Suicidality in Tribal Primary Care Settings

Steven Sust, MD
July 29th, 2021
Introducing the Presenter

Steven Sust is the middle child of 3 boys born to Hong Kong immigrant parents who raised them in downtown Philadelphia. He received a bachelor’s degree in psychology from GWU, medical degree from UVA, and postgraduate training at UPenn and Stanford. His work experiences range broadly from state psychiatric hospitals, county specialty MH clinics and emergency rooms to school mental health and schizophrenia research at NIMH. Current interests include primary care behavioral health integration, cultural psychiatry, school mental health, and working with underserved populations.
Disclosure Statement

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• There is no commercial interest support for this educational activity.

Disclaimer

The views expressed in this presentation are those of the speaker and do not necessarily represent the views, policies, and positions of the Indian Health Service (IHS), or the U.S. Department of Health and Human Services (HHS).
Personal Disclosures

• I am a cisgender male of Cuban influenced Chinese descent
• I have no formally diagnosed family history of mental illness
• I have sought out and received my own mental health care
• I have both knowingly and unknowingly contributed to bias and most “isms,” and will try to improve upon these areas of growth
Objectives

At the end of this presentation, participants will be able to:

1. Acquire new understanding of suicide and how it affects Native American and Alaska Native youth, in order to assess risk and protective factors.
2. Understand 2 interventions for suicide and how interventions can be applied at a macro and micro level.
3. Apply new knowledge, skills, therapeutic interventions, and techniques in assessing and providing culturally relevant care.
National Epidemiology in Native Americans (2019)

10 Leading Causes of Death, United States
2019, Both Sexes, All Ages, American Indian

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Suicide Rates by Race/Ethnicity and Age

Key

- **WHT** = White Non-Hispanic
- **BLKAA** = Black/African American Non-Hispanic
- **AIAN** = American Indian/AK Native Non-Hispanic
- **API** = Asian / Pacific Islander Non-Hispanic
- **HISP** = Hispanic

Both Sexes Combined

2013-2017 data
MASLOW’S HIERARCHY OF NEEDS (INFORMED BY BLACKFOOT NATION (ALTA))

Western Perspective

- Physiological needs
- Safety needs
- Belongingness and love needs
- Esteem needs
- Need to know and understand
- Aesthetic needs
- Self actualization
- Transcendence

First Nations Perspective

- Self Actualization
- Community Actualization

Expansive concept of time and multiple dimensions of reality

Individual rights privileged one lifetime scope of analysis

Huit, 2004; Blackstock, 2008; Wadsworth,
Zero Suicide in Indian Country
Stigma and the Confusing Data Collected

In some Tribal systems, deaths by suicide are recorded as traffic accidents, accidental overdoses or other types of accidents...even though there is evidence to suggest that these deaths were a direct result of self-harm. This false recording is often a result of the surviving family’s request to keep this part of the loss away from the records because of shame. Many Tribes (but certainly not all) across Indian Country believe that, if a person ends their own life, their spirit does not automatically “walk” to Creator, but that it stays in a land apart from Creator. Sacred ceremonies conducted by Traditional Healers amongst some of the Tribes seek to retrieve those spirits and take them to Creator.
Ask Our Audience

Name some cultural barriers that affect talking about suicide

Our Tribe believes in “ghost sickness.” We do not talk about anyone who has ended their own life. We believe that if we do, it will bring that energy to us and will cause others to do the same (take their life). So we don’t talk about it at all. —Cultural Liaison working with one of the Southwestern Tribes on Zero Suicide

My job in Sundance is to go out into the Spirit World to a place where the spirits of those who ended their own lives reside. Because they took their own lives, they are blinded to where they need to go in order to enter the sacred space where Creator resides. Through sacred ceremonies, special prayers and through the use of our traditional medicines, we can help those spirits find their way to Creator by acting as their eyes, their guides. Once they are on this road, Creator welcomes them home.

— Anishinabe Buffalo Dancer
Identifying/Screening

While the Zero Suicide framework does not promote the use of one screening or assessment tool over another, it highly recommends use of evidence-based assessment and screening tools. Once any evidence-based tools have been selected, they should also undergo a thorough examination by the leadership/implementation team to ensure cultural relevance and appropriate language, based on the Tribal community in which they are being used. As previously discussed, the term evidence-based often has little resonance with Indigenous people as very little of that evidence, especially around tools for screening and assessment of suicide risk or treatment models, was validated in or on Tribal populations. Therefore, in the IDENTIFY element, often the task that is required is to take existing tools that were validated in other populations and rework them to make them relevant to Tribal people without compromising their validity. Often, as in the example below, that relevance is achieved by simply ensuring that the language is not offensive or disturbing to the Tribe and that it reflects the ways in which the Tribe articulates loss of life by suicide.

