Suicide Prevention in Alaska

REPORT

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U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Division of Prevention, Traumatic Stress, and Special Programs
Suicide Prevention Branch

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INTRODUCTION

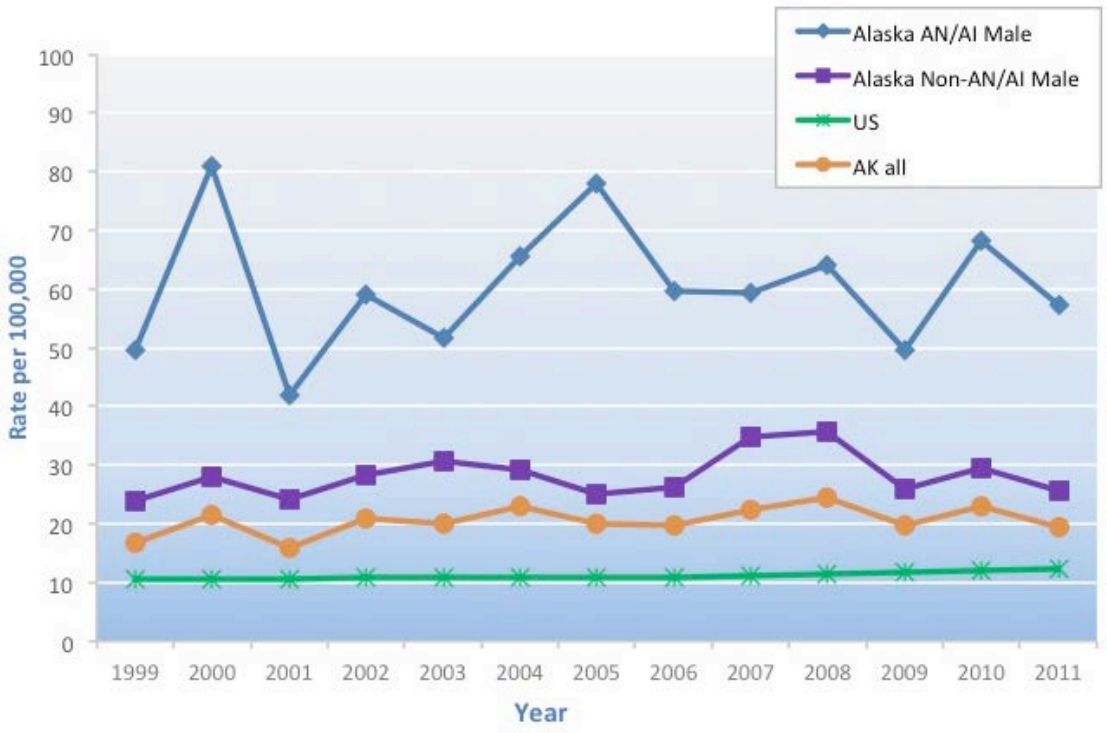
Suicide continues to be a significant public health problem in the United States. In 2011, suicide was the 10th leading cause of death, claiming more than 39,500 lives (Web-based Injury Statistics Query and Reporting System [WISQARS, 2011])[1] and resulting in an economic cost estimated to be $34 billion, largely associated with lost work productivity (American Foundation for Suicide Prevention [AFSP], 2014). In that year, someone in the country died by suicide every 13.3 minutes (AFSP, 2014). As of 2011, the national suicide rate had risen slightly for the fifth year in a row from 12.1 per 100,000 in 2010 to 12.3 per 100,000 (WISQARS, 2011).[2] In addition, in 2012, 483,596 people were treated in emergency departments for self-inflicted injuries, suggesting that approximately 12 people harm themselves (not necessarily intending to take their lives) for every reported death by suicide (WISQARS, 2011; AFSP, 2014). Findings from the 2012 National Survey on Drug Use and Health (NSDUH) indicate that the prevalence of suicidal thoughts among adults aged 18 or older in the United States remained unchanged from 2008 to 2012 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). In 2012, 7 percent of adults, age 18-25, reported having serious thoughts about suicide and 2.7 million persons (1.1 percent) made suicide plans within the last year (SAMHSA, 2013). In 2012, 1.3 million adults aged 18 or older attempted suicide (SAMHSA, 2013). Non-fatal injuries due to self-harm cost an estimated $3 billion annually for medical care; another $5 billion is spent for indirect costs, such as lost wages and productivity (AFSP, 2014). Findings from the 2013 Youth Risk Behavior Survey (YRBS) indicate that 17 percent of high school students reported having serious thoughts about suicide in the past 12 months and 13.6 percent reported having made suicide plans within the last year (CDC, 2014). That same year, 8 percent reported having attempted suicide and 2.7 percent reported having made a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (CDC, 2014).

[1] To measure changes in the prevalence of suicide over time, the Centers for Disease Control and Prevention (CDC) calculates the country's suicide rate each year. The suicide rate expresses the number of suicide deaths that occur for every 100,000 people in the population for which the rate is reported. CDC figures for death by suicide are currently lagging by more than a year. At the time of this writing, information was not yet available for 2012 or 2013.

[2] While the latest CDC reports show a continued rise in the suicide rate through 2011, it is important to note that as the data for 2012 and 2013 had not yet been released at the time of this writing, it is difficult to identify the most current trends.

Within the United States, the rates of suicide among some populations are exceedingly high. While the suicide rate decreased slightly for Alaska Native and American Indian (AN/AI)[3] people between 2010 and 2011, this population continues to experience one of the highest suicide rates of all racial and ethnic groups tracked by the Centers for Disease Control and Prevention (CDC) (WISQARS, 2011). In addition, as has been the case for many years, males continue to die by suicide at a rate of roughly four times that of females (of those who died by suicide in 2011, 78.5 percent were male and 21.5 percent were female) (WISQARS, 2011). Moreover, the State of Alaska's overall suicide rate continues to be nearly twice the national rate (19.37 compared to 12.32 per 100,000, respectively) (WISQARS, 2011). Suicide rates in Alaska mirror those in the United States, with higher prevalence among Alaska non-AN/AI males and an even higher prevalence among the Alaska AN/AI male population (WISQARS, 2011; Exhibit 1).

Exhibit 1: Suicide Rates Over Time: U.S. and Alaska by State, AN/AI Male and Non-Native Male



[3] Throughout this document, both the term "Alaska Native" and the abbreviation "AN/AI" are used to refer to all Alaska Native and American Indian people who reside in Alaska.

In 2011, Alaska Natives statewide were 2.2 times more likely to die from suicide than non-Natives in Alaska (36.22 and 16.35 per 100,000, respectively, $p<0.05$) and Alaska males were 3.9 times more likely to die from suicide than females (30.58 and 7.84 per 100,000, respectively) (WISQARS, 2011). Suicide is a significant concern across the life cycle for Alaska Native communities; however, Alaska Native youth are at particularly high risk. While suicide is the second leading cause of death for youth aged 15-24 in the U.S. (Table 1), it is the leading cause of death for AN/AI youth aged 15-24 in Alaska (WISQARS, 2011).[4]

Table 1. Suicide Rates for Youth Ages 15-24

Youth Ages 15-24		Suicide Rate (per 100,000)
U.S.	All Male Female	11.0 17.65 4.04
U.S. AN/AI	All Male Female	17.72 27.67 7.07

WISQARS, 2011

Particularly in the last 15 years, local, state, and federal agencies have devoted attention and resources to addressing the problem of youth suicide in Alaska, often by developing strategies in partnership with and with attention to the cultural context of Alaska Natives. At the state level, the Alaska Statewide Suicide Prevention Council (the Council—SSPC), established by the Alaska Legislature in 2001, advises state leaders and decision-makers regarding approaches to improve the health and wellness of Alaskans by reducing suicide, improving public awareness of suicide and risk factors, enhancing suicide prevention efforts, building and strengthening partnerships to prevent suicide, and creating and implementing a statewide suicide prevention plan (SSPC, 2013a). The Council's 2012 5-year statewide suicide prevention plan, *Casting the Net Upstream: Promoting Wellness to Prevent Suicide*, is informed not only by the suicide prevention literature, but also by "the wisdom and experience of Alaskans all over our State." "A uniquely Alaskan endeavor," (SSPC, 2013a, p.2), the state suicide prevention strategy is also aligned with key national suicide prevention goals and plans, including the National Strategy for Suicide Prevention (NSSP) and the American Indian and Alaska Native National Suicide Prevention Strategic Plan (n.d.), developed by the National Tribal Advisory Committee in collaboration with the Indian Health Service (IHS)'s Division of Behavioral Health. A central tenet across these plans is that traditional practices must be honored and respected in the implementation of suicide prevention initiatives.

At the federal level, key agencies addressing suicide prevention in Alaskan communities include the U.S. Department of Health and Human Services' IHS, whose mission is "to raise the physical, mental, social,

[4] From 2008-2011, suicide is the leading cause of death for Alaskan youth aged 15-24 (ANTHC, 2012).

and spiritual health of American Indians and Alaska Natives to the highest level" (IHS, n.d.), and the Substance Abuse and Mental Health Services Administration (SAMHSA), which administers an array of programs that address tribal behavioral health and suicide prevention in AI/AN communities, including in Alaska. Among the SAMHSA-sponsored initiatives, such suicide prevention programs include the Garrett Lee Smith Youth Suicide Prevention and Early Intervention Program (GLS Youth Suicide Prevention Program) and the Native Aspirations Project (which ended in 2013 and was replaced by the Native Connections Program and a tribal technical assistance program), whose goals and objectives were also closely aligned with the blueprint for suicide prevention outlined in the NSSP. The GLS Youth Suicide Prevention Program, which includes the GLS State/Tribal Program and GLS Campus Program, has been devoted to suicide prevention for youth and young adults aged 10–24 years, addressing a key population at risk in the U.S. The Native Aspirations Project was designed to address high rates of youth suicide, as well as substance misuse, bullying, and school violence, in AN/AI communities in the U.S. through the implementation of culturally appropriate, evidence-based interventions. The GLS Suicide Prevention Program and Native Aspirations have provided significant resources and support for tribal communities, including communities in Alaska, to promote the development of suicide prevention programs. (See Appendix A for an overview of federally supported suicide prevention programs in Alaska.)

A leading federal agency in the field of suicide prevention, the Substance Abuse and Mental Health Services Administration (SAMHSA) administers related suicide prevention initiatives, including the Garrett Lee Smith Youth Suicide Prevention and Early Intervention Program and programs to address tribal behavioral health and American Indian/Alaska Native suicide prevention, including the Native Connections program.

Parallel with program efforts, ongoing cross-site evaluations of both the GLS Youth Suicide Prevention and Native Aspirations programs have been designed to improve understanding about the extent to which these programs have achieved their goals and strengthened suicide prevention efforts for key populations, including young people in Alaska. Over the last decade, both evaluations have included multiple methods of data collection, such as surveys, focus groups and interviews with service providers and other community members in Alaska, to assess existing suicide prevention resources, community strengths, and challenges and progress related to the design and implementation of suicide prevention efforts.

The purpose of this report is to inform tribal communities, policymakers, and public health professionals about suicide prevention efforts in Native Alaskan communities and to recommend actions to advance future suicide prevention work within those communities.

This report includes:

- a review of Alaskan community context relevant to consideration of suicide prevention efforts, including location, geography, culture, history and health service infrastructure;
- a summary of local perspectives regarding risk and protective factors for suicide and violence as well as existing suicide and violence prevention programs and suicide prevention progress;
- community feedback related to ongoing challenges and needs across communities;
- findings from multiple data sources informing suicide prevention progress (including the cross-site evaluation of the GLS Youth Suicide Prevention program and the national evaluation of the Native Aspirations program); and,
- recommendations for future suicide prevention efforts in Alaskan communities.

BACKGROUND

Cultural Context

Alaska is the largest, and yet, in some respects, smallest state in the Union. At over 586,000 square miles, it is one-fifth the size of the contiguous 48 states—often referred to by Alaskans as the "Lower 48"—yet, it maintains a population of only 732,298 people (U.S. Census Bureau, 2012; State of Alaska, 2014). At 1.2 persons per square mile on average, Alaska has the lowest population density of any state. By contrast, Washington, D.C. is populated by more than 9,856 people per square mile on average (U.S. Census Bureau, 2012). The largest city in the state, Anchorage, at 286,174 persons, hardly qualifies as a big city by the standards of the Lower 48. Comparatively, New York City has a population of more than 8.3 million. With more than 130 villages under 1,000 people and another 40 villages with populations between 1,000 and 6,000, Alaskans seem to know everyone and often consider themselves members of the largest small town in the union (City Data, 2003–2011).

In addition to sheer landmass, Alaska encompasses a vast diversity of climate and topography with mountains, arctic Tundra, rivers, ocean coast, and islands. As Naske and Slotnick (1979), Alaska historians, have noted, "the diversity of this lonely and lovely subcontinent is just as incredible as its size (page 6)." Village locations—mountain to coastal, Northern to Southern—directly influence the culture and traditions of the communities that have existed and evolved in Alaska over thousands of years. Alaska Native peoples from the 10 main tribes—Yup'ik, Inupiaq, Athabascan, Aleut, Eyak, Chugiak, Tlingit, Haida, Koniag, Tshimsian—continue to practice a subsistence lifestyle, which variously includes fishing, harvesting, and hunting, depending on the season and climate. The tribes differ with respect to their language, legends, customs, songs, and stories of origin; yet they are drawn together in their reliance upon the land and waters that have sustained them for many centuries and in the common experience of challenges they have faced in the modern era (Alaska Native Cultures, n.d.).

This report focuses on suicide prevention in Alaska, particularly in communities that experience some of the highest suicide rates, such as the Athabascan, Inupiat, Yup'ik, and Cup'ik communities. Table 2 highlights cultural values common (and specific) to each tribe, which is useful in considering the ways in which ties to culture and tradition serve as a protective shield against suicide within tribal communities.

Table 2. Highlights of Alaska Tribes' Cultural Values[5]

Athabascan—Interior and Southwest	
■ humor, honesty and fairness ■ sharing and caring ■ respect for Elders ■ respect for land and nature ■ respect for knowledge ■ honoring ancestors ■ spirituality	■ self-sufficiency and hard work ■ care and provision for the family ■ family relations and unity ■ love for children ■ village cooperation ■ wisdom from life experiences ■ practice of Native traditions
Yup'ik—Southwest, Northwest Arctic, Interior	
■ love for children ■ respect for others ■ sharing ■ humility ■ hard work ■ spirituality ■ avoid conflict ■ respect for land	■ cooperation ■ family roles ■ knowledge of family tree ■ knowledge of language ■ humor ■ respect for nature ■ hunter success ■ domestic skills
Cup'ik—Southwest	
■ help other people ■ help with family chores and needs ■ early to bed and early to rise ■ provide time to see how your life is going ■ there's always time to play AFTER your work is done ■ Pingnatugyaraq—learn to do things yourself ■ respect and honor your elders	■ always show good behavior ■ listen to all advice given to you ■ remember what you are taught and told ■ respect other peoples belongings ■ respect the animals you catch for food ■ gather knowledge and wisdom from the elders ■ never give up trying to do what you set your mind on

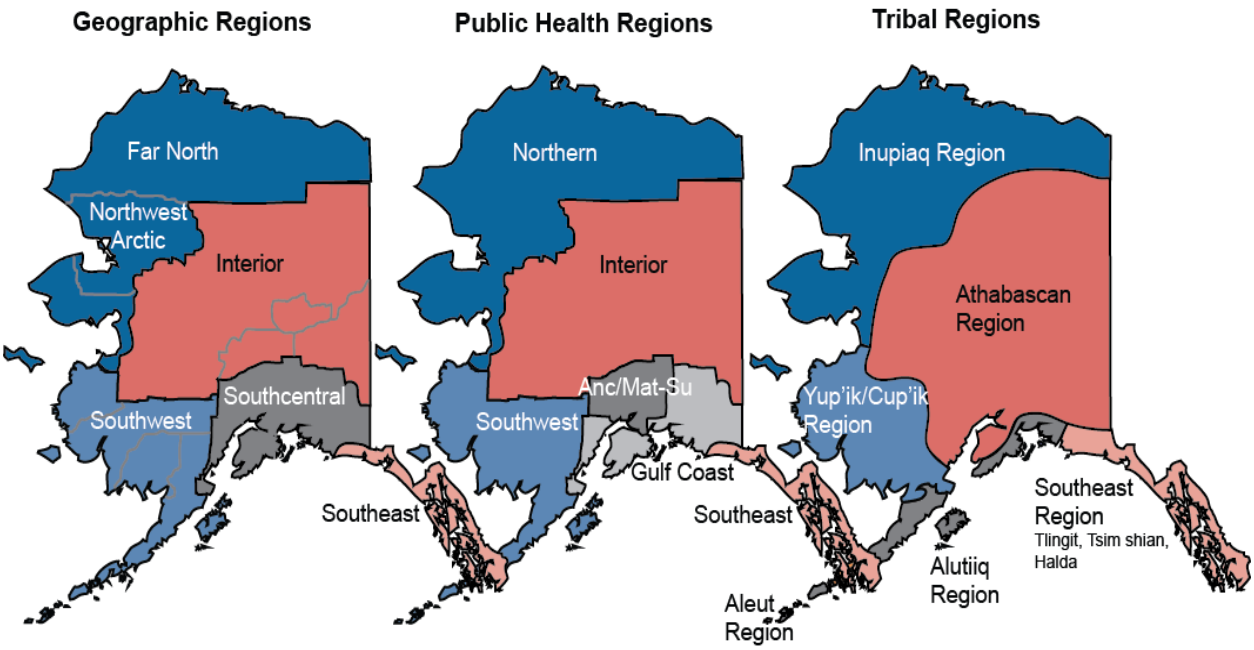
[5] Cultural values and phrasing are tribal specific and taken from Alaska Native Knowledge Network, http://www.ankn.uaf.edu/ancr/Values/index.html

Table 2. Highlights of Alaska Tribes' Cultural Values (continued)

Inupiaq—Northwest Arctic, Far North	
■ knowledge of language ■ sharing and cooperation ■ respect for others ■ respect for Elders ■ love for children ■ hard work ■ hunter success ■ responsibility to tribe	■ knowledge of family tree ■ avoidance of conflict ■ respect for nature ■ spirituality ■ humor and humility ■ family roles ■ domestic skills

Because of Alaska's size and diversity (e.g., geographic, cultural, rural/urban), areas of the state are often subdivided into multiple service areas and referenced in different ways, including tribal, public health, and geographic. These and other regional schemes, which overlap borders, are useful in assessing suicide prevalence and related issues throughout Alaska—which vary within and across geographic and tribal boundaries. These subdivisions and regional demarcations also are useful in understanding relevant cultural context and the multiple prevention approaches underway throughout the state. Exhibit 2 presents an overview of several maps reflecting various ways in which Alaska is subdivided. The different regions are presented here to give context to the bounded areas described and referenced in this report. Public Health Regions, for example, are how the state demarcates different regions to present state health data (e.g., Behavioral Risk Factor Surveillance System and Youth Risk Behavior Survey data) as opposed to geographic or tribal regions.

