

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
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(SAMHSA)**

**Suicide Prevention Branch's
Research Highlights Podcast Series**

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PROCEEDINGS

THE OPERATOR: Welcome, and thank you for standing by. I'd like to remind all participants that today's conference is being recorded. If you have any objections, you may disconnect at this time. You may begin.

DR. CHELSEA BOOTH: Thank you very much and welcome, everyone, to the Research Highlights Podcast Series, presented by the Substance Abuse and Mental Health Services Administration, Suicide Prevention Branch. This series is part of our effort to bring research findings with crucial public health significance to the prevention and treatment communities. I am, as always, Chelsea Booth, Public Health Advisor at the Substance Abuse and Mental Health Services Administration, and your host today.

Today's episode features Dr. Lisa Wexler, associate professor in the Department of Public Health at the University of Massachusetts, Amherst. She received her doctorate in community education and youth study at the University of Minnesota in 2005. Dr. Wexler's collaborative research aims to deepen an understanding of indigenous youth suicide and resilience in ways that offer possibilities for action. She's been working with Alaska Native communities for over 15 years. Her five-year community based participatory dissertation focused on the practices and meanings related to youth suicide and suicide prevention in Northwest Alaska.

In a recent international five site interdisciplinary study from 2008 to 2012, she worked with researchers and community members in Siberia, Alaska, Canada, and Norway, to understand, and therefore, better support young indigenous people as they mature.

Her work in Northwest Alaska includes maintaining a long-standing suicide surveillance system with Maniilaq Association and expanding the system into Bering Straits in collaboration with Norton Sound Health Corporation.

Dr. Wexler also supports several locally driven prevention initiatives, through program planning and evaluation of suicide prevention programs and training, through SAMHSA's Garrett Lee Smith Tribal Funding, received by Maniilaq Association and Kawerak in the Bering Straits region. She has also cofounded Northern Alaska Wellness Initiative, a group of Alaska Native community members, behavioral health providers and academics dedicated to translating research to practice. Her current work often utilizes participatory visual and digital methods to engage young people in research as co-investigators.

So after that extensive introduction, Dr. Wexler, we are absolutely delighted to have you here today.

DR. LISA WEXLER: Thank you for having me. So welcome to all those listeners and viewers. This is my first podcast and I'm very excited to be sharing some of the work that we've been doing in Alaska, with you today. So I'm going to talk about how we can build on local understandings and the relationships that we develop in doing suicide prevention work and also health promotion.

My goals today are to think about suicide a little bit broader than just one thing. And I'll explain what that means in a few slides from now. I want to also tell you what we know

about Alaska Native suicide. There might some inferential understandings that you can apply to other indigenous groups throughout North America and the world, and to other marginalized communities. I want to talk also about what is left out of the understandings, when we just look at epidemiological information as our main source for understanding in retrospective studies. So we'll talk about what we might not know about suicide and how we might better find out.

And then lastly, I'm going to talk about two promising approaches that myself and tribal collaborators have come up with that I think address some of the problematics that we've talked about, as far as building on local understandings and wisdom and strengthening local relationships so that programming isn't imposing on local communities, but is rather growing local capacity to handle the problems in more efficient and effective ways. Those two programs are PC-Cares, which is an alternative to gatekeeper training that was developed through NAWI. That would be the Northern Alaskan Wellness Initiative that Chelsea talked about earlier, and IDEA, which is Intergenerational Dialogue Exchange and Action, which was done in Northwest Alaska.

Okay. So the first thing I want to talk about is suicide is more than just one thing. These images can be interpreted in lots of ways, but at different times and for different people, and for different places, suicide has meant different things. Suicide is an act, more than anything else. And we make meaning from that act differently. So in ancient Greco-Roman times, oftentimes suicide occurred when someone lost his honor, or it was associated with political protest. In Romeo and Juliet, suicide can be seen in a romantic light, as a tragic outcome of their condemned love. For a Samurai, suicide

offered a way to die with honor, rather than fall into the hands of enemies.

These are all truncated definitions, but my point is to think about all the different ways in which suicide maps onto local understandings. And many times it's much broader than just associated with mental illness or depression, which is oftentimes that narrow way we understand it today. I am contending that if we understand it in multiple ways, then we can come up with many more different and more effective ways to address it.

So now I'm going to sort of back into talking about suicide in more traditional, epidemiological terms, just to give you a sense of prevalence, which many of you probably already know. But I want to point out a few things that I think might be important to understand, in light of indigenous communities.

So first, a lot of people die by suicide every year, worldwide. It represents a good chunk of the global burden of disease. When we think about the places or the countries in which suicide occurs more, Eastern Europe, which has just undergone tremendous rapid social changes, has the highest rates of suicide, which is important to note. And Latin American and Muslim countries report the lowest rates of suicide.

