Yellowhawk Tribal Health Center

Circles of Hope Youth Suicide Prevention Program

Community Readiness Assessment Results

Submitted to:

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COMMUNITY READINESS ASSESSMENT RESULTS 2019

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Informing Policy and Improving Programs
to Enrich People's Lives

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Background

The Community Readiness Assessment (CRA) helps communities assess their level of readiness to create and implement prevention and intervention activities tailored to their own unique community. The underlying idea is that if a community is not ready for a particular type of prevention or intervention, then efforts to implement those activities will be unsuccessful. Not meeting the community where it is will result in wasted time and resources.

The CRA uses key informant interviews to help identify community characteristics that correspond to different levels of community readiness for change. It provides a systematic method for determining the level of readiness to address a certain issue. Then, based upon that level, it provides guidance for developing effective prevention strategies appropriate to the current readiness level. The CRA developers write that the CRA "Is a model for community change that integrates a community's culture, resources and *level of readiness* to more effectively address suicide prevention" (Community Readiness Manual, 2017, p. 4, italics and capitals in the original text).[1]

Circles of Hope Youth Suicide Prevention Program

The Circles of Hope (CoH) Youth Suicide Prevention program is funded by a 5-year grant that ends in September 2019. In 2014, as part of the funding proposal, CoH staff at Yellowhawk Tribal Health Center (Yellowhawk) used the CRA model to help develop strategies for suicide prevention in the Confederated Tribes of Umatilla Indian Reservation (CTUIR) community.[2] In 2019, the CoH team was interested in learning whether their efforts over the past 5 years had led to a different level of readiness from 2014.

Conducting the Community Readiness Assessment at CTUIR

In accordance with the CRA model, the CoH project team generated a list of key stakeholders who have different types of knowledge about CTUIR, CoH activities, and the youth served by the program. The developers of the CRA built their model on extensive research showing that interviewing a cross section of individuals from various parts of a community results in a surprisingly robust assessment of community readiness.

CoH staff contacted the interviewees to set up an in-person or telephone interview with the project evaluator who interviewed 6 community members in person in a private Yellowhawk talking room, and 2 people by telephone. The interview questions can be found in Appendix A.

[1] The Community Readiness Model developers updated the manual in 2017 specifically for suicide prevention. This 2017 manual guided the 2019 Yellowhawk suicide prevention CRA. Plested, B. A., Jumper-Thurman, P., & Edwards, R. W. (Revised March 2017). *Community Readiness Manual*. The National Center for Community Readiness, Colorado State University: Fort Collins, CO.

[2] The CoH evaluator conducted interviews with 9 key stakeholders between April 15, and April 24, 2014.

She recorded their answers on a password-protected laptop. Interviewees were assured that the interviews were confidential and that their answers would be put together with all the other interviewees' answers for the report. The CRA tool used in 2019 has 27 questions related to the six dimensions of community readiness to engage in suicide prevention efforts.

The Six Dimensions of Community Readiness

The six dimensions of community readiness are:

1. Community Efforts
2. Community Knowledge of the Efforts
3. Leadership (includes appointed leaders and influential community members)
4. Community Climate
5. Community Knowledge About the Issue
6. Resources Related to the Issue (time, money, people, space, etc.)

For each dimension of readiness, a community can have a different readiness level. Based upon criteria created by the developers of the CRA model, answers to the interview questions are summarized by dimension into rating scores ranging from 1 to 9 for each individual person interviewed. The individual scores for each dimension are then averaged for one overall dimension score. Using the six average dimension ratings, staff can choose appropriate suicide prevention strategies. For example, if there are many efforts (high score on Dimension 1), but no one knows about them (low score on Dimension 2), then that would suggest that more—or more effective—advertising about the efforts is needed. More in-depth descriptions of each dimension are included with the dimension results below.

Scoring of Interviews to Determine Readiness Level

Interviews were scored separately by two NPC researchers following specific guidelines provided in the CRA Manual. Based upon dimension-specific interview answers, each dimension received a score from 1-9 according to an anchored scale for that particular dimension (pp. 20-25).[3] The researchers then met to compare scores and come to consensus on the final score for each interview and each dimension. The 8 interviewees' dimension scores were then averaged for each dimension, resulting in the final six dimension scores. According to the CRA Manual, average scores are rounded down to a whole number for the final dimension score.

