



Preventing and Responding to Suicide Clusters in American Indian and Alaska Native Communities

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Preventing and Responding to Suicide Clusters in American Indian and Alaska Native Communities

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

Between 2009 and 2011, two tribal communities located approximately 3,000 miles apart—an American Indian tribe on a reservation in New Mexico and a group of closely knit Alaska Native villages in western Alaska—experienced clusters of youth suicides. Across these communities, 25 young people, all American Indian or Alaska Native (AI/AN), took their own lives. At least 28 others attempted suicide, 19 of whom were hospitalized, and more than 60 other young people were identified as being suicidal.

Many other reservations and tribal villages have experienced, and continue to experience, similar tragedies, including an Alaskan village in the same region, where nine young people attempted suicide in 2013.

Researchers note that one of the most distinctive features about suicide clusters is that they occur almost exclusively among teenagers (Gould, 2003; Hazel, 1993). While suicide clusters are relatively rare events, accounting for fewer than 5 percent of all suicides in teenagers and young adults (Gould, Wallenstein, and Kleinman, 1987; Gould, 2003), one study found that the relative risk of suicide following exposure to another individual's suicide was 2 to 4 times higher among 15- to 19-year-olds than among other age groups (Gould et al., 1990). Similar age-specific patterns have been reported for clusters of attempted suicides (Gould et al., 1994). Some researchers report that, compared to adults, youth are more susceptible to suicide behavior modeling, social norming of suicidal behavior (often described as “contagion”), and imitating suicide methods (Haw et al., 2013). This susceptibility has been described as particularly acute among higher risk subgroups of youth such as AI/AN young people (Brave Heart & DeBruyn, 1998; Bechtold, 1988; Wissow, Walkup, Barlow, Reid, & Kane, 2001), especially those who live in small, intense social networks in remote villages or on rural reservations (Goldston et al., 2008). Researchers found that American Indian youth who spent two-thirds or more of their lives on a reservation were at higher risk for suicidal ideation and suicide attempts compared to American Indian youth who spent the majority of their lives in an urban area (Freedenthal & Stiffman, 2004). While additional research is needed to understand the contributing factors, some research has pointed to considerable exposure that AI/AN youth have to suicide on isolated reservations and in rural villages (Bender, 2006).

Within a number of tribal communities experiencing clusters, including some in New Mexico and Alaska, local and regional leaders have declared states of emergency and dispatched crisis response teams to contain and prevent additional suicides. The teams provide support for families and community members as they work toward recovery. Local and regional leaders have also intensified efforts, in partnership with state and federal governments, to direct suicide prevention funding and programming

What is a suicide cluster?

A suicide cluster "can be defined as a group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected on the basis of statistical prediction or community expectation." (CDC, 1988)

to disproportionately impacted communities, many of which are located in isolated, rural areas with limited health infrastructure and crisis response resources.

The purpose of this report is to learn about suicide clusters and responses in tribal communities; identify strength-based approaches to prevention, response, and recovery; explore existing and needed resources for prevention, response, and recovery; and provide recommendations for tribal communities, and for federal, state, and partners.

The authors of this report used a qualitative methodology to learn more about the events and responses within the two tribal communities in Alaska and New Mexico that experienced clusters between 2009 and 2011. The principal sources of information were community members identified through their involvement with SAMHSA-funded programs (i.e., Native Aspirations or Garrett Lee Smith Youth Suicide Prevention and Early Intervention Program), recommended by tribal/village leadership, or both. Individuals chosen to be interviewed reflected a variety of perspectives and included elders; tribal leaders; teachers and school personnel; mental health and other youth service providers; young people who lost peers to suicide; and mothers, fathers, grandparents, and other tribal members who lost family members to suicide. The categories are not mutually exclusive, with many interviewees providing multiple perspectives.

This report includes:

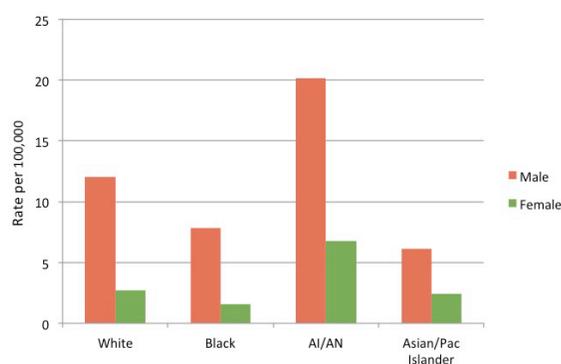
- Background information based on research literature, media reports, and surveillance data regarding suicide rates in the affected communities; clusters and contagion; risk and protective factors in tribal communities; and contextual information about the regions where the cluster events occurred. This includes the local health service infrastructure and access to behavioral health resources, as well as the impact and response to the clusters in each community;
- A description of data sources used for this report, including interviews and document reviews;
- Findings related to the impact of clusters on individuals and communities, community response and recovery, suicide prevention strategies, and existing and needed community resources; and
- A discussion of the findings as they relate to future resources to prevent and respond to suicide clusters in AI/AN communities.