In the United States, it's important to think about who is at highest risk and how this maps on -- and actually, let me go back to the worldwide significance because in some ways, these understandings can provide clues. So if we think about who is at highest risk and how that maps onto larger social issues, communities that have undergone disruption and changes where people are trying to figure out what it means to be a

person in a community and a society that's rapidly changing and has economic disparities and have new problems that didn't exist for the generations before them. All of those issues might not bond to indigenous communities, as we'll see later on.

Okay. So in the United States, when we look at demographics, the oldest Americans are at highest risk for suicide. And the youngest Americans are disproportionately represented by suicide deaths. Men are at highest risk. And when we look at ethnic groups -- and we're lumping all American-Indian, Alaska Native cultures together in this assessment -- those native groups are at highest risk of suicide.

So another way of understanding suicide, in epidemiological terms, is look per state. And as this map shows, Alaska has some of the highest rates of suicide in the country. And within the state of Alaska, Alaska-natives are at highest risk. None of this is probably news or something that you didn't know, but if we break out the different cultural groups or the different areas of this state, they're not all the same. And so when we look at this slide, there are different regions of the state. N Slope is North Slope. The next is Northwest Artic. The next is Nome Bering Straits region, et cetera.

And as you'll see, there is a real disparity in suicide rates across the state. So when we look at the state as a whole, it looks like we've got much higher rates than other states, but when we break up the different areas, there are different things going on. And I want to return to this, too, later on when we look at what other kinds of community level factors might map onto suicides. So if we're taking suicides and we're looking at it as maybe a community and a social issue, as well as a biological and psychological one,

then we come up with new ways of understanding why some of these disparities exist.

So I'm going to focus in on, as you can see here, Northwest Alaska has one of the highest rates of suicide in the state. And we've done a lot of work on that. Maniilaq Association has been innovative in their suicide surveillance. There has been surveillance in this region since 1989, which is hugely impressive for a small tribal health corporation.

So when we look at our suicide behaviors in this region, we know a lot about them. We can tell you the numbers of deaths. I put a question mark next to the attempts because many attempts are not recorded and these are non-fatal suicidal actions. We are doing a better job of tracking that as we go, but still, many are unrecorded. We know the age and the gender of the people that are dying from suicide. We know the methods. We know some of the situational factors. We have a surveillance system, which includes things like some of the most common experiences that we've seen, like break-ups, or someone losing their job; those kinds of things.

So we know some of the situational factors. We know whether substance abuse was related to the incident where the person hurt themselves, and we know if that person was identified as somebody who abuses substances. And we know whether or not they've had counseling experience. So we know all of that, which are many things that many smaller communities do not know on a community level in this area. And it gives us some clues, some, to better prevent suicide, but not enough.

So we're going to go through some of these. These are suicidal behavior, both non-fatal and fatal suicidal behavior in this region. So this is just for northwest. And this is based on the surveillance system that I just talked to you about. One of the things that stands out in this graph is that suicide in this region is mostly young people. As I said before, we were looking across the United States. There would be a big lump in the older people. Indian/Alaska society has a strong respect for elders. There is a really important community and social role that elders play. And as you can see, elders are much less likely to commit suicide than other age groups in this community.

The other thing that you might notice is that males are more likely to die by suicide and that both males and females are pretty close in their number of non-fatal attempts. But the thing that really stands out is young people are at highest risk. We did a survey that was an open-ended survey to find out why people thought young people were killing themselves and why, in this region, we have such high rates. Everyone who lives there, I would say it touched by suicide in one way or another. And these were some of the ways that people understood the problem.

Substance abuse, which is something that many researchers would certainly concur with. Low self-esteem is another one that actually many researchers would say is a really important thing to pay attention to, but less community members thought. Grief; another one that is surprisingly not as common as you would think. Something that people are oftentimes surprised at is this idea of boredom; many adults said that boredom was the main reason for suicide.

I want to just pause here and look at what boredom can mean. Marshabas (ph), in Australia, has written some about what boredom can mean as a post-colonial condition. And she writes, "Boredom is generated at the intersection of the old ways in post-colonial time." But for it to be experienced there has to be a lack of meaning. So the people that are experiencing this boredom, it's a sense of "anomie" that Durkheim talked about, for all you researchers out there. But it's a way of having a lot of empty time, a lot of space to fill that is hard to figure out how to make it work for you; how to make it work for others. It's a "meaningless fit," and that's a quote from Marshabas.

So if we think about boredom as a condition in which young people lack a sense of meaning, feel like many of the things that they're involved with don't matter, and don't matter in important ways. That's the kind of boredom that I'm imaging that people that filled out our survey were referring to, rather than the kind of boredom that is much less profound. So when we asked, "What could adults in your community do to prevent suicide?"

I think there's an interesting difference between the adults that answered this question and the young people. The young people, above and beyond, answered: *talk with them*. Talk with them every day. It doesn't have to be deep, insightful conversations, but it's just having an adult who is looking out for you, is asking how you're doing, on an everyday basis. These were the young people saying that they felt like that that would make a huge difference in preventing suicide. And that's an important thing to note.