The various stages of readiness are **1 – no awareness**, **2 – denial**, **3 – vague awareness**, **4 – preplanning**, **5 – preparation**, **6 – initiation**, **7 – stabilization**, **8 – confirmation/expansion**, and **9 – a high level of community ownership**. More details about the characteristics of these stages is included in Appendix B.

[3] Scorers also considered answers to questions in other sections that might inform the dimension.

CTUIR Readiness Score Results

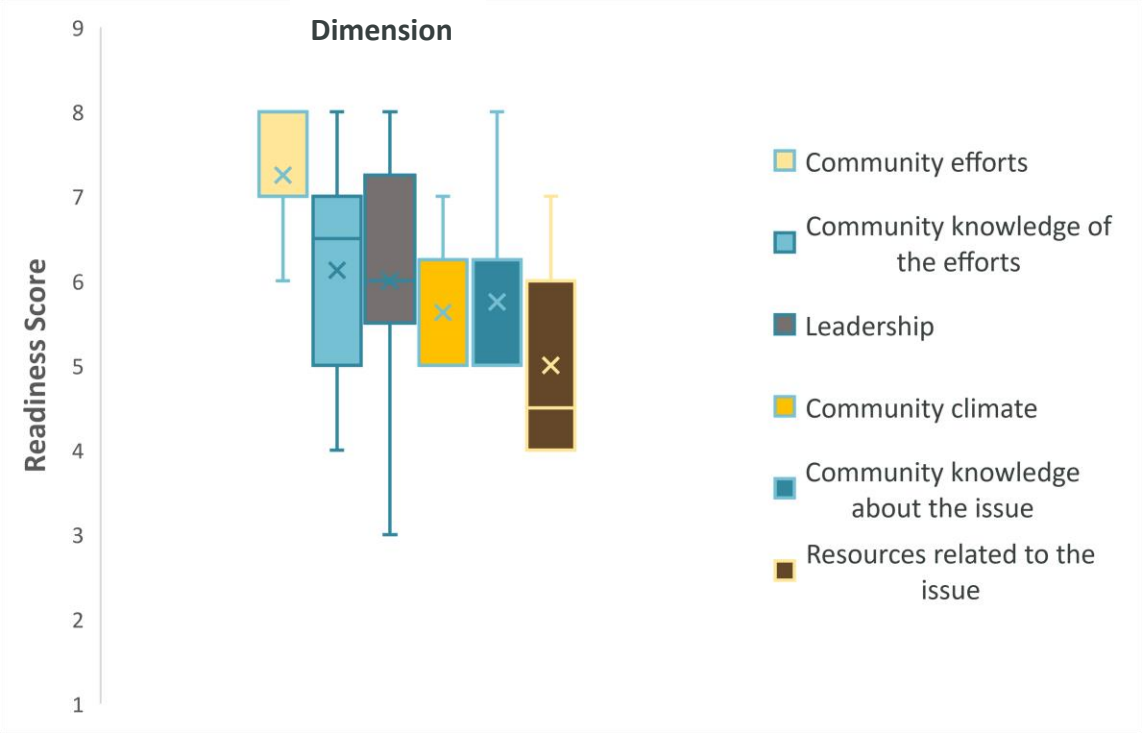
The final combined interview scores for each of the 6 dimensions in 2019 as compared with the scores in 2014 are found in Figure 1.

With the exception of **resources** (which stayed at 5 points from 2014 to 2019), all of the other dimensions showed an increase from 2014 to 2019. **Community knowledge of the efforts** increased more than the other dimensions – from 4 points in 2014 to 6 points in 2019. **Community knowledge of the issue, community climate, leadership,** and **community efforts** increased by one point each from 2014 to 2019. Fuller discussions about the results for each dimension begin on page 4.

Figure 1. CRA scores, 2014 and 2019

The range of scores for the 8 interviewees on each dimension is shown in Figure 2 below. For example, interviewees had the most diverse opinions on how supportive **leadership** is of suicide prevention efforts, with the lowest score being a 3 and the highest being an 8 (represented by the grey box with long aqua tails). The least diverse range of scores was only 2 points for both **community efforts** (6 to 8 points) and **community climate** (5 to 7 points), indicating more agreement between the interviewees on these dimensions. The "x" in each box indicates the average score across all interviewees for each dimension.