Authors of screening tools, assessments and other tools used in the Zero Suicide framework are often amenable to the adaptation of their instruments to align with the needs of the community being served and there are many examples of this type of cultural adaptation. It is possible that this alignment may be accomplished without compromising the validity of the instrument.

One example of a cultural adaptation of an evidence-based tool is the ASQ, presently undergoing pilot testing in several IHS Service Units. At the Chinle Indian Health Service in the Diné Nation in Arizona, studies are underway to validate the ASQ with language changes that include replacing “dead” with “not alive” and “kill yourself” with “take your own life.” The Chief of Primary Care, Dr. Nurit Harari, has conducted focus groups, not only with the Diné medical staff at the Service Unit, but also with Elders, Traditional Healers, and youth in the Tribal community being served by the Service Unit, to ensure the cultural adaptation is done appropriately. Two important things from the youth came out of these conversations: 1) the youth did not want others in the room while they are being screened and; 2) even if youth did not screen positive for suicidal thoughts or behaviors, they wanted a resource card with relevant numbers, websites, etc.¹
Risk in 2SLGBTQIA+

Today, Two Spirit Societies and Alliances have been formed all over Turtle Island in an effort to enfold the children, to give them a sense of place and belonging and to provide them with safe spaces. Organizations such as WeRNative.org, also seek to not only affirm Native youth in general but have Two Spirit-affirming messaging, information, and resources available for both Two Spirit and Native LGBT youth.

Tips for working in culturally-affirming ways with Two Spirit people in general and youth in particular

›› If and when a Two Spirit young person trusts you enough to tell you who they are, honor and believe them

›› Be extremely attentive to pronouns, even if presentation may indicate something contrary to how the person identifies themselves

›› It’s not up to us to identify the person coming for services...they are who they say they are

›› Do not ask “What are your preferred pronouns?” Always ask “What are your pronouns?” Using the word “preferred” minimizes their reality

›› If you make a mistake, apologize, slow down, and be more deliberate in the future

›› Respectfully ask for assistance from others with identifying Two Spirit Elders in the Tribe. If the Tribe is less traditional in their ways, do an internet search for the nearest Two Spirit Society or Alliance and ask for help

›› Consult with behavioral health organizations such as WeRNative for advice, and materials. Pamphlets in your waiting room, and posters on your walls focusing on Two Spirit people act to indicate to them that they are welcome there and that it is a safe space

›› Consider having a Two Spirit Talking Circle with Two Spirit Elders and allies and let the community know that it is happening
Synergy of Evidence Based Treatment(s)

The Treatment for Adolescents With Depression Study (TADS)

Long-term Effectiveness and Safety Outcomes

The TADS Team

Context: The Treatment for Adolescents With Depression Study evaluates the effectiveness of fluoxetine hydrochloride therapy, cognitive behavior therapy (CBT), and their combination in adolescents with major depressive disorder.

Objective: To report effectiveness outcomes across 36 weeks of randomized treatment.

Design and Setting: Randomized, controlled trial conducted in 13 academic and community sites in the United States. Cognitive behavior and combination therapies were not masked, whereas administration of placebo and fluoxetine was double-blind through 12 weeks, after which treatments were unblinded. Patients assigned to placebo were treated openly after week 12, and the placebo group is not included in these analyses by design.

Participants: Three hundred twenty-seven patients aged 12 to 17 years with a primary DSM-IV diagnosis of major depressive disorder.

Interventions: All treatments were administered per protocol.

Main Outcome Measures: The primary dependent measures rated blind to treatment status by an independent evaluator were the Children’s Depression Rating Scale-Revised total score and the response rate, defined as a Clinical Global Impressions—Improvement score of much or very much improved.

Results: Intention-to-treat analyses on the Children’s Depression Rating Scale—Revised identified a significant time × treatment interaction (P < .001). Rates of response were 73% for combination therapy, 62% for fluoxetine therapy, and 48% for CBT at week 12; 85% for combination therapy, 69% for fluoxetine therapy, and 65% for CBT at week 18; and 86% for combination therapy, 81% for fluoxetine therapy, and 81% for CBT at week 36. Suicidal ideation decreased with treatment, but less so with fluoxetine therapy than with combination therapy or CBT. Suicidal events were more common in patients receiving fluoxetine therapy (14.7%) than combination therapy (8.4%) or CBT (6.3%).