BACKGROUND

National Backdrop

Suicide is a significant public health problem in the United States, with the rates of suicide within some populations being particularly high. Suicide is the second-leading cause of death for AI/AN youth and young adults aged 10–24 years (NCHS,

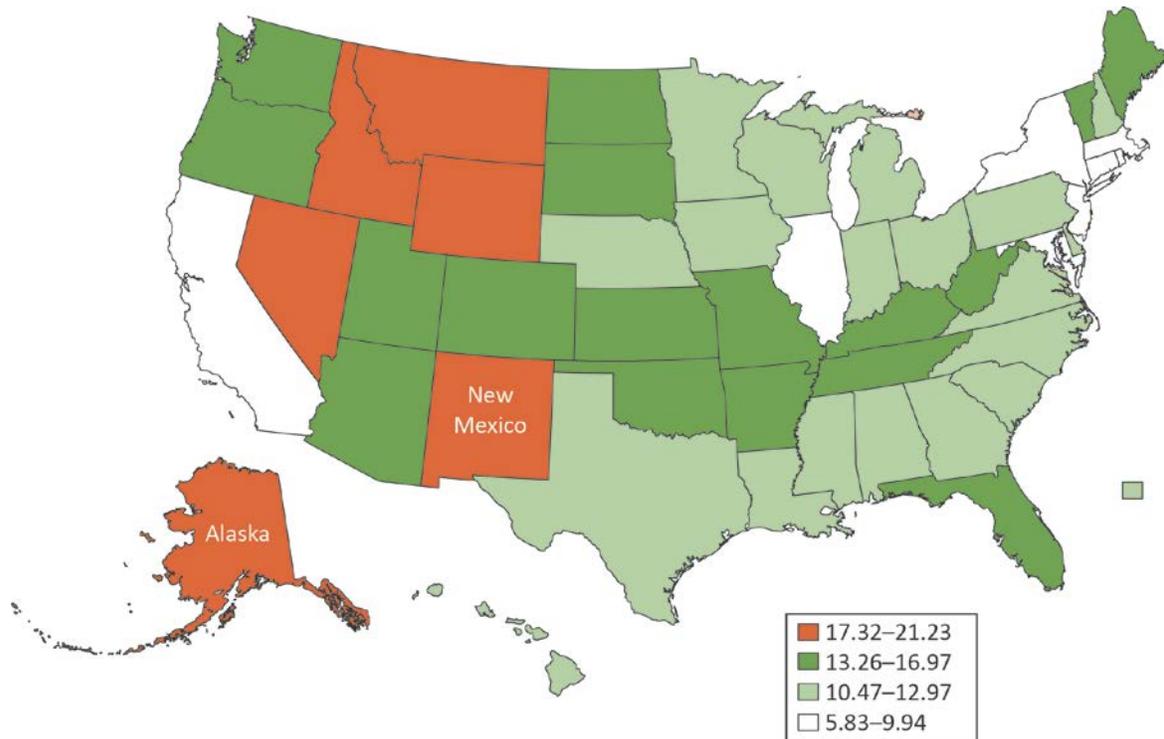
Exhibit 1. Suicide Rates among Youths Aged 10 to 24, by Race/Ethnicity and Sex, United States, 2005–2011*



*National Center for Injury Prevention and Control, CDC
Data Source: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates.

2011a). The suicide rate for this group is two to four times the rate of other Americans in this age group (NCHS, 2011b; Exhibit 1). While the suicide rate decreased slightly for AI/AN people in the United States 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; NCHS, 2011b). Within some states, overall suicide rates are much higher than the national average, with the highest rates occurring in Alaska, the Rocky Mountain states, and in the Southwest region, including New Mexico (NCHS, 2011b; American Foundation for Suicide Prevention, 2014; Exhibit 2). In general, states in the West consistently experience higher suicide rates than states in the Northeast, Southeast, and Midwest. For example, between 2005 and 2011, five western states had average age-adjusted rates that were more than 19 per 100,000: Alaska (21.24), Montana (21.01), Wyoming (20.88), New Mexico (19.40), and Nevada (19.06). This is nearly double the overall U.S. age-adjusted rate of 11.57 per 100,000, over the same time period (Exhibit 2).

Exhibit 2. National Suicide Rates



*Age-adjusted suicide rates per 100,000 population by state, 2005-2011 (NCHS, 2011b)

In Alaska and New Mexico, suicide rates among AI/AN youth are significantly higher than rates among youth from other cultural or ethnic groups. Suicide is currently the leading cause of death for AI/AN youth aged 15–24 living in Alaska (NCHS, 2011a), with a rate more than nine times that of all youth within that age range in the United States (98.88 and 10.04 per 100,000, respectively). At 152.83 per

100,000, the suicide rate for AI/AN males aged 15–24 years in Alaska is nearly nine times that for all males aged 15–24 in the United States (16.23 per 100,000). Young AI/AN females in Alaska die by suicide 11 times more often than all U.S. females in that age group (41.02 and 3.53, respectively; NCHS, 2011b).