The adults that wrote, talked with them, and we have lumped these answers into really

broad categories. We're more inclined to think about talking to them as in, "Are you thinking about suicide?" And reaching out in a more gatekeeper kind of a way. The other thing that we thought was interesting about the results from this -- and these were about 350 surveys in a region with about 8,000 people -- is that adults were much more likely to say: *activities for youth*. That youth need activities that are sort of structured for them because they do have a lot of empty time.

Kids also answered this, but the kinds of activities were more like taking them places with them in a more informal way. So it's important to think about how young people want informal engagement in every day kinds of ways to be in relationship with adults. And adults were thinking about it in a more formalized programming for young people, which is a different kind of relationship.

I think this is the last slide from the survey that I wanted to share with you. This also is about everyday involvement activities, so that the most prevalent answer to this was just to talk with young people about their future, as a way to get them excited about it. So another way of understanding suicides is to not be committed to your envisioned future. So when kids are not committed to their envisioned future, it's -- I'm going to use the word "easier" to kill yourself because you're not committed to something else.

So when we asked people about this, young people really felt like having someone to talk to, to plan out, to map, to help understand what their future could look like. And could look like in the best possible way, to help imagine their future, was really important to them. And that wasn't like a guidance counselor at school, necessarily.

This, again, was more informal conversations. What are you going to do when you graduate from high school? Have you thought about this? You know, I know this person who, you know, has done this thing that you want to do. So just making those informal, relational kinds of future planning was important for young people.

So the other thing that we've done in this region that we've studied suicide for a long time in, is to ask young people about suicide in many different ways. So I just shared with you some of what we found out from a survey that we did. So we also did ethnographic research, in which we talked to young people about suicide, and one of the things that stood out for me was how common it was.

Suicide was seen as sort of a normal reaction to hard times. It was definitely associated with things like relationship problems. And so when young people are forming these really intimate bonds with, you know, in their first real, sort of feeling romantic relationships, to have something go wrong and not knowing how to navigate that is one of the ways in which they understood suicide occurring.

The other thing that people talked about was when young people sometimes say I'm going to kill myself if you...blank. It was a way to get people in their immediate circles to respond to them differently. So it was a way of mobilizing support. And that, at least to my ears, sort of pointed out there has to be other ways to get that support and we need to be really mindful of letting kids know how else they can get that support so that they can get it without having to call on suicide to activate their social networks.

More often than not, suicide was not associated with psychological disorders. Although sometimes, and adults were more likely to say it happens when you're depressed. Oftentimes we see anger more associated with suicide than depression in our studies. And to think about it only as a mental health issue, really limits the scope of ways that we can respond to it. So I want to leave that as a question mark so that we can open up our thinking about it being more than just psychology.

Another way to think about suicide in indigenous communities -- and this is taken from Chandler and Milan's work -- is that in indigenous communities in British Columbia, suicide rates have been connected to community level cultural continuity factors. That's what Chandler and Milan -- they're researchers -- said. And they had a lovely study which shows this - that high rates of suicide are associated with social disorganization, places that didn't have community spaces to do things; that didn't have cultural activities; that didn't have tribal leadership; that didn't have sovereignty battles.

We've also talked to many community members and they've associated suicide with culture loss and with historical trauma. So those are not individual levels, psychologically driven issues. Those are much bigger than that. And as a counter to that, low suicide rates in indigenous communities have been associated with things like community empowerment, social connectedness, family cohesion, sovereignty battles, cultural identity. Those things are protective. And so we can think about suicide prevention as a collective, as a community level endeavor, rather than an individually focused and clinically-based endeavor. And I'm going to point out some of what I think are the drawbacks of only focusing in on individuals and mental health clinical

interventions, which is typically how we think about suicide prevention and how many of our gatekeeper type trainings think about it because the end result then is referring to mental health.

So what happens when we think about that from an imminent point of view? What happens when we think about it from a community member's point of view? And we have done this and we've had these conversations and I want to share some of them with you now. So when we think about suicide prevention it is important to see warning signs and to intervene, ask the suicide question. And ,if the person is suicidal, to refer to mental health. That's your typical suicide intervention regime.

When we talked about this in native communities that I've worked in, they talk about how it doesn't really make a lot of sense to tell a stranger. And many times, the mental health clinicians that are working in tribal communities are short-term residents; they're not from the communities. So does it make sense to pull someone from the outside and to tell a stranger from somewhere else, who doesn't know what it's like to be here? Doesn't know the families, doesn't know the patterns of relationships to help them fix it.

And the other thing that this does, when we do that handoff, when we find out somebody is suicidal and then our job is to refer to mental health, that process takes responsibility away from local people to solve their own problems. And that's one thing that I think we should think about, critically, because when we talk to young people about this experience, oftentimes it doesn't work for them in ways that feel beneficial. And sometimes that means they're less likely to seek that help, even when they think

about hurting themselves.

