

**National Center for American Indian and Alaska Native Mental Health
Research
Data Request Form**

Date: March 1, 2007

Name: _____

Project: _____

Wave(s) Needed: All _____

Data Form (check one):

ASCII file (free form)

SPSS system file

SAS system file

File Name (s): Select components of the item-level, scale, and diagnostic data sets.

Specific Variables (or "All"): Please see attached proposal

Purpose of Analyses: Please see attached proposal

Disclaimer:

As a part of being granted access to data obtained from the NCAIANMHR's database, the requester must agree to acknowledge both the appropriate funding source and the National Center specifically. In preparing publications / presentations from this data, the requester must keep in mind issue pertaining to confidentiality. No tribe, site, nor individual involved in the project may be referred to by proper name.

Data Access Proposal

NAME

TITLE

This proposal serves as a request to the National Center for American Indian and Alaska Native Mental Health Research for access to data from the American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (AI-SUPERPPF). Access to the data would enable an investigation of individuals' mental health service use and help-seeking around the time that they thought about or attempted suicide. Identifying positive and negative correlates of help-seeking during a suicidal episode can help inform suicide prevention efforts, specifically programs designed to increase help-seeking among American Indians at risk for suicide.

The investigator, Dr. __, is an assistant professor at the University of Denver Graduate School of Social Work. Her research foci are suicide prevention and help-seeking. Her dissertation, which was funded by the National Institute of Mental Health, examined predictors of mental health service use among recently suicidal adolescents surveyed in the National Household Survey on Drug Abuse. This study revealed substantial racial and ethnic disparities in mental health service utilization among the recently suicidal youth, with White youth most likely to have used mental health services (__ , 2007).

Dr. __ has previous experience investigating suicidality and help-seeking among American Indian youth in a southwestern state. As part of the American Indian Multi-sector Help Inquiry (AIM-HI), for which __ and __ were the principal investigators, Dr. __ investigated suicide risk factors and help-seeking in a mixed sample of urban and reservation youth. Dr. __ served as first author of two journal articles from that study: “__” and “__.” She also led interviewer training sessions at the reservation site.

The following material describes the proposed study's background and significance, research questions, analytic methods, and variables requested from the AI-SUPERPPF data set.

Background and Significance

Suicide in American Indians

Suicide is a pressing public health problem in many American Indian communities. Although suicide rates vary among the 561 American Indian and Alaska Native tribal entities and groups in the United States (Bureau of Indian Affairs, 2005), with some Indian reservations having lower suicide rates than average (Van Winkle & May, 1993), the overall suicide rate among American Indians and Alaska Natives is 2 times higher than the national average (Indian Health Service, 2004). Suicide is the 8th leading cause of death among American Indians and Alaska Natives, compared to 11th in the general U.S. population (Centers for Disease Control and Prevention, 2007). Notably, the suicide rate among American Indians is highest among adolescents and young adults, the reverse of the overall pattern in the United States of older adults having the highest suicide risk. Suicide at any age is a tragedy, but the loss of young American Indians also represents the loss of future generations for a group already threatened by centuries of oppression, persecution, and forced acculturation.

Suicide attempts also appear to occur at higher rates among American Indians than among the general U.S. population. Among adults, a study using AI-SUPERPFP data from 1,638 Northern Plains participants (ages 15 to 57) found that 11% of women and 7% of men reported a lifetime suicide attempt (Garrouette et al., 2003). In comparison, only 4.6% of 5,877 adults in the National Comorbidity Survey indicated that they had ever attempted suicide (Kessler, Borges, & Walters, 1999). Among American Indian and Alaska Native adolescents, suicide attempt rates of 14% to 27% have been reported (Borowsky, Resnick, Ireland, & Blum, 1999; Frank & Lester, 2002; Freedenthal & Stiffman, 2004). Most studies of suicide attempts in American Indian and Alaska Native youth center on adolescents, who are at highest risk for such behaviors; in one study of 194 suicide attempts on a Northern Plains reservation, more than half occurred among adolescents and fewer than 5% took place among people older than 44 (Zitzow & Desjarlait, 1994).

