A SUICIDE EPIDEMIC IN AN AMERICAN INDIAN COMMUNITY

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Abstract: Suicide among American Indians has long been a concern for public health professionals and the communities which suffer these losses. The focus on suicide among American Indian adolescents is more recent and has engendered a great deal of apprehension about the forces that impinge upon the lives of these young people. In particular, the epidemic-like occurrence of teenage suicide and suicide attempts has increased general awareness of this problem.

This paper describes the suicide epidemic which occurred on the Wind River Reservation during August and September of 1985. During this two-month period, there were 12 reported deaths from suicide and an additional 88 verifiable suicide attempts or threats. The Wind River Reservation is like many other Indian reservations where a suicide occurs, a cycle of additional suicides follows, and the community attempts to reassert a sense of control. This discussion of the Wind River experience begins with an overview of suicides and attempted suicides, and a brief summary of the epidemic itself. A three-stage model for intervention during an epidemic will be presented, and long-term programs which were developed will be described.

The Suicide Epidemic And Its Context

The Behavior Health Program (BHP) on the Wind River Reservation has kept statistics on suicide attempts and completions since 1970 (Figure 1). Until 1981, the statistics showed an inverse correlation between attempts and completions (that is, when attempts were high, completed suicides were low, and vice versa). Then, in 1981, the numbers of both attempts and completions began to shift upward. While the numbers are too small for statistical comparisons to be significant, in retrospect the Program's staff felt that this pre-epidemic upward trend was an early warning sign.

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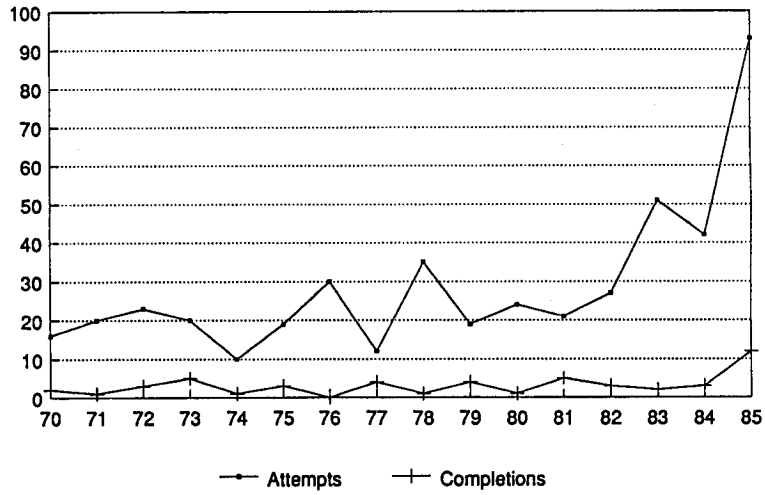

Figure 1: Suicide Attempts and Completions From 1970 Through 1985

When the BHP staff prepared a graph reflecting the geographic distribution of attempts and threats, they found that the highest incidence occurred in the housing projects on the reservation. In addition, law enforcement statistics indicate that most calls for assistance come from those projects, and that a large number of calls pertain to violence stemming from alcohol and drug abuse. Alcohol intoxication was a factor in four of the nine suicides, and a history of alcohol abuse and/or history of suicide attempts or completion within the extended family or immediate peer group of the victims was also found.

Other underlying issues were identified by tribal leaders. These included high unemployment, negative attitudes toward American Indian people in surrounding non-Indian communities, and loss of attention to tribal ceremonies and traditions. The tribal leaders felt that loss of traditions (including the traditional proscription against suicide), along with loss of the tribal languages, had contributed to a lack of positive values for young people. All of these factors were cited as having contributed to feelings of hopelessness and helplessness within the community at large.

Although the issues identified above may have created an environment that was vulnerable, there are many communities across the country with similar issues in which no epidemic has occurred. The question then becomes: Why did this epidemic occur? One possible explanation involves the combination of an unexpected adolescent suicide in a vulnerable community. Another factor in the contagion among adolescents may be what has been called the "romance of suicide", i.e., a lack of appreciation

"trigger" by stimulating a wave of overwhelming despair among other adolescents and the community at large.