Conclusions: In adolescents with moderate to severe depression, treatment with fluoxetine alone or in combination with CBT accelerates the response. Adding CBT to medication enhances the safety of medication. Taking benefits and harms into account, combined treatment appears superior to either monotherapy as a treatment for major depression in adolescents.

Trial Registration: clinicaltrials.gov Identifier: NCT00066286

Arch Gen Psychiatry. 2007;64(10):1132-1144

5. Q. What do the results of the study mean for children who have depression?

A. The results suggest that combination treatment is the safest and most effective treatment overall for adolescents with depression. Fluoxetine alone or in combination with CBT accelerates recovery from major depression compared to CBT alone. Although the response rate of CBT alone “catches up” to the response rate of fluoxetine alone several weeks later and to the combination therapy several months later, those few months in the life of an adolescent with depression can seem like a very long time. Further, adding CBT also appears to lessen the risk of suicidal thinking and behavior in patients given fluoxetine, and helps them develop new skills to contend with difficult, negative emotions.

However, every child or adolescent is different, and no one-size-fits-all treatment approach exists. Decisions about treatment for adolescents with depression must be made on a case-by-case basis. Before starting treatment, each child should be carefully and thoroughly evaluated by a doctor to determine if medication is appropriate. Those who are prescribed an antidepressant should be monitored regularly and frequently by a health care professional, especially during the first few weeks.
FDA’s black box warning on suicidality in youth

Antidepressants’ Black-Box Warning — 10 Years Later
Richard A. Friedman, M.D.

In 2004, the Food and Drug Administration (FDA) issued a black-box warning on antidepressants indicating that they were associated with an increased risk of suicidal thinking, feeling, and behavior in young people. The agency’s decision was immediately controversial; many members of the medical community worried that this warning would do more harm than good because it would discourage depressed patients from seeking help and discourage doctors from prescribing antidepressants when they were clinically indicated. Now, 10 years later, there are substantial epidemiologic data to address these important concerns. What effect has the FDA warning had on the rates of detection and treatment of depression? And is there any evidence that rates of suicide or suicide attempts have changed?

In retrospect, it seems that the FDA had little choice but to issue its black-box warning. The agency had conducted a series of meta-analyses of 372 randomized clinical trials of antidepressants involving nearly 100,000 participants, which showed that the rate of suicidal thinking or suicidal behavior was 4% among patients assigned to receive an antidepressant, as compared with 2% among those assigned to receive placebo, although none of the suicide attempts documented in the trials were fatal. Subsequent age-stratified analyses showed that this increased risk was significant only among children and adolescents under the age of 18 years; there was no evidence of increased risk among adults older than 24 years, and among adults 65 years of age or older, antidepressants had a clear protective effect against the development of suicidal ideation and behavior. The meta-analyses provoked considerable debate about various methodologic issues. In particular, some experts questioned the validity of the assessment of suicidality in the trials that were included, which were generally not designed to prospectively assess suicidality.

The FDA was obviously mindful of the need to balance the small risk associated with antidepressant treatment against its proven benefits: the expanded black-box warning issued in 2007 stated that depression itself was associated with an increased risk of suicide. Has this well-intended warning accomplished its task — to educate clinicians about risk without discouraging appropriate treatment of depression?

Some worrisome trends in the rates of treatment of depression, diagnoses of new cases of depression, and suicide attempts since the black-box warning was issued suggest that the answer may be no. In a very large cohort study — including 1.1 million adolescents, 1.4 million young adults,
Healing Through Unity

When I entered the Medicine Lodge for the first time in 1970, I had tried to end my life multiple times. I had a serious addiction to intravenous heroin and cocaine and I was diagnosed as having PTSD and a bi-polar challenge. I thought I was the only one who went through a terrible childhood as a result of Mother having been put in a brutal residential school for ten years, from the ages of 6 through 16, but sitting around that sacred fire, I heard my story recounted by nearly everyone in the Circle. I began to believe I was not alone...that my story was not unique...that I could begin to heal with the help of our sacred medicines, our Elders, and the Relatives in that Circle. It’s been nearly 50 years and I’m still healing every day...still holding on to that sacred Circle. I know it works, and I’m here to prove it.