So what happens when you refer to mental health and the person is considered to be a danger to themselves and others? So as a clinician, as a disclaimer, I was a clinician in Northwest Alaska. And within this situation, you know, the only safe thing to do then is to put that person into a facility of some sort to make sure that they are safe. When working in rural tribal areas -- and this is particularly true for Alaska -- that is a plane ride away. So you're taking the young person, oftentimes a young person, away from their home community, away from their family and putting them into a clinical setting, far away from home.

So what does that do not only to the family members who are left behind, and therefore, not as actively engaged in that treatment or the supports of that person, it also makes the young person to feel isolated from all of the things that were involved in both feeling suicidal, but also feeling loved and supported. It takes them away from that potential stress, which could be seen as good, but also the potential to fix some of that stress in their everyday lives.

The next sort of step, once someone is referred to mental health and they are assessed for suicide risks, if the clinician decides or sort of has to decide the level of risk, and if that person is considered imminent risk that they're going to hurt themselves or others in the near future, then they're sent to a longer-term institution for more assessment and for treatment. So that is sort of the system of care that we have going on. The potential drawback for that for some individuals -- and I guess I should put in a

disclaimer here that it's not across the board, but these are some things to bear in mind that the system doesn't work for everyone all the time and shouldn't be done in an uncritical manner. We should really be thinking about all of the meanings of things when we're taking young people away from their families and their communities, especially in context, ripe tribal communities where that method of colonization was really meant to disempower families and to take the socialization of their children away from them. So it's a really important thing, I think, to be careful about, as we move forward with care.

So when we take young people away and we send them to a longer-term facility to get mental health care, sometimes that's terrific for them. Sometimes, in some of the kids that we talked to, really talked about being sent to jail and feeling like they sort were punished for feeling suicidal. And there also became a real distrust for if I share this information, if I share how I'm feeling about hurting myself that I'm going to be sent away, I'm going to be sent to jail. And that creates a double bind for both family members that are trying to support those young people, for the clinicians that are trying to help those people, and for the systems of care that are involved in liability. So it becomes something that is really tricky.

And many of these care systems are built on normative assumptions that are not necessarily shared by the local people that they're serving. So I have brought this up several times in this talk, and I'll do it again. That system of care is based on the idea that suicide is a response to individual psychological distress or disorder. So it's an individual problem. That's why the individual then is taken out of their local community

so they can be sort of fixed, or managed, or helped to understand in ways that they weren't before; or medicated in ways that will help them become less suicidal. That assumption, however, doesn't work if it's a community level problem that grows out of things like cultural loss and systematic disempowerment of community and lack of social role. Then that kind of intervention, that kind of treatment doesn't make as much sense.

The mental health system has expertise in resources to intervene, psychologically, but they have less ability to intervene socially and certainly with this system in place, less ability to do the colonial practice. So there are many parts of this system I think that need to be critically assessed and working in communities to figure out how best to make some of the systems of care map onto local needs and understandings better than they do now.

So the outcome of what we're seeing; so all of that is trying to understand why suicide is occurring, what systems we have in place. This is one way -- this is a very busy slide, so let me just take you through it. So when we look at how our systems of care are working, this slide is really intended to show that they're not working very efficiently in Northwest Alaska, anyway. And that's not to say that we don't have great therapists and that we're setting up systems of care as they can be reimbursed, et cetera.

So there are all of those sort of larger structural issues to contend with, but currently -- and this is all information from our suicide surveillance system -- what we know is that 60 percent of the people who attempt or die from suicide have a history of alcohol

misuse. We also know that over 60 percent of those people, their friends and their families have noticed some warning signs. We also know that half of the suicide attempters and almost 70 percent of the people that die by suicide receive no behavioral health care.

So if we think about our primary response in this region and all over the place, is mental health services. And we clearly see that most of our suicides do not receive mental health care. There's a problem there. There's a catchment issue. We also know in this region that 75 percent of the referrals to mental health for suicide are done at the state of emanate risk. Meaning, the clinician is put in a situation where they really have to, sort of ethically bound, to remove that person from their home situation and put them in a safe, monitored setting - clinical setting, so that they can keep them safe.

If clinicians were called earlier in the process, then there would be much more ability to work with families, to work with friends, to work with people that were important to the suicidal individual to help make things right. To help things work better in their home life and their community life. But at that point of imminent risk, there's really only one choice to the clinician, if a person is a danger to themselves is at high risk, then really, the only solution then is to put them in a clinical setting. As I said, oftentimes that's far away from family, friends, and home community.

After 24 to 48 hours, they're reassessed, and if considered high risk, they can be sent -- and in rural communities, they can be sent very far away to psychiatric hospitals for further treatment. If they have a low risk, they're sent back to their home community;

this time, as I talked about, with a little less trust or at least more awareness of when they talk about suicide, they might be sent far away. The really unfortunate health outcome of the system that's not working very well is that we have very high rates of suicide, and particularly, young people.