While youth suicide rates are lower in New Mexico than in Alaska, New Mexico nevertheless exhibits a similar trend. The suicide rate for AI/AN youth aged 15–24 years is more than three times the rate for all youth within that age group in the United States (33.03 and 10.04 per 100,000, respectively). For young AI/AN males, the rate is 49.15 per 100,000, over three times the rate for all males that age in the United States. For young AI/AN females, the rate is 16.44 per 100,000, over four times the rate for all females that age in the United States (NCHS, 2011b).

Suicide Clusters and Contagion

A suicide cluster can be defined as “a group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected on the basis of statistical prediction or community expectation” (CDC, 1988; Gould, Jamieson & Romer, 2003). There are two main types of suicide clusters: *point* and *mass* (Haw, Hawton, Niedzwiedz, & Platt, 2013; Joiner, 1999; Rezaeian, 2012). Point clusters are close in both location and time, occur in small communities, and involve an increase in suicides above a baseline rate observed in the community and surrounding area (Haw, Hawton, Niedzwiedz, & Platt, 2013; Joiner, 1999; Rezaeian, 2012; Cox et al., 2012). Mass clusters involve a temporary increase in suicides across a whole population, close in time but not necessarily location. Mass clusters have been documented following suicides of high-profile celebrities or others who receive considerable media attention (Cox et al., 2012; Joiner, 1999).

In her literature review of the impact of media coverage on suicide, Gould provides evidence that extensive newspaper coverage of suicide is associated with a significant increase in the rate of suicide, with the magnitude of the increase proportional to the amount, duration, and prominence of media coverage (2001). Young people appear to be particularly susceptible to heightened risk brought about by certain types of media reporting of suicide (Gould, Jamieson, & Romer, 2003). A retrospective, case-control study of suicide clusters in young people in the United States between 1988 and 1996 (before the arrival of social media) indicated an association between certain kinds of newspaper reports about suicide and the beginning of clusters (Gould et al., 2014). Story characteristics involving front-page placement, headlines containing the word suicide or a description of the method used, and detailed descriptions of the suicidal person appeared more often for cluster-related suicides than non-cluster suicides (Gould et al., 2014).

While the mechanisms underlying suicide clusters are unclear, it has been proposed that point clusters may result from a process of “contagion,” whereby one person’s suicidal thoughts and behaviors are transmitted from one victim to another through social or interpersonal connections (Cox et al., 2012; Joiner, 1999). According to some researchers, a suicide contagion is similar to the spread of infectious disease (Haw, Hawton, Niedzwiedz, & Platt, 2013). Just as flu is most likely to affect individuals with weakened immunity, in poor health, and in close contact with someone who is sick, suicide is more likely

to affect individuals with a history of mental illness, who are close friends or relatives of the person who died by suicide, and who are experiencing poor mental health (Haw, Hawton, Niedzwiedz, & Platt, 2013). Other researchers have cautioned that suicide contagion has yet to be clearly defined (Joiner, 1999).

The suicide clusters discussed in this report are point clusters that occurred in two tightly knit and geographically isolated communities. The affected Alaskan villages are not on the road system and are accessible only by small plane, which forces a higher level of self- and communal reliance. Most individuals are related through blood or marriage. In the case of the Alaska community, extended family and relations live in nearby villages that essentially function as a single community. Thus, when a suicide occurs in one village, it immediately impacts residents in neighboring communities.

Risk and Protective Factors

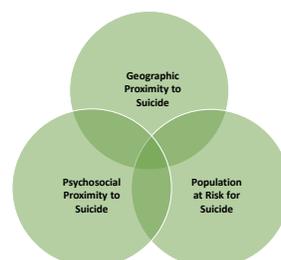
Suicide risk factors among AI/AN youth are well-known and have been widely reported. Many AI/AN youth face poverty, isolation, historical trauma, discrimination and racism, disrupted family units, previous suicide attempt(s), access to lethal means, exposure to others who have died by suicide, physical or sexual abuse, barriers to care, high rates of alcohol and drug use, and interpersonal violence (Alakanuk Community Planning Group et al., 2009; BigFoot, 2007; Borowsky, Ireland, & Resnick, 2001; Borowsky, Resnick, Ireland, & Blum, 1999; Christman, 2012; Duran & Duran, 1995; Yoder, 2006). Growing up in two cultures that have very different world views can create cumulative stresses that may increase susceptibility (LaFromboise & BigFoot, 1988). Moreover, the estimated probability of attempting suicide dramatically increases as the number of risk factors to which youth are exposed increases (Borowsky et al., 1999; Borowsky et al., 2001).