Figure 2. The range in CRA dimension scores for the 8 interviewees, 2019



COMMUNITY EFFORTS - 7

The first dimension, **community efforts**, reflects the extent to which suicide prevention services, programs, and policies exist in the community. The readiness score for this dimension was **7** in 2019 – the highest readiness score of all 6 dimensions. This level of readiness indicates program **stabilization**, the phase where "Activities are supported by administrators or community decision makers. Staff are trained and experienced" (p. 10). The individual readiness scores for this dimension ranged from 6 to 8.

When asked about suicide prevention efforts, programs, or activities that are available in the community, all but one key stakeholder mentioned the QPR and/or ASIST suicide prevention trainings that are offered year-round by CoH staff. Other activities that were mentioned were the GONAs, Family Fun Nights, the Basketball Against Alcohol and Drugs (BADD) Tournament, Walk for Healing, salmon walks, Sons and Daughters of Tradition, behavioral health classes at Nixya'awii Community School (NCS), and counseling in NCS and other local schools. Interviewees

also mentioned the many ways that CoH promotes awareness, including through tribal newspaper (Confederated Umatilla Journal) articles and ads, tribal radio station interviews, a billboard, and distributing awareness information and items with the National Suicide Prevention Lifelines number, etc., at powwows and other community events.

Additionally, a few interviewees mentioned that each client coming to a medical appointment at the Yellowhawk receives a Patient Health Questionnaire (PHQ) – either the 2-question version and/or the 9-question version – to screen the patient for depression and thoughts of suicide. The Integrated Mental Health staff members are co-located in the medical clinic and respond to patients who may have a high PHQ screening score and/or who medical staff feel could benefit from talking to a trained therapist.[4]

One person pointed out that there used to be a crisis response protocol whereby Yellowhawk Behavioral Health would be called to respond in the emergency room if a tribal member was in crisis, but that this service was discontinued.

As can be expected, the number of program efforts any one key stakeholder mentioned varied widely. All of them said that the efforts had been going for at least 4 years, and most said 10 years or more. One person noted that, in particular, the BAAD Tournament had been happening for more than 30 years.

Mental Health Integration has helped, we've gone two years with no suicide… Maybe people don't want to call Behavioral Health for an appointment, so they might come to medical more to get these services.

[4] This Integrated Mental Health position was initially funded by the GLS grant in 2015, based upon data collected for the previous GLS grant (2011-2014) that indicated such a position would facilitate patients getting timely services. The position has now been sustained and a second position was added in 2017.

COMMUNITY KNOWLEDGE OF THE EFFORTS - 6

The next dimension, **community knowledge of the efforts**, refers to whether community members know about local program efforts, what they know about the effectiveness of those efforts, and who can access the efforts. For example, does the community know about plans for upcoming program events and do community members participate in carrying out the event? The readiness score for this dimension was a **6**, indicating that the community is in **initiation** stage. This stage is described as, "Enough information is available to justify efforts. Activities are underway" (p. 10). Interviewee readiness ratings ranged from 4 to 8.

In 2014, most key stakeholders "understood suicide prevention as what trained clinicians do at the point when someone is experiencing suicidal thoughts and behaviors, rather than a broad-based effort to prevent those thought and behaviors in the first place" (2014 CoH Community Readiness Results Report, p. 5). By 2019, almost all key stakeholders recognized that suicide prevention efforts took many different forms in order to reach as many people as possible. One stakeholder noted that there were so many activities it was sometimes hard to keep track of them all and that might be the reason why some activities are not well attended. Another person recognized that there were many activities happening, but that the "community doesn't know about these things. If we had more radio announcements, fliers, something to make everyone aware. Maybe if there were a 30 second radio announcement 3 times a day, you would know it is happening."