Exhibit 2. Alaska's Overlapping Regional Schemes



To discuss suicide prevention in Alaska, it is important to understand the geographic isolation of Alaska as well as the cultural traditions and history that have shaped the state. As noted, Alaskan villages are small, ranging in size from 20 to 6,000 residents, with an average size of 300 residents (AI Environmental Office, 2013). The majority of Alaska's villages are not on the road system and are accessible only via bush plane or, in Southeast Alaska, the Alaska Marine Highway, or ferry system. This separation from the road system—which, for most inhabitants of the Lower 48, provides a connection to food, shelter, and entertainment—forces a higher level of self- and communal-reliance in Alaskan villages. Among other similarities across tribes, individual, family and community roles are often determined by age, knowledge, skills, and connection to natural resources such as land and water (Burch, 2000, 2005, 2006). Traditionally, men and boys hunt land and sea animals for food while women and girls handle the processing and preparation of food, clothing, and utensils from animals (Hensel, 1996). Village Elders—men and women who have achieved rank and status by virtue of age and wisdom—provide leadership and spiritual guidance to their community (Lewis 2008). Historically, Elders have been, and continue to be, the keepers of their communities' oral history, which includes a vast collection of parables and insights learned over a millennium of survival in Alaska. However, age alone is not sufficient for achieving the status of Elder. Individuals are ascribed leadership roles depending on their position in the social network and whether their past performance garnered community endorsement (Wexler, 2011). Because of their prominence and collective wisdom, Elders are consulted in all community decision-making.

In many respects, the community context within Alaskan villages—geographically remote and socially close-knit, a subsistence lifestyle with traditional roles for men, women and Elders—has remained consistent for many generations. However, in other respects, the Yuuyaraq ("the way of being human"), as spoken in the language of the Yup'ik people, is in a state of change (Napoleon 1991). As the noted leader Harold Napoleon posits in his seminal essay, "Yuuyaraq: The Way of the Human Being," it is necessary to recognize this change and what led to it in order to understand the context of suicide in Alaska (Napoleon 1991).

Western Influence and Historical Trauma

With the first Western contact, the trajectory of Alaska Native history was profoundly altered. Series of wars, oppression, racism, discrimination, the introduction of diseases and forced acculturation shook the fabric of traditional society as whole communities were sickened, killed, relocated, and re-educated. The resulting historical traumas have jeopardized the overall health and well-being of the population.

The events culminating in historical trauma largely began in the mid-1800s with the introduction of whalers, traders, miners, and missionaries, along with their diseases (Napoleon, 1996; Alaska Public Lands Information Centers n.d.; Alaska Kids, 2000–2014.). The introduction of microbes to which Alaska Natives had no natural immunity led to massive disease outbreaks and death in a stunningly short period of time (Napoleon, 1996). Further trauma was inflicted upon the population as missionaries and others sought to disrupt the languages and the traditions of Alaska Natives. From 1790 to 1920 (Hoxie, 1984), the United States sought to culturally assimilate Native Americans, including Alaska Natives, to convert Native American culture to European–American culture; education was seen as the primary method in the acculturation process. Thus, children were forcibly taken to boarding schools where they were often verbally, physically, and sexually abused (Napoleon, 1996). They were separated from their families, culture and traditions, and left unmoored—not White but no longer fluent in their Native ways. As these children grew up and begot families, their unresolved grief and trauma was subsequently handed down to their children. The cultural anchors that should have served to ground and enhance adolescent development—from childhood to adulthood and parenthood—were missing, and, in many

For thousands of years, Alaska's Native people have hunted, fished, and prospered in one of the world's most challenging environments. The first European explorers marveled at the resourcefulness and ingenuity of the original inhabitants of the Great Land. Yet now, at the beginning of the 21st century, Alaska's Native people, who have survived and prospered for thousands of years, are threatened by a growing crisis — alcoholism, suicide, and other physical and mental health disorders.

— Paul Berg, Alaska journalist and educator (Berg, 2012, para. 4)

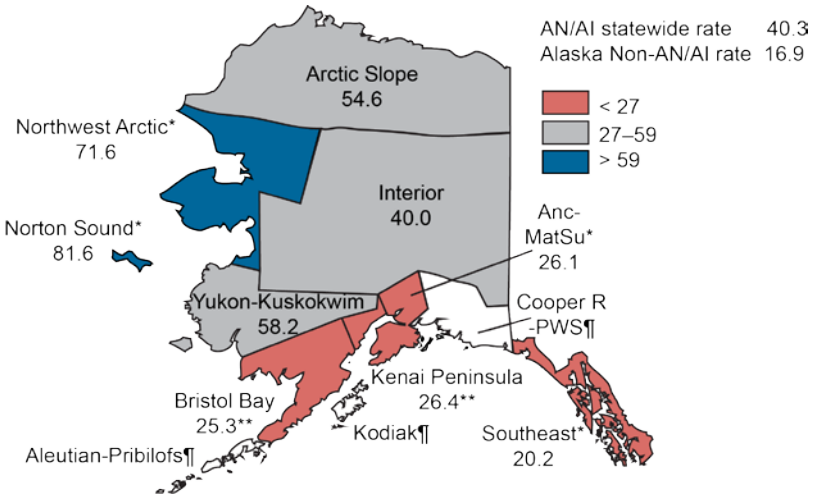
cases, dysfunction was left in its place. Historical trauma, or "the legacy of colonization," is defined as the "cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma" and results from unresolved grief surrounding the historic traumas (Alcantara & Gone, 2007; Brave Heart, 2003, 1998).

Coupled with the historical traumas resulting from this forced acculturation was the transition from a subsistence and trade economy to a cash economy. Given the Western influence of modernity and capitalism, the old ways of living wholly off the land are no longer sufficient (e.g., money is needed for fuel and bullets); however, opportunities for participation in the relatively new cash economy are limited. As researchers at the Institute of Social and Economic Research, University of Alaska Anchorage, describe, Alaskan villages—by nature of their small size and remoteness—have limited opportunities for market-based activities and commercial resource development. In addition, decisions related to economic and resource development are often made outside of the village at the state and federal levels (Huskey & Morehouse, 1992). Further, the types of jobs often available in village settings, such as school administrators and teachers, do not match the local labor supply (Goldsmith, 2008). As a result, "young men, in particular, find themselves caught between two cultures as they struggle to balance traditional family roles of hunting and fishing with the demands of a cash-fueled Western economy" (Hopkins, 2014).

Suicide and Comorbid Conditions

Against this backdrop of historical trauma and oppression, Alaska now has exceedingly high rates of suicide and comorbid conditions, including domestic violence, sexual assault, and alcohol and drug misuse. According to the Alaska administration of the Youth Risk Behavior Survey (YRBS), a national school-based survey that monitors health-risk behaviors among youth, 16.2

Exhibit 3. Suicide Death Rate by Tribal Health Region, Alaska Native People, 2002–2011[6]



[6] Data Source: AKBVS (2002-2011); Death rate per 100,000 age-adjusted to 2000 U.S. standard population; *Southeast, AncMatsu, Norton Sound, and Northwest Artic are significantly different from the AN/AI statewide rate (p<.05); **Kenai Peninsula, and Bristol Bay rates are based on 10–19 deaths and should be interpreted with caution; ¶Aleutian–Pribilofs rate not calculated due to small number of deaths (<10).

percent of Alaskan students surveyed in 2013 report seriously considering attempting suicide; 13.9 percent report making a suicide plan; and 8.4 percent attempted suicide (AKDHSS, 2013). Between 2007 and 2011, there were 771 suicide deaths in Alaska, with an average of 154 suicide deaths per year (Alaska Violent Death Reporting System [AKVDRS], 2007–2011). In 2010 alone, this equated to more than 4,000 years of potential life lost due to suicide (NCHS, 2010). All regions of Alaska are affected by suicide; however, rates are not consistent across the state. The northern and western regions bear the highest burden with a rate of 54.6 on the Arctic Slope; 71.6 in the Northwest Arctic; 81.6 in Norton Sound; and 58.2 in the Yukon Kuskokwim (AKBVS, 2002-2011; Exhibit 3). As suicide affects primarily the young in Alaska, these regional differences are reflected in the YRBS as well, with the Northern and Southwest regions of the state reporting the highest incidence of suicidal ideation and attempt among youth (AKDHSS, 2013).

Suicide is a major health concern for Alaska, among other health issues that are often related. For example, the CDC and Kaiser Permanente's Adverse Childhood Experiences (ACE) study has demonstrated clear linkages between exposure to one or more adverse childhood experiences (e.g., psychological, physical, or sexual abuse; violence against mother; living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned) and increased risk for suicide attempt, depression, alcohol misuse, and substance misuse in later life (CDC, 2010; Felitti, 1998). Like suicide, domestic violence and sexual assault (DVSA) are prevalent in Alaska. The Alaska Victimization Survey, first launched in 2010, found 59 percent of Alaska women, at some point in their lifetime, have experienced domestic violence, sexual assault or both; and in the past year, 12 percent have experienced domestic violence, sexual assault or both (AVS, 2010). Of the Alaskans surveyed by the Behavioral Risk Factor Surveillance System (BRFSS), more than 20 percent reported seeing or hearing, as a child, their parents being physically hurt by a spouse or partner; among Alaska Natives, this rate was 33.6 percent (BRFSS, 2009). In addition, youth are experiencing violence at alarming levels. Among youth, 9.1 percent report being hit, slapped, or physically hurt by their girlfriend or boyfriend in the past year and more than 9 percent report being forced to have sex (YRBS, 2013). In 2011, more than 2,500 cases of substantiated child maltreatment were reported (defined as neglect and/or physical, sexual, and emotional abuse) in the state (CDC, 2009). This translates into approximately 17.1 children per every 1,000. Over half of the victims (53 percent) were Alaskan Native (Kids Count Alaska 2011–2012).

As with high rates of violence, alcoholism and substance misuse are also pervasive throughout Alaska (Leeies, Pagura, Sareen, & Bolton, 2010). Nearly 20 percent of adult Alaskans report binge drinking and 7 percent report heavy drinking (more than two drinks per day for men). As indicated by the National Survey on Drug Use and Health, illicit drug use in the past month among Alaskans ages 18 to 25 was more than 26 percent; for marijuana, the rate for Alaska is nearly 25 percent (SAMHSA, 2012). Alaskans are not waiting until adulthood to begin experimenting with drugs and alcohol. Nearly 14 percent of youth in 2013 reported having their first drink before the age of 13 years, and 22.5 percent of students reported having had one or more drinks in the past month (AKDHSS, 2013). In addition, almost half of the youth (42.7 percent) reported having tried drugs and more than 22 percent report currently using

marijuana or unprescribed drugs (AKDHSS, 2013). This alcohol and drug use does not happen in a vacuum. Individuals who begin drinking in their early teens are at increased risk of suicidal ideation and attempt, as well as alcohol dependence in later life (National Institutes of Health [NIH], 2006; Swahn, 2010; Vieira, 2007). As the Alaska Suicide Follow-Back Study demonstrates, this is a deadly mix. According to the study, 46 percent of suicide decedents for whom toxicology reports were available had measurable amounts of alcohol in their blood and 50 percent tested positive for illegal or nonprescription drugs (Alaska Injury Prevention Center, 2006).

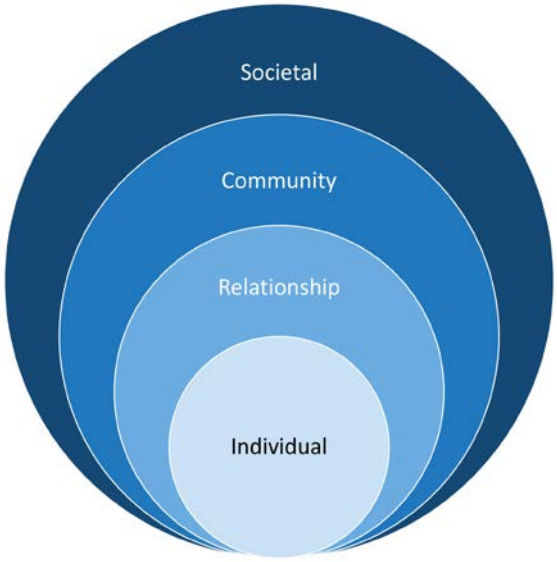
In their work, "Historical Trauma," May and Van Winkle describe that acculturation, or the confluence of Western and traditional cultures, led to chaos in families—child neglect, substance misuse, and alcoholism (1994). Brave Heart, who conceptualized the term "historical trauma," took this further, showing that historical trauma also is strongly tied to psychological states of unresolved or prolonged grief, posttraumatic stress disorder (PTSD), depression and substance misuse (2011). Moreover, Olson and Waheb (2006), in their review of the literature, cite the relationship between historical trauma and suicide:

> *Where pressures to acculturate have been great and tribal conflict exists concerning traditional religion, governmental structure, clans, and the importance of extended families, the suicide rate in the adolescent and young adult population is high.*

Risk and Protective Factors

The social ecological model (Exhibit 4), which conceptualizes risk and protective factors across interrelated "levels" from the individual to the relationship, community, and societal levels, provides a useful framework for understanding and addressing the myriad factors that impact an individual's decision to attempt suicide. Some factors are at the individual level, but many transcend the person and are symptoms of the larger community. Indeed, as Alcantara and Gone (2007), in a paraphrase of Felner and Felner's (1989) transactional ecological framework, state, the "roots of pathology can be and often are outside of the person."

Exhibit 4. Social Ecological Model



For Alaska Natives, "Indigenous suicide is associated with cultural and community disruptions, namely, social disorganization, culture loss, and a collective suffering" (Wexler, 2012, p. 800). Thus, in these communities, significant cultural- and societal-level stress is a risk factor that is often linked to or interacts with factors at other levels, elevating suicide risk for this population. For example, illustrating

the potential interaction of historical trauma and drug or alcohol misuse as risk factors, one study finds that AN/AI adults who attended boarding school as children reported higher rates of illicit drug use and alcohol use disorder and were also significantly more likely to have attempted suicide and to have experienced suicidal thoughts in their lifetime compared to nonattendees (Evans-Campbell et al., 2012).

As with risk factors, the social ecological framework provides a useful lens for identifying and addressing factors that serve to protect youth from suicide. Ongoing efforts to ensure the healthy growth and development of AN/AI youth have built on growing literature related to the risk and resilience of adolescents (Institute of Medicine, 2002). For AN/AI youth, "resilience" refers to a set of qualities that help to ensure that, despite stress and adversity, youth do not succumb to negative outcomes, including school failure, substance misuse, mental health problems, bullying, or juvenile delinquency (Peacock, 2002). Risk and resilience research is aimed at identifying the contextual factors related to adolescent health and well-being in multiple domains (e.g., family, peer group, school, community, culture) in an effort to understand both the risk factors that lead to a greater likelihood of a negative outcome in an adolescent's health or behavior and the protective factors that mitigate against these negative outcomes. Highlights of risk and protective factors for suicide are presented in Table 3 (Alcantara & Gone, 2009; Rodgers, 2013; Olson & Wahab, 2006; Wexler & Goodwin, 2006).

In many ways, this framework, which supports consideration of the complexity of factors impacting suicide risk, the interaction and relationship between and across such factors, and possible strategies and entry points for prevention and intervention, is currently being used to help guide and focus suicide prevention work in Alaska. For example, the State of Alaska's suicide prevention plan was created with attention to current research and understanding of the "web of causality" of suicide, or the fact that "suicidal behavior results from a combination of genetic, developmental, environmental, physiological, psychological, social, and cultural factors operating in complex, and often unseen, ways" (SSPC, 2013a, p. 2).

Table 3. Risk and Protective Factors for Suicide

Individual	
Risk Factors	**Protective Factors**
■ Prior attempt ■ Mood, mental and addictive disorders ■ History of trauma/abuse ■ Alcohol and/or substance misuse ■ Sense of isolation ■ Hopelessness ■ Access to lethal means	■ Self-efficacy ■ Connectedness ■ Spirituality

Table 3. Risk and Protective Factors for Suicide (continued)

Family/Relationship	
Risk Factors	**Protective Factors**
■ Family history of suicide ■ Intergenerational trauma ■ Family history of abuse ■ Family stress	■ Role models ■ Clear expectations ■ Connectedness ■ Restricted access to lethal means
Societal/Community	
Risk Factors	**Protective Factors**
■ Exposure to others who have died by suicide ■ Historical trauma ■ Shame and embarrassment related to seeking behavioral health care ■ Socio-economic class, unemployment and/or lack of educational opportunities ■ Barriers to care	■ Safe places ■ Role models ■ Opportunities ■ Cultural connectedness ■ Cultural continuity

Suicide Response and Health Infrastructure

As alluded to in the Introduction, the problem of suicide in Alaska is receiving local, state, and federal attention. Entities at the local level (e.g., tribal councils); the state level (e.g., State of Alaska, RurAL CAP); and the federal level (e.g., Indian Health Service, SAMHSA, and others) are developing culturally relevant suicide prevention approaches that attempt to address the complex and multilayered nature of the challenges Alaska Natives face.