Haw and colleagues (2012) reviewed the literature on suicide clusters to describe the risk factors and proposed psychological mechanisms underlying point clusters. The authors identified two kinds of literature: (1) papers describing individual suicide clusters, which included characteristics of cluster victims and environmental risk factors; and (2) papers hypothesizing the mechanisms underlying cluster formation and, which in a few cases also provided empirical data testing a specific hypothesis. The review found that risk factors for suicide clusters are similar to risk factors for suicide in general. The authors conclude that nearly all cluster studies were uncontrolled and involved relatively small numbers of suicides, and that further research is needed to improve understanding of the mechanisms involved.

“Circles of vulnerability” (Exhibit 3) is a model that may provide insight into mechanisms of suicide clusters. Developed to assess community trauma, the model considers geographical proximity, psychosocial proximity, and population at risk (Lahad & Cohen, 2006; Zenere, 2008, 2009).

Geographical proximity is the physical distance from the initial suicide; **psychosocial proximity** is the closeness of the relationship with the person

Exhibit 3. Circles of Vulnerability



who died; and **population at risk** refers to an individual's risk factors, such as mental illness, history of trauma, substance misuse, and history of suicidal thoughts and behaviors (Zenere, 2008, 2009). The intersection of the three circles reflects the point of highest vulnerability.

Through the lens of this model, the risk profile of Native youth is often quite high. Community members typically live in close proximity and are related to one another; adolescent social networks are small and intense (Goldston et al., 2008); and individual risk factors (e.g., alcohol use, depression, the death of family and friends by suicide) tend to mount and multiply (BigFoot, 2007). While youth connectedness to family and community is generally a protective factor, it can also become part of the contagion process if young people begin to perceive suicidal behavior as normal among their peers or people they admire (Action Alliance, 2014).

A social ecological model is also useful for understanding risk and protective factors across four levels: individual, relationship, community, and societal (U.S. HHS and NAASP, 2012). Some factors are at the individual level, but many transcend the person and are influences of the larger community. As Gone and Alcántara (2007) state in a paraphrase of Felner and Felner's (1989) transactional ecological framework, the "roots of pathology can be and often are outside of the person." Categorizing risk and protective factors within the model's levels shows the factors' complexity, the interaction and relationship between and across such levels, and possible strategies and entry points for prevention and intervention.

Consideration of community- and societal-level risk factors is particularly important for AI/AN populations, as "indigenous suicide is associated with cultural and community disruptions, namely, social disorganization, culture loss, and a collective suffering" (Wexler & Gone, 2012, p. 800). Among the risk factors for suicide unique to AI/AN youth, these communities continue to be impacted by historical trauma stemming from colonization and loss of connection to spiritual and cultural practices (Brave Heart, Chase, Elkins, & Altschul, 2011).

Historical trauma is the "cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences" (Brave Heart, 2003). A primary feature of historical trauma is that "the psychological and emotional consequences of the trauma experience are transmitted to subsequent generations through physiological, environmental and social pathways resulting in an intergenerational cycle of trauma response" (Sotero, 2006). Suicidal ideation and behavior, substance misuse, depression, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions have all been identified as components of the historical trauma response (Brave Heart, 2003).

"Multiple traumas in Indian Country are cumulative and can increase feelings of hopelessness and helplessness that can lead to suicide."

(BigFoot, 2007)

Efforts by the United States to assimilate American Indians into the European-American mainstream culture and "to end the tribe as a separate political and cultural unit" (Cohen, 1982 ed., p. 139) are well-documented and include policies such as criminalizing traditional tribal governance and cultural

practices, such as funeral procedures and specific dances and ceremonies (Cohen, 1982 ed., pp. 128-145). Efforts to use boarding schools to force assimilation of Native children spanned from 1790 through 1920 (Hoxie, 1984). Children were removed from traditional families (including extended family and clan system cultures) and from other traditional forms of social organization and sources for identity development, to live in boarding schools, where they were often verbally, physically, and sexually abused (Napoleon, 1996). Brave Heart (1999) discusses the process of boarding schools depriving families of traditional Native parenting role models, “impairing their capacity to parent within an indigenous health cultural milieu.” The cultural anchors that should have served to ground and enhance healthy development—from childhood through adulthood and parenthood—were missing, and, in many cases, dysfunction was left in its place.