Rating of community awareness of suicide prevention efforts

As part of the section on **community knowledge of the efforts**, interviewees were asked to rate how aware of suicide prevention efforts, policies, and activities the community was on a scale from 1 to 10, with 1 being "not at all" and 10 being "a great deal." The average rating was 6 (the lowest was 3 and the highest was 9). These were factored into the overall dimension score. Interviewees provided the following comments about their ratings:

- Community members know there's a suicide prevention hotline because they post those in the clinic bathroom, etc. Maybe they know the [suicide prevention] staff
- I don't think the community knows what the grant is or what the objectives of the grant are, but they understand the concept that we have suicide prevention services at Yellowhawk and trained staff to do the work
- The people who show up [to activities] are already interested and most likely are professionals in the community… I don't think a majority of people are informed. They might see the billboard or articles in the papers but until it affects them, they don't pay attention
- We as staff know about it, because of the trainings. But the community not so much. The community may not want to be involved in these efforts
- At one time, the community did have knowledge because they had an advisory board and shared info with families and other community members

Rating of how much of a priority suicide prevention is to the community

Key stakeholders were also asked how much of a priority suicide prevention is to the tribe and community, with 1 being "not a priority at all" and 10 being "a high priority." The average rating was 8 (the lowest was 5 and the highest was 10). Most commonly, interviewees' comments were used to explain why they did not give a full 10 rating.

- It seems that there is more of a concern with substance abuse and just day to day survival
- It is more prioritized in Yellowhawk but not tribe wide. They need to do more tribe wide
- No one wants to lose a family member, but there is some apathy with the number of people who are using substances. Some people only care after someone has died by suicide
- Suicide is a known problem, but it is hard to get support from staff to provide services outside of work hours. Leadership has not made it a priority

LEADERSHIP – 6

There are leaders who serve on coalitions and committees that support suicide prevention efforts.

The third dimension of prevention efforts in the community readiness model is leadership, which refers to how supportive appointed/elected leaders and influential community members (those who are neither elected nor appointed) are about suicide prevention. The readiness score for CTUIR leadership was **6**, indicating that the community is in **initiation** stage. This stage is described as "Enough information is available to justify efforts. Activities are underway" (p. 10). Readiness ratings for the **leadership** dimension reflect the very diverse opinions of the interviewees: the individual scores ranged from 3 to 8.

As an example of the wide range of opinions on leadership's attitude toward suicide prevention, one interviewee said that "[leaders] have shown that [high rating] through conversations I've had with them… They want to ensure that there are zero suicides in the community." On the other hand, another person commented that, "they always push back on anything to do with mental health. The funding is not there. They want to hear about it, but don't take action." Similarly, this duality can be found in two other interviewees' responses:

- They are looking for grants, they are considering laws for mental health holds
- Leadership is aware of the [suicide] issue and that it is happening, but don't support the efforts financially. They put the blame/responsibility on other people

One key stakeholder noted that both the Board of Trustees (BOT) and the Health Commission "are aware of suicide, problems, and programs. However, sometimes they become numb. We've been hearing about [suicide] since the 1970s. With the latest mortality data, US is increasing but here we have seen decreases. We need to get the positive message out."

Someone else noted that because there are other topics high on their radar right now, like drugs, gangs, and shootings, suicide prevention might not be a top priority. This person continued, "It might be to our detriment, but that's what happens."

When asked how the leadership supports suicide prevention efforts, most interviewees mentioned that there are some leaders who are involved in activities. Different types of involvement have included some leaders being trained in QPR, some sitting on suicide prevention-related committees, some attending suicide prevention activities and events, some speaking at these events, and some being called in to pray and sing songs for a family touched by suicide. Another contrast illustrated by the interviews was that one interviewee mentioned that there are leaders who are more involved because suicide has touched their family, while another one said that some leaders will not go to the funeral of someone who has died by suicide because they do not believe in suicide.

The most striking difference between the CRA responses about leadership in 2014 and 2019 is that in 2014, leadership was often described as being "in denial" about the issue of suicide. In 2019, no interviewees mentioned that leadership was in denial. Respondents unanimously felt that leadership would support additional suicide prevention efforts. Two people believed that leadership would not go out of their way to generate suicide prevention ideas, but would support efforts if they were presented.

COMMUNITY CLIMATE – 5

The fourth dimension is **community climate**, which refers to the general attitudes of the community toward suicide prevention and intervention. The readiness score for community climate is **5**, or the **preparation** stage: "active leaders begin planning in earnest. Community offers modest support of efforts" (p. 10). Interviewees' dimension scores ranged from 5 to 7.