Since 2001, Alaska's Department of Health and Social Services has allocated more than $10 million toward funding large- and small-scale grants to locally implement suicide prevention strategies, including nearly $1 million in 2013 alone (Alaska State Suicide Prevention Report, 2010; SSPC, 2013b). These prevention strategies include developing community and regional suicide prevention coalitions; creating community resources; and conducting public education and outreach (Alaska State Suicide Prevention Report, 2010; SSPC, 2013b). In addition to

Alaska State Funded Suicide Prevention Example

School-based screening and intervention program using the Signs of Suicide Prevention Program in the Juneau School District

***Alaska Statewide Suicide Prevention Council*, 2010.**

providing grants for local communities, the State of Alaska oversees a number of efforts designed to strengthen Alaska's suicide prevention infrastructure. For example, the state's Suicide Prevention Council helped create and, more recently, update the Statewide Suicide Prevention Plan, which is currently in its second iteration (SSPC, 2013a). The Council has partnered with the Alaska Mental Health Trust Authority to develop a suicide prevention media campaign, as well as partnered with the State of Alaska Division of Behavioral Health to develop a postvention resource and training to help communities in crisis heal; a Web site (StopSuicideAlaska.org); and a Facebook page designed to increase access to suicide prevention resources (SSPC, 2013b). The state also operates the Alaska Careline, a suicide prevention hotline available 24 hours a day, 7 days per week (Alaska State Suicide Prevention Report, 2010; SSPC, 2013a, 2013b).

Availability, Access, and Utilization of Behavioral Health Services in Alaska

The strong financial support from state and federal agencies has led to a proliferation of suicide prevention efforts within Alaska, particularly in the last decade. Many of these efforts are coordinated by regional tribal health consortia located in hub communities. The Alaska Tribal Health Compact, created in 1994, authorizes tribal health organizations to operate health and health-related programs within Alaska (Alaska Native Health Board, n.d.). Twenty-one tribes or tribal consortia (made up of numerous tribes) belong to the Compact, including eight large regional tribal health consortia and one state-level health consortium, Alaska Native Tribal Health Consortium (ANTHC), that provide services to much of the state (Alaska Native Health Board n.d.). These regional tribal health consortia direct and manage health promotion, behavioral health, and general health services for the villages in their region. ANTHC provides specialty, tertiary and primary care services at the state level as well as community health services, and environmental health and engineering for the Alaska regions (ANTHC EpiCenter, 2005–2014). Together, these tribal health consortia make up the Alaska Tribal Health System and oversee health services for most of the 12 tribal health regions in Alaska: Aleutians and Pribilofs, Anchorage/Mat-Su,

Tanana Chiefs Conference

Tanana Chiefs Conference (TCC)—the traditional tribal consortium of the 42 villages of Interior Alaska—is a nonprofit organization that works toward meeting the health and social service needs for more than 10,000 Alaska Natives spread across a region of 235,000 square miles of Interior Alaska (TCC, 2014).

Manillaq Association

Manillaq Association represents the 12 federally recognized tribes in the Northwest Arctic providing health, tribal, and social services to 6,500 people in the region (Manillaq, 2003).

Arctic Slope, Bristol Bay, Interior, Kenai Peninsula, Kodiak Area, Northwest Arctic, Norton Sound, Southeast, and Yukon-Kuskokwim (Alaska Department of Health and Social Services, 2012; Alaska Native Tribal Health Consortium, 2005-2014a).

BEHAVIORAL HEALTH SERVICES

As part of the Alaska Tribal Health System, the regional tribal health consortia offer mental health and substance use services to Alaska Natives free of charge (Allen at al., 2011). While services available at the health consortia vary by region, consortia offer a range of services. These services are centralized in the hub communities where the consortia are based. To access most services, village residents must leave their village and travel to the hub community, usually by air taxi. To increase access and availability of mental health services in the villages, in 2004, ANTHC instituted a behavioral health workforce model throughout Alaska (KANA, n.d.). The Behavioral Health Aide (BHA) Program certifies providers at the BHA I, II, III and Practitioner levels (UAA, 2013). BHAs serve as counselors, health educators, and advocates within their communities (ANTHC, 2005–2014; van Hecke, 2012). BHAs practice under the supervision of licensed clinicians based in the regional hubs and are trained to provide case management and referral, community education and prevention services and, at the highest level of training (the BHA Practitioner) treatment planning and community evaluations (van Hecke, 2012). BHAs are now in every tribal and geographic region of the state; however, fewer than half of Alaska's 280 villages have a BHA (Alaska Native Tribal Health Consortium, 2005–2014b).

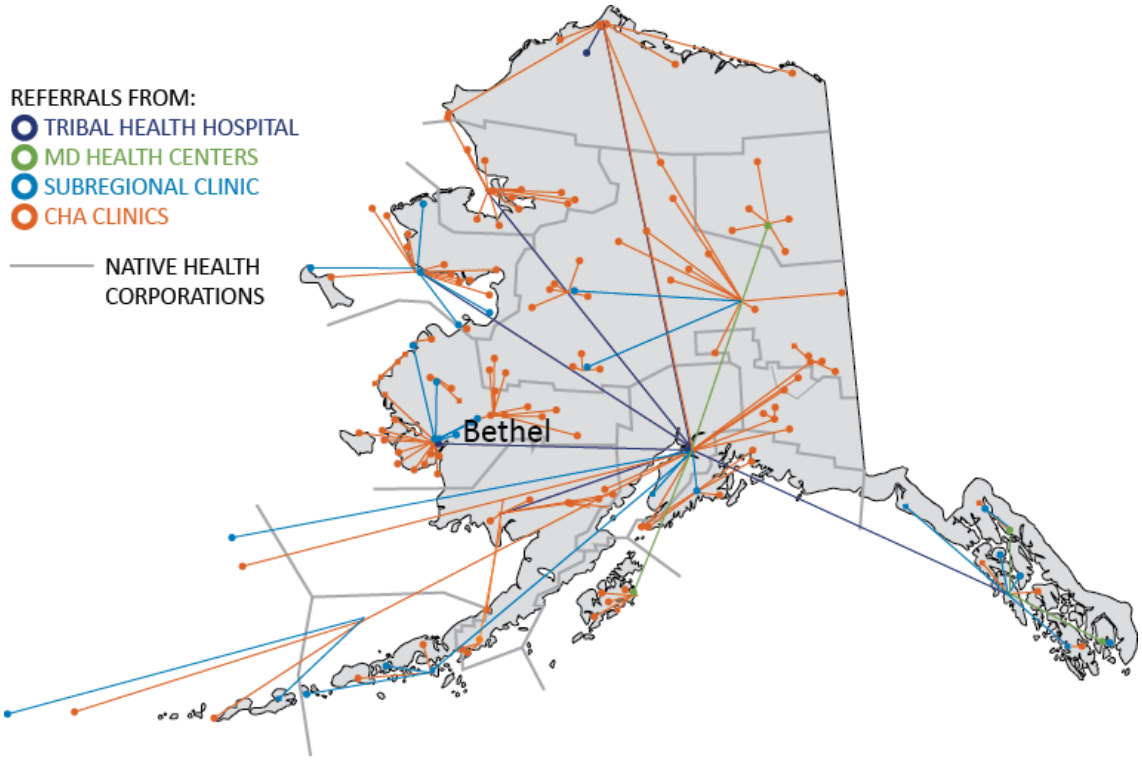
Behavioral Health Services Provided by Regional Tribal Health Consortia

- Screening
- Brief intervention
- Health education
- Assessment
- Pretreatment
- Residential
- Outpatient
- Psychotherapy
- Psychiatry
- Case Management

As mentioned, access to behavioral health services are limited in communities outside larger Alaska cities and transport from villages to hub communities is necessary to receive most services. Exhibit 5 depicts the referral and service access pathways for village community members outside of their local village to a subregional or regional hub.[7]

[7] ANTHC, 2007

Exhibit 5. Referral and Access to Regional Behavioral Health Services[8]



Where BHAs are present, they are typically from the communities in which they work. This can be both an advantage and disadvantage. As residents of the community, BHAs are fluent in the culture of the community and can be a welcoming familiar face. However, given the small and close-knit nature of the communities, concerns about confidentiality and embarrassment associated with receiving behavioral health care may limit service utilization as community members are reluctant to seek care from individuals they have known, in many cases, their entire lives (van Hecke, 2012). Telebehavioral health, which has become available in some of the regional hubs and villages over the last 10 years, provides an additional level of behavioral health service that can help allay some of the concerns around confidentiality as the telebehavioral health provider is based in the regional hub and not intimately familiar to the community. Yet, telebehavioral capacity for village communities is limited given the lack of stable internet and phone connections to telebehavioral health services in subregional or regional hubs (i.e., limited internet and phone infrastructure in remote communities often prohibits community member use of these types of services). Thus, in spite of the recent increase in services at the local level

[8] MD Health Centers are physician staffed health centers; CHAs are village community health aide clinics.

as a result of the BHA program and the growing capabilities of telebehavioral health at subregional or regional hubs, behavioral health access remains sharply limited and out of reach for many Alaskans.

Crisis Services

While each community responds differently in the face of a suicide threat or an attempt, there are common resources available including the Alaska Careline—a 24 hour, seven day a week crisis intervention line for individuals experiencing crisis, depression, or considering suicide (Alaska Careline, http://www.carelinealaska.com/). Outside of the cities (e.g., Anchorage, Fairbanks), most rural communities in Alaska do not have the resources to safely stabilize individuals who are experiencing a mental health crisis. As a result, such individuals are often "Title 47'd" or taken into protective custody by the Village Public Safety Officer (VPSO) or other peace officer and held in the community jail until he/she can be transported to the nearest treatment facility. Typically, passage to the nearest treatment facility requires transport via small bush plane and often requires Alaska State Trooper transport support. Alaska's only psychiatric hospital—Alaska Psychiatric Institute—is located in Anchorage. Hospitals in Juneau and Fairbanks have psychiatric units (Alaska Mental Health Board, 2008).

Removal from the community can have a destabilizing effect as high-risk youth are separated from the familiar comforts of their own home and support network (State of Alaska, 2011; Wexler & Gone, 2012). Suicide interventions that include removal of youth from their families and village life can have implications for the community as well. Community members may feel disempowered and feel greater distrust of community outsiders that remove children, particularly against the will of family or community members (Wexler & Gone, 2012). As coercive measures of removal are exercised, greater distrust of outside behavioral health providers grow. Where possible, communities may try to implement more localized responses to youth in crisis including having family and friends stay with the youth at all times until the crisis subsides, linking the youth with trusted adult and Elder mentors, family, and friends (Wexler & Gone, 2012).

SUICIDE PREVENTION IN ALASKA—THE FINDINGS

In the participating Alaskan communities, both quantitative and qualitative data collection activities provided an opportunity to improve understanding about risk and protective factors for suicide, violence, and, in some cases, bullying (to the extent that respondents were able to comment); assess community awareness, knowledge and behaviors related to these issues; examine the nature and extent of suicide prevention programming in the participating villages, including the way in which cultural context informs suicide prevention efforts; and assess facilitators and ongoing challenges and gaps in service availability. In addition, federal and state surveillance data were used in this report to supplement and support qualitative findings. A detailed description of primary and secondary data sources can be found in Appendix B. Qualitative data collection occurred in villages within the Interior and Northwest Arctic regions of Alaska, each of which have particularly high suicide rates (see Appendix C for additional description of these communities). The facilitating factors for the prevention of suicide, violence, and bullying that emerged mirrored information presented in other sections of this report; thus, for a review of such factors, see the following sections: "Protective Factors" and "Resources for Suicide Prevention." Specific community names (i.e., tribal villages and communities) are not disclosed in this report as information presented here was primarily gathered to be presented in aggregate and not to evaluate and report on individual community activities.

Contextual Factors Related to Suicide Prevention

Interview and focus group participants from the Interior and Northwest Arctic regions of Alaska provided their perspectives about the most important risk and protective factors for youth suicide in their Alaskan villages. The themes from these data are presented in the following sections, along with additional data from the cross-site evaluation of the GLS Suicide Prevention program and secondary data sources such as surveillance data.

RISK FACTORS

Participants responded that the most critical risk factors for suicide, violence, and, in some cases, bullying were: 1) alcohol and drugs; 2) the loss of family/friends who have died by suicide; 3) the continuing shame and embarrassment around help-seeking; 4) youth hopelessness; 5) the loss of culture; and 6) social isolation and lack of connectedness. In the subsequent subsections, these themes are described in more detail.

Alcohol and Drug Use / Loss of Family and Friends

While the Northwest Arctic village is technically "dry" (i.e., the sale, importation, and possession of alcohol is illegal), and the Interior village is "damp" (i.e., possession and limited importation is legal, but sale of alcohol is not), respondents from both communities described the ease with which alcohol and drugs can be procured. One respondent stated, "*We all know that alcohol and drugs are very available… it's supposed to be a dry village, but it does come in*." Another respondent described, "*A lot of people make 'home brew' or they bring it into the village*." A third respondent suggested that alcohol and drugs are substantial problems in the village—even more so than suicide; however, as noted in the research literature and emphasized by respondents, alcohol and substance misuse are clear risk factors for suicide. Respondents confirmed this anecdotally, suggesting that while some villagers use alcohol to cope with and alleviate the pain associated with their problems, the result instead is more intensive problems, including suicidal ideation and suicidal behavior. One respondent explains, "I think that's why a lot of alcoholism is going on, because they numb the problem. [Those who drink] just numb it. They need to deal with [the problem] and so it just has a domino effect…." Another respondent, in describing her own suicide attempt that occurred under the influence of alcohol, illustrates this "domino effect." She explains that she drank to cope with the loss of her friend who died by suicide and then became suicidal herself. Mirroring her experience, her son—attempting to cope with the loss of his friend who died by suicide—began drinking and talking about wanting to kill himself. Her story is emblematic of a community in which, respondents attest, each community member has been impacted by suicide.

Of the 771 suicide deaths recorded by the Alaska Violent Death Reporting System in 2007–2011, the most commonly documented incident characteristics included proven or suspected alcohol intoxication and current depressed mood. In addition, 156 (20 percent) decedents had a known alcohol problem or dependency (AKVDRS, 2013).

"There is not one family here that's not been affected by someone committing suicide, and that's very sad."

Interview Respondent

Alcohol Use: Youth Risk Behavior Survey (AKDHSS, 2013)

	Alaska		Interior Region		Northern Region	
Percentage of students who…	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Think drinking one or two alcoholic beverages nearly every day has slight risk or no risk of harm	45.23	30.82	45.39	27.49	47.93	32.86
Think drinking five or more alcoholic beverages once or twice a week has slight risk or no risk of harm	34.70	24.96	34.56	25.17	49.04	34.19

Shame and Hopelessness

Among other factors leading to suicide and violence, respondents pointed to the issue of shame related to seeking treatment for depression and suicidal ideation, a known risk factor. They suggested that youth are not inclined to seek help because they feel hopelessness along with shame and embarrassment around needing or wanting help. In addition, they are unable to relate to, and thus seek help from, older generations. Moreover, they do not understand that help is available. One respondent stated, "[Youth] don't see how other people can help them, just being uneducated [as to resources]." Another respondent suggested that youth would not consider seeking help to address their despair because "they feel so hopeless, there's no hope ….There's no tomorrows." Other respondents suggested that youth feel that "people will look down upon them" and that there is a "myth that people are crazy if they ask for help."

Hopelessness and Suicidal Ideation: Youth Risk Behavior Survey (AKDHSS, 2013)

	Alaska		Interior Region		Northern Region	
Percentage of students who…	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities during the past 12 months	19.02	35.66	19.15	44.90	18.82	38.91
Had seriously considered attempting suicide during the past 12 months	10.88	21.67	11.83	18.26	11.0	25.63

Loss of Culture

Respondents suggested that lack of connection to cultural heritage can leave youth unanchored, drifting and at heightened risk for suicide, as they may become isolated, depressed and/or influenced by alcohol or drug use. While in many respects, these communities continue to participate in a traditional subsistence lifestyle, some youth are less involved in, and thus less invested in, tradition or culture. Respondents suggested that youth have become less connected to their cultural heritage because: 1) knowledge about traditional practices is diminishing within the family; 2) male family members who can be role models, particularly for boys, are lacking; and 3) some families cannot afford the tangible resources needed to participate in subsistence activity, as it exists in Alaskan communities today (e.g., such resources may include fuel, a boat or a snow machine). As discussed previously, Westernization, in many respects, disrupted family dynamics and traditional knowledge and skills transmission and profoundly altered the way of life for Alaska Natives. Coupled with the advent of a cash economy, physical survival is no longer dependent on living off of the land. Thus, the knowledge and skills to do so are slowly being lost. A dwindling number of families have the skill set or are financially able to participate in traditional subsistence activities such as "fish camp," a seasonal practice in which fish are gathered and preserved. As one respondent stated, "Of course there are some families that do take their kids to [fish] camp and that's a wonderful place for upbringing for youth, but there is not a lot of families that do that." For some families, it is because, as one respondent explained, "*They don't have an opportunity at home. Some parents don't have boats or trucks or anything to bring them out. And like a boy doesn't have a father or a grandparent, a male [role model].*" An older respondent described changes in cultural practices that had occurred within his lifetime:

"Even in my own home, we don't do that. We do things as a family but we're limited, too, as to what we can do. When I was younger, my parents, we did everything together. We went berry picking together whether we wanted to or not. We went fishing whether we wanted to or not. It had to be done. That was our survival."

The introduction of social welfare, in providing a relatively secure and stable source of food and shelter, also was regarded by some respondents as a risk to their communities' overall well-being. Combined with already fading traditional knowledge and skills, some respondents lamented what they saw as further deterioration in individual and communal self-determination and self-sufficiency as a result of social welfare initiatives such as the Supplemental Nutrition Assistance Program. One respondent summarized, *"It's making our people lazy."* Another respondent noted a prevailing attitude of, *"[I] don't have to go to work…don't have to go to school."* Yet another respondent said:

> *"According to my mother [an Elder], who died 2 years ago… we live in a generation where we know there's funding out there, and we say, what are you going to give me? What are you going to share with me? I didn't earn it, but what are you going to give me? So, we're in that phase of being dependent instead of being go-getters."*

Respondents regarded lack of individual or communal initiative as a risk factor for suicide as it further disengages community members from traditional practices that inherently emphasize communal reliance and self-sufficiency.