A number of studies have also looked at protective factors among American Indian and Alaska Native youth. Perceived connectedness to family; discussing problems with friends or family; consistent, healthy attachment to family and school; traditional cultural values and practices; emotional health and well-being; and access to mental health services have all been identified as protective against suicide attempts (Borowsky et al., 1999; Borowsky et al., 2001; Kral et al., 2011). Similarly, Wolsko and colleagues (2009) found that tribal members who follow a more traditional way of life reported greater happiness, more frequent use of religion and spirituality to cope with stress, and less frequent use of drugs and alcohol to cope with stress. Garrouette et al. (2003) found “a strong and persistent protective association between cultural spiritual orientations and [lifetime self-reported] suicide attempts” (p. 1576), even when risk factors such as substance misuse and psychological distress are experienced. They defined “Cultural spiritual orientations” not as belief systems, but as “ways of encountering and interpreting self, world, and experiences....[that] reflect American Indian cultural views of the connectedness of humans to all other physical and transcendental entities” (Garrouette et al., p. 1573). Moreover, connectedness is protective when it occurs within and between multiple levels of the social ecology—between individuals, families, schools and other organizations, neighborhoods, cultural groups, and society as a whole (Action Alliance, 2014).

Preventing and Responding to Suicide Clusters

One of the most widely cited documents about preventing and managing suicide clusters is CDC’s “Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters” (CDC, 1988). The recommendations underscore the critical importance of developing community plans before suicide clusters occur and they guide community leaders and stakeholders in developing specific strategies. This helps accelerate prevention efforts and facilitates swift, coordinated, and effective response in the event of a cluster. The document

CDC Lessons Learned In Responding to Suicide Clusters

Potential opportunities for prevention were often missed during the early stages of the [suicide cluster] response as community leaders searched for information on how best to respond to suicide clusters.... In the early days of an evolving suicide cluster, there has typically been a great deal of confusion. There is often a sense of urgency in the community that something needs to be done to prevent additional suicides, but there has usually been little initial coordination of effort in this regard (CDC, 1988, p.2).

suggests that such a response plan should be implemented in two circumstances: (1) when a suicide cluster occurs in the community or (2) when one or more traumatic deaths¹ occur in the community, especially among adolescents or young adults, who may be at higher risk for contagion. Related to the second circumstance, CDC notes that “several clusters of suicides or suicide attempts (have been) preceded by one or more traumatic deaths—intentional or unintentional—among the youth of the community” (CDC, 1988, p. 5).

CDC’s recommendations are based on the experts’ experiences and lessons learned assisting various local communities in addressing suicide clusters. One key example is the fact that community leaders responding to an evolving suicide cluster face the simultaneous tasks of attempting to prevent the cluster from expanding, while also managing the existing crisis (Askland, Sonnenfeld & Crosby, 2003; Office of Safe and Drug-Free Schools, 2007). To ensure the timeliest reaction possible, the recommendations urge that the response plan and roles of each participant be developed, agreed upon, and understood by all relevant participants before the onset of a crisis.

The recommendations emphasize the need for including all sectors of the community (e.g., public health, mental health, education, local government, clergy, parent groups, the media, community organizations) in planning and the implementing the prevention and response effort. With the goal of building a coordinated, collaborative initiative, CDC urges that “[e]very effort should be made to promote and implement the proposed plan as a community endeavor.... No single agency ... has the resources or expertise to adequately respond to an evolving suicide cluster” (CDC, 1988, p. 3). The document stresses the need to include representatives of the local media in developing the plan, to ensure that the “legitimate need for information” can be satisfied without the kind of sensationalized reporting that has been shown to contribute to suicide contagion.

Overall, the document presents a set of broad principles and sequentially ordered steps that local communities can undertake to prevent and plan for clusters as part of their overall suicide prevention planning process. The recommendations emphasize that community prevention and response plans must be adapted to the particular needs, resources, and cultural characteristics of the community.

A 2012 literature review aimed at understanding effective prevention and

Common Response to Contain a Youth Suicide Cluster

- 1) Development of a community response plan
- 2) Educational/psychological debriefings
- 3) Individual and group counseling for affected peers
- 4) Screening of high-risk individuals
- 5) Responsible media reporting of the suicide cluster
- 6) Promotion of health recovery within the community

(Cox et al., 2012)

¹ Traumatic death refers to any death in the community that is not the result of old age or sickness.

postvention² strategies for suicide clusters (Cox et al.) found that few studies actually documented response strategies and only one evaluated its efforts. However, the authors identified a number of strategies that show promise, including six common approaches to cluster containment frequently adopted by communities and schools (see text box).

Suicide Settings of Focus: Cluster Locations and Responses

Tribe in New Mexico

In New Mexico, the suicide cluster occurred on a tribal reservation³ located in the U.S. Indian Health Service's (IHS) Albuquerque Area. The Albuquerque Area, which extends over most of New Mexico and all of Colorado, provides health services to American Indians in numerous tribal groups, each with their own history, language, and culture (IHS, n.d.). In the New Mexico portion of the Albuquerque Area (Exhibit 4), the tribes served include the 19 Pueblos, the Jicarilla and Mescalero Apaches, and the Alamo, Canoncito, and Ramah chapters of the Navajo Nation. While the previous generations of the affected tribe were nomadic hunters and gatherers, tribal members now fish, hunt, manage ranches, and support an active tourist industry (IHS, n.d.).