The first question in this section asked interviewees to describe their community. Nearly all responses mentioned how close knit people in the community are. Other comments mentioned the strong culture, number of resources, that most people are good people just trying to get by, and that the community is trying to improve. Examples included:

- We're a pretty closely tied community, lots of relations, we're strong in our culture and traditions, strong in community wellness, strong in helping each other, utilizing services, and we have a lot of resources
- The local native community is very well-connected, well versed on what is going on, well informed. We have our differences and cliques, but you can't have a death without being related, friend, or know about that person. Few silos. Like a spider web
- The majority of the community is hard-working, good, law abiding people that just try to live their lives and have a good time, pay bills, raise children
- Our community is trying to improve but that doesn't mean all the problems are gone

Two people felt that the community's attitude toward suicide prevention is "positive" and "compared to the general population, very high." One interviewee said that the community is "hopeful that measures are being taken" which might indicate that suicide prevention efforts are considered to be someone else's responsibility, rather than a matter for the whole community to be involved in.

Our community is small and closely connected. We've all been touched by suicide and have lost someone to suicide, we're keenly aware of the problem.

Another person noted that some religious groups in the community say that suicide is wrong and that this perspective will be mentioned at funeral services for someone who died by suicide—even though the family is grieving. This is something that makes people "feel alone and hopeless and there is a lot of depression and oppression."

On the question of community attitude towards suicide, this key stakeholder said, "If you ask, they will say they are 100% against suicide but, in their daily lives, they have apathy because it doesn't affect them directly. [The attitude] ebbs and swells."

The last question in this dimension was about how supportive or involved in suicide prevention efforts the community is. Answers indicated that people will be involved if an activity is planned or a family is in need:

- When an activity comes up, like a suicide prevention walk… As long as it's presented to them, they'll jump right in
- They come together if there is an attempt to support the one that has attempted or they come together as a crisis team to help the family
- Booths at the community picnic are well attended. Suicide prevention has multiple events with family fun and awareness [activities] that are well attended

One person added that the community is "supportive but I don't know how involved, other than the Yellowhawk counselors."

Community Knowledge About the Issue – 5

The next dimension looks at the extent to which community members know about and/or have access to information on suicide prevention and intervention and its impact on the community. This dimension is **community knowledge about the issue** and the readiness stage is **5 – preparation -** the same level as **community climate**. Interviewees' dimension scores ranged from 5 to 8.

Questions in this section revolved around what types of information about suicide prevention and local data are available in the community, as well as how informed about signs, symptoms, and data community members are.

When asked about the types of suicide prevention-related information that are available, people tended to answer *where* they might get the information, such as text messages, Yellowhawk web pages, CUJ articles, billboard, PSAs, flyers, suicide awareness walks, rallies, peer mentors for kids, behavioral health groups, the teen health and wellness curriculum Native Stand, postvention vigils, and suicide prevention cards. Answers that provided some information about the types of information available included:

- The signs and symptoms are on the QPR cards [handed out by staff]
- Sons and Daughters of Tradition talks about signs [of suicidality], how your day is, about culture and suicide
- Young people are knowledgeable because some of their peers have attempted suicide
- They only know if someone in their family has died by suicide. They don't notice when somebody starts getting their affairs in order and other atypical behaviors in the lead up to killing themselves
- People come to Yellowhawk where we have different information packets. They can talk with staff members, who can provide them with U Matter cards or see a clinician. This info is available at all community events

Interviewees were asked how knowledgeable community members are about suicide prevention, such as, signs and symptoms of suicide.