Social Isolation and Lack of Connectedness

Many respondents pointed to a lack of connectedness to family and community as a major risk factor for suicide, violence, and bullying. For example, some respondents observed that parents struggle to engage with their children. One respondent stated, *"There are some children out there that feel like they don't have a connection to their parents."* Among the consequences of connectedness with family, respondents indicated that youth lacking close parent relationships are at greater risk for suicide because when they feel despair or depressed, they also feel that *"nobody cares for me, so nobody will miss me if I do something."* In addition, youth may have difficulty relating to others in their community if they struggle to relate to family members, suggested one community member, "*children need to learn more respect at home in order to be respected, to earn respect. We don't see a lot of that here in our town*." Community members expressed frustration watching young people struggle to connect with parents and family. One respondent described the challenge of attempting to help their neighbors become more engaged with their children: "*You're limited at what you can do or say [to parents]. There's no real way to change people. You could inform them. You could try to give them ideas but a lot of people are hard-headed on how to raise their own kids*." Another respondent suggested that bullying can be prevented with the help of stronger role models at home: "*Anti-bullying could be done at home with the parents because most things are learned at home. What a child learns in life is – that's what I think, they learn more at home than they do anywhere else*."

Parents and Bullying: Youth Risk Behavior Survey (AKDHSS, 2013)

	Alaska		Interior Region		Northern Region	
	Male	Female	Male	Female	Male	Female
Percentage of students who did not have at least one parent who talked with them about what they were doing in school about every day	62.95	55.39	52.63	58.88	69.56	69.50
Percentage of students who had been bullied on school property during the past 12 months	15.97	25.54	15.70	19.40	22.33	26.19

Compounding cultural loss and the sense of eroding self-sufficiency is the fact that opportunities for youth to become engaged in community activities are limited—i.e., there are not enough "things to do," in one respondent's phrasing, consistently and routinely offered for young people. Without enough positive opportunities for engagement, learning, work and recreation, respondents suggest that youth begin to feel isolated and to break away and disassociate from their community. As one respondent explained, *"[Youth] don't have a youth center or a tech center or anything other than the school. They don't have nowhere to go."* Once a young person graduates from high school, the options become even more limited. Without enough opportunities for work or advanced education, respondents said: "A lot of youth [are] out just walking the streets now" and "They stay home and slept. It's hard for them. It was hard for me. I understand it."

Youth Community Involvement: Youth Risk Behavior Survey (AKDHSS, 2013)

	Alaska		Interior Region		Northern Region	
Percentage of students who…	Male	Female	Male	Female	Male	Female
Do not take part in organized activities after school, evening, or weekend activities on one or more days during an average week	50.14	43.26	45.88	42.00	49.48	44.76
Do not spend one or more hours helping or volunteering at school or in the community during an average week	52.32	41.02	55.12	51.91	40.30	34.27

PROTECTIVE FACTORS

Among the key themes in participant responses related to protective factors for suicide, violence, and, in some cases, bullying, the following factors emerged as most critical: 1) youth connectedness; 2) the presence of safe and caring adults; 3) the role of Elders; and 4) reestablishing ties to culture. These

factors are presented individually; however, they are closely intertwined and blend across ecological layers (individual, relationship, societal/community). Themes in participant responses are presented below along with data from the cross-site evaluation of the GLS Suicide Prevention program.

Youth Connectedness

74% of youth surveyed agreed that "*I feel like I belong to my community*."

CKABS–Y

Beginning at the individual level but also spanning the relationship and societal/community levels is youths' sense of connectedness to their community. By participating in community traditions, culture, and practices, respondents suggest, youth build resilience as they connect to something larger than themselves. Respondents noted that they witnessed the connection and general involvement of youth in important community functions. One respondent, describing a "memorial potlatch," or celebration of life, commented that "all the kids get involved in that, dancing, helping serve the food and stuff, get it ready." As active participants, youth integrate themselves into and "give back to" their community. In addition, based on respondent perspectives, youths' sense of connectedness is built, in large part, through the contributions of adults in the community who are motivated to take an active role in protecting and supporting youth in their village in general, beyond their own family.

Beyond school-based activities such as basketball, volleyball and wrestling, community members provide other safe and healthy outlets for youth. As one respondent explained in her community:

> *"We'll go through periods of time where we do tons of activities…like there's little league all day, …But then we do other things, too, like… for example, this winter, there was sledding parties down at the bank, where the riverbank goes down, and then so all the kids in the community, adults, everybody would gather down there just to have fun sliding down and you have a picnic at the same time."*

These activities and opportunities for youth foster connectedness across families, youth, and the community as a whole, and serve as a community-level protective factor.

Safe and Caring Adults

While lack of family and community connectedness were seen as important risk factors for youth in these villages, the presence of safe and caring adults in the community was described as a counterweight serving to protect youth. As one respondent suggested:

"If a student knows that he or she is loved beyond their mistakes and their capabilities… it makes them aware that [they] count. So it goes down to parenting and family values and… who is encouraging them in the right direction because everybody want attention."

Further emphasizing the impact of caring adults, several respondents explained that when youth begin to struggle with depression or other difficulties, "We see the difference in them. And if there's something that we see that's different, we ask them. We ask them what's going on." Another respondent observed, "I've noticed with our youth… even if they hit that brick wall once, as long as there's somebody out there to touch them, and we have a large amount of people that do that, they do all right." One of the young adults interviewed describes, "When I was getting in trouble at school, I didn't want to do anything about it. But then lots and lots of people kept coming up to me and telling me I should just do it. So [I] got my education." Because not all youth have positive adult mentors in their family, community members often reach out to connect youth in need with other caring adults. One respondent explained, "A boy doesn't have a father or a grandparent, a male, then *the community gives him some other male member to actually help that boy doing cultural stuff."* By substituting other adult mentors in the absence of available family members, these communities ensure that all youth have opportunities for developing safe and secure relationships, often across generations.

Role of Elders

77 percent of adults surveyed indicated that they would get advice from an Elder if they noticed a young person begin to lose interest in activities or withdraw.

CKABS–A

As mentioned previously, Elders are respected knowledge bearers in their communities. As keepers of their communities' long history, they play a significant role in supporting youth. By interacting with youth, they are able to pass on the wisdom and traditions of the past—information that has allowed the villages to survive and thrive in the face of a harsh environment and threats of cultural extinction and assimilation from outsiders. One respondent, demonstrating the vital role of Elders, explained that Elders have a "strong voice" in the communities and that they *"were all leaders at one point, spiritual leaders, just running the village… they teach people how to do stuff, like [ritual] speeches and memorial…and stuff. They pass that on to the younger guys."* Another respondent stated, Elders *"just teach, because we don't know. That's the only way for us to learn is for them to tell us."* Elders' Councils serve the community, in part by establishing mechanisms and programs for cultural transmission. For example, several respondents in the Northwest Arctic community were enthusiastic about the development of a culture camp being established close to the village. One respondent said, *"Our Elders are just building a culture camp. It's just a little ways up the river. We don't have to travel and… I'm excited about this."* When Elders work with youth, positive change becomes a possibility and a camp

nearby affords a substantial opportunity for this. Another respondent stated, *"Getting involved with activities and learning about our culture and getting involved with Elders. That helped [troubled youth] a lot."*

Reestablishing Ties to Culture

The influence of Elders carries into the community setting as communities as a whole make a point to integrate culture into everyday activities (e.g., school, work and play). As one respondent stated, *"It's even in school, our teachers are really involved in teaching the cultural ways."* With the recognition that schools are an ideal setting for reaching youth, many Alaskan communities have worked with schools to formally integrate cultural programming, including Native language classes, Native studies, and traditional arts and crafts, into the school curriculum. Describing a "dog mushing program" in her Interior Alaska community, one respondent commented that the organizers of the program *"work with the school so the kids could get credit for going to the classes in the dog yards and then you see a lot of self-esteem being built up in kids."* Some schools also provide opportunities for youth to participate in traditional subsistence practices such as fish camp, where youth learn how to harvest and preserve fish for the winter. One respondent explained the importance of embedding culture into everyday activities,

> *"Everything we do, there's culture embedded in it, one way or another….without it, I think we lose our identity. So the more that we're involved in trying to teach our kids (about culture)… just the whole community in general is stronger."*

"Culture camps" are a common means of integrating culture into youths' lives, particularly important for those youth who otherwise do not have the means to participate in traditional subsistence activities. The culture camps also provide opportunities for youth to experience the seasons traditionally. As one respondent explained, "*They could set up camp so that the community can get together at springtime with the kids and put fish racks [for drying fish]. Different seasons, they'll do something else like get together and go pick berries."* Not only do the youth learn new skills, but they learn that their cultural heritage is valued and useful. In addition, as much as modernity has changed the face of village life, Alaskan villagers still live close to the land. As one respondent described, *"In our culture, you're fishing, you're hunting, you're camping, you're outdoors, you're not in the village… you're out there on the land with the berries and everything that mother nature has to provide us with."* For

these reasons, respondents suggest, it is critical that these skill sets are passed on to younger generations.

In summary, as the protective factors community members identified (e.g., safe and caring adults, the role of Elders, opportunities for cultural integration and learning) exist at overlapping levels of the social ecology, they reinforce the others, providing a protective net for youth. Underlying each of these protective factors, and related to the close-knit feel of the villages, respondents discussed a key community asset or strength: a sense of sincere mutual care and concern for others within the villages; a sense of shared purpose in many respects; and a spirit of cooperation in addressing common interests, which creates the possibility for outcomes greater than any one individual could achieve alone. Explaining the spirit of cooperation tied to the seasonal harvests, one respondent explained,

> *"We work together. And now we're set for the winter with fish. Then we work together getting moose. We work together and we put that away again together. We help each other. That goes a long [way]… I mean, people do that in villages. They help each other, especially families help each other or friends help each other."*

Another respondent summarized, "*A lot of Alaska natives are so close, we know a lot of people in the next village. We have relatives (there). We just have a lot of care for each other*."

Suicide Prevention Resources

Supplementing the information provided in the Background section of this report based on a literature and document review regarding available resources for suicide prevention in Alaska, community members provided their perspectives regarding resources, strategies, and models within their communities that contribute to suicide prevention. Some of these resources are not specifically dedicated to suicide prevention; however, they each focus on expanding care and support for youth and the community as a whole and often address risk factors and enhance protective factors related to youth suicide. Despite some overlap, resources for suicide prevention generally fall into five broad categories: 1) school-based; 2) tribe/city-based; 3) Elders (also viewed by community members as a "protective factor"; for related discussion, see the "Protective Factors" section of this report); 4) community programs, leaders, and collaboration; and 5) behavioral health services. Overall, resources ranged from formal services to informal community activities and opportunities for youth engagement.

SCHOOLS

As one of the largest entities within Alaskan communities, the school—kindergarten through 12th grade (K–12)—is the primary provider not only of education but also of after-school activities and enrichment. Schools often serve as a central gathering place for the community as a whole. Due to shortages in locally qualified personnel, most teachers and administrators are not from local communities; however,

increasingly, school administrators are recognizing the benefits of place-based learning that involves students as participants in the life of their communities, advances environmental stewardship, and increases civic engagement. As a result, school faculty are working with communities to integrate cultural programming into the standard K–12 curricula. This is a shift from recent years when, as recently as the late twentieth century, Alaska schools, influenced by Western efforts to "assimilate" Alaska Natives, taught primarily Western history and culture. The history of Alaskan Natives in schools was, as Inupiat researcher Ongtooguk (n.d.) states, "virtually silent about [Alaska Natives], our society, and the many issues and challenges we faced as a people caught between two worlds." Several respondents noted that schools in their villages had begun to incorporate local traditions and culture. One respondent explained, *"They try to teach them [the youth] our language. They have field trips once or twice a year to go out fishing, trapping."* Another respondent observed that the school brings traditional learning into the classroom:

> *"They'll have different activities… like they did a carving, like carving boats, so they had somebody go out in the woods and get the carving wood off the trees and somebody from out of town sent them carving kits to the school. So an Elder came in and did that with them."*

Some schools allow youth to receive credit for participating in cultural extracurricular activity that respondents say boosts a variety of competencies, self-esteem, and ability to cooperate with others. When youth participate in such activity, one respondent noted, *"You see a lot of self-esteem being built up in kids and being able to work together, cooperate and learn a lot of new skills."*

The school in the Northwest Arctic community also sponsors a youth leaders program that builds youths' leadership skills. The Teck John Baker Youth Leaders Program was implemented in 2009 in the Northwest Arctic School District with support from the Kawerak/Maniilaq GLS program. Based on the Comprehensive Health Education Foundation's Natural Helper curriculum and adapted to Alaska Native/Inupiaq culture, this model harnesses the strengths and talents of students to promote health and wellness, particularly to reduce youth substance misuse and its consequences among school-aged youth. Among other activities, respondents describe, youth leaders in the program promote positive messages for other youth, for example, by developing motivational signs and posting them throughout the school: *"They'll do nice signs, like 'stop bullying,' 'be nice in the hallway,' 'way to go.'"* Youth leaders also counsel other students about the dangers of bullying and suicide. Another respondent explains, *"They were talking about bullying and suicide that were getting mixed up with our culture."*

Moreover, schools often have the only gym in town, offering sports-based programs including basketball, volleyball, and wrestling not only for students but the community as a whole; that serves as another avenue for safe and healthy activity.

TRIBE/CITY

Together, the tribal council and city council serve as an additional suicide prevention resource within the communities. Beyond the day-to-day tribal and city operations, the tribe and city are often recipients of funding, in some cases specifically dedicated to suicide prevention (e.g., SAMHSA's Native Aspirations program) and, in other cases, less specifically focused. However, respondents noted, the tribe and city tend to direct general funds toward initiatives aimed at positive youth development, including the prevention of suicide, violence, and bullying. At a recent tribal council meeting, one respondent described, the tribe prioritized programming for youth over other pressing issues: "Just a focus on the kids. There's a lot of problems here that could be [a priority, but] – they prioritize it, they were number one, kids." Another respondent described that the tribal council had earmarked funds for positive youth development, stating "I know the tribal council was adamant that the grant went for the kids because a couple among the community and the tribal council was agreed that that was to help the kids." The tribal and city councils also help to provide meaningful opportunities for employment for youth in the form of summer jobs programs and internships. In addition to providing a means for youth to earn income, these programs enable youth to gain skills and experience, helping to facilitate a healthy transition into adulthood. Respondents explained, "The jobs come around in the summer for the youth so they can make money and they would have the job experience for the next year," and "they just had a youth clean-up recently that the city hired a bunch of kids for town clean-up…that's a big boost to them, knowing that they can make money."

In addition, respondents suggested that tribal courts, which are administered by the tribe and handle cases related to child protection, juvenile delinquency, domestic violence and other issues, are a powerful symbol of self-determination within the community. Not only do tribal courts act with legally recognized authority, they also focus on restorative justice, an approach to justice focused on the needs of the victims and the offenders, as well as the involved community, instead of simply satisfying abstract legal principles or punishing the offender. Often, this approach enlists all stakeholders affected by an injustice in discussing how they have been affected and deciding what should be done to repair the harm (Braithwaite, 2004). The courts emphasize locally determined solutions to local problems and take an active role redirecting youth and families onto healthier paths that encourage community contribution and connectedness. For example, one respondent said, *"The tribal court judge is always referring kids to go for higher learning."*

COMMUNITY ACTIVITIES, LEADERS, AND COLLABORATION

Within the larger community, beyond the schools and the tribal and city leadership, respondents noted, multiple entities and sponsor events to address risk factors and enhance protective factors for suicide, violence, and bullying. Related to the "safe and caring adults" protective factor (for additional discussion, see the "Protective Factors" section of this report), such events are often organized and implemented by community members dedicated to improving the health of the community and

promoting community connectedness and resilience. Both villages are replete with individuals who take on multiple jobs and volunteer positions to contribute to and improve their community. As one respondent said, *"We all wear different hats at different times." Such hats include: 'volunteer fire chief,' 'planning committee member,' 'parent,' 'teacher,' 'main grant writer in the community,' and 'backbone of our city council.'"* Respondents suggested that community members who take on multiple roles and responsibilities not only greatly improve the community in many respects, but they also serve as examples and role models for youth. One respondent explained:

> *"I think everybody is a leader in their own way. It's just different things, different hats at different times…and just doing little things and it makes a big difference….We have a lot of leaders that take care of different things, but it helps the whole community function."*

By communicating and collaborating, community members accomplish positive change. As one respondent stated, "It's like a team effort to make any kind of activity happen because it requires a lot of input from all of the different agencies in our community." Effective collaboration is critical as it allows, as one respondent said, the "whole community to work together to ensure that our children and our future grandchildren will be able to have the best lives that they can possibly have and be successful in whatever field they choose."

In their roles as mentors for youth, active adults in the community provide another valuable resource within their communities—"safe homes." Safe homes provide secure and supervised spaces where youth can, as one respondent explained, *"just go hang out and just kind of hang out with their own ages, just kind of visit and not have a whole lot of adult talk in it."*

Sports leagues and activity nights, with activities from talent shows to impromptu gatherings, are also resources supporting positive youth and community engagement. One respondent describes, *"And then we might put on a talent show, so anybody that sings, dances, does anything, gymnastics, whatever, plays instruments, then they can come and do their talent."* Another describes activities that are more loosely organized, *"We'd get together at the community or… one night me and my friend… we took the kids to the elementary and we put the music on and they'd have dance."*

League sports (softball and basketball) provide healthy outlets for both youth and adults. They also provide opportunities for regional community gatherings. One respondent described, *"We do have city league ballgames and tournaments throughout the year and throughout the region where they all go and participate with their team."* Community members regard the leagues as more than just recreational; they also are opportunities to support and encourage the positive development of youth. As one respondent explained, *"[the] community comes in and we all agree, we're here to not only be entertained, but to encourage our kids to keep up what they're doing and stay in school."* Sports provide another means for teaching life lessons. One respondent said, "[The youth] love the competition. But the most important thing that's taught is… sportsmanship is the most important [aspect of] a game."