In response to the suicide cluster, which involved not only multiple deaths but many attempts and expressions of suicidal ideation (strong thoughts of engaging in suicidal behavior), the community formed a crisis response team to determine priorities, strategies, and steps for prevention and containment. Consistent with CDC recommendations, the response reflected broad collaboration among tribal, local, county, state and federal programs and partner agencies. Examples of actions included providing assessment training and support for emergency medical service providers, Bureau of Indian Affairs law enforcement officers, tribal conservation officers, and medical providers. Law enforcement officials agreed to notify and involve the IHS within 24 hours of any suicide attempt or threat. The crisis response team planned suicide prevention awareness trainings in schools and other community settings. The community provided outreach to tribal youth in tribal and public schools

Exhibit 4. New Mexico IHS Albuquerque Service Area and Tribal Lands



² Suicide postvention is defined as “Response to and care for individuals affected in the aftermath of a suicide attempt or suicide death” (U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2010, p. 141). The goals of postvention may include (1) supporting the bereaved survivors, (2) preventing imitative suicides by identifying other individuals at risk for self-destructive behavior and connecting them to intervention services, (3) reducing survivor identification with the deceased, and (4) providing long-term surveillance (Gould & Kramer, 2001).

³ The specific location of the clusters and related details will not be disclosed in this document to maintain the confidentiality of interview participants.

across four communities, offering health services, mental health services, and suicide prevention activities, including evening events.

Just prior to the cluster, the tribe had begun developing a suicide prevention team with federal grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). As the cluster evolved, the team implemented numerous suicide prevention programs, including a peer-to-peer program modeled after “Natural Helpers,” which had been previously used with success in a tribal community (May et al., 2005). Serna describes Natural Helpers as a “peer-helping and leadership development program based on the premise that within every school an informal ‘helping network’ exists among peers. Students with problems seek out other students whom they trust.” (2011) In adapting the program to their community, the New Mexico tribal suicide prevention team surveyed students to understand sources of distress in their lives and identified “natural” peer supporters among students. The team taught the peers how to mentor students who were struggling, encourage them to talk with their support networks, and seek out adult counseling. The team also integrated social media to reach youth and identify students at risk of suicide.

The tribe falls within the IHS Albuquerque Area, which is divided into ten service units, each of which provides services at the community level (IHS, n.d.). The local IHS Service Unit includes inpatient and outpatient services, as well as field health programs. Specialized services (e.g., surgical and orthopedic care) are referred to contract hospitals in the region. At the time of the cluster, the IHS Service Unit mental health clinic employed two independently licensed counselors. Other mental health resources, including clinical psychologists, psychiatrists, social workers, etc. were more than 200 miles from the tribal setting for this cluster—not an uncommon scenario for rural, tribal communities. Access to behavioral health services was further limited because several tribal substance use provider positions were vacant.

When the cluster developed, the IHS director, in concert with the tribe, requested and received a 90-day deployment of United States Public Health Service mental health teams to stabilize and address the high number of attempted and completed suicides. The teams worked with four school districts and communities, providing counseling services to students and staff, and implementing processes to track and monitor suicide-related data (e.g., numbers of suicide attempts, the age of the person, whether drugs or alcohol were involved). Additionally, IHS instituted a telebehavioral health service to connect local residents with behavioral health staff in other areas.

Villages in Western Alaska

This report focuses on three Yup’ik or Cup’ik communities located on the Bering Sea coast, with populations ranging from 530 to 1,100.

The high rates of suicide—beyond what would be expected—across many villages in the Yukon-Kuskokwim (YK) Tribal Health Region (Exhibit 5) mean that there are almost continual suicide clusters in the region. Often referred to as the YK Delta, this area has one of the highest suicide rates (58.2 per 100,000) in the state and the country. The rate is nearly 3 times higher than Alaska as a whole (21.28)

and more than 5 times higher than the United States (11.38) (Alaska Bureau of Vital Statistics, 2002—2011; NCHS, 2011b).

The YK Tribal Health Region covers approximately 58,000 square miles and is home to 58 federally recognized Yup'ik, Cup'ik, and Athabascan tribes (Yukon-Kuskokwim Health Corporation [YKHC], n.d.). The region's 25,555 residents, 82 percent of whom are Alaska Native, live in 50 villages ranging in size from 6 to 1,100 residents (U.S. Census Bureau, 2012; YKHC, 2011 – 2014). All of the villages within the region are accessible only by small plane or by snow machine trails in winter. The town of Bethel serves as the regional hub community and is home to 6,080 residents (U.S. Census Bureau, 2012). Various air taxis provide regular, albeit expensive, service between Bethel and the villages. Round-trip tickets between Bethel and the villages cost between \$200 and \$700, depending on the distance (ERA Alaska, 2014).