Suicidal ideation is less studied than suicide and suicide attempts. Of 1,353 high school students, 3.5% screened positive for suicidal ideation in the prior month (Novins, Beals, Robert, & Manson, 1999). A study of Northern Plains Indians participating in the AI-SUPERPFP study discerned 5.3% and 8.2% lifetime prevalence rates of suicidal ideation for, respectively, men and women (LeMaster, Beals, Novins, & Manson, 2004). In contrast, 13.5% of 5,877 respondents in the National Comorbidity Survey reported any prior suicidal ideation (Kessler et al., 1999). It should be noted that the NCS analysis contained a subset of the study's 8,098 respondents, and this subset comprised all individuals who met criteria for a psychiatric diagnosis, as well as randomly sampled participants from the overall study. Although NCS results were weighted to account for the differential probability of selection to the subset, the disproportionately high membership of people with a psychiatric disorder could account for its higher prevalence of suicidal ideation data; nevertheless, the specialized subset had a lower suicide attempt rate than the general sample of AI-SUPERPFP respondents.

Suicidality and Help-Seeking

Only a few published research studies have examined American Indians' use of mental health services or traditional healers during a suicidal episode. Using data from the AIM-HI study in the southwest, Dr. ___ and I found that 40% of 101 American Indian youth (ages 15 to 21) reported seeking help from a mental health professional when they thought about or attempted suicide (___, 2007). Only 2 youth in the sample went to a medicine man or other traditional healer for help with suicidal thoughts or behavior. Commonly reported barriers to formal or informal help-seeking centered on attitudinal factors, such as stigma and fear, rather than structural factors such as transportation and costs.

Another study looked at health service use prior to suicide on a Plains reservation (Mock, Grossman, Mulder, Stewart, & Koepsell, 1996). Findings showed that 24% of 21 suicide decedents (ages 15 to 28) had consulted any type of medical professional at the reservation's hospital or clinics, and 10% had received mental health services, in the six months before their death. Among 40 people who made a nonfatal suicide attempt, 57% had used any health services in the 6 months before the attempt, and 35% had talked with a mental health professional.

Besides these studies, no others have looked at formal and informal help-seeking related to suicidality specifically among American Indian youth or adults. Looking more broadly,

studies on help-seeking among suicidal people in general have examined mental health service use both prior to suicide and, in living study participants, around the time of suicidal thoughts or behavior. On average, only 32% of suicide decedents met with a mental health professional within a year of their death (reviewed in Luoma, Martin, & Pearson, 2002). In national studies of youth, almost 30% of those reporting suicide ideation or a suicide attempt in the prior year had seen a mental health professional during the same time period (Freedenthal, 2005; Pirkis et al., 2003).

Help-Seeking and Service Use in American Indians

The AI-SUPERPFP studies have revealed much about American Indians' help-seeking and service use, and these studies will inform the proposed investigation. Specifically, 11% to 13% of American Indians sampled used formal or traditional types of help for psychiatric problems, including substance use, in the previous year (Beals et al., 2006; Novins et al., 2004). Almost 7% of 2,595 AI-SUPERPFP participants used biomedical services, including specialty mental health, and 3% to 8% saw a traditional healer for emotional or substance use problems (Novins et al., 2004). Among participants who met criteria for a psychiatric disorder, less than one third had ever used specialty mental health services (Beals et al., 2005). Ethnic identity positively related to service use in various AI-SUPERPFP analyses (Beals et al., 2006; Novins et al., 2004).