Long (1986a) has made several interesting points that may be relevant here. She states that the contagion effect of suicide is greatly enhanced on reservations because "it is not happening to strangers", Long (1986b) also points to the "mix of transcultural pressure and prejudices resulting in a 'no-win' situation for Indian youths" as contributing factors.

In the final analysis however, there is no good answer to why an epidemic of suicides occurred on the Wind River Reservation in 1985. It seems likely that a combination of factors were involved. Only further study will reveal the relative strength of each of these factors and the extent to which they are multiplied when more than one is present.

Statistical Breakdown Of Suicide Attempts And Completions

During August and September of 1985, there were nine deaths from suicide and 88 verified suicide attempts or threats on the Wind River Reservation. Table 1 details the ages of individuals attempting or threatening/attempting suicide.

Table 1
Age Range Of Individuals Attempting/completing Suicide
August - September, 1985

Age Range	Total
0 - 12	2
13 - 19	40
20 - 29	24
30 - 39	15
40 - 49	5
50 - 59	1
60 - 69	1
TOTAL	88

Completed Suicides

Four of the victims were between the ages of 14 and 19, and five were age 23 to 26. Alcohol was a direct contributing factor in four of the suicides, with two of the deaths occurring while the victims were in jail, intoxicated. In fact, the first suicide that occurred was in jail. According to a national study of jail suicides (Hayes, 1983), the typical suicide in jail occurs within 24 hours of incarceration, with the typical victim being a young adult male arrested for public intoxication and presumably under the influence of alcohol or drugs at the time of arrest. Both of the suicides that occurred in jail in this study fit Hayes' general profile.

While there were nine suicides during this epidemic, many people on the reservation felt that three additional deaths -- of males between the ages of 18 and 23 -- should also be considered as connected to the epidemic. The three additional victims had close ties to the reservation and to some of those who died in the epidemic.

Suicide Attempts/Threats

During the two month period of the study, there were 88 verified suicide attempts or threats. Of these, 46 of the individuals involved were male and 42 were female; 29 attempts occurred before the epidemic began and 59 occurred afterwards. Alcohol was involved in 47 of the attempts/threats. Fifty-nine individuals were hospitalized, with the majority of hospitalizations occurring during the epidemic.

The greatest number of attempts/threats (40) occurred among adolescents ages 13 to 19. The second highest number of attempts/threats (24) was in the 20- to 29-year age group. Both attempts and completions were highest in these two age groups. Fourteen-year-olds had the highest frequency of attempts/threats for a single age group, with 12 attempts or threats made (three by males and nine by females).

Immediate Response

The immediate family members of all the victims received crisis intervention and grief counseling by BHP staff. Other friends and relatives who were thought to be at risk were provided with follow-up counseling and referral through the combined efforts of BHP, Community Health Representatives (health technician/patient advocates), and the Community Mental Health Center.

The BHP staff held several community information meetings after the first three suicides occurred. They provided suicide prevention information through the media and began working with school counselors to contact students who were considered to be at risk. BHP also began to diagram family and friendship ties of the victims in order to conduct a psychological autopsy of the victims and to identify other at-risk individuals. These sociograms provided vitally important information early in the epidemic.

At the same time, the Shoshone and Arapaho Tribes began taking other steps to remedy the situation: one night of Bingo was cancelled and the halls were made available for youth recreational activities. Many parents volunteered as chaperons and recreation leaders. The schools extended hours for learning labs and gymnasiums. The Alcohol Treatment Program began holding weekly alcohol-free teen dances, which were widely attended. Community Health representatives and groups of concerned parents organized Halloween parties, "fun runs," field trips, and a youth recognition program. All these activities were designed to provide a safe

environment for young people and to communicate the concern of the community. This support from the parents was effective in alleviating the extreme level of fear felt by many adolescents during the epidemic -- and probably in preventing further suicides.