So if Alaska Native suicide is connected to things like culture loss and colonialism, and not having a place in society and not having many avenues for thinking about an exciting future because of economic possibilities or having trouble with the school system. Or whatever it is, if they are bigger than an individual psychological disorder, we really need to think very carefully about how our prevention systems map onto that. And we really need to make sure that prevention, as I just described, is not another form of marginalization or colonization.

We talked to many people, and this is a quote, "So over time, we felt like our ability to control our lives has been taken away from us." And this is yet one more way in which there's the control, the decision to how to care for the person who is suicidal is taken away from families, from loved ones, from communities, who might have a lot of other kinds of ways to support that person. So I think we need to really think carefully and think with communities about how best to do this, and to keep the person safe at the same time.

To move this point, to go a little deeper into this point, I think it's important to think about how standard intervention protocols are built on a whole cadre of ideas that are Western. That is based on a medical model and an idea of personhood that might not

be shared with indigenous communities in which we work. So this is one way to bifurcate, to make a contrast, in sort of Western versus indigenous. And just by doing that, it makes it a little bit false. But the point is the sort of contrast done here. So if we think about Western systems, and I just described one of our Western systems for suicide care, suicide intervention, it's really thinking about the person in sort of medical/psychological terms. It's looking at individuals as independent of community, family, culture. Those kinds of things. It's thinking about mental health as separate from spiritual health, as separate from relational and social health. As separate from all of those other ways in which wellness occurs and it's linked. It's thinking about intervention as technical, therefore, mental health clinicians, if it's a mental health problem, are the best technical supporters. They can get in there and they can figure out, you know, they can diagnose and they can figure out what treatment would be most important.

And it's secular, so that system is not intended to fix spiritual problems. It's not intended to fix social problems. It's not intended to fix social problems. It's not intended to fix interactional problems. And so that's what that system is built on. But what if suicide is different, a more relational problem, cultural problem? And we've seen people link, as I said, cultural loss to suicide a lot. We have seen people link relationship problems to suicide a lot. People have talked about it being a spiritual problem and having people be sort of drawn to suicide by folks who have died before them, who have come back to them in different ways.

So there are many different ways to think about what's happening when someone is

suicidal. And if we think about it as cultural, then there should be a cultural solution. If we think about it as spiritual, then there would be a spiritual solution. So there are many different ways to think about intervening and building support networks in a variety of ways that's not just medical. And so once we think about it in those terms, it opens up a lot of possibilities for action that were not there before.

So suicide is about relationships, social ties, and need that we really want to get families and communities, and culture, and tribes involved in the solution. I think I have belabored that point. Okay. I was getting ahead of myself a little bit. So if suicide is response to colonialism, then we really need to make sure that suicide prevention is a decolonizing process. We need to work with local communities. We need to make sure that the service systems are working in sync with local understanding and community systems of care and community systems of support.

If suicide is about relational problems, then it's really important to be in an authentic relationship with the person, rather than to have some technical knowledge about psychology. So how can we build suicide prevention around relationships that are already in place, around people who already care about the individual? And what we have learned time and time again is that suicide intervention works best when the right person does it in the right way and before a crisis. That might sound really obvious, but when we're thinking about intentions of a lot of suicide prevention programming's being referring to a technician, a mental health clinician, that person doesn't necessarily have a relationship with a suicidal person.

And as we saw in our suicide statistics in Northwest Alaska, the people that died from suicide are most likely to have never been in treatment for mental health problems. So it's not likely that that mental health clinician is going to have a previous relationship with a suicidal person. So in this frame, mental health services become a potential resource that can be utilized by community members. They can be brought in at different points to add expertise to bring resources, to bring perspective, to offer different kinds of insights. But the driving force should be a collaboration with people that care about that particular person.

When we think about suicide prevention, there are many ways to think about it, and we can move from universal prevention, which is basically targeting everyone, to selective prevention, where we're talking about people at highest risk, to an indicated kind of prevention, where we're really focused in on those at highest risk for suicide. And as I said, 75 percent of the cases where mental health is brought in are at that scary point where the mental health clinician has no choice but to institutionalize the person, even for a short period of time.

So my intention here is to get us to think about how to move it so that we're captioning more people. So we're thinking about vulnerability to suicide, rather than suicidal intent. And if we can catch people are a more universal or primary prevention level, we can catch more people and we can do more community engaged, community strengthening processes. So that's what I'm going to talk about today, that 1) PC-CARES and 2) the IDEA interventions are two things that I think can begin to address some of the problematics that are brought up around suicide prevention as its currently being done.

So right now gatekeeper training is a very popular way of doing suicide prevention, and most of the federally-funded youth suicide prevention programming in the U.S. has some form of gatekeeper training in it. I guess I should mention that gatekeeper training by itself has not really been shown -- we don't have much evidence about its efficacy as a standalone program. Programs that utilize that in and among other multi-level interventions have been shown to be efficacious.