Research Questions

The proposed study seeks to build on previous AI-SUPERPFP research by looking at the prevalence, pattern, and correlates of receiving help (formal or traditional) specifically among study participants who reported suicidal thoughts or a suicide attempt in the previous year. The study will be guided by the following questions:

1. How many American Indians who reported suicidal thoughts or a suicide attempt used one or more of the following types of services: psychiatric, substance use or traditional healing?
 - a. How many American Indians who reported suicidal thoughts or a suicide attempt in the *prior year* used services in that year?
 - b. How many American Indians who reported *lifetime* suicidal thoughts or a suicide attempt ever used services?
2. Using a well-known model of health care utilization, what predisposing, enabling, and need factors relate to receipt of the different types of help (past year and lifetime) in the *previously suicidal participants*?
3. How do suicide-related need factors interact with predisposing, enabling, and other need factors when statistically predicting receipt of help in *the entire sample*?

Practical Implications

To date, none of the published AI-SUPERPPF research has broken down receipt of formal or traditional help by prevalence of suicidal thoughts or suicide attempts. Yet the data contain a wealth of variables that could illuminate the prevalence of help-seeking by American Indians who thought about or attempted suicide within the prior year or ever in their life, as well as the patterns and correlates of such help-seeking. Such information would be valuable to tribal leaders, Indian Health Service administrators, national policy makers and others involved in suicide prevention efforts for American Indians. Understanding the rates, types, and correlates of help-seeking could improve suicide prevention efforts by leading to, among other things, outreach campaigns targeted toward a specific audience (e.g., men), a greater understanding among clinicians of barriers to explore (e.g., access to care), and sector-specific (e.g., traditional healers) suicide education for popular types of care.

Analytic Plan

Measures

The behavioral model of health service utilization (Andersen & Aday, 1978; Andersen, 1995) will provide a framework for answering the research questions. This model posits that other factors, besides need for care, dictate whether people seek care when they need help. These factors unrelated to need largely hinge on sociodemographic and financial variables, and they may account for racial and ethnic disparities in health service use (Aday & Andersen, 1981).

For the proposed study, *predisposing factors* will include age, gender, blood quantum level, and cultural identity. Employment status, health insurance status, and social support will comprise *enabling factors*. Suicidality is itself an indicator of need for care; participants will be categorized according to whether they had a) no lifetime or 12-month history of suicidality (ideation or attempt), b) a history of suicidality but none in the prior year, c) suicidal thoughts in the prior year but no attempt during that time, or d) a suicide attempt in the prior year; it may be necessary to collapse ideators with attempters, for the sake of statistical power. Other *need-related factors* will include a family history of suicidal behavior, diagnosis of depression or anxiety, substance use disorder, or comorbid depression / anxiety and substance use disorder.

Specific variables, with code names, to be included in the proposed study are listed in the table further below.

Analyses

Descriptive statistics will address the first research question, which asks about rates of help-seeking by recently suicidal study participants. Prior to addressing Research Questions 2 and 3, bivariate analyses (*t* tests and chi square analyses) will compare rates of help-seeking, by type, according to each predisposing, enabling, and need-related factor.

To answer the second research question, logistic regression models will be built for each type of helper (specialty mental health, medical or traditional) if possible; these research questions concern statistical predictors of service use by suicidal people only. If insufficient statistical power exists to examine the sectors of care separately, then any type of help-seeking

will be the dependent variable. Only the predisposing, enabling, and need factors significant in bivariate analyses, as well as those crucial as control variables (e.g., gender), will be included in the regression models. Additionally, exploratory analyses will test for bivariate interaction effects by suicidality and each variable; significant interactions will be tested in the overall multivariate model and retained when significant, if sufficient statistical power exists. Similar analyses will be carried out to answer the third research question, except the entire sample will be used and level of suicidality will be an independent variable.

Statistical Power

To compute statistical power, I used the least powerful method of assessing associations, the 2x2 contingency table. Even with this less powerful method, the data have 80% power to detect an odds ratio of 2.6 among the smaller subsample of recently suicidal participants ($n=170$) in a 2x2 contingency table with an alpha of .05, service use as the dependent variable, and an independent variable (e.g., gender) with a 50 / 50 split; using findings from the AI-SUPERPFPP study of the Northern Plains tribe (LeMaster et al., 2004), I estimated that 170 people in the study thought about or attempted suicide in the prior year.

