a variety of ways. The team has publicized its services in a number of newsletters reaching American Indian communities throughout the United States. IHS Area Mental Health reviews, led by Headquarters Mental Health Program Branch personnel, help to alert local IHS and community personnel to the services provided by the team. The IHS Mental Health Branch Chiefs, one for each of the 12 IHS Areas, have been active in utilizing the team's services, and are always contacted when a request is received that involves a site visit in their respective Areas. Finally, the team has been invited to present on its activities and violence-related topics at a number of conferences involving American Indian leaders, community members, and community health providers.

When the team receives a request for community consultation, it determines whether the services requested can be addressed by the team and the immediacy of the need. A team member is assigned primary responsibility, with another member providing backup, and appropriate personnel are contacted to coordinate a site visit. Response time is determined primarily by the nature of the request and by other activities in which team members are presently engaged. A request for crisis intervention is addressed as quickly as possible.

A community analysis is conducted when the SIT is involved in long-term projects consisting of program planning, development, and evaluation of activities to address violent behaviors. This analysis is developed through first reviewing available documents on the history and cultural background of the community, socioeconomic status and geographic distribution of the American Indian population and local non-Indian communities, and any other materials which address community dynamics in relation to violent behaviors. Second, a set of questions is developed for the initial site visit to gain insights from local tribal leaders and community health providers on the current status of the community in relation to economic, social, and cultural issues, and how violent behavior problems are viewed and addressed. The team then develops a report that is given to the local tribal leaders and community health providers to be utilized as a basis for the creation of locally relevant intervention and prevention activities to address violence.

During the site visit(s), the request is discussed in detail with local leaders and health providers, and plans are made concerning the best methods of response. These planning efforts also assist in determining whether other issues need to be included. For example, a request may be made for assistance to develop a suicide prevention program or suicide register. In working with local community providers and leaders, the team helps to outline the various factors that need to be involved in such activities, including other social issues related to violence which may influence suicides and suicide gestures in that community. Further, the team encourages local leadership and personnel to outline the strengths in the community (e.g., family, culture, positive values) that may be utilized in program activities.

Although the team may be asked to address one type of violent behavior in relation to program planning, we encourage local providers and leaders to entertain the possibility that these problems occur in relation to other forms of violence or social issues, and that certain violent behaviors, which can vary from community to community, may cluster together over time and in families or cohort groups. Whenever possible, the team encourages a data collection effort to assist in documenting such behavior patterns. These data, in turn, can be used for further program development, evaluation of program effectiveness, community education, and seeking additional resources.

When planning intervention strategies and/or prevention programs, the SIT strongly encourages local leaders and health providers to implement the following activities: (a) assess community attitudes and values regarding violent behaviors; (b) assess community strengths that can be called upon to address violent behaviors; (c) encourage the use of volunteer help--resources in the form of natural community leaders including elders, religious leaders, and young people are often useful in creating awareness; (d) encourage community awareness through ongoing community education outreach; (e) look for and encourage strong leadership in the community; (f) educate program personnel, teachers, other providers, and the community at large as to the indicators that constitute high-risk behaviors; (h) empower and train law enforcement agencies and courts to effectively address violent behaviors; (i) create a multidisciplinary team approach with diverse personnel and community leadership to respond to community crises and develop community-wide education and prevention activities; (j) develop protocols for responding to crises that are realistic and well-supported by tribal leadership; and (k) encourage community leaders, health providers, and community members to persist, recognizing that activating and realizing positive social change requires time.

Special Initiatives Team Projects and Programs

Since June 1987, SIT has been involved in developing a number of projects and programs. Examples are described here to illustrate how the team has incorporated its philosophy and method of operation in the field. It is too early to tell the outcomes of the team's and respective communities' efforts to combat violence, but initial community response has been encouraging and hopeful.

Social Services Program for Child Abuse and Suicide Prevention

The first project involved a request from a rural West Coast American Indian community to determine the scope of the problem surrounding the need for a social services program to address suicide, child abuse, and other violent behaviors. The rural clinic had no social services, and clinic service providers were becoming more aware of the need for intervention in relation to violent behaviors. Team members met with clinic and tribal personnel, developed a community analysis report that outlined the needs of the community, and offered recommendations that local health providers might implement. One of those recommendations underlined the obvious need for a social services program. That program is now in place. Subsequently, the team arranged for the clinic director to make a visit to a Southwest clinic and hospital to obtain ideas as to the most optimal ways of developing the new program. Further site visits are planned by the team to assist in evaluating the program's effectiveness and to provide examples of protocols for the development of child protection teams and suicide prevention efforts.

Community Violence Elimination Program

The second project involved an initial request for assistance to develop methods to combat violent behaviors on a Northwest reservation. This project has become an ongoing effort. The reservation tribal council, IHS, and BIA administrative and health personnel have formed a coordinating committee with a threefold approach to eliminate violence on the reservation by the year 2000. The three approaches to violent behaviors include making the coordinating committee an integral part of the tribal program structure. After initiating community education efforts, a citizens' committee will be formed, comprised of community members and leaders, to continue to combat violence. Second, the coordinating committee has implemented a data collection project to gather information on violent events over a 1-year period to describe the pattern of violent behaviors on the reservation, to assist in increasing the effectiveness of programs to combat violence, and to develop proposals for acquiring further resources. A data collector has been hired and the tribe has purchased a computer to analyze the data. Third, the coordinating committee is developing ongoing community education efforts to alert the reservation community to the

impact of violent behaviors, high-risk indicators, and what community members can do to assist in the violence elimination activities. SIT has and will continue to conduct site visits as deemed appropriate by the coordinating committee and the tribal council to assist in this project.