- They have a pretty good grasp on the signs and symptoms
- High. Signs and symptoms are complex…There is isolation and high risk behavior. These classic symptoms are very well known
- There are pamphlets everywhere you look, online, the information is everywhere
- They are aware of National Suicide Prevention Lifeline through cards, CUJ ads, booths, and QPR and ASIST trainings. Right now state data are pretty old
- Not very knowledgeable

With the exception of one key stakeholder who listed off local data such as mortality rates and a local community study that St. Anthony's did, interviewees were generally unsure about whether local data about suicide or suicide prevention existed. These responses included:

- There is no local data really, they know that AIAN suicides are high, veteran [suicide] numbers, but that's about it
- The community is aware of suicide deaths when that information is shared. Right now, we don't have any information about this
- Not sure about data – not sure if people care too much about this
- There is data from the [CoH] grant, but I haven't seen much data coming out

The last question in this section asked *where* people obtain local data. Almost everyone mentioned Yellowhawk and Yellowhawk staff, although one person added that they were not sure what data Yellowhawk would provide. Other responses included, "I wouldn't know where to find it," "hotlines," and "Data? That's a darn good question, I don't have a clue."

Resources Related to the Issue – 5

The last dimension is **resources related to the issue** and it represents how many local resources, such as people, time and money, action plans/proposals, and/or evaluation efforts are available to support prevention efforts. The readiness score for this dimension is a 5 – **preparation** stage. This was the only dimension score that showed no increase from 2014 to 2019. Readiness ratings for this dimension range from 4 to 7.

All but one key stakeholder felt that the community would help out with time, effort, and/or participation in events.[5] One person said that people help out with distributing information and posting on social media. Another person noted that there was plenty of space, but that people were probably not going to provide financial donations.

As for proposals or action plans supporting suicide prevention in the community, three people were able to think of something specific. These examples included the Yellowhawk annual work plan that includes suicide prevention, the Zero Suicide Initiative (also at Yellowhawk), and the crisis response and postvention resolutions passed by the BOT last year. None of the other interviewees knew of any other proposals or action plans.

Two interviewees were able to identify evaluation activities on suicide prevention efforts, such as the prevention strategies inventory (which is a monthly compiling of all suicide prevention related activities and numbers of participants); the Sweat House survey; mortality data; and data on PHQ screenings, referrals, and whether those individuals who were identified and referred to services actually accessed mental health services. Someone else mentioned the Quality Improvement focus groups at Yellowhawk and the fact that the suicide prevention program provided reports to the General Council and Health Commission. Four people said they did not know about any evaluation efforts.

> ***[Community members] are invested and supportive of suicide prevention efforts. They know [how] to recognize suicide and to call somebody for help. They may not know how to perform an intervention, but they know who to call.***

[5] The one remaining person said they "did not know."

Other Themes That Emerged from the Community Readiness Interviews

Strengths and Weaknesses of Suicide Prevention Efforts

In the first section of the interview, there was a question about the strengths and weaknesses of the efforts. Table 1 below lists interviewee responses to these questions. Most interviewees mentioned at least one strength and one weakness, some provided more. If there was more than one of the same answer, they are counted only once in the tables.

Tables 1&2. Strengths and weaknesses of suicide prevention efforts, 2019

Strengths of Suicide Prevention Efforts	Weaknesses of Suicide Prevention Efforts
Community driven *- community members work on the team, so they have good connections with people on the CoH team*	*There is* ***confusion about all of the Yellowhawk programs*** *and who goes with what program and how to contact them*
QPR trainings *are making people aware of how to recognize the signs of someone struggling and what to do; people with QPR are* ***asking the right questions*** *and they are* ***making the right calls to police***	***Trust and confidentiality*** *– tribal members don't have trust in Behavioral Health. When you go to the clinic and talk in the lobby, other people hear (so it's not always the healthcare provider sharing this information)*
Staff putting forth the efforts are ***culturally appropriate*** *and know the traditions to get people the help they need spiritually and culturally*	*Honestly, I have not seen many weaknesses; we could* ***add more formal protocols*** *around what happens when people in crisis walk through the door*
The CoH team is ***hard working****, they have* ***good hearts and souls****, and want the best for the community*	*Not all CTUIR departments* ***hear about upcoming QPR trainings;*** *they need to put* ***money in for food*** *for people so they'll show up for QPR trainings*
Clinicians in the schools *has been good*	*That* ***efforts are only grant funded*** *is a big weakness*
Staff are all ***trained in QPR****; Staff are well trained and can assist people*	*It is still hard for people to talk about it - people don't want to share that they are attempting suicide;* ***there is still stigma***
[Suicide prevention] ***activities don't exclude anyone***	***Services only available during working hours*** *is a weakness. Lots of stuff happens after hours*
They [CoH staff] are ***doing a wonderful job***	*With all of the efforts going on around here, the prevention programs and* ***activities might not get the attention they need***
They try to make activities around an ***approachable topic****, they don't always say suicide prevention, maybe they will call it a lunch*	***More critical inspection of the data****: how many youth go to the ER for a suicide attempt? Is there follow up? Are they in counseling? Do a chart review/peer review on each person*