During the initial phase of the epidemic, the Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA) instituted an augmented emergency response system. An important part of this system included hospitalization as an alternative to jail for intoxicated patients with suicide attempts/threats. Nearly all adolescent attempters were considered to be at high risk and were admitted to short-term psychiatric care. BHP staffing was increased to provide 24-hour emergency coverage to augment the emergency coverage provided by IHS physicians and the State Community Mental Health Center. The BIA added law enforcement personnel and increased the coverage to high-risk location. The law and order staff, IHS physicians, and BHP staff formed an Emergency Task Force which met frequently and worked together closely at the local level. At the Area level, the IHS and BIA formed a Joint Suicide Prevention Task Force that met weekly to review the status of the epidemic and to make additional resources available when indicated.

During the epidemic, tribal spiritual leaders and other spiritual leaders of all faiths on the reservation joined forces to help one another and the families of the victims. This laying aside of theological and political differences was widely commented upon in the community, and was seen as a positive force. In addition, during the first full week in October, Tribal ceremonial leaders also performed a historical, traditional medicine ceremony. This ceremony was held following the ninth suicide. It was an important cultural and spiritual event that aided in the resolution of grief and increased cohesiveness in the community. No further deaths occurred after this prayer ceremony was held. The suicide attempts remained abnormally high for approximately two months following the ninth suicide, and then attempts, too, began to subside.

Impact Of Media Coverage

During the initial phase of the epidemic, there was exhaustive coverage by the media. This coverage tended toward sensationalism and at times was intrusive and insensitive, e.g., a television crew attempted to enter a funeral service for a victim. The extensive media coverage was felt to be highly detrimental to efforts to stop the epidemic, and the tribal leaders eventually barred reporters from the reservation. A high number of attempts followed directly on the heels of the heaviest media coverage in mid-September.

Agency Coordination

During the height of the epidemic, the IHS brought in outside, University-based psychiatrists to consult to the Community Task Force. There was mixed reaction within the community to the outside consultants. The principle learned in regard to consultants was that local staff have the best knowledge of community problems and know the past history, values, and lifestyle. Outside experts can provide valuable input regarding the dynamics of an epidemic and case consultation, but they should not be the primary decision-makers.

After the epidemic subsided, it was recommended by the Community Task Force that the Service Unit/Agency directors of the IHS and BIA, the director of the Community Health Representative Program, and the BHP staff remain involved with Tribal Council. The purpose of the proposed committee was to facilitate communication, resolve program and funding problems, and maintain a united front.

Although prevention activities such as youth employment programs, supervised recreation programs, emergency child care programs, increased law enforcement staff and community development activities were seen as being outside the direct responsibility of the IHS, these issues were seen as having a direct impact on the problem of suicide. The perception of the Task Force was that each agency had a responsibility, along with the Tribe, to communicate and coordinate activities in the interests of building a comprehensive system of programs within the community.

Long-term Prevention

Maintaining an adequate law enforcement system and developing consumer controls was seen as important in dealing with high levels of violence and crime in the housing projects. Since the epidemic, the community has acquired a large grant for prevention of violence, suicide, and alcoholism. This grant was one of only 12 awarded nationwide by the Kaiser Foundation. The tribes, the IHS, the BIA, and the State Community Mental Health Center participated in the development and planning process.

The project focuses on programs such as parent groups, education on parenting skills, use of the media for community education, SADDS, ALATEEN, school prevention, and intervention programs for youth substance abuse, cultural/recreational groups, wilderness experiences for youths, consumer action groups, and the improving of community relations. The Youth Recognition program which was expanded to include a reservation-wide Youth Council, was a joint effort of the Community Health Representative Program, the Tribal Council, and the schools.

In January 1986, the tribes brought in resources to assist Tribal members in setting up their own businesses. Federal, state, and Tribal

resources were coordinated to bring employment services and jobs to the reservation.

Child abuse and neglect along with alcoholism was recognized as a problem underlying many suicides. A study by Deykin and associates (Deykin, 1985) pointed to early child abuse as a risk factor for suicide attempts in adolescence. To address the problem of child abuse on the reservation, intensive efforts were instituted to coordinate the BIA and IHS with state and federal agencies for investigation, protection, and treatment of abused children. In 1986, an inter-agency Memorandum of Agreement was implemented between the BIA and the IHS regarding child protection team responsibilities.