So gatekeeper training by itself is questionable. We don't know yet. There are a couple of studies going on right now to begin to discern that, but there have been studies in Canada, looking at one indigenous community, where they found that people learn skills and gain knowledge, but were less likely to refer to mental health after the training. And we can talk more about that later.

So the traditional gatekeeper training does these things: it communicates risk factors and warning signs. It prepares gatekeepers to communicate and to ask the suicide questions, to ask if you're feeling suicidal, and to do a little risk assessment, so that if the person is saying yes, I am suicidal, then sort of the next step is to refer to mental health services. That's the way gatekeeper training works. And throughout this talk, I've sort of referred to that as typical model for suicide prevention.

So instead, what we want to do is to build relationships in local communities that do two things; our professional community collaborations for at-risk youth engagement and

support, which will now will be known as PC-CARES for the rest of this talk. It's trying to bring together some of that same information, but to put it in local context. And we want to do that by inviting sharing of information between professionals and what we know about suicide prevention from professionals and from research. And also to pull together what local people know about it so that we can begin to integrate local meanings and practices into prevention schemes.

The other thing that we're really trying to do with PC-CARES is to increase hope and possibility. And at the beginning, I shared a little bit about some of our survey results, where young people were asking the adults in their lives to spend more time just checking in with them, just every day contact, talking to them about what's going on in their lives, about their futures. Those kinds of everyday things can make a really big difference for young people. So what PC-CARES does is really create a platform for encouraging that kind of interaction.

So what's the difference between PC-CARES and gatekeeper training? And why is that important? Because I think some of the content, some of the information that we're sharing overlaps, but we're beginning and we're doing it a little bit differently. So with gatekeeper training, we're starting, generally speaking, with facts. So this is what we know about suicide in general. These are the people at highest risk of suicide.

Part of those facts are done from retrospective studies and has to do with framing suicide as a mental health problem, which I think -- I've done a lot of writing about how that limited scope is only one perspective. It's not all the perspectives that are out

there. So oftentimes in gatekeeper training, the trainer shares this information with the audience. There is some participation. Oftentimes there is a role-play; it's a slightly longer term. They talk about risks and protective factors, in general. So we know that people that are not graduating from high school or don't have a certain education level are at highest risk. We know if you're unemployed, you're at a higher risk. We know that if you're abusing substances, you're at higher risk. Those kinds of things. That's what I mean by decontextual information.

There is some rational assessment. So this is again teaching sort of technical skills. So you do these things, you ask these questions. You ask someone if they're feeling suicidal, and then if they say yes, you're supposed to follow these other steps to assess the risk. So do you have a plan for that? So that's a rational assessment. And then you promote crisis intervention, with the end result really being if a person is suicidal that you're referring to mental health. All well and good, but I think we can do it better. And that's what PC-CARES is trying to emphasize.

So instead of starting with didactic kinds of educational strategies, we want to start with stories and we want to start with the people in that room, their stories of reaching out. We want to have both local people. So people from the community and a mental health clinician both working together to deliver the training. And really, it's less delivering the training than it is facilitating a conversation. And the way that that starts is one of those two people, either the clinician or the local person who's working with them, in this case, village-based counselors are really a perfect role to do that. They would tell a story about reaching out to someone who is suicidal and they would ask people to share their

own stories of doing that. And then they would draw information from those stories.

So instead of starting, as in gatekeeper training, with decontextualized risk factors, we're starting with stories and bring out, drawing out the ideas of how we would notice that that person was in pain. How we would notice that they needed a little bit extra loving or support. And then we talk through how the different people reached out and made sure that they were safe. So that we're really emphasizing personal knowledge and personal commitment to the people who are already in other people's lives.

So some of the benefits, it builds on local service systems. So it has, as I said before, native village counselors and non-native mental health clinicians facilitating those sessions. The content is generated from participant stories. So because it's based on local stories, it should have cultural relevance and show that the wisdom that people are bringing to the room matters and is relevant to the work.

The other thing about this process is it's highlighting what's right, what's working, how people are currently reaching out in their communities. How they are currently giving support to people in their lives, rather than talking about suicide, you know, the high rates of suicide and all of those risk factors. We're really wanting to focus on what can be done in order to -- instead of leaving with a sense of inevitability and risk, we want people to leave with a sense of hope and self-efficacy. We can do this.

Also, talking about what's right in community is can foster a sense of solidarity and a sense of collective empowerment, which is really, really important. We're also hoping

that by having both the local clinician and the village-based counselor facilitating those sessions, that it's going to 1) build relationships between those two service providers; one having psychological expertise, the other has local expertise. And so if you bring those together, it becomes a much stronger support team. And then between those two service providers and the local community members who are interested in helping support people in their community.