Exhibit 5. Yukon-Kuskokwim Tribal Health Region



In the Yup'ik or Cup'ik communities impacted by continual suicide clusters, the region's main health care provider (YKHC) deploys a crisis response team of behavioral health providers. The team provides mental health counseling (including talking circles⁴) for families who lose loved ones to suicide, and debriefing and postvention services for first responders. YKHC and federal and state programs, including suicide prevention programs, have worked with the communities to develop prevention plans that engage youth and limit high-risk behaviors such as alcohol and drug use. Village schools take an active role in community response by increasing their emphasis on the social and emotional well-being of students. The schools positively acknowledge youth and implement the Natural Helpers peer-to-peer program.

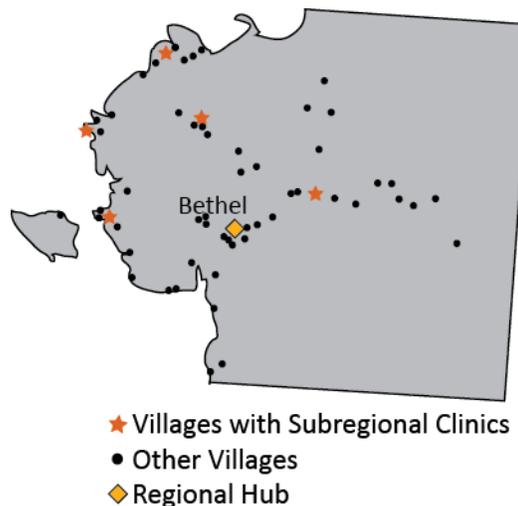
Village tribal councils respond to suicide clusters by calling community meetings to discuss the impact of suicide, its relation to historical trauma and to drug and alcohol use, and contemporary and traditional ways to heal. In direct response to the high numbers of suicide that affected the region in 2010, Alaska Senator Lisa Murkowski convened a summit, a joint effort involving the governor, members of the Alaska Suicide Prevention Council, the SAMHSA tribal affairs advisor, and members of the U.S. Senate Indian Affairs Committee. Summit participants discussed the high rates of suicide in western Alaska and heard from young people about ways to better address the problem (DeMarban, 2010).

The YKHC, located in the hub community of Bethel, is the regional tribal health consortium and main health care provider for the villages in the YK service area (Exhibit 6), provides hospital, dental, and

⁴ The *talking circle* is a traditional way for tribal people to solve problems. There is no beginning nor end in a circle; thus, no one person is in a position of prominence. The talking circle creates an environment where people can speak freely, air their differences, and resolve problems.

behavioral health care; health promotion and disease prevention; and environmental health services (YKHC, 2014). YKHC also provides basic health services within the villages, through clinics staffed by Community Health Aides (CHAs). These local individuals are the frontline of medical care and support within their villages. CHAs are certified at the CHA I, II, III and Practitioner (CHAP) levels and are selected by their communities to receive training for their roles. For each level, the training lasts approximately 3 weeks (Alaska CHAP, n.d.). CHAs operate in an established referral relationship with mid-level providers, physicians, and the regional hospitals (Alaska CHAP, n.d.). Within the YK Delta, there are also five subregional clinics, each of which serves the villages within its subregion. Subregional clinics offer a higher level of service than the village clinics and include preventative and urgent care, as well as laboratory and X-ray services. The subregional clinics are staffed with at least one mid-level provider, typically a nurse practitioner or physician assistant. Subregional clinics provide ancillary services (e.g., dental, behavioral health), often in the form of traveling care to the handful of villages in their sub-region. Comprehensive mental health and substance use services (including inpatient and outpatient services) are available at the YKHC in Bethel. However, access to comprehensive behavioral health services requires leaving the village via bush plane.

Exhibit 6. Yukon-Kuskokwim Service Area



To increase access to mental health services in villages, in 2004 the Alaska Native Tribal Health Consortium (ANTHC) collaborated with IHS to institute a statewide behavioral health workforce model that was similar to the CHA. By 2008, the Behavioral Health Aide (BHA) program had been incorporated into the federally recognized Community Health Aide Program. The existing Community Health Aide Certification Board Standards and Procedures were amended to include standards for Behavioral Health Aides (BHA I, II, III and Behavioral Health Practitioner (BHP) certification and practice (ANTHC, 2005–2014). Like CHA/Ps, BHA/Ps’s have a limited scope of practice and serve as health educators and advocates within their communities (ANTHC, 2005–2014; van Hecke, 2012). Practicing under the supervision of licensed clinicians based in the regional hubs, BHAs I, II and III provide case management, referral, community education, and prevention services; BHPs also provide treatment planning and community evaluations (van Hecke, 2012).