Moreover, the communities support awareness-raising events such as "Choose to Live," "Walk for Life," and "Choose Respect," all walking events aimed at providing an opportunity for the community to come together in solidarity around issues such as suicide and domestic violence. Most of these walks are statewide initiatives that occur annually. One respondent described:

> *"We'd set up a table to pass out pamphlets on – we'd have a theme for it, like child abuse or like suicide prevention or domestic violence, like pretty soon, we will be doing one called 'Choose to Live,' and that's a suicide prevention one, and then we also participate in 'Choose Respect Across Alaska,' so we do that every March."*

Churches serve as another resource within the community, providing activities such as a "kid's club," teen group, and couples counseling. In addition, clergy serve as "lay counselors" and are regarded, at least by some community members, as safe individuals with whom to discuss behavioral/mental health issues. One respondent said, *"Most people go to the reverend or preacher that have [suicidal] problems like that."*

BEHAVIORAL HEALTH SERVICES

In addition to the resources offered with support of the school, tribe and city, and larger community, each of the participating communities also has a behavioral health aide (BHA), a locally based paraprofessional who serves as counselor, health educator, and advocate within the community both preventatively and in times of crisis (ANTHC, n.d.; van Hecke, 2012; for additional information, see the Background section of this report). Supported with state funding through the BHA program as part of the behavioral health workforce model implemented throughout Alaska (KANA, n.d.), the BHA is a primary recipient of referrals for behavioral health services in both villages, respondents attest. A teacher, said, "A lot of times when people come to me, now that we have a behavioral health aide, I mostly refer to her." While a benefit, the BHA's skillset is limited to basic counseling, health education, and advocacy. To supplement the care provided by BHAs, itinerant clinical counselors, based at the regional tribal health consortium, travel to the villages on a regular basis to provide clinical care. They are responsible for reaching out to meet the behavioral health counseling needs of village residents by providing individual, family and group therapy, substance use treatment, and making appropriate referrals to other programs. The itinerant therapists report directly to a clinical supervisor at the regional tribal health consortium. In addition, school districts also have itinerant counselors and specialists, although respondents note that the support they provide is limited given staff shortages and the large number of villages served by each district. As such, visits often are limited to once per school year.

Further, respondents described the changing landscape of service provision whereby video and teleconferencing has become more readily available. Referred to as "telebehavioral health," this capability allows for remote connection between the villages and the regional hub clinics. This is a

relatively recent and important advance within the communities that allows near immediate access for village residents to behavioral health clinicians, who have higher level training than BHAs, particularly in times of crisis. One respondent commented, "Their parents want (the youth) to get services (in the village); they can see the counselor that comes in once a month, or they do it through a video call conference." Another respondent described,

> *"We have video teleconferencing now with TCC [Tanana Chiefs Conference, the regional health consortium] behavioral health….And if [patients] have something that's going on right now, most of the time, you can set up a video teleconferencing like within an hour…but that's just recently starting to be utilized a lot now."*

Moreover, respondents pointed to crisis hotlines such as the Alaska Suicide Prevention Careline, or regional tribal health consortia numbers, in addition to telebehavioral health, as a particularly beneficial resource for Alaskan villages considering that anonymity can be elusive in a small, close-knit village context. One respondent explained, "*Sometimes if [a village resident] wants to talk to someone that they don't know, I call the TCC hotline or behavioral health hotline for them*." Another respondent stated, "*I know there's people that call them at our [TCC] hotline*."

Finally, for treatment for addictions, outside resources are typically the only options available to communities. When asked about resources available to support community members struggling with alcohol or drug addiction, one respondent replied, "*Well, they have to send them out*." For that community, "out" is Old Minto Family Recovery Camp, a residential substance use treatment center, outside of Fairbanks, operated by TCC. One respondent, though, expressed doubts about the effectiveness of the program, stating "*They've been sending them to, a lot of people… they send them to Old Minto. I don't know how successful that is…. It's a 30 day treatment*."

ADDITIONAL RESOURCES

The resources described in this section reflect respondents' point of view when asked to describe external resources available to the community (i.e., resources from outside the community) and are not a comprehensive list of programs and services provided from outside of the villages; for example, generally, respondents were more aware of supports offered through the regional tribal health consortia than federal programs. The resources identified are typically provided with support from regional tribal health consortia located in hub communities whose services complement the resources developed within the community. Respondents suggested that regional tribal, for-profit corporations such as NANA, in the Northwest Arctic, which maintains a charitable giving program, supplements activities aimed at enhancing protective factors for suicide. Such funding supports community events such as picnics and door prizes for awareness events such as "Walk for Life." One respondent commented that communities appreciate such funding: *"They participate—NANA, Maniilaq, I believe some funding came from the Red Dog Mine Health [NANA]. The entities, they put together some monies*

to furnish (community events). So that's a big thing." The regional corporations also provide support through grant-based programs aimed at supporting positive youth development. One respondent stated, *"Sometimes they have grants, I think, monies available and then they start some programs…for the youth."* In addition, regional tribal health consortia support has included the provision of gun safes to restrict access to lethal means. One respondent described, *"I know we got a whole bunch of gun safes that was part of suicide prevention. And I know of some instances where someone is drunk and trying to get a gun and couldn't get it out of their safe."*

In addition, one respondent in the Northwest Arctic referenced the digital story workshops that were held as part of Kawerak/Maniilaq's GLS program, Project Life, saying, *"They kind of just travel, like they show you how to use a computer to put your pictures and music on there."* While the link to suicide prevention was not apparent to the respondent, the workshops were remembered as engaging and interactive.

Suicide Prevention Progress

GLS AND NATIVE ASPIRATIONS PREVENTION STRATEGIES

Through the Native Aspirations (NA) Project and the GLS Suicide Prevention Program grants, a range of suicide prevention strategies were employed in an effort to mobilize existing community resources and integrate prevention services into AN/AI tribes and villages to reduce violence and suicide. Native Aspirations communities participated in the Gathering of Alaska Natives (an adapted GONA) and CMP activities; developed community mobilization and sustainability plans; and worked with tribal/village oversight committees to develop activities and goals for their prevention programs. NA activities included general wellness and prevention workshops; peer and youth leadership engagement; cultural and community events; and outreach and awareness activities with community members.

GLS Program Example

One Alaska GLS grantee created a regional coalition and initiative to implement suicide prevention and early intervention strategies within their region. Serving more than two dozen villages, the program uses a culturally relevant and strengths-based approach to engage all ages from youth to Elders to address village needs and promote youth well-being. Strategies including culture camps for youth and a youth leadership program were developed and implemented with Elder guidance to promote positive youth outcomes. Villages are supported in developing village wellness teams focused on capacity building and empowerment. In addition, the grantee, again with guidance from Elders, adapted the ASIST gatekeeper training to be more "Alaskan" and culturally relevant with an emphasis on overall wellness and the signs of symptoms of "not being well." The training has been positively received within the local schools and community where training has taken place.

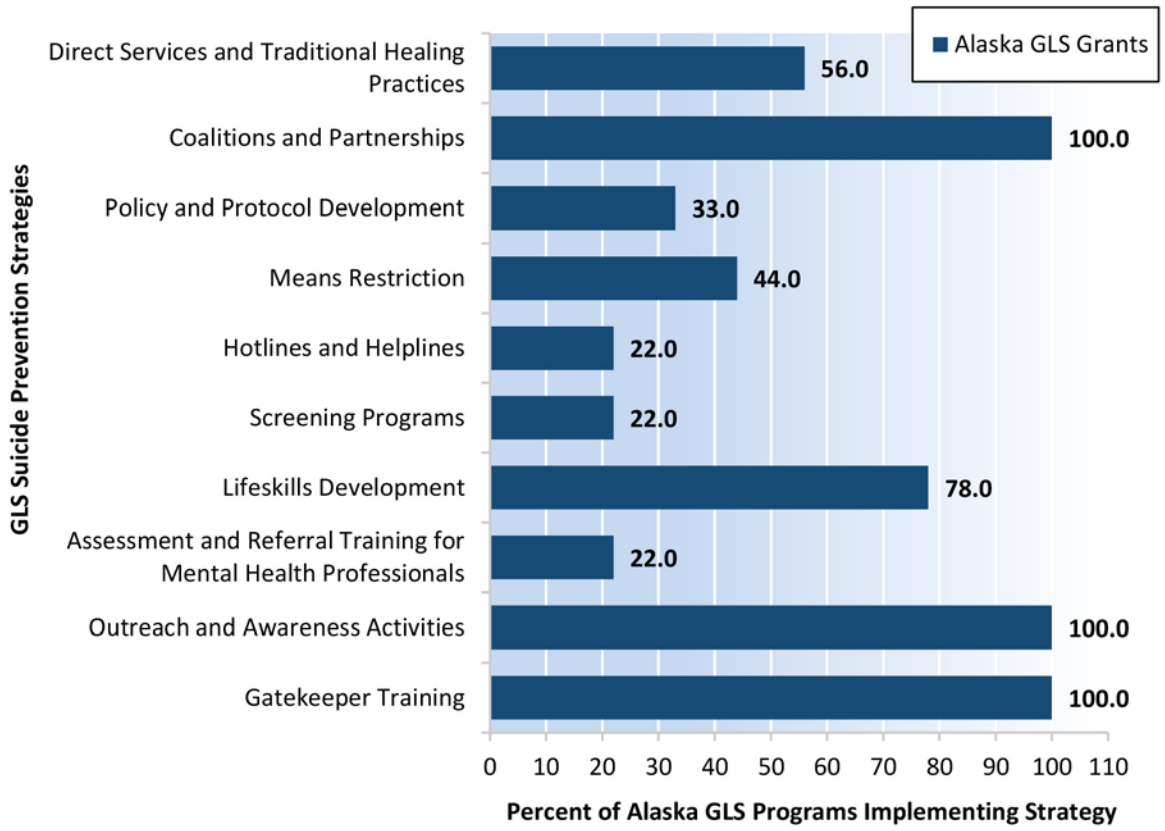
GLS Youth Suicide Prevention strategies included Outreach and Awareness products and activities, such as community walks and public service announcements to increase knowledge about local services and reduce shame and embarrassment surrounding mental health seeking, as well as participation at wellness fairs and community events to raise awareness about warning signs for suicide. Youth/peers and adults from villages participated in gatekeeper trainings—school and community-based.

Alaska Suicide Prevention Strategies

- **Gatekeeper training of BHA and other community members**
- **Written intervention protocols distributed to village based counselors**
- **Resiliency presentations and awareness workshops for youth in village schools (3rd to 12th grade)**
- **Lifeskills culture camps for youth and Elders**

Grantees distributed gunlocks and lock boxes to reduce access to lethal means and implemented direct services and traditional healing practices that included mental health and postvention services, crisis response services, and case management services. Exhibit 6 shows the proportion of participation of GLS grantees by prevention strategy type (n=10; data reflect eight grantees and ten grants from 2007 to December 2013).

Exhibit 6. Alaska Based GLS Suicide Prevention Strategies



On average, Alaska GLS Youth Suicide Prevention strategy budgets were allocated to Coalitions and Partnerships (22 percent), Lifeskills Development (22 percent), Outreach and Awareness activities (21 percent), and Direct Services and Traditional Healing Practices (10 percent). Approximately 17 percent of GLS budgets were allocated to the development and implementation of gatekeeper trainings.

Reach and Outcomes of Gatekeeper Training Strategies

GLS grantees and the Native Aspirations communities participated in a range of training activities with youth and adult community members. Native Aspirations communities implemented Applied Suicide Intervention Skills Training (ASIST); SafeTalk; American Indian Lifeskills Development Curriculum; Question, Persuade, and Refer (QPR); and locally developed cultural trainings.

Over 235 individual trainings have been implemented and over 4,000 trained through GLS sponsored training activities.

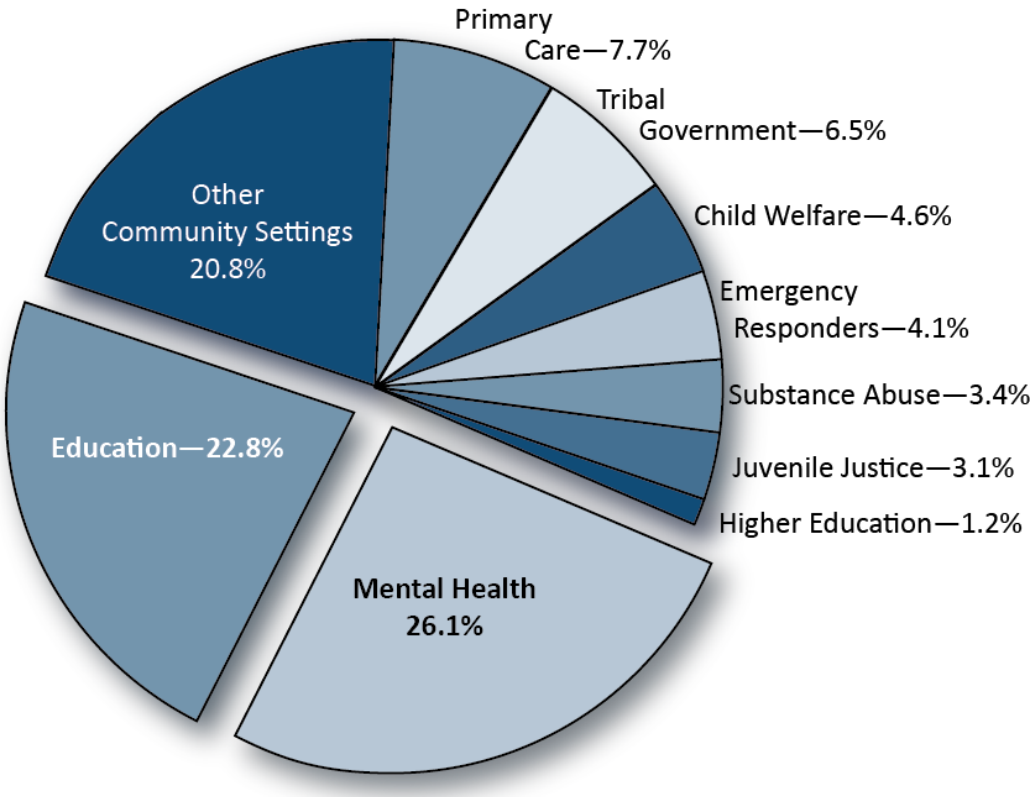
(Prevention Strategies Inventory)

One-third of all Alaska-based GLS grantees implemented ASIST gatekeeper training.

GLS grantees implemented similar types of trainings and GLS data provide a snapshot on the number and types of training activities conducted, the profiles of adult training participants, perceptions of the training by trainee participants, and the impact of training on participant knowledge. The majority of GLS-sponsored trainings (62 percent) were gatekeeper trainings with nearly one-quarter being trainings for youth under 18 years of age. Nearly 4 percent were online trainings and 26 percent were clinical trainings. Just over one-quarter of trainees (26.1 percent) were from a mental health agency/setting and 20 percent representing the community at-large.

Most GLS trainees were from mental health or education settings (see Exhibit 7) with additional attendees having a primary role in Tribal Services/Tribal Government and primary care.

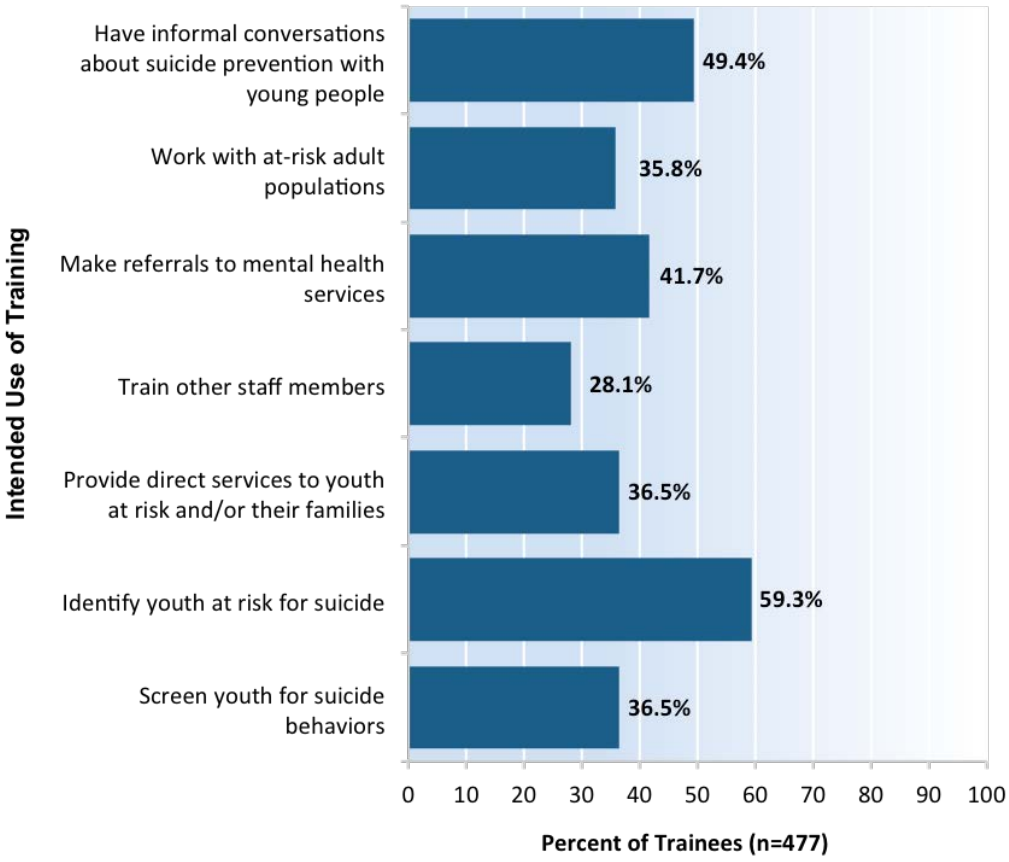
Exhibit 7. Alaska Trainee Profiles



Percent of Trainees by Trainee Role

After their trainings, participants were asked about how they intended to use what they learned in their training. Over one-quarter of participants indicated that they would train other staff members and over half indicated that they would use what they had learned to identify youth at risk for suicide (see Exhibit 8).