Hopefully those relationships, as their being strengthened, will increase earlier help seeking. So that we are hoping that instead of 75 percent of the time, mental health clinicians are called at crisis stage. We're hoping that way before that mental health clinicians or village-based counselors are going to be called in to help family members figure out what to do or what they could do to support people. And then instead of really focusing in on like, what are the suicide risk factors and what's the assessment of risk, if we just back up three steps and talk about people who might be showing signs of vulnerability, people that might need a little extra support. It 1) makes the net wider that we can strengthen to support all people in the community that might need a little bit of support and help, and that it creates less stigma. So we're going to be focusing in on people. And this is everybody at some point, need more support and help.

Suicide has a really low base rate and many times our assessments are not super accurate. So it sort of wastes time and energy focusing in on that. Seems like we could use that time better by focusing in on vulnerable people and building support networks. The U.S. military, some of the work with the Air Force has really done some really great work in just focusing in on vulnerable people. That includes people that

have suffered from domestic violence, people who show vulnerability as far as substance abuse goes. All of that maps onto suicide. Suicide just being the tip of the iceberg. So if we broaden our scope of support, we're liable to catch more people.

So this approach, too, focusing on health promotion, focusing on more than just suicide, hopefully can move from a sense of inevitability. This is going to have happen no matter what we do. And we've heard that a lot. People have talked about the problem being bigger than us. That suicide will continue. That we're victims of progress, and it's difficult to cope with problems of today. As I shared with you earlier, people also connect us to this overwhelming sense of culture loss and loss of control in their community. So all of those things can be a real dark cloud that doesn't help motivate people.

There's been research that has looked at how when you focus on things that are more positive, when you focus on approaching, rather than retreating. When you focus on possibility instead of risk. So those tend to motivate people in a much more active and engaged way. So that's what we're hoping to do. And this is particularly important in the context of indigenous communities who have suffered from imposed social changes and marginalization, and economic disparities, and health disparities in the last half-century.

So in Native communities, this is probably not new to many of the listeners, but suicide is associated with things like identity struggles and acculturation stress. I talked with you earlier about how it's associated with community level factors, like engaging in

sovereignty battles as a protective factor at a community level. So for native young people, and this is my guess, my best guess about why young native people are at highest risk for suicide, has to do with cultural loss. But specifically, we have to deal with the cultural disruptions that can sometimes sever traditional rights of passage. Can sort of confuse or muddy young people's ideas about sort of how they should exist in the world, how they relate to dominate values and norms. And that process of social change can also cut them off from traditional resiliencies. So without a real clear sense of both cultural and personal identity and a sense of social context with which to enact those identities, young native people are more vulnerable. And we can see this. I've done some writing about this, just in linking heritage to health and identity.

As we know from adolescent development, identity development is a key part of this sliced age, figuring out how to craft your own autobiographical narrative. How to figure out how you fit in the larger context of your society, of your community is really important. And indigenous youth are at a disadvantage in doing this because oftentimes they're misrepresented or absent from dominate discourses, from the media, from all of the different messages, indigenous views are often misrepresented, iconized, or they are just absent. And the other pieces that oftentimes, particularly in the Artic, young people's parents and their grandparents have had very different growing up experiences, where the grandparents speak a different language than their young grandchildren.

So it becomes harder for the adults in young people's lives to figure out how they can

usher them into adulthood because the adulthood nowadays, and young people's experience in schools and in communities, and even out on the land, is really different from, many times, the older people in their lives. So oftentimes when we talk to parents and grandparents, particularly grandparents, it's that they are struggling with how to best help young people become responsible adults in this day and age because it's such a different experience than their own.

So the IDEA, that's the Intergeneration Dialogue Exchange and Action program that we have come up with, really provides opportunities for older people to actively mentor, actively teach younger people in their lives about how to become a responsible adult that is adhering to both traditional values and is successful in whatever realm they choose.

So we did this project -- this is a National Science Foundation project -- because we really wanted to highlight -- and this is what we heard from our tribal partners -- how culture matters today and how traditional culture fosters resilience, ways to get through hardship, across generations, that have meaning, even if you are growing up in a very different circumstance. We wanted to create a platform for young people to learn from their elders and to develop a sense of hope through that sharing this process. And we wrote about it.

At the end of this PowerPoint slide, there is a list of references. This is one them, where it sort of goes through exactly what we did for this research project. What we did was we recruited youth researchers and it ends up that those youth researchers were really at risk youth themselves. They were kids who were coming out of psychiatric

facilities, coming back to their home communities. They were coming out of jail. They were at risk of dropping out. And then a few of them were actually, you know, like, in school and what you would call less risk kids.

So we recruited these youth researchers and we talked to them about what they hoped to learn from people in their lives, from mentors. And we really wanted them to focus on resilience, on positive things, on wellness, on strengths, on values, on things that were positive, as I said before, because that tends to generate movement in a really positive way. So the young people and myself, as a researchers, and I had a student with me, we talked with young people about what they wanted to learn and then we got them to identify people that they wanted to learn from. So these are people in their local communities that they admire. That they feel could teach them something about resilience and about strength.