In order to address the problem of adolescent alcohol abuse, the Anti-Drug Abuse Act of 1986, P.L. 99-570 (which focused national attention on the problem of adolescent substance abuse, child abuse, and suicide prevention), was utilized to increase prevention and treatment services. The Shoshone and Arapaho Tribes utilized P.L. 99-570 to bring additional resources to the community for training, treatment, and recreation for adolescents. Locally, and at the area office level, IHS policies were rewritten to include multidisciplinary case staffings on all child abuse cases and all adolescent inpatient referrals. Interagency training was provided on child protection services and alcoholism as a family illness in an effort to improve coordination of services.

The need for additional BHP staff was another long-term goal identified by the Community Task Force. Positions for a psychologist and social worker were added in 1986 by the IHS.

Because the epidemic had a bimodal age distribution (i.e., 14-18 years and 23-26 years), somewhat different issues were considered in terms of long-term planning for the two age groups. Nationally, a significant portion of the American Indian male population between the ages of 19 and 35 are at risk for suicide (Hayes, 1983). The clinical experience in the BHP staff indicated that there was a high incidence of undiagnosed, untreated depression in 19-24 year old males. In this age group, the profile of the victims was an unemployed individual who lacked job skills, was abusing alcohol, and who was involved in marital and child custody problems. During the epidemic, the most important intervention for this age group seemed to be referral to a primary residential treatment for alcoholism. Alcoholism treatment seemed to represent a "window of hope" for a number of male attempters 19-24 years old. In contrast, the "window of hope" for the younger adolescents seemed to be the efforts of the parents, spiritual leaders and Tribal Council on their behalf.

Anniversary Of The Epidemic

The anniversary date of an epidemic is a critical time for relatives and friends of victims, and for the community as a whole. The plan for the anniversary of the epidemic was developed by the Community Task Force

comprised of Tribal Council members, Director of the Community Health Representative Program, the IHS, the BIA and university-based child psychiatric consultants.

The plan that was developed included some items which ultimately were not carried out, but they are presented here as guidelines to be considered by other communities. The recommendations were:

1. BHP staff would contact the families of the nine suicide victims for grief counseling.

2. Community Health Representative Program and BHP staff would offer services to persons who attempted suicide during the epidemic.

3. Community/parent information meetings would be held to discuss the anniversary phenomena.

4. A Tribal ban on media coverage would be developed to avoid sensationalizing an epidemic.

5. IHS and BIA would coordinate with schools and Tribal programs to provide a summer youth recreation program.

6. IHS would provide an update on diagnosis and treatment of depression for IHS physicians.

7. BHP and law enforcement staff would review the reservation's emergency call system and the protocol for referral of suicide attempts and intoxicated/depressed individuals.

8. State Community Mental Health Center personnel would provide awareness training in off-reservation jails.

9. IHS would make plans for the possible increase in need for psychiatric hospitalizations for serious suicide attempts/threats.

There were no suicides on the anniversary of the epidemic. In retrospect, the Behavioral Health Program staff felt that the most important preventive measures were the many traditional spiritual ceremonies which were performed during that time.

Community Response To An Adolescent Suicide Epidemic

One important principle we learned during the epidemic was that many strategies must be implemented simultaneously. Based upon this experience and others like it in different American Indian communities, some general strategies for intervening in a suicide epidemic can be offered.

Initial Phase

First, each community needs to look at their own particular situation and develop the plan that will work for them. Involvement of Tribal leaders is critical because youths need to see that community leaders are concerned and in control. It is important to form an Emergency Task Force consisting of members of the Tribal council and key agency staff in order to develop an immediate plan for dealing with emergencies, providing counseling, arranging for community education, and controlling exposure in the media.

Development of an abbreviated psychological autopsy of victims is important to identify at-risk individuals and to develop an understanding of the epidemic. During this epidemic it appeared that with an adolescent suicide, any friend of the victim was at high risk for a period of time. Providing supportive counseling in the school is also important early intervention strategy. Providing culturally-appropriate grief counseling to a victim's family and friends is an immediate task.