Exhibit 8. Intended Use of GLS Suicide Prevention Training

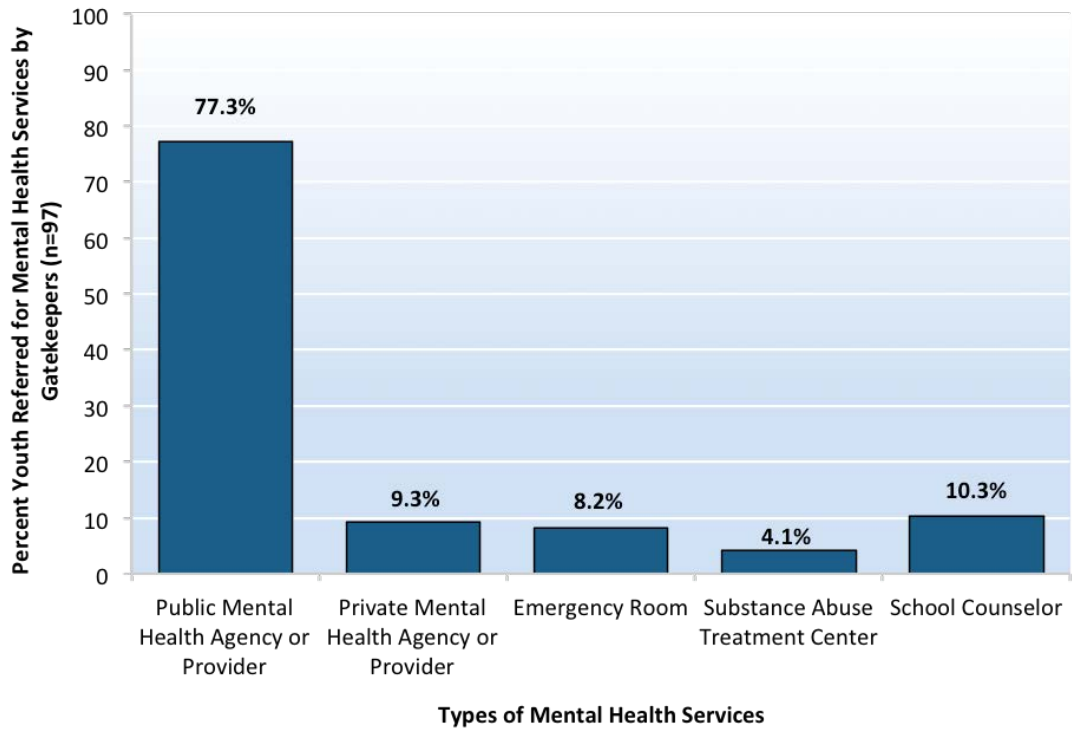


Impact of Trainings—Early Identification of Youth at Risk for Suicide

Information about 224 Alaskan youth identified at risk for suicide are available from the Early Identification, Referral, and Follow-up (EIRF) data activity as part of the GLS Suicide Prevention Evaluation, either through a positive screen on a screening assessment or identification by a gatekeeper (see Appendix B for a description of the EIRF). Just over 20 percent of youth were identified in a school-based setting and 14 percent were identified in their home setting. Over 95 percent of those identified at risk received a referral for mental health services and over 40 percent received a referral for non-mental health services. Over 70 percent of youth, who received a referral for mental health services,

received services within three months of referral—in 45 percent of cases where youth did not receive follow-up services after a referral, an appointment had been made but the youth did not attend the appointment. In just over one-quarter of cases where a referred youth did not receive services, parents either refused services or could not be contacted. For youth who received mental health services (within 3 months of referral), 62 percent received a mental health assessment and just over half (54.5 percent) received mental health counseling. Of those youth identified by trained gatekeepers, three-quarters received a referral to a public mental agency (see Exhibit 9) and over half (57.6 percent) were provided information about a crisis hotline (not depicted in Exhibit 9). In the Alaska context, mental health referrals are typically made to the village BHA at the village clinic. If higher level mental health care is needed, the youth may be sent out of the village to a regional tribal health consortia (in a hub community—see Exhibit 5) or linked with a mental health clinician via telebehavioral health if available. Finally, youth may receive services from itinerant clinicians when available.

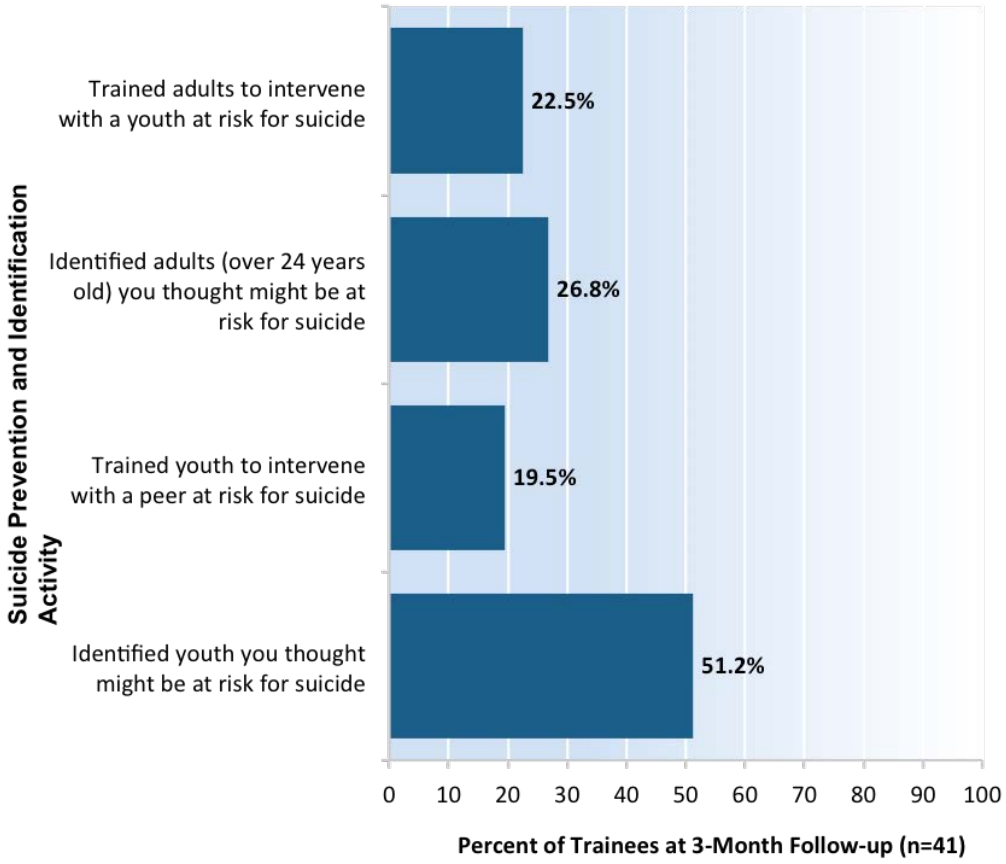
Exhibit 9. Types of Mental Health Referrals for Youth Identified as At Risk for Suicide by Gatekeepers



In addition to early identifications and referral for services, follow-up data were gathered from training participants to understand how information learned in gatekeeper trainings was used (within 3 months of the training). A sample of Alaska GLS trainee participants (n=41) were asked to report on ways that they used information learned in the training within the last 3 months. Over half (62.5 percent, n=40) indicate that they have used this information to inform identification of a youth who might be at risk for

suicide and 85 percent have used the information they learned to have informal conversations about suicide and suicide prevention with youth and others. The sample was also asked whether they had participated in specific suicide prevention activities (e.g., early identification, referral of youth at risk for suicide). Exhibit 10 highlights how individuals report using training knowledge and information learned. Just over half report that they had make an identification of a youth at risk for suicide (51.2 percent, n=41) and just over one-quarter indicated that they had made an identification of an adult (over 24 years old) who might be at risk for suicide suggesting that trainees are using knowledge and information gained through trainings beyond their primary role in a youth setting (e.g., education, mental health) but in other aspects of their lives to identify persons at risk for suicide.

Exhibit 10. Alaska Trainee Use of Gatekeeper Training Information



COMMUNITY PERSPECTIVES ON PROGRESS

Focus group and interview participants were asked to share perspectives about their communities' progress in suicide prevention, particularly what they consider to be the most effective programs and

resources. While the feedback on program effectiveness was limited, the themes in responses are summarized below. Most often, respondents described progress which, while not attributed to particular programs, may be the result of the combined impact of the multiple efforts to enhance suicide prevention. It should be noted that the comments are not necessarily representative of the community as a whole and, in some cases, reflect the comments of only a few respondents.

- Awareness Walks: While one-time awareness walks may have limited impact on lasting changes in a community, respondents commented that "Walk for Life" and other walking events are very well-attended. One respondent said, *"I don't really know of any (event like Walk for Life) that never has a huge turnout. Everything, anything that happens, the whole community is out there participating."* Community participation is high, as one respondent explained, because, *"Everybody wants to be as one, and that's really great, and everyone wants a part and be behind something that's very tragic and it's preventable."* Respondents also expressed that youth actively participate in these events and seem to be absorbing the prevention messages they convey. One respondent said, *"I noticed that every year those things are held, young people are standing up and voicing out their hurts when somebody committed suicide, they are voicing how much it hurts. There's crying and that's when I noticed the younger generation really intently listening into what's being said."*
- Teck John Baker Youth Leaders Program: Respondents suggested that this program implemented in the Northwest Arctic School District, developed with support from the Kawerak/Manillaq GLS program, is showing success in promoting positive youth development and reducing suicide risk. A former youth leader suggested that, in her experience, the program model is effective and that her peers were willing to confide their feelings of sadness or despair, allowing the possibility of connecting the youth with behavioral health resources: *"I told the youth… that they could trust me, and they opened up to me and then they started telling me."* Based upon the Comprehensive Health Education Foundation's Natural Helper curriculum and adapted to Alaska Native/Inupiaq culture, this model harnesses the strengths and talents of students to promote health and wellness, particularly to reduce youth substance misuse and its consequences among school-aged youth. This program was chosen for evaluation as an evidence-based intervention through the Native American Service-to-Science Initiative at SAMHSA.
- Gatekeeper Training/Awareness Building: Without attributing this resource to a particular program or source, some respondents noted that teachers and school staff in particular are being trained in some ways as gatekeepers to recognize the warning signs for youth distress, depression, and suicidal ideation, and to be aware of resources and avenues for referral to appropriate services. A school teacher shared, "*We have those guidelines where they give us numbers, hotline numbers, Web sites to go to, where you could refer students to an age-appropriate resource where they could get more information*." According to another respondent, "*Three days before school starts, [we have] an intense get together where all the*

teachers, aids, janitor, have a big gathering in the gym where teachers are invited to speak up about their concerns and expectations and …they're inviting different health professional people to come in and talk to the new teachers just coming in. Once in a while there's an Elder to tell the teachers what to expect." The respondent elaborated, *"[We learn] what the kids in the rural villages go through so [we know not to] expect to come and teach them right away… how to act in class and to sit quietly."* Respondents suggested that teachers and others in the community who regularly work with or come into contact with youth have become more skilled in identifying warning signs that may signal youth distress, depression and potential suicidal ideation. They also noted that teachers, parents, and others in the community are more aware of behavioral health resources and other resources that may benefit troubled youth. One respondent reported, *"If we have, I don't want to say problems with the kids, but like some of them, just little things, and so we go through the behavioral health aide and she would answer our questions and tell us how to go about it."* Another said, *"Some of the guys my age that aren't related to law enforcement realize the importance of stepping in and talking to someone who might be experiencing some difficulty, and so we try to help them out."* A third respondent commented, *"In the last 2 years I noticed… has anybody been watching to see what's going on? I'm always watching just to be on the safe side, even if there's nothing. I'm really happy with the local effort of everybody here. Whether our services have changed I don't know, but in the last 2 years I've really seen progress. It's the most accountable I've ever seen this community."*

- Increased Service Utilization/Shift in Referral Practices (Behavioral Health Aide and Telebehavioral Health): With the addition of a BHA position in the Interior community as well as the advent of telebehavioral health capabilities, respondents suggested that behavioral health service use has increased as well as altered referral practices. Respondents attest that the BHA is now the primary recipient of referrals for behavioral health services in both villages. With a BHA present in the communities, gatekeepers can immediately refer individuals to the BHA rather than relying solely on the itinerant clinical counselors whose travel schedules vary. However, when they are available, itinerant clinical counselors still receive referrals, especially when the services required exceed the scope of practice of the BHA. Both the BHA and itinerant counselor now also have the opportunity to refer to telebehavioral health services, which have become available recently, and village residents are taking advantage of this new option. One respondent described, *"Their parents want (the youth) to get services here (in the village); they can see the counselor that comes in once a month, or they do it through a video call conference."* Another respondent commented, *"There are some people that have weekly sessions because we have video teleconferencing now with TCC behavioral health."*
- Inroads in Addressing Shame: Respondents reported mixed impressions about progress related to addressing shame about discussing depression or suicidal ideation (a risk factor for suicide, as it inhibits help-seeking and service utilization) and around seeking behavioral health services. Most say they have witnessed increased openness in discussing such topics, which, coupled with

perceptions around increased behavioral health service utilization noted above, may reflect decreasing levels of shame. Respondents reported: *"It's easier now to actually ask somebody, 'Are you thinking about suicide?' and at one time I couldn't ask somebody that";* and "*It's not a hush-hush topic anymore. It's not a whispering topic where that family is going through that tragedy. It's out in the open, which is good*." However, several respondents suggested that embarrassment related to the shame of having a mental health problem is still a key challenge, combined with the fact that some residents are uncertain about "how to start, and where to go [for services]."

- Decrease in Social Acceptability of Drinking: Two respondents in the Interior community commented that drinking alcohol at community-wide events has become less socially acceptable. One respondent noted, *"[In the past, during] memorial pot latches, the majority of the people would be drinking. [Now], it's just more unacceptable to show up to community events drinking."*
- Decrease in Youth Suicide: While community members did not comment on changes in the number of suicide attempts, several in both villages discussed their personal perception that suicide completions have decreased over the past 1–3 years. According to a respondent in one community, *"For a year we haven't had anybody take their own life."* A respondent in the other community described, *"What I've noticed here recently is we used to have quite a few suicides, just sometimes a whole bunch and sometimes spread out in a year's time or whatever it was. But the last five or six funerals here have been all Elders. Now, that shows that [community] is doing something right. No more suicides the last few years."*

Ongoing Challenges and Suggested Solutions

Given their insight about risk and protective factors *and* existing and needed resources, community members are a critical resource for identifying ongoing challenges, such as gaps in service provision related to the prevention of suicide, violence, and bullying, and to share ideas regarding solutions to address these challenges. Community members identified a number of ongoing challenges and suggested actions and resource needs.

EMPHASIZE PREVENTION RATHER THAN RESPONSE

Some respondents suggested that, generally, village residents and regional health consortia alike need to place greater emphasis on prevention activity in comparison to response to suicide attempts and deaths by suicide. One respondent describes that when a suicide occurs, *"The whole community just drops what they're doing and helps out the family, which is an excellent idea. Once burial and the potluck are over, we go back to our lives and try to see where we fit back in. We need a consistency where we are able to help one another…to find ways to let them know, 'Hey, we're here for you.'"* While some respondents expressed appreciation for the various ways in which the regional health consortia

support prevention activity and programs locally, a few suggested that the community receives the most attention from the health consortium when a violent death or suicide occurs. One respondent stated, *"Maniilaq (regional hub consortia) comes just only when there's a death and they'll do talking circles and they leave, and that's it."* Respondents suggested that key needs for suicide prevention include:

- Resources for Prevention Skill-building: Enhanced resources dedicated to skill-building activities such as gatekeeper training designed to build awareness and increase appropriate referrals and behavioral health service utilization.
- Prevention Efforts Drawing on Community Strengths: Prevention efforts should draw on a natural strength of both of the local villages, a strong collaborative spirit, and continue to involve as many community members as possible in shared goals for suicide prevention. One respondent said, *"There are solutions; we just need to figure out what's best… But we need to work together."*
- Prevention Efforts Addressing Risk/Protective Factors: Respondents also recommended a number of "upstream" suicide prevention activities—activities focused on addressing risk factors and enhancing protective factors for youth suicide. Several respondents urged a continued emphasis on efforts and activities such as culture camps that connect youth to their cultural heritage and traditions (e.g., beading, sewing, food preparation and management). Another respondent suggested that simple efforts to promote close ties in the community across families and generations (e.g., through activities such as organized hikes, snowmobile rides, walks to the beach, sports leagues, Friday night movies, game nights) would strengthen community and youth resilience. A few respondents suggested greater opportunities for youth to seek employment including job fairs and job training programs. One respondent suggested, *"Having some work for these young people to go to. I always wish I had more, I hear some of those kids on the radio asking for work and I just know they want to work, they want to be healthy."*

ADDRESS BEHAVIORAL HEALTH SERVICE GAPS

While each of the participating communities has a Behavioral Health Aide (BHA), as described, the BHA's skill set is limited to basic counseling, health education, and advocacy. Itinerant clinical counselors based at both the regional health consortia and with the school districts travel to the villages periodically and help to supplement and enhance the availability of behavioral health services. While these are important resources, they are also limited in many respects, raising the following considerations:

- Confidentiality: Where BHAs are present, they are typically from the communities in which they work; while a strength given the small and close-knit nature of the communities, concerns about confidentiality and embarrassment surrounding behavioral health issues may limit service utilization as community members are reluctant to seek care from individuals they have known,

in many cases, their entire lives (van Hecke, 2012). Respondents note that itinerant counselors and the newly available telebehavioral health services offer options that can help allay some of the concerns around confidentiality.