So they went and they asked these older people, adults and elders, if they would be interviewed. If they would come and do interviews. And all of them agreed to do it. And amazingly, almost all of them refuse to get a little stipend that we had; I think it was like, \$75 or something, for participating in the research project. The vast majority refused it. They said it was just a pleasure to get to talk to young people about things that they felt were important in their lives.

So the way that the interviews were conducted, myself and Stacey Harris, who is from the community, did those interviews. And we did them in front of the young people. So it's very traditional for young people to sit and listen to elders. So we did the interviews

in a very public forum and got amazingly rich data from it. So the young people sat and they listened to their elders, answered the questions that they had created. And this was over a course of six weeks, where they listened to the elders and they just sort of digested it.

And after we did all the interviews, we were tape recording and collected data, as that process went, but the young people were also sort of taking in that information, and at the end, the young people produced digital stories. And the remarkable thing about those digital stories is that many of them had adopted some of the amazing quotes and some of the really important ideas from the elders and the adult stories that they had heard over the course of the six weeks and they had just incorporated them into their own personal stories. And those digital stories, which are three to five minutes, they used photos, they used music, they used storytelling. They're put together. They're like short films that the young people put together to share. And we did a public screening, where we invited all the respective elders and adults that we had interviewed, plus family members, plus friends, to a public screening, where the kids got to share what they had produced. And so that was another way of sort of showing how young people were making sense of older people's stories, and they were overwhelming positive and powerful stories.

So both of these, both the interviews of the respective elders and adults, and the digital storytelling by young people, sharing it in a public way in their community, generates all kinds of ideas, new relationships, wonderful new directions. And it begins to start to fill some of the gaps that are talked about between generations in tribal communities, as a

way of both ushering young people into adulthood in healthy ways, but it also gives a real platform for adults to become and to sort of take on those traditional roles that have sometimes been displaced by school systems and different structures of communities nowadays.

So it was a great project. That article that I'll refer to at the end, explains in detail sort of how it worked. And there's another reference to it in looking across three generations and you can see some of the data, some of the sense that we made out of it. Some of the ways in which we learned about cultural resilience and how that maps onto personal resilience in really important ways.

The two examples that I shared with you today, the PC-CARES model and the IDEA model, offer alternatives to traditional sort of programming. So instead of having a manual with curriculum that is done the same across communities, both of these projects really invite local people to identify local strengths and local practices at work - local cultural understandings that make sense and support resilience. And it creates space for that sharing to occur.

So in the first alternative to gatekeeper training, the PC-CARES, it creates a process where we can share information and skills that are really important for suicide prevention so that people are reaching out more often in their everyday lives, noticing people that might be vulnerable, and figuring out ways to support them. But instead of doing it in a way that is didactic, where the person that's presenting tells the people how to do it, we're really trying to build those understandings from the ground up. From the

stories that people share, and to make meaning from those. So that we know that they are culturally appropriate. We know that they are locally appropriate and we know that they respect local wisdom and local forms of doing and knowing.

In that same way, the Intergenerational Dialogue Exchange and Action, IDEA, provides opportunities for older people in the community to really support young people. And we give the young people a role in figuring out what they think they need to know. What they feel like they need to learn from older people. And then we create artifacts that can move on and take a life of their own. I know that some of the additional stories that were created by the young people in that project were shared at ASM. They were shared in statewide gatherings. They were shared in national gatherings as a way to sort of share what's really special and important about both these kids, but also cultural resilience. How that shows up for kids and how that really matters in promoting health in these communities.

So both of these programs, if you will, to these approaches build on local strengths, utilize and strengthen local wisdom in ways that I hope are respectful. I just wanted to acknowledge several of the people that have been really helpful in all of these projects: Evon Peter and Bridie Trainor, and Linda Jewel, and Brenda Goodwin, and Joe Garoutte, and all of these different associations who have been incredibly supportive of this work. And lastly, these are the references that I cited. Thank you.

DR. CHELSEA BOOTH: Well, thanks to you, Dr. Wexler, for speaking with us today. I think you've given us all a great deal to think about. I'm just going to hold up the

references page for one more minute. Well, a few seconds, actually. And if you are interested in these, please feel free to pause the podcast so that you can take down some of these really good references.

But to our audience, I thank you again for listening to this edition of the Suicide Prevention Branch's Research Highlights. If you have questions about today's presentation or suggestions for topics that you'd like to see highlighted in future editions, please feel free to email me, Chelsea Booth, at the email address on your screen. So on behalf of the Substance Abuse and Mental Health Services Administration, Suicide Prevention Branch, I thank you all for listening and for your continued interest in suicide prevention. I look forward to seeing you again for our other research highlights.

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