Sustainability of Suicide Prevention Efforts

Interviewees were also asked about sustainability, which is important considering that the CoH grant funding ends in September 2019. As mentioned in the weaknesses section above, one interviewee noted that the suicide prevention efforts are only grant funded – at least so far.

Answers to the question, "What types of plans are in place to continue these services?" drew the following responses:

- Yellowhawk is a fiscally sound organization, so I think that it should be sustainable, but don't know what they can bill for
- I believe there are the grants, and they will find ways to retain the staff who have been trained in suicide prevention
- QPR trainings—the trainers can continue training
- Crisis response and postvention will continue. There are other prevention programs that provide protective factors and will continue
- Maintaining the two Integrated Mental Health staff in medical because they fund themselves

Note that, with the exception of the last item about Integrated Mental Health positions, which are mainly treatment positions rather than prevention positions, no specific sustainability mechanisms are listed.

Other Feedback

At the end of the interview, people were asked if they had any other comments on topics related to suicide prevention that they wanted to communicate. Two of the four answers involved treatment, the third involved training, and the fourth was the wish that leadership would prioritize suicide prevention:

- There should be more groups for adults about suicide prevention and more one-on-one contact with youth because there are kids who are scared to get help
- Cannot emphasize enough that there needs to be comprehensive care for people in crisis because almost all of them are in both mental health (MH) and alcohol and drug (A&D) crisis. Typically, there is only bed space for A&D or MH. We need more bed space too. Maybe the tribe could put together a detox and treatment center. Jail is talking about more bed space especially for people with behavioral health issues
- Get students (middle school and high school) trained up [in suicide prevention] or find some ways to help their peers. Give them the information/tools they need to know
- Wish that leadership (Yellowhawk and BOT leadership) would make suicide prevention more of a priority

Appendix A. Community Readiness Interview Questions for Suicide Prevention

Appendix A. Community Readiness Interview Questions for Suicide Prevention, 2019

Introductory script:

Hello, my name is _____ and I am with _____. We are conducting in person and/or telephone interviews at CTUIR to get your thoughts about suicide prevention in the tribal community. On behalf of the Circles of Hope Youth Suicide Prevention Program, I'm contacting key people and organizations in (name of community) that represent the areas of treatment, mental health, medical, community members at large, school, law enforcement, parents, Indian Child Welfare, religious/spiritual and elected officials. **The purpose of the interview is to learn more about how your tribe/community is addressing suicide prevention so that we may be adequately informed to develop prevention and treatment activities for the tribe/communities to implement.** This interview should last between 30-60 minutes and of course, the entire process, including individual names, will be kept confidential.

Our definition of suicide prevention is… Knowing the warning signs and risk factors (something that increases the chances) for one wanting to take their own life and the protective factors (something that decreases the chances) to prevent someone from taking their own life.

A. COMMUNITY EFFORTS

1. What types of suicide prevention programming has happened/is happening in the community?
2. How long have these efforts been in place?
3. Who can receive services from these programs/efforts?
4. What are the strengths of these efforts?
5. What are the weaknesses of these efforts?
6. What types of plans are in place to continue these services? *(added in 2019)*[6]
7. How is evaluation data being used to develop new efforts? *(added in 2019)*
8. Please describe any policies that are in place in our community that address or support suicide prevention.
9. How long have these policies been in place? *(added in 2019)*

B. COMMUNITY KNOWLEDGE OF THE EFFORTS

10. In your opinion, using a scale from 1 to 10, how much of a priority[7] is suicide prevention to the tribe/community, with one being not a priority at all and ten being a high priority? Please explain your rating.
11. In your opinion, using a scale from 1 to 10, how aware is the community of these efforts, programs, activities or policies, with one being not at all and ten being a great deal. Please explain your rating.
12. Please explain what you believe that the community knows about the efforts, such as: purpose? What services they offer? How to access the services?
13. Are there community members who are involved in sharing information about activities or efforts? Please explain.