Community Suicide Prevention Program

A third project has involved developing an in-depth community analysis of a Western reservation where assistance was requested for a suicide prevention program effort. Team members visited the reservation community and met with IHS personnel and tribal leaders to determine local strengths and barriers to the development of such a program. Recommendations were made by the team that are in the process of being implemented. This particular project has produced the basic format for assisting other communities, including isolated villages in Alaska, in the development of suicide prevention efforts, suicide registries, and protocol for response to community crises.

American Indian Mental Health Videotape

A fourth project has been initiated by the team along with the Mental Health Programs Branch to develop a training videotape on American Indian mental health. This is being done in conjunction with a Northern Plains tribe and its community college. The tribal health program was selected because of its exemplary cultural awareness efforts and its collaborative mental health, social services, and substance abuse approach to social problems. The videotape will include historical comments by tribal leaders and elders in relation to the health of American Indian people, demonstrations of clinical intervention modalities for violent and other behaviors in relation to cultural aspects, and excerpts from multidisciplinary team meetings to show an integrated team approach to mental health, social services, and substance abuse to address human problems. The video should be completed by late 1988. Although the videotape will show themes specific to this reservation, the underlying message hopefully will be useful to all American Indian populations. The video will be available nationally to assist community providers in the development of multidisciplinary teams specific to their respective communities and to help new health providers understand the necessity of being familiar with the cultural and historical background of the American Indian/Alaska Native people they serve.

National Resource Directory

SIT is also developing a National Resource Directory of foundations, consultants, materials, and programs which address mental health and social service issues related to violent behaviors that can be utilized specifically for American Indian communities. Included are materials developed by the team,

such as a protocol for the operation of child protection teams, information on suicide clusters, and variables that may be included in data collection formats regarding violent behaviors in American Indian communities.

Summary and Conclusions

The SIT of the Mental Health Programs Branch, IHS, was formed to assist American Indian/Alaska Native communities address issues of suicide and other violent behaviors. The key word is assist, in that the team is committed to the premise that the real strength and vision for positive social change is inherent in the local community itself. For such change to occur, albeit over time, the direct involvement of local community leaders and tribal health programs along with the support of local and Area IHS health providers are essential.

SIT is committed to long-term efforts at the community level aimed at addressing violence issues when such assistance is deemed appropriate by local leaders and health providers. In addition, confidentiality is maintained as to the specific communities with which the team is involved, unless permission is given by local authorities and/or the local community wishes to make known its antiviolence programs and activities.

Essential to team philosophy and operation is the encouragement of (a) community education, to develop a sense of community ownership and positive sense of responsibility to address issues surrounding violent behaviors, as well as emphasizing community and family strengths; (b) data collection/ development of protocols, to outline the scope of problems and methods to address those problems, to measure effectiveness of the program efforts against violence, and to develop additional resources; (c) resource development, both at the community level through community leadership and by networking with IHS and non-IHS entities to place communities and their programs in contact with potential consultants and funding sources; and (d) multidisciplinary teams, for both crisis intervention and prevention planning in addressing violent behaviors.

Where possible, local leaders and health providers are encouraged to share their successes and planning strategies with other American Indian and Alaska Native communities. These persons become consultants to other American Indian and Alaska Native communities who are attempting similar antiviolence efforts in their own communities. Sometimes the team facilitates this networking. Often it is unnecessary for the team to be involved at all.

In essence, the SIT, in its provision of outside consultation, can serve as a catalyst for American Indian and Alaska Native communities which have taken the first steps in recognizing the severe ongoing effects of violent behaviors, and are committed to addressing them actively and positively. Although effective change in relation to violent behaviors takes time, community-based and

community-controlled efforts can effect positive social change. SIT believes that American Indian/Alaska Native communities themselves can and will make this happen.

Department of Health and Human Services
Public Health Service Administration
Indian Health Service - Mental Health Programs
2401 12th Street, N.W.
Albuquerque, New Mexico

References

Berlin, I. R. (1986). Psychopathology and its antecedents among American Indian adolescents. *Advances in Clinical Psychology, 9,* 125-151.

Deloria, V., & Lytle, C. (1984). *The nations within: The past and future of American Indian sovereignty.* New York: Pantheon Books.

Fischler, R. S. (1985). Child abuse and neglect in American Indian communities. *Child Abuse and Neglect, 9,* 95-106.

Indian Health Service Task Force on Suicide (1986). Unpublished manuscript.

May, P. (1987). Suicide among American Indian youth: A look at the issues. *Children Today, 16(4),* 22-25.

National Center for Health Statistics (1983). Data for underlying cause of death. Indian Health Service Areas. Unpublished manuscript.

Rosenberg, M. L., Starke, E., & Zahn, M. A. (1986). Interpersonal violence: Homicide and spouse abuse. In J. M. Last (Ed.), *Public health and preventive medicine* (pp. 1399-1426). Norwalk, CT: Appleton-Century-Crafts.

Unger, S. (Ed.). (1977). *The destruction of American Indian families.* New York: American Association of Indian Affairs.

White, R. (1977). *Navajo child abuse and neglect study.* Baltimore, MD: Department of Maternal and Child Health, Johns Hopkins University.

Wischlacaz, C., Lane, J., & Kempe, C. H. (1978). Indian child welfare: A community team approach to protective services. *Child Abuse and Neglect, 2,* 29-35.