The Emergency Task Force should develop a plan of action and assign specific responsibilities. For instance, the 24-hour emergency response system should be reviewed in order to fix any gaps in the system, i.e., need for equipment, need for law enforcement staff to transport individuals to a hospital rather than jail or need for increased staffing. A plan must be developed to provide a clinical response to intoxicated individuals, who will be at a higher risk for suicide during the epidemic. It is also important to provide training in crisis intervention for law enforcement and jail staff.

The Emergency Task Force may consider obtaining consultation from an outside group that has had experience in managing a suicide epidemic on an Indian reservation. Other outside resources which could be considered during the initial phase are the Centers for Disease Control in Atlanta, the Special Initiatives Team of the IHS Mental Health Program, as well as university medical school staff. However, it is important to point out that bringing too many outsiders into the community may create confusion and increase the community's sense of loss of control. While many individuals may offer to help, it is important to screen out self-styled "experts" who claim to have all the answers.

Middle Phase

In this phase it is important to form a Case Management Team to follow patients admitted to inpatient and outpatient services, and to continue to identify at-risk individuals. At this time it may be appropriate to develop a Community Task Force to replace the Emergency Task Force. This larger group can focus on community education and development. The value of the Community Task Force is that it can begin to address prevention and the needs of the community at large. A developmental strategy is to bring all community service providers together (including churches) for an educational workshop. This will also provide an opportunity to review and coordinate the services being provided. In this phase, weekly meetings of the Community Task Force are important to build communication and avoid fragmentation.

End of the Epidemic

After the epidemic has ended, it is painful but important for the Community Task Force to evaluate what has been learned. This is also the time when plans for long-term prevention programs should be initiated and planning for the anniversary of the epidemic should begin. All staff who have been deeply involved in the epidemic need a support workshop or debriefing session. Staff need to express the almost universal feelings of guilt and responsibility which develop during the epidemic.

While conducting an in-depth epidemiological study through local resources may not be possible, an outside group such as the Center for Disease Control in Atlanta or the National Center for American Indian and Alaska Native Mental Health Research might be considered for this effort. The importance of the epidemiological data is that it can provide the base for grant proposals to fund long-term prevention projects. In this case, the local BHP staff developed the epidemiological data presented in this paper; however, if staff time or expertise is not available locally, an outside group can be very useful.

The Community Task Force should be prepared to deal with a higher-than-normal number of attempts for at least one year following a suicide epidemic, and possibly for two years. There will also be new suicides which may or may not be related to the epidemic. Thus, establishing an ongoing epidemiological database is crucial in order to determine trends.

Conclusion

Suicide among American Indians and Alaska Natives is a national issue. The statistics provided by IHS headquarters in the Chart Series of February 1985 and fiscal year 1986 (U.S. Department of Health and Human Services, 1986) indicate a preponderance of suicide in the age group

between 15 and 24 years old. The rate for male American Indian and Alaska Natives is 50/100,000, while the rate for this age group in the United States population as a whole is 20/100,000. In this epidemic, the age range of deaths was 14 to 26.

A look at the ages for all suicide deaths on the reservation indicate that 59% of all deaths were among 15-to 24-year-olds; and 41% were among 25-to 60-year-olds. This may support what some people on the reservation have been saying: suicide among older American Indian people is increasing, which is contrary to the national norm. Considering the important role elders play in American Indian culture, this trend toward a higher than expected incidence of suicide among older American Indian people may be an important point to consider in terms of prevention of epidemics among adolescents.

There is a developing body of experience that can help cope with suicide epidemics on Indian reservations even though each situation will have somewhat different dynamics and will need to be considered individually. Each community does, ultimately, possess the strengths within itself to stop an epidemic. This epidemic and the national statistics point to a need for the IHS to involve Tribal leaders, mental health professionals, American Indian research resources and American Indian psychiatrists from across the country in a long term effort to address the problem of suicide in American Indian communities.

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The opinions expressed in this paper are those of the author and are not necessarily those of the IHS.

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