[6] The updated 2017 Community Readiness Manual added these 3 questions to the interview.
[7] In 2014, the question asked about "concern" rather than "priority."

C. LEADERSHIP

14. In your opinion, using a scale from 1 to 10, how much of a priority is suicide prevention to the leadership in your community; with one being not a priority at all, and ten being a high priority? Please explain.
15. How do the "leaders" in your community support and promote SUCICIDE PREVENTION efforts, activities, or events? *(Prompt: leaders on committees, attend events, speak on the issue in public)* Please explain.
16. Would the leadership support additional efforts? Please explain.

D. COMMUNITY CLIMATE

17. Describe your tribe/community.
18. What is the community's attitude about suicide prevention?
19. How supportive or involved is the community in the support of suicide prevention? Please explain.[8]

E. COMMUNITY KNOWLEDGE ABOUT THE ISSUE

20. In your community, what type of information is available regarding suicide prevention issues?
21. How knowledgeable are community members about suicide prevention issues? Such as, signs, symptoms, and local data, etc. Please explain.
22. What local data on this issue are available in your community?
23. How do people obtain this information in your community?

F. RESOURCES FOR THE ISSUE

24. What is the community's attitude about supporting efforts? Such as people volunteering time, making financial donations, and providing meeting space?
25. Are you aware of any proposals or action plans that have been written to support SUCICIDE PREVENTION in your community? If yes, please explain.
26. What types of evaluation are being conducted on these efforts?
27. Do you have any additional comments?

[8] On the 2014 version, there was a question not used in 2019 (because it was not in the updated 2017 Community Readiness Manual): "What are the primary obstacles to efforts in your community?"

Appendix B. The Stages of Readiness

Appendix B: Stages of Readiness

The stages of readiness from pages 34-35 of the CRA Manual are as follows:

1. **No Awareness** – No identification of the issue as a problem. "It's just the way things are." Community climate may unknowingly encourage the behavior although the behavior may be expected of one group and not another (i.e., by gender, race, social class, age, etc.)
2. **Denial** – Recognition of the issue as a problem, but no ownership of it as a local problem. If there is some idea that it is a local problem, there is a feeling that nothing needs to be done about it locally. "It's not our problem." "It's just those people who do that." "We can't do anything about it."
3. **Vague Awareness** – Beginning of recognition that it is a local problem, but no motivation to do anything about it. Ideas about why the problem occurs and who has the problem tend to be stereotyped and/or vague. No identifiable leadership exists or leadership lacks energy or motivation for dealing with this problem.
4. **Preplanning** – Clear recognition of the issue as a problem that needs to be addressed. Discussion is beginning, but no real action planning is taking place. Community climate is beginning to acknowledge the necessity of dealing with the problem.
5. **Preparation** – Planning on how to address the issue is underway and decisions are being made on what to do and who will do it. There is general information about local problems and about the pros and cons of prevention activities, actions, or policies, but it may not be based on formally collected data.
6. **Initiation** – An activity or action has been started and is ongoing, but it is still viewed as a new effort. There may be great enthusiasm among the leaders because limitations and problems have not yet been experienced. There is often a modest involvement of community members in the efforts.
7. **Stabilization** – One or two efforts or activities are underway and stable. Staff are trained and experienced, but there is no in-depth evaluation of effectiveness. There is little perceived need for change or expansion. Community climate generally supports what is occurring.
8. **Confirmation/Expansion** – Standard efforts are in place and leaders support improving the efforts. Original efforts have been evaluated and modified. Resources for new efforts are being identified, and modified and new efforts are being planned or tried in order to reach more people. Data are regularly obtained on the extent of local problems, and efforts are made to assess risk factors and causes of the problem.
9. **High Level of Community Ownership** – Detailed and sophisticated knowledge about the issue exists within the community. Community members want to know what's going on and feel ownership and involvement. Highly trained staff are running programs or activities, leaders are supportive, and community involvement is high. Special efforts are targeted at specific populations as well as more general efforts for the whole community. Effective evaluation is routinely used to test and modify efforts and this evaluation information is provided back to the community on a regular basis through newspaper articles, media, etc.