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What Works in Indigenous Suicide Prevention?

Adopting & Adapting Evidence-Based Practices

Opening

- Who Am I?
  - Academic Psychologist
    - Clinically-Trained
    - Community-Engaged
    - Culturally-Attuned
  - Research Interests
    - Culture, Coloniality, & Mental Health
    - Indigenous Psychologies
    - Cross-Cultural Interventions

Opening

- Goals of Presentation
  - Present the Rationale for Evidence-Based Practice
  - Review the Evidence Base for Mainstream Suicide Interventions
  - Describe the Evidence Base for Indigenous Suicide Interventions
  - Reflect on Strategies to Reduce Indigenous Suicide

Rationale for Evidence-Based Practice

Round 1

Rationale for Evidence-Based Practice

- Why EBP in Mental Health (MH) Services? *(Gone & Alcantara, 2007)*
  - Need for MH treatments eclipses availability (allocation of scarce MH resources)
  - Most workaday MH IVs have not been rigorously evaluated (clinician practice deviates from structured IVs)
  - MH providers believe that their IVs work best (based on training & experience)

Rationale for Evidence-Based Practice

- Why EBP? (cont)
  - Beliefs in efficacy can be mistaken *(Lilienfeld et al., 2014)*
  - Some treatments have been shown to cause harm (e.g., Facilitated Communication, D.A.R.E., CISD)
  - Commitment to provide healthcare services that are maximally likely to help people (& to not harm them)

Rationale for Evidence-Based Practice

- How to Develop EBP in MH Services?
  - Evidence-Based Practice (EBP) *(Kazdin, 2008)*
    - Best Research Evidence
    - Client Values & Preferences
    - Clinician Expertise
  - Development of EBP Starts as a Research Endeavor

Rationale for Evidence-Based Practice

- How to Develop EBP (cont)
  - Empirically-Supported MH Treatments
    - Originates in tightly-controlled efficacy trials to establish cause & effect (but such studies are highly artificial)
    - Confirmed through replication of positive results across multiple studies (but most studies are not extensively replicated)
    - Expanded to *effectiveness trials* in workaday healthcare settings to ensure generalizability (but reduced effectiveness can be observed)
    - Proven benefits across numerous studies are incorporated into formal Clinical Practice Guidelines (but this requires large numbers of participants in high-quality studies)
    - Proven IVs are rolled out to the real world through Dissemination & implementation efforts (but training is burdensome)

Evidence-Based Suicide IVs

Round 2

Evidence-Based Suicide IVs

- Hofstra et al. (2020) Systematic Review & Meta-Analysis
  - Formal meta-analysis of 15 controlled studies (3 types) from 2011-2017 with 29,071 participants focused on completed suicides (N = 62) & attempted suicides (N = 1006)
  - Findings
    - For preventing completed suicides
      - Any IV = large effect
      - Setting: Psychiatric ward (large effect) > Community-level IV (large effect) > Emergency room (n.s.) > Outpatient specialty MH (n.s.)
      - Multilevel IVs = Large effect, Non-multi-level IVs = n.s.
    - For preventing attempted suicides
      - Any IV = moderate effect
      - Setting: Outpatient specialty MH (large) > Psychiatric ward (moderate effect) > Community-level IV (small effect) > Emergency room (small effect)
      - Multilevel IVs = Large effect, Non-multi-level IVs = moderate effect

Evidence-Based Suicide IVs

- Hofstra et al. (cont)
  - Findings (cont)
    - Better Outcomes from Combining IVs (Single-level IVs = small effect, Two-level IVs = moderate effect, Three-level IVs= large effect)
  - Implications
    - Small number of controlled studies (N = 16) targeting completed or attempted suicide (*not* ideation)
    - Suicide IVs have different effects on different outcomes across different settings
    - Recommend multilevel approaches across different providers, domains, & settings (but further research is needed)

Evidence-Based Suicide IVs

- Mann et al. (2021) Systematic Review in *AJP*
  - Included 97 RCTs & 30 epidemiological studies from 2005-2019 focused on suicide, attempted suicide, or suicidal ideation
  - Narrative review (not meta-analysis) that assessed *replicated efficacy* & *scalability* of IVs
  - Findings
    - Effective & Scalable IVs
      - Educating primary care physicians in diagnosis & treatment of depression (e.g., antidepressants)
      - Educating high school students about MH
      - Means restriction
      - Predischarge education & outreach following hospitalization or crisis

Evidence-Based Suicide IVs

- Mann et al. (cont)
  - Findings (cont)
    - Effective but Less Scalable IVs
      - Psychotherapies = Cognitive Behavioral Therapy + Dialectical Behavior Therapy
    - Unproven but Scalable & Promising IVs
      - Fast acting medications (Ketamine)
      - Internet-based screening & treatment + Passive monitoring via smartphone
    - Ineffective IVs
      - Educating gatekeepers about youth suicidal behavior
    - Many Limitations: Small samples + Few studies + Lack of replication + Suicidal ideation as outcome + Effective IV elements are unknown + Ambiguous criteria for scalability