The larger sample size ($N=3,084$) gives the data 80% power to detect an odds ratio as low as 1.4. Power increases in multivariate models, because the addition of multiple covariates has a noise-reducing effect, resulting in smaller standard errors. Katz (1999) states that, in multivariate models, 20 participants are needed for each independent variable. Thus, the model for the recently suicidal subsample will of necessity be constrained to 8 independent variables, which will be selected after bivariate analyses, as described earlier.

Although previous AI-SUPERPFPP articles have reported a low rate of formal and traditional help for mental health and substance use problems in the overall sample, rates typically are much higher when focusing on individuals with a high need for help. For example, although Beals et al. (2006) found that 13% of the sample received help for substance use problems, this proportion increased to 38% when looking only at those who had a substance use disorder in the prior year; hence, the extrapolated bivariate odds ratio for service use equals 4.1 for the substance use disorder group. Likewise, high need for help is commonly found in those with suicidality.

Variables Requested

CONSTRUCTS	VARIABLE NAMES / IDENTIFIERS
Sample weights	(Not listed in survey)
Demographics	
Location / site	11 / SITE
Years lived on reservation	470-472 / FH05A
Years lived near reservation	473-475 / FH05B
Years lived far from reservation	476-478 / FH05C
Years lived in current community	483-484 / FH06_MO & 485-486 / FH06_YR
Birth year	16-17 / BYEAR
Gender	18 / GENDER
Current year	23-26 / CURRYEAR
Marital status	

Are you currently married...	43 / A03
Does your spouse live here...	44 / A03A
Are you in a marriage like...	45 / A03A_
Are you currently living with...	46 / A03B
Number of children	396-397 / D02A
Education	
Highest grade in school	51-52 / E01
High school graduate / status	53 / E02
GED	54 / E02A
Ever attend college / university	59 / E03_5
Currently attend college / university	71 / E03E_CU
Degree from college / university	72 / E03E_DE
Race / Ethnicity	
Blood quantum	274-279 / ET04
Religion	
Protestant	513 / FH10A
Catholic	514 / FH10B
Mormon	515 / FH10C
Native American Church	516 / FH10D
Traditional Indian belief	517 / FH10E
Other	518 / FH10F
None / No religion	519 / FH10G
Spirituality	1377 through 1433 / SP01 through SP47
Cultural factors	
How much was (native language) spoken...	520 / FH11
How much was English spoken...	521 / FH12
How much was Spanish spoken...	522 / FH13
Health	
In general, would you say your health is...	899 / FS01
Compared to one year ago, how rate health	900 / FS02
Enabling Factors	
Income	
Family income in 1996 (total)	294-295 / I01
Personal income in 1996 (total)	302-303 / I02
Employment	
Working full-time now	138 / F01A
Working part-time now	139 / F01B
Working on and off	140 / F01C
Unemployed / laid off	141 / F01D
Retired	142 / F01E
Student	143 / F01F
Disabled	144 / F01G
Never worked for pay	145 / F01H
<i>If 2 or more of above:</i>	
Main activity now	147 / F02
How long had (full-time) job (months / years)	148-149 / F03_MO & 150-151 / F03_YR
How long had (part-time) job (months / years)	163-164 / F10_MO & 165-166 / F10_YR
How long unemployed	180-181 / F19_MO & 182-183 / F19_YR
How long retired	209-210 / F30_MO & 211-212 / F30_YR
Working as retiree	214 / F32
How long in school	223-224 / F36_MO & 225-226 / F36_YR
Working as student	227 / F37
How long disabled	238-239 / F42_MO & 240-241 / F42_YR