— Mi’kmaq First Nation Elder
Suicide contagion

Werther

Papageno

THE INFLUENCE OF SUGGESTION ON SUICIDE: SUBSTANTIVE AND THEORETICAL IMPLICATIONS OF THE WERTHER EFFECT*

DAVID P. PHILLIPS

State University of New York at Stony Brook


This paper shows that suicides increase immediately after a suicide story has been publicized in the newspapers in Britain and in the United States, 1947-1968. The more publicity devoted to a suicide story, the larger the rise in suicides thereafter. The rise in suicides after a story is restricted mainly to the area in which the story was publicized. Alternative explanations of these findings are examined: the evidence indicates that the rise in suicides is due to the influence of suggestion on suicide, an influence not previously demonstrated on the national level of suicides. The substantive, theoretical, and methodological implications of these findings are examined.

Role of media reports in completed and prevented suicide: Werther v. Papageno effects

Thomas Niederkrotenthaler, Martin Voracek, Arno Herberth, Benedikt Till, Markus Strauss, Elmar Etzersdorfer, Brigitte Eisenwort and Gernot Sonneck

Background
Media reporting of suicide has repeatedly been shown to trigger suicidal behaviour. Few studies have investigated the associations between specific media content and suicide rates. Even less is known about the possible preventive effects of suicide-related media content.

Aims
To test the hypotheses that certain media content is associated with an increase in suicide, suggesting a so-called Werther effect, and that other content is associated with a decrease in suicide, conceptualised as a Papageno effect. Further, to identify classes of media articles with similar reporting profiles and to test for associations between these classes and suicide.

Method
Content analysis and latent class analysis (LCA) of 497 suicide-related print media reports published in Austria between 1 January and 30 June 2005. Ecological study to identify associations between media item content and short-term changes in suicide rates.

Results
Repetitive reporting of the same suicide and the reporting of suicide myths were positively associated with suicide rates. Coverage of individual suicidal ideation not accompanied by suicidal behaviour was negatively associated with suicide rates. The LCA yielded four classes of media reports, of which the mastery of crisis class (articles on individuals who adopted coping strategies other than suicidal behaviour in adverse circumstances) was negatively associated with suicide, whereas the expert opinion class and the epidemiological facts class were positively associated with suicide.

Conclusions
The impact of suicide reporting may not be restricted to harmful effects; rather, coverage of positive coping in adverse circumstances, as covered in media items about suicidal ideation, may have protective effects.

Declaration of interest
None.
Resources

See slides with links embedded in pictures

Weaving Culture into Suicide Prevention Strategies

Rob England of the Yurok Tribe and United Indian Health Services, Inc., highlights the merits of weaving culture into evidence-based suicide prevention strategies to engage multiple generations of Native community members in prevention efforts that are effective and transformative.

Wholeness and Wellness Through Stick Games and Flower Dances

Virgil Moorehead from Two Feathers Native American Family Services and Dr. Cutcha Risling Baldy, professor of Native American Studies at Humboldt State are collaborating to study the impact of cultural practices and ceremony and to rethink Native American Mental Health.

Cultural Continuity as a Hedge Against Suicide in Canada’s First Nations

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Abstract  This research report examines self-continuity and its role as a protective factor against suicide. First, we review the notions of personal- and cultural continuity and their relevance to understanding suicide among First Nations youth. The central theoretical idea developed here is that, because it is constitutive of what it means to have or be a self to somehow count oneself as continuous in time, anyone whose identity is undermined by radical personal and cultural change is put at special risk of suicide for the reason that they lose those future commitments that are necessary to guarantee appropriate care and concern for their own well-being. It is for just such reasons that adolescents and young adults—who are living through moments of especially dramatic change—constitute such a high-risk group. This generalized period of increased risk during adolescence can be made even more acute within communities that lack a concomitant sense of cultural continuity which might otherwise support the efforts of young persons to develop more adequate self-continuity-warranting practices. We present data to demonstrate that, while certain indigenous or First Nations groups do in fact suffer dramatically elevated suicide rates, such rates vary widely across British Columbia’s nearly 200 aboriginal groups: some communities show rates 800 times the national average, while in others suicide is essentially unknown. Finally, we demonstrate that these variable incidence rates are strongly associated with the degree to which British Columbia’s 196 bands are engaged in community practices that are employed as markers of a collective effort to rehabilitate and vouchsafe the
Thanks to collective efforts of IHS and Tribal Community Members
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