- Infrequent care: Itinerant clinical counselors with the health consortia are available infrequently; they travel to the village on average once per month and stay for 1 to 2 days. In the case of school district counselors and specialists, as a result of the large number of villages served by each district, the visits are even more infrequent—typically once per school year. One respondent explained, *"We have…a family youth specialist, which… just kind of checks on kids' wellness and how kids are doing in the home. But she only came out, I think, once last year just to check on a child, somebody had made a complaint, but… I mean, she's got 15 schools to kind of travel around to."*
- Inconsistent care: A counselor's ability to improve the use of behavioral health care depends on his or her ability to connect with community residents. One respondent explained, *"Now we have a behavioral health aide and we have also a counselor that comes once a month and we refer people to him. One thing that I really like about [the counselor] is a lot of people go back to him because we had a counselor that came once a month before that nobody ever went back to after the first time."* Staff shortages and turnover among itinerant counselors also limit the availability of care and the opportunity to develop strong, consistent therapeutic relationships. One respondent said: *"For a while there, it was like the counselor came in for a month, and then the next month it would be somebody new. It would be them for a couple of months, and then the clients would get used to that person, and then [that person leaves]…so it was like they haven't settled. Continuity is real important."*

Telebehavioral health has helped to fill in gaps in availability of care to an extent. Still, behavioral health services continue to be limited and inconsistently available in Alaskan villages, particularly in comparison to cities in the Lower 48, where residents have a range of options to choose from (e.g., behavioral health clinics, various private therapists and counselors) and fewer issues to consider regarding confidentiality. Respondents streamlining the referral process for receiving behavioral health services and ensuring more rapid access to services. One respondent suggested, *"When you get this list of resources for Alaska, like somebody's is having trouble here and goes to the health aid or whatever and she refers them to the next step in line, which is Fairbanks or Anchorage or wherever, make sure there are faster services.*" Another respondent recommended, *"Cut the red tape. Don't let [individuals seeking health services] wait too long."*

CREATE OPPORTUNITIES FOR SUSTAINABILITY

Alaska Native community members suggested that the sustainability of prevention efforts is a key ongoing challenge, in part because grant-funded programs are typically short-term and the village

residents often do not have the resources to continue related efforts after the funding period has ended. One community member noted, *"Funding is a big issue, if you don't have funding, you don't have programs."* Another suggested, the villages need *"big organizations to donate."* Respondents described that another challenge associated with grant-funded programs is the need to write grants to obtain funding for suicide prevention. Some say grant-writing skills are desperately needed in the communities. One respondent described, *"There are good programs out there, but we limit ourselves, too, and say 'No, I don't think we could do it here.' But we never even try, we never go for it."* A respondent from the Northwest Arctic village reported, *"[There are] grant moneys available but [we are] not educated on how to apply."* As a solution to this problem, one respondent recommended grant-writing workshops to increase the communities' interest and willingness to apply for funds.

DISCUSSION AND RECOMMENDATIONS

Discussion

Suicide continues to be a significant problem in Alaska, with the state suicide rate roughly twice the national average and young people as well as Alaska Natives disproportionately impacted, particularly young indigenous men. The cost of youth suicide in Alaska is substantial—resulting not only in significant financial costs as described in this report, but also in the pain and suffering of the individuals who die from suicide as well as the enduring impact on their families, peers, and communities.

As the literature review and findings confirm, suicide among Alaska Native populations is linked to cultural, family, and economic stress as well as alcoholism, substance misuse, and hopelessness or depression, which often go untreated and are often related to the loss of family or friends to suicide in these small and tightly knit communities. While social isolation has been associated with increased risk of suicide, the findings are also consistent with research suggesting that connectedness is protective when it occurs within and between multiple levels of the social ecology—i.e., between individuals, families, schools and other organizations, neighborhoods, cultural groups, and society as a whole (e.g., Action Alliance, 2014). Community members discussed the importance of youth attachment not only to parents and immediate family, but to safe and caring adults in the community who can serve as role models for youth, including Elders, as well as the importance of youth involvement in community activities tied to culture and tradition. The prominent role of schools in the communities, as a source not only of education but also of after-school activities and cultural enrichment, coupled with limited opportunities for higher education or employment for youth, helps explain why high school graduation for Native youth can be an isolating and disorienting experience, rather than a hopeful opportunity.

Fostering resilience in young people is not a new practice for AN/AI people and may even help explain historic survival in these communities that have faced adversity (Strand & Peacock, 2002). Alaska Native youth benefit generally from protective factors provided through family support, extended tribal family support, as well as school and community support (e.g., HeavyRunner & Morris, 1997), and the degree to which children are embedded in traditional culture has been found to positively affect school performance (Whitbeck, Hoyt, Stubben, & LaFromboise, 2001) and protect against drug use (Kulis, Napoli, & Marsiglia, 2002; Moran, Fleming, Somervell, & Manson, 1999). Such research is often termed "cultural resilience research," or research focused on "the use of traditional life to overcome the negative influences of oppression, abuse, poverty, violence and discrimination" (Strand & Peacock, 2003). While much has been written about risk, resilience, and risk and protective factors related to positive youth development in general and youth suicide specifically, with general consistency in the types of factors identified, less has been written about the interaction of such factors, particularly in the case of Alaska Native youth, which could help to inform and improve suicide prevention approaches tailored to Alaska Native communities.

Recommendations

The following recommendations are based on the literature review as well as the findings included in this report:

- *Emphasize "Upstream" Approaches*. Based on the literature and our findings, approaches that emphasize upstream strategies (i.e., efforts that prioritize strengthening protective factors) may have greater likelihood of preventing suicide. Community members commonly described that, despite exposure to risk factors such as alcohol use, the loss of friends or family to suicide, disengagement from school, or a sense of being isolated from family or community, youth are often able to cope and survive as a result of one or more protective factors in their lives—for instance, a safe and caring adult or a relationship with an Elder. Some community members observed that even when youth face many stressors, if they are protected in one of these ways, "*they do okay*." In contrast, community members describe that some strategies aimed at addressing only risk factors—such as banning alcohol in the villages—have been much less effective. Similarly, a 2014 study finds that banning alcohol in Alaska's most isolated villages, a suicide prevention attempt aimed at addressing the problem of alcohol use and misuse as a known risk factor for suicide did not statistically impact suicide attempts. However, the study finds that Alaska Natives are statistically less likely to die by suicide if they live in villages with prominent traditional Elders, a high number of married couples, and access to jobs (Berman, 2014). In recent years, the State of Alaska has also emphasized upstream approaches as part of its suicide prevention planning process based on the perspective that "in addition to helping someone in crisis, Alaskans have to focus on what is happening during life that can lead a person to being at risk for suicide… the further up the wellness stream you go to intervene, the more likely you are to avoid serious health problems like suicide" (Alaska Statewide Suicide Prevention Council, 2013). An example of an evidence-based program that holds promise for Alaska Natives is the Good Behavior Game (Wilcox et al., 2008; National Research Council and Institute of Medicine, 2009), a program for elementary-school aged children that has been implemented successfully by several American Indian tribes and within Manitoba, Canada (where it included First Nation children) (Manitoba Provincial Report, 2014).

- Future suicide prevention support in Alaska should include these assets-based approaches reflecting insight about the current statewide suicide prevention plan, so that partnerships can be developed to maximize the impact of such efforts. These approaches should ensure that community voices and perspectives are integrated that leverage culture, resiliency, and protective factors.

- *Increase Availability of and Enhance Behavioral Health Services*. As described in this report, the strong financial support from state and federal agencies has led to a proliferation of suicide prevention efforts within Alaska, particularly in the last decade. According to Alaska's Casting

the Net report focused on suicide prevention, the number of Alaskans who received mental health services grew 17 percent between FY 2009 and FY 2011 (8,834 individuals in FY 2009 compared to 10,353 individuals in FY 2011). The number of Alaskans who received substance use disorder treatment has also grown 5.7 percent since FY 2009 (6,994 individuals in FY 2009 compared to 7,391 individuals in FY 2013). However, while the increase in the number of Alaskans seeking treatment and recovery services is promising, the resources available to the behavioral health system remain static (Alaska Statewide Suicide Prevention Council, 2013). In addition, as the findings indicate, despite advances in the behavioral health system (BHA, itinerant counselor, telebehavioral health), behavioral health care is still largely unavailable and/or insufficient for many residents of rural Alaska. Further, crisis intervention services needs must be further explored to ensure that adequate services are available beyond large Alaskan cities (i.e., removal of youth from villages to regional hubs or cities).

- *Incorporate Community Empowerment and Engagement*. Building on a community strength and protective factor that spans level (i.e., individual initiative and collaborative spirit within the communities) the findings also suggest that programs would benefit from a community-specific approach that meaningfully considers local perspectives in the development of community-tailored suicide prevention planning. To be effective in implementing suicide prevention plans, communities need high-quality, hands-on and consistently available training and technical assistance to support a culturally competent needs and resource assessment, priority mapping, coalition development, identification of strategies and integration of the plan within the communities' current infrastructure.

- *Coordinate Resources/Foster Collaboration across Sectors*. While numerous public and private resources have been provided to address diverse public health and social challenges in Alaskan communities, often they are targeted to a single problem that may be tied to other problems (e.g., suicide with drug or alcohol misuse). Prevention strategies should consider the interrelated nature of these problems and ways in which solutions can be more comprehensive.

- *Promote Youth Employment*. To address risk factors related to youth boredom and "lack of things to do," particularly after graduating high school, programs aimed at promoting positive youth development should include opportunities for employment—particularly given high unemployment rates in rural Alaska and the need for economic development. Based on the findings, local programs that offer employment opportunities for youth have been successful in strengthening youths' sense of connection and self-efficacy, protective factors for suicide. In addition, as found in fields such as positive psychology, which focuses on promoting healthy living rather than simply treating depression and other psychopathology, work and job satisfaction are second only to personal relationships in determining quality of life (Henry, 2004; Snyder et al., 2011). Based on such findings, employment can contribute to a more fulfilling life, particularly given its positive impact on identity, social support, purpose and challenge (Henry, 2004; Snyder et al., 2011).

- *Provide Opportunities for Long-term Suicide Prevention Efforts*. As an alternative to short-term suicide prevention funding often relying on local volunteerism, which respondents suggested is less likely to result in sustainable positive outcomes, the findings suggest that community members are interested in opportunities to build the local capacity and infrastructure to address the crisis of suicide in their communities. Suicide prevention programs targeted to Alaska Native villages should include opportunities for community members to serve in suicide prevention roles that are paid positions rather than relying on volunteers, particularly considering that the villages are cash poor with insufficient economic opportunity. As a practical point, one respondent summarized, "*We love to volunteer but we need to pay our bills too*." Resources may also include stipends for Elders and community coordinators as compensation for program participation and funding to pay for concrete resources such as fuel and supplies.
- *Reflect Insight about Culture and History*. Prevention program and evaluation activities should be planned with insight about historical trauma, cultural traditions and history, and rural/urban lifestyles in Alaska. For example, in rural Alaskan villages that practice a subsistence lifestyle, program or evaluation timelines should be planned around subsistence timelines as such activity is vital to cultural and personal survival and naturally take priority over other agendas, including plans for programs or projects. Engagement efforts with communities should begin in the fall to provide adequate time to involve the communities in project or evaluation activities before the main subsistence season begins in the late spring and early summer.
- *Support Risk/Resilience Research and Evaluation in Alaska Native Communities*. Risk and resilience related to suicide and suicide prevention among Alaska Native youth is a promising and needed area of inquiry for further evaluation and study dedicated to the improvement of service delivery and social support for AN/AI youth. The findings in this report are consistent with recent recommendations from the Research Prioritization Task Force of the Action Alliance to Prevent Suicide (outlined in the 2014 publication, "*A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives*"), particularly the general call for studies that focus on understudied, hard to reach and/or high risk communities and care settings, including Alaskan villages, as well as research specifically designed to improve understanding about how to sustain beneficial social connection processes that reduce suicide risk (Action Alliance, 2014). The findings in this report also suggest the need for evaluation to assess the reach and implementation of crisis services, where youth access crisis services, how telebehavioral health systems are or are not being used to support youth in crisis, and the outcomes of telebehavioral health crisis services for Alaska Native communities.
- *Build Opportunities through Statewide/Regional Gatherings*. Consider taking advantage of existing statewide or regional gatherings and maximize these opportunities to connect with large numbers of community leaders from multiple regions and villages. For example, these may include:

- Alaska Federation of Natives (AFN)—occurs annually in the fall
- Elders and Youth Conference—occurs annually in the fall
- Rural Providers Conference—occurs annually in the spring
- State Suicide Prevention Council—occurs biannually in winter

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Appendix A: Suicide Prevention Programs in Alaska

APPENDIX A—SUICIDE PREVENTION PROGRAMS IN ALASKA

Native Aspirations Project (SAMHSA)

Administered by SAMHSA from 2005 through 2012, the Native Aspirations (NA) Project was launched to address the high rates of youth suicide, bullying, and school violence in Alaska Native and American Indian (AN/AI) communities by emphasizing community capacity building and through implementation of evidence-based, culture-based, and practice-based interventions (EBI/CBI/PBI). NA was not a grant program; tribal communities were invited to participate on the basis of factors such as high rates of suicide, violence, and bullying, and limited suicide prevention resources. Upon agreement, communities were provided supports, including technical assistance on topics such as high risk youth, EBI/CBI/PBI (e.g., American Indian Life Skills Development Curriculum, Gathering of Native Americans [GONA], Canoe Journeys), resource management, community planning, and preparation for community mobilization. A Community Mobilization Planning (CMP) process was used to identify goals and mobilize efforts within the community. Communities were eligible to receive up to $25,000 per year for 2 years to support initial community-based prevention activities and sustainability planning. SAMHSA awarded Kauffman and Associates, Inc. (KAI) a contract to engage and support AN/AI communities in their efforts to prevent youth suicide, violence, and bullying.

Native Aspirations Project Objectives

- Decrease risk factors that contribute to suicide and school violence
- Increase protective factors that are linked to the healthy and safe development of children and their families

Native Aspirations Community Objectives

- Increase Native youth and families' awareness, knowledge and skills regarding suicide, violence, and bullying
- Build pro-social and help-seeking behaviors among youth
- Promote the development of suicide prevention and intervention services for youth
- Develop community strategic plans for the coordination of behavioral health, justice, and education systems supporting youth

Through 2012, more than $3 million has been provided to 65 communities, including more than a dozen in Alaska.

Garrett Lee Smith Youth Suicide Prevention and Early Intervention Program (SAMHSA)

Administered by SAMHSA since 2005, the GLS Youth Suicide Prevention Program, which includes the GLS State/Tribal Program and GLS Campus Program, has been devoted to suicide prevention for youths and young adults aged 10–24 years. Suicide prevention activities supported by GLS grantees have included education, training programs such as gatekeeper training, screening activities, and enhancement of infrastructure for improved linkages to services, crisis hotlines, and community partnerships. Aligned with the NSSP, GLS State/Tribal grantees focus on reducing rates of suicidal ideation and suicide attempts and deaths; improving the continuity of care and follow-up of youth discharged from emergency departments (EDs); providing direct treatment; providing wrap-around and recovery support services; conducting system wide training; conducting and monitoring local surveillance on nonlethal suicide attempts and deaths by suicide; conducting outreach and engagement with diverse populations; addressing behavioral health disparities; and addressing suicide prevention among high-risk populations, especially youth, AN/AI, and military families. In contrast to the NA program, GLS Youth Suicide Prevention grants are awarded through a competitive application and review process. Since 2005, there have been eight rounds of 3-year GLS grants funded with 93 state/tribal grantees receiving funding, including nine within Alaska. Funded Alaska programs include Maniilaq Association, Kawerak, Southcentral Foundation, Bristol Bay Area Health Corporation, Association of Village Council Presidents, Tanana Chiefs Conference, SouthEast Alaska Regional Health Corporation, and the State of Alaska Department of Health and Social Services Division of Behavioral Health.

Most Common GLS Suicide Prevention Activities in Alaska

- Gatekeeper Training (ASIST, QPR)
- Outreach and Awareness Activities
- Lifeskills training
- Provision of direct services and traditional healing practices, including sacred fires, moon ceremonies, and talking circles development of children and their families

Tribal Training and Technical Assistance Center (SAMHSA)

Administered by SAMHSA, the Tribal Training and Technical Assistance Center (TTTAC) provides training and technical assistance (TA) to AN/AI communities using culturally tailored, evidence-based, holistic approaches to support infrastructure development, capacity building, and program planning and implementation. The technical assistance covers behavioral health and wellness, including suicide prevention, mental health promotion, substance use prevention, and mental health disorders. The TTTAC serves rural and urban tribal nations and organizations, SAMHSA tribal grantees, technical assistance contractors who provide support to tribal grantees, and government and nongovernment agencies and organizations. For more focused support, the center also provides more intensive technical assistance to a select group of communities.

Native Connections (SAMHSA)

Administered by SAMHSA, Native Connections is a tribal behavioral health grant program designed to prevent and reduce suicidal behavioral and substance abuse among AI/AN young people through age 24. The program is also designed to promote mental health. The goals of the program are to reduce the impact of substance misuse, mental illness, and trauma on AI/AN communities through a collaborative public health approach.

Methamphetamine & Suicide Prevention Initiative (IHS)

Administered by the Indian Health Service, the Methamphetamine and Suicide Prevention Initiative (MSPI) is a national pilot demonstration which provides funding to 125 federal, tribal and urban programs to provide methamphetamine and suicide prevention and treatment services.

MSPI Project Objectives

- Expand community-level access to effective methamphetamine and suicide prevention programs
- Promote the development of successful evidence-based and practiced-based models of prevention, treatment, and aftercare for AI/AN communities

MSPI aims to address the high rates of methamphetamine use and suicide in American Indian/Alaska Native (AN/AI) communities by expanding community-level access to effective prevention, treatment and aftercare. As a requirement of funding, all pilot programs are expected to develop models that: coordinate community services relative to methamphetamine and suicide; participate in a nationally coordinated program focusing on increasing access to prevention and treatment; develop community-based and focused programs; establish community-level baseline data; assess and document community-level need; and implement programs at a scale likely to produce measurable impact. Programs are encouraged to integrate mental health into tribal culture through the use of traditional healing practices and spirituality.

Participating communities, including 17 in Alaska, are provided supports, including technical assistance on topics such as project management, EBI/CBI/PBI (e.g., American Indian Life Skills Development Curriculum, GONA, Motivational Interviewing), media campaigns, and evaluation. Annual appropriations for MSPI are approximately $16 million, including more than $5 million to Alaska through 2011.