Working though disabled	242 / F43
Eligible for VA benefits	1182 / HS060S
Social support	1170 / SL02 through 1216 / SL45
When you had emotional problem, did you talk to a friend or family member about it?	1359 / SAM01
“ ” past year	1360 / SAM01A
Coping skills	1291 / AC02 through 1298 / AC09
Need-related Factors	
Suicidality	
Ever wanted to die for 2 weeks or more	2325 / DP47 (1142)
Thought about committing suicide	2326 / DP48 (1143)
Ever attempted suicide	2327 / DP49 (1144)
Thoughts of committing suicide in past month	1241 / SY26
Ever seriously thought about committing...	1309 / SU01
Ideation frequency, past year	1310 / SU01A
Ever planned how would commit suicide...	1311 / SU01B
Plan in prior year	1312 / SU01B1
Ever told someone thinking about suicide	1313 / SU01C
Family member	1314 / SU01C1A
Friends / peers	1315 / SU01C1B
Co-worker	1316 / SU01C1C
Trusted confidant	1317 / SU01C1D
Service provider	1318 / SU01C1E
Other	1319
Told someone about ideation in past year	1320 / SU01D
Family member	1321 / SU01D1A
Friends / peers	1322 / SU01D1B
Co-worker	1323 / SU01D1C
Trusted confidant	1324 / SU01D1D
Service provider	1325 / SU01D1E
Other	1326
Ever attempted suicide	1327 / SU02
# times attempted	1328 – 1331 / SU02A
Attempted suicide in past year	1339 / SU02C
Family history of suicide / attempted suicide	527 / FH18
Natural mother	528 / FH18_1A
Natural father	529 / FH18_1B
Stepmother	530 / FH18_1C
Stepfather	531 / FH18_1D
Mother substitute	532 / FH18_1E
Father substitute	533 / FH18_1F
Brother	534 / FH18_1G
Sister	535 / FH18_1H
Stepbrother	536 / FH18_1I
Stepsister	537 / FH18_1J
Other	538 / FH18_1K
Anyone in family talked to doctor or counselor about suicide problem	539 / FH18_2
" " traditional healer or medicine man / suicide	540 / FH18_3
also:	
"Did a family member or someone close to you ever commit suicide?"	617 / TR16
Frequency	618-621 / TR16FQ

First age	622-624 / TR16AGE1
Last age	625-627 / TR16AGE2
Witnessed event	811 / TRI16.02WT & 812 / TR16.02FO
Family history of depression	FH19 / 541
Natural mother	542 / FH19_1A
Natural father	543 / FH19_1B
Stepmother	544 / FH19_1C
Stepfather	545 / FH19_1D
Mother substitute	546 / FH19_1E
Father substitute	547 / FH19_1F
Brother	548 / FH19_1G
Sister	549 / FH19_1H
Stepbrother	550 / FH19_1I
Stepsister	551 / FH19_1J
Other	552 / FH19_1K
Anyone in family talked to doctor or counselor about depression	553 / FH19_2
" " traditional healer or medicine man / dep.	554 / FH19_3
Self-rated mental health	901 / FS02A
Psychiatric disorder	
Major depressive disorder	<i>As these variables were constructed using a diagnostic algorithm, the instrument does not contain their codes. I request these variables for both lifetime and 12-month diagnoses.</i>
Dysthymic disorder	
Generalized anxiety disorder	
Panic disorder	
Posttraumatic stress disorder	
Alcohol abuse	
Alcohol dependence	
Drug abuse	
Drug dependence	
Depressive and / or anxiety disorder only	
Substance disorder only	
Comorbid depressive / anxiety and substance	
Help-Seeking and Service Use	
Attitudes toward help-seeking	1340 – 1358 / AM01 – AM19
Help-seeking	1359 – 1376 / SAM01 – SAM09-YR
Family history of help-seeking (professional)	569 / FH21
Family history of help-seeking (traditional)	570 / FH22

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