Evidence-Based Suicide IVs

- Take-Home Points
  - There are forms of suicide IV that work
  - Combining more than one IV into multilevel approaches works even better (e.g., Zero Suicide Model *[Brodsky et al., 2018]*)
  - BUT not all popular suicide IVs have been shown to work (e.g., Gatekeepers for youth)
  - Research evidence on suicide IVs is complex & evolving, & keeping up to date is a challenge for everyone

Indigenous Suicide IVs

Round 3

Indigenous Suicide IVs

- Pham et al. (2021) Systematic Review of IV Outcomes in *SSM-Mental Health*
  - Research Question: *What interventions work to prevent American Indian / Alaska Native suicide?*
  - Broad inclusion criteria to capture wide range of IV outcome studies
  - Identified 28 studies for 23 unique IVs from 1976-2020 using:
    - Direct measures of suicidal behavior (e.g., attempt, ideation) (N = 11)
    - Indirect measures of proxy variables (e.g., hopelessness, alcohol abuse) (N = 26)
  - Narrative review: Diversity across studies prevented formal meta-analysis
  - Impressive corpus, given challenges of Indigenous community research
  - Many of these researchers are involved in today's workshop

Indigenous Suicide IVs

- Pham et al. (cont)
  - Major Finding: Designs of these studies preclude conclusions about effectiveness
    - Controlled Studies: 1 RCT *(Tingey, 2020)* + 3 Quasi-experiments *(LaFromboise et al., 1994, 1995; Allen et al., 2018)*
    - Uncontrolled Studies: 21 Single group designs + 3 Case reports
  - Lessons Learned
    - It is not possible from this corpus to scientifically conclude which IVs "work" to prevent Indigenous suicide
    - Only 4 studies included comparison/control groups (with just 1 RCT)
    - Only 2 IVs appeared across multiple outcome studies (American Indian Life Skills + Qungasvik) = Limited replication

Indigenous Suicide IVs

- Pham et al. (under review) Systematic Review of IV Rationales
  - Research Question: *What logics or rationales have structured interventions aimed at preventing suicidal behaviors among American Indian / Alaska Native populations?*
  - Broad inclusion criteria to capture wide range of IV studies reporting implementation findings
  - Identified 32 studies about 24 distinct IVs from 1976-2020 focused on attributes & characteristics of these programs
    - Concentrated in few US regions (e.g., Southwest, Alaska)
    - Settings include schools (N = 9) & communities (N = 8)
    - Youth focus (N = 16)

Indigenous Suicide IVs

- Pham et al. (cont)
  - Classified studies according to established CDC prevention strategies
    - Promote connectedness (N = 15)
    - Create protective environments (N = 12)
    - Identify & support people at risk (N = 12)
    - Teach coping and problem-solving skills (N = 10)
    - Strengthen access & delivery of suicide care (N = 5)
    - Lessen harms & prevent future risk (N = 3)
    - Strengthen economic supports (N = 3)

Indigenous Suicide IVs

- Pham et al. (cont)
  - Trends in Indigenous Suicide Research
    - Most communities *adopted* mainstream suicide IVs as the backbone of their programs
    - Most communities *adapted* these IVs to fit community needs & sensibilities (e.g., collectivist self-orientations, culture-as-treatment, strengths-based approaches)
    - Comparably less emphasis on: transforming healthcare services (e.g., hiring more providers, improving depression treatment) + community-wide policies (e.g., firearm control, regulating alcohol access)

Indigenous Suicide IVs

- Pham et al. (cont)
  - Adaptations for Indigenous Orientations & Commitments
    - Sociocentric selfhood & collectivist identities
    - Shared suffering, historical trauma, & psychosocial anomie
    - Preference for local (nonprofessional) helpers
    - Implementation of suicide prevention as a form of decolonization

Indigenous Suicide IVs

- Pham et al. (cont)
  - Take Home Points
    - Indigenous communities both adopt and adapt mainstream suicide prevention strategies
    - Processes of IV adoption & adaptation are responsive to community orientations & commitments
    - Rigorously-designed scientific outcome studies are extremely rare
    - Effectiveness of these adapted community IVs remains an open scientific question

Reflections on Preventing Indigenous Suicide

Round 4

Reflections on Preventing Indigenous Suicide

- Four Facets of Indigenous Suicide Prevention
  - Development of EBP requires scientific research on IV outcomes
  - Robust IV outcome research is challenging & rare in our communities
  - Promotion of formal evidence-based suicide prevention in our communities will therefore require both adoption & adaptation of mainstream IVs
  - Our communities are already doing this

Reflections on Preventing Indigenous Suicide

- Four Questions Concerning Evidence-Based Suicide IVs (EBSIs)
  - How confident are we that mainstream EBSIs deserve special recognition & promotion in our communities?
    (as opposed to cultivating our own approaches)
  - What are the prospects for adopting & adapting additional mainstream EBSIs (e.g., means restrictions, better depression treatment)?
    (given striking capacity & resource constraints)
  - How can we design multilevel suicide IV programs across providers, domains, & settings?
    (despite existing administrative challenges)
  - What resources are available to us to develop more comprehensive suicide prevention services & to assess the impacts of those services?
    (as opposed to designing, adopting, & adapting *without* keeping track of outcomes)

Closing

Closing

- For more information on these projects (& to download my publications) go to:

gonetowar.com