Circles of Care (SAMHSA)

Circles of Care is a SAMHSA initiative to promote the development of culturally appropriate strategies to serve young people with serious behavioral health challenges and their families. Since 1998, tribal organizations have been eligible to receive a one-time, 3-year grant of up to $400,000 per year to

reduce the gap between the need for mental health services and the availability and coordination of mental health, substance use, and co-occurring disorders for children, youth, and young adults from birth through age 25, and their families. Circles of Care draws on the system of care philosophy defined as a coordinated network of community-based services and supports to meet the mental health needs of youth and their families. To date, three Alaska-based grantees have been funded, with the most recent grantee funded in the 2008-2011 funded cohort.

Appendix B: Sources of Information for This Report

APPENDIX B—SOURCES OF INFORMATION FOR THIS REPORT

Both primary and secondary data were used to inform this report. Data gathered through and about the Native Aspirations Project represent both primary (i.e., data collected and analyzed for this report) and secondary (i.e., data collected for previous evaluation activities and analyzed for this report) data sources. GLS data presented in this report were gathered for the purposes of the GLS Youth Suicide Program but are analyzed and presented in this report to describe how Alaskan communities are preventing youth suicide, the conditions under which strategies in these communities are being implemented, the context for suicide prevention efforts, and outcomes related to suicide prevention efforts. Secondary data sources include national surveillance and State reporting system data used to provide context for suicide prevention in Alaskan communities. The following provides an overview of data sources used for this report.

Community Mobilization Plan Interviews

As part of the Native Aspirations Project, each participating community began the process of developing a "community mobilization plan" aimed at outlining steps to address youth suicide in the community. CMP interviews were conducted to describe and understand how communities put their Native Aspirations community plans (both the CMP as well as a follow-up sustainability plan) into practice; how closely the original plan was followed; what helped the community conduct planned activities; and what difficulties and successes the community had with its plan. The interviews assessed how implementation of the plan affected the community and organizational and community awareness and involvement with the NA Project. The interviews gathered information about the outcomes of the overall NA Project on the community. Interview participants included community members who were involved in development of the CMP.

Service Provider Focus Groups

Service provider focus groups were conducted to describe the services available in Native Aspirations communities to help Native youth as well as the accessibility of these services. Focus groups were used to understand how services changed as a result of Native Aspirations. Providers (both clinical/agency staff and nonclinical staff) were asked about the types of services available for youth in the community, including services for mental health promotion and services to promote health and wellness; how various service agencies collaborate; challenges related to providing services for youth; and changes in service provision since the beginning of the Native Aspirations Project.

Community Knowledge, Awareness, and Behaviors Survey—Adult Version (CKABS–A) and Youth Version (CKABS–Y)

The CKABS—A is a self-administered questionnaire used to improve understanding about the knowledge, attitudes, and behaviors (KABS) of adults around violence, bullying, and suicide in the community. The survey assesses: risk and protective factors in the community related to violence, bullying, and suicide; willingness of adult community members to intervene with youth experiencing depression, suicidal ideation, or bullying; shame and embarrassment related to mental health seeking; awareness of community crisis hotlines and/or mental health service providers that can serve as a referral point for youth at risk of suicide; the level of involvement of parents with their children; and family participation in cultural activities. CKABS–A data (n=119) presented in this report represent four villages gathered from 2009 through 2013. The CKABS—Y is a self-administered questionnaire used to improve understanding about the KABS of youth around violence, bullying, and suicide in the community. The survey assesses: youth exposure to risk and protective factors related to violence, bullying, and suicide; help-seeking behavior among youth and shame and embarrassment related to use of mental health services; exposure to and participation in bullying behaviors; exposure to dating and sexual violence; awareness about suicide and approaches to prevention; willingness of Native youth to intervene if a friend is experiencing depression, suicidal ideation, or bullying; awareness of community crisis hotlines, mental health service providers and other resources; and youth perceptions of parental involvement in their life. CKABS–Y data (n=35) presented in this report represent two villages where data were gathered from 2009 through 2013. Sampling plans for both CKABS—A and CKABS—Y were developed with participating NA tribes and villages and data were collected once in each participating tribe/village.

Prevention Strategies Inventory (PSI)

The PSI is a Web-based survey administered quarterly by the GLS Suicide Prevention cross-site evaluation team. The PSI collects cumulative information on the number and types of prevention strategies that grantees have implemented in their GLS-funded suicide prevention programs as well as budget allocations by prevention strategy. Prevention strategies may include: outreach and awareness; gatekeeper trainings; assessment and referral training for mental health professionals and hotline staff; life skills development; screening programs; hotlines and helplines; means restriction; policy and protocol development; coalitions and partnerships; and direct services and traditional healing practices. PSI data in this report are from eight GLS grantees (10 grants) gathered from 2007 through December 2013.

Early Identification, Referral, and Follow-up (EIRF)

The EIRF is a required component of the cross-site evaluation of the GLS Suicide Prevention Program used to evaluate the impact of suicide prevention activities related to the early identification of youth at

risk for suicide, referrals for services, and service delivery. The EIRF reviews information related to three key program activities: 1) early identification; 2) referral; and 3) follow-up or receipt of services. The intent of the EIRF is to track information on all youth identified as being at risk for suicide. EIRF data for this report represent data from six grantees (seven grants) gathered from 2007 through December 2013.

Tracking youth who are identified as being at risk and the resulting service linkages is critical to understanding the effectiveness of GLS Programs.

Training Exit Survey (TES)

The TES collects data from participants aged 18 and older in training activities that are part of the GLS State/Tribal grantee programs. The purpose of the TES is to assess the content of the training, the participants' intended use of the skills and knowledge learned, and self-efficacy toward implementing training concepts. TES data in this report represent eight grant programs gathered from 2007 to December 2013 through nine grants.

National Center for Health Statistics (NCHS) Vital Statistics System

CDC's NCHS provides the nation's official vital statistics based on the collection and registration of birth and death events at the state and local level. This system contains information on all births and deaths in the U.S. and provides the most complete and continuous data available to public health officials at the national, state and local levels, and in the private sector. Examples from the NVSS include teen births and birth rates, preterm birth and infant mortality rates, leading causes of death, and life expectancy.

Alaska Bureau of Vital Statistics (AKBVS)

The AKBVS is responsible for managing vital records in the State of Alaska. Records include birth, death, fetal death, and divorce and marriage certificate data, along with reports of adoption.

National Violent Death Reporting System (NVDRS)

Created in 2002, CDC's NVDRS is a surveillance system that collects data on violent deaths in 18 states, including information such as suicides, homicides perpetrated by an intimate partner (e.g., boyfriend, girlfriend, wife, husband), and child maltreatment or child abuse fatalities. NVDRS data help to inform decision-makers and program planners about the magnitude, trends, and characteristics of violent deaths in their state or community so that appropriate prevention efforts can be identified and implemented. NVDRS data also help to facilitate the evaluation of state-based prevention programs and strategies.

Alaska Violent Death Reporting System (AKVDRS)

The AKVDR is an active surveillance system that collects risk factor data about all violent deaths that meet the National Violent Death Reporting System case definitions.

National Survey on Drug Use and Health (NSDUH)

Sponsored by SAMHSA, the NSDUH provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including nonmedical use of prescription drugs) and mental health in the United States on individuals 12 years and older.

Behavioral Risk Factor Surveillance System (BRFSS)

CDC's BRFSS collects state data regarding health-related risk behaviors and events, chronic health conditions, and use of preventive services. Currently, all states collect BRFSS data to help establish and track state and local health objectives, plan health programs, implement disease prevention and health promotion activities, and monitor trends. Adults 18 years or older are asked to take part in the survey. Results are analyzed to improve understanding of Alaskan's health habits and measure progress toward health objectives at the State and national level.

Youth Risk Behavior Survey

CDC's YRBS is an epidemiologic surveillance system that monitors priority health risk behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the U.S. These include behaviors associated with suicide and violence, alcohol and other drug use, and other health-related outcomes. The YRBS includes national, state, and local school-based surveys of representative samples of 9th through 12th grade students. CDC conducts the national survey. In Alaska, state and local district surveys have been conducted by the Alaska Department of Health and Social Services and the Alaska Department of Education and Early Development in cooperation with local school district.

Web-Based Injury Statistics Query and Reporting System (WISQARS™)

CDC's WISQARS is an online database that provides fatal and nonfatal injury, violent death, and cost of injury data from a variety of trusted sources. WISQARS data helps assess the public health and economic burden associated with unintentional and violence-related injury in the United States.

Appendix C: 2013 Native Aspirations Community Engagement

APPENDIX C—2013 NATIVE ASPIRATIONS COMMUNITY ENGAGEMENT

Community Engagement

In the winter of 2013, as part of the Suicide Prevention Evaluation, an evaluation team at ICF International attempted to engage five rural Alaskan communities to participate in local site visits for the purposes of collecting data through service provider focus groups, CMP implementation interviews and the CKABS surveys. These communities included one village each in the Southeast, Interior and Western regions of Alaska and two villages in the Northwest Arctic.[9] The communities were involved in either the first or second cohort of Native Aspirations. In each of these communities, initial contact was made almost immediately, via either e-mail or phone. After initial responsiveness and expressed interest from each of the communities, after a period of months, several of the communities fell out of contact. Through alternate channels, the evaluation team learned that one of the Northwest Arctic communities had suffered a devastatingly low subsistence harvest, which may have impacted the community's ability to participate. In addition, in the case of the Western Alaska community, a change in Tribal administration had occurred. Lack of familiarity with the NA project may have resulted in e-mails and phone calls being unanswered. While communication was often sporadic, two of the communities ultimately participated in local site visits—including one in Interior Alaska, and one in the Northwest Arctic, each funded as part of the first or second cohort of NA communities and also supported through GLS Suicide Prevention awards to Tanana Chiefs Conference, Maniilaq and Kawerak.

Overall, community engagement was a time-intensive process requiring repeated phone calls and e-mails over many months of time. In all but two communities, this was ultimately unsuccessful. For the purposes of future evaluation planning, the challenges to community engagement are summarized below:

- Time Lapse and Lack of Funding: In the case of each of the communities invited to participate, a minimum of 5 years had passed since their initial participation in the NA program. In some cases, this resulted in lack of immediate recognition of the NA program and/or confusion regarding the connection between the current evaluation and the prior NA program. Some local contacts asked whether the current evaluation involved funding to support the continuation of

[9] As agreed upon during engagement, Native Aspiration community names are not included in this report.

NA activities. Without additional funding and many competing priorities, local contacts may not have been able to prioritize participation in the evaluation.

- Local Events/Challenges: Various local events and challenges impacted communication. These included vacancies and turnover in village administration, village level crises, including poor subsistence harvests and storms, and individual crises, such as illness and injury which incapacitated community contacts. In many cases, if a local community contact became unavailable due to illness or turnover, no replacement or alternate contact was available.
- Many Responsibilities for Local Contacts: The local contacts often juggled multiple roles and had many responsibilities in the community. This posed a challenge to engagement because community contacts had many more pressing issues and projects to attend to before they could turn attention to the NA evaluation. Site visit planning was often put on hold until the community contact was available once again.
- Timing/Subsistence Season: Engagement attempts began in midwinter when community members are most available to participate in external projects. However, as the engagement process extended, due to factors such as the infrequency of Tribal Council meetings needed to approve participation and/or lack of quorum, the evaluation timeline ran into "spring breakup," the traditional start of the subsistence season. During this time, most community members, including the Tribal Administrators and community contacts, become engaged in subsistence activities. During subsistence season, which lasts through late summer and early fall, traditional and cultural activities take priority over other programs, projects, or activities. This resulted in a fairly limited window to schedule site visits and identify and recruit potential participants.

Participating Communities

In 2013, an evaluation team at ICF International conducted site visits in two small, rural Alaskan villages, one located in the Northwest Arctic and the other in the Interior region of Alaska, where the suicide rates are among the highest in the U.S. In the Interior region, the suicide rate is 40 per 100,000, similar to the statewide rate for AN/AI (40.3) (AKBVS, 2002–2011). In the Northwest Artic region, the suicide rate is significantly higher at 71.6 per 100,000 (AKBVS, 2002–2011). This compares to a statewide non-Native rate of 16.9 (AKBVS, 2002–2011) and U.S. rate of 12.1 per 100,000 (CDC, 2013). These villages are each accessible only by plane or boat (there are no roads linking the villages to other areas of the state) and are characterized by geographic isolation and remoteness, which is typical of rural Alaska (Alaska Culture, 2014).

VILLAGE IN INTERIOR REGION

Largely uninhabited wilderness, the Interior region is the original home of Alaska's Athabascan Indians. Approximately 15,019 Alaska Native people live in the Interior Region, reflecting 13.8 percent of the

Interior's total population of 108,463 (Alaska Department of Labor and Workforce Development, 2009). Small towns and Alaska Native villages are scattered throughout, mostly along the highway and river systems. Denali National Park and Preserve is located in the Interior, home to Mount McKinley (also widely known by its local name of Denali), the highest point in North America. The natural environment of the Interior is drier and less fertile than in Southeast or Southcentral, with wide expanses of Tundra. Subsistence activities are central to Athabascan social and cultural values. Like many Alaska Natives, Athabascans follow a pattern of subsistence activities that reflect the seasonal cycle of harvestable resources (U.S. Fish and Wildlife, 2013). The climate includes very warm and mild summers and harsh winters that are cold and clear with temperatures dropping to 50 to 60 degrees below zero—some of the lowest recorded in the State (AlaskaWeb, 2014).

Characteristics of Athabascan Villages

- Small, remote
- 80–700 people
- Few community institutions (one post office, one school)
- Subsistence lifestyle

(TCC, 2005)

In June of 2013, an evaluation team member traveled to an Athabascan village in the Interior several hundred air miles from Fairbanks—the largest city in the Interior, and second largest in the state—to conduct a site visit (June 26–28). To increase the likelihood that more of the residents would be in the village, the site visit was scheduled for the small window between "spring fishing" and before "summer fishing" and berry season. The village is populated by less than 350 residents; approximately one-third of them are children or youth enrolled in the K–12 school. Most residents in this village are related by birth or marriage. The sale of alcohol is banned in the community, while importation and possession are allowed.

In advance of the site visit, the community contact solicited potential participants for two focus groups. To recruit participants for the community survey, flyers were posted and announcements were made on the VHF radio encouraging participants to come by the tribal office to take the survey. Two Service Provider Focus groups were conducted:

- Focus Group 1 included nine participants (all women). The participants included: a Head Start teacher, city administrator, behavioral health aide, tribal workforce development worker, school aide, head of "search and rescue," Fire Chief, Tribal Family Youth Specialist, and AmeriCorps service worker.
- Focus Group 2 included nine participants (eight women, one man). The participants included: an elementary school teacher, a retired elementary teacher, a Head Start worker, a Health Aide, a young adult, an Elder, and an Elder Program cook.

Overall, focus group participants reflected a diverse cross-section of the community and included young adults, Elders, tribal staff, City staff, teachers, youth service workers, and health clinic staff. All participants received a VISA gift card as a thank-you incentive for participating. In addition, 37 adults

and 13 youth completed the community survey and were entered into a drawing for eight (four for adults, four for youth) gift cards.

VILLAGE IN NORTHWEST ARCTIC

Located on the Chukchi Sea, the Northwest Arctic Borough of Alaska has been occupied by Inupiat people for at least 10,000 years (NAB, 2013). Today, the region includes the largest concentration of Inupiat people in the world (Maniilaq Association, 2003), with an overall population estimated to be 7,685 in 2013 (U.S. Census, 2014), about 75 percent of which is Inupiat Eskimo. The region includes 11 villages in addition to the city of Kotzebue, the service and transportation center for the villages, as well as 4 National Parklands and a National Wildlife Refuge (Maniilaq Association, 2003). Reflecting the geographic isolation of the region, the Kobuk Valley National park, noted for the Great Kobuk Sand Dunes, is reachable only by foot, dogsled, snowmobile, and chartered air taxis (no roads lead into the park), and it is one of the least visited in the National Park System (NPS, 2013). Similar to other Alaska Native communities, subsistence activities are a vital part of the lifestyle. Residents in the Northwest Arctic rely on caribou, reindeer, beluga whale, birds, four species of seals, berries, greens and fish (NAB, 2013). The region experiences a transitional climate, characterized by long, cold winters and cool summers. Temperatures range from -52 to 85 degrees (NAB, 2013).

Two ICF evaluation team members traveled to a village in the Northwest Arctic to conduct a site visit October 23–24, 2013. The village is mainly an Inupiat Eskimo community that participates in a subsistence lifestyle, depending on caribou, fish, moose, waterfowl, and berries for survival. The population is about 650 people, the majority related to one another. Among the community institutions, is one school (K–12), with 187 students enrolled; a large community hall for recreation or community meetings; and three small stores, one located in a private residence. Overall, youth have few places to gather. One village public officer serves as a first responder; otherwise, the village relies on State troopers (located outside of the village). Like other villages in the Northwest Arctic, the sale, importation, and possession of alcohol are illegal here.

ICF faced a number of challenges during the site visit:

- The week of the site visit, a date chosen by the community, it was learned the annual Alaska Federation of Natives conference was being held in Fairbanks that week and many of the identified potential evaluation participants, those who either had been involved with Native Aspirations or were involved in service provision to youth, were attending. Thus, the evaluation team was unable to involve these individuals in the data collection.
- The community contact had attempted to arrange a focus group with alternate participants; however, ultimately, these participants did not arrive and the focus group did not occur. A search-and-rescue operation began immediately prior to the scheduled time of the focus group, which may have affected participation as many alternate participants were involved.

- The school, where the team intended to administer the youth community, knowledge attitudes and belief survey, was not in session the days of the visit due to teacher in-service training.
- On the first night in the village, a shooting incident occurred which resulted in the community being on lock-down for 18 hours. As a result, the evaluation team was not able to recruit additional participants as neither they nor community members were able to leave their location.

After arriving in the village, the evaluation team recruited participants largely via word-of-mouth advertising as well as via announcement on the VHF radio. Throughout the first day, a diverse range of community members came to the school to participate in the interviews and/or survey. Eight CMP Implementation interviews and 17 adult community, knowledge attitudes and belief surveys were collected during the visit. All interview participants received a VISA gift card for participating and survey participants were entered into a drawing for one of four gift cards. Attempts to reschedule a focus group via teleconference with the community contact after the visit were unsuccessful.

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