While every western Alaska village does not have a BHA program, those that do select residents of their own village, fluent in the culture of the community, who is a welcoming and familiar face. However, given the close-knit nature of the communities, concerns about confidentiality and shame about behavioral health may limit service utilization. Community members are often reluctant to seek care from individuals they have known, in many cases, their entire lives (van Hecke, 2012).

Available in some villages for 10 years, telebehavioral health is an alternative venue for receiving care and may help allay privacy concerns. But even with the addition of the BHA program and access to telebehavioral health, access to behavioral health care is extremely limited and simply out of reach for many Alaska Natives.

SOURCES OF INFORMATION

SAMHSA and the authors (federal contractors) of this report selected communities based on clusters reported within the past 5 years. The authors then engaged the communities to discuss the purpose of the study, answer questions, and determine their interest in participating. When a community expressed its interest, the authors met with the tribal council or village leadership and signed a Memorandum of understanding (MOUs) between the tribe/village and the federal contractor. The contractor sought and obtained institutional review board approval for all procedures used in this study.

This report is informed by multiple sources, including qualitative data collection, review and analysis of existing data (YRBS, BRFSS, NVDRS), and archival records. The contractor recruited nine community members from the tribe and Alaska villages to participate in individual telephone interviews, securing informed consent before the interviews. Interviews were conducted between June 2013 and February 2014, and recorded, transcribed, and analyzed using statistical software. The contractor also reviewed and analyzed archival records, including testimony; meeting minutes from community and legislative meetings; newspaper and media sources; and other documents and e-mails.

While the individuals that participated in the interviews are diverse in terms of age, gender, role in the community, and level of involvement in suicide prevention work in the community, the sample was not intended to be representative of the village or tribe perspective. Rather, a range of information was gathered to understand and inform prevention and response to suicide clusters from direct experiences and unique cultural and tribal/village contexts. In addition, the sample sizes across the settings are not even (i.e., more interviews took place with village members in Alaska than with New Mexico tribal members).

FINDINGS

Based on the interviews and other data sources, this section presents findings related to the impact of suicide clusters on the community, and existing and needed suicide prevention resources (both community-based and external). The summary includes recommendations from community members on factors that hindered or facilitated suicide prevention and response to suicide clusters.

Effect of Suicide Clusters on the Community

In both the tribe and village settings, relationships in the communities are close—individuals know their neighbors, and in many cases they are related. As one respondent described, *“Our community is one big family.”* Thus, the effect of the suicide clusters and suicide attempts was pervasive and personal. The impact was reflected in participants’ stories, in their reactions to the repeated suicides and attempts, in

their description of the contagion, and in the ways that the community response was remarkably unified and healing.

All respondents indicated that they, along with others in the community, were deeply and personally impacted by the suicides, attempts, and “near misses”—suicide attempts and potential suicides narrowly averted. In addition to the recent clusters, some recalled earlier times when suicides occurred with shocking frequency. One respondent recalled, “Back in the ‘90s, I was a VPSO [first responder] in my village, and we had a suicide a week for a long time, over a year or for some months.”⁵ Respondents also described the acute and cumulative pain caused by experiencing and responding to multiple suicides in the community over the years. One respondent recalled,

“We used to go to Anchorage ... and douse ourselves with booze for one and try to forget everything because we’ve handled too many bodies. We’d clean and wash off the blood (accumulated) over the years.”

In western Alaska, some described a rhythm of life interrupted with regular emergencies related to imminent suicide attempts. A respondent recalled one occasion: “A young lady called me, she was about to hang herself. So I ran to her house and spoke with her at length, great length.” He went on to say,

“My wife was running superfast towards her sister’s house, my sister’s house. And I called my folks. I was like what’s going on? And one of my nephews is locked in his room screaming, screaming, screaming....I called my sister right away and they were crying so hard....I thought my nephew was dead.”

Community responses reflected the frequency of deaths by suicide, the enduring pain these events have caused, the lack of healing experienced by the community, and the way in which the threat of additional suicides or attempts lingers in the community—infecting into everyday life elements of psychic pain and hyper-vigilance.

Since many community members help others during a response to suicide clusters, many experience “burnout” and exhaustion from constantly being in a state of emergency: “We had a suicide a week for a long time, over a year or for some months.... We didn’t have [any] debriefing ... sometimes I feel like I need a little break, but then I go forth again.”

Respondents consistently described or referenced the contagion effect—the transmission of suicidal thoughts and behaviors from one victim to another—in describing that a suicide in one community

⁵ VPSO is the acronym for Village Public Safety Officer. VPSOs are trained and employed by the Alaska State Troopers. They are local, village residents who serve as first responders to village public emergencies such as fires, search and rescues, emergency medical assistance, basic law enforcement and community public safety and crime prevention (Alaska State Troopers, n.d.).

seemed to trigger additional suicides either within the same community or, in the case of western Alaska, in neighboring villages. Related observations included:

“It’s a small community, everyone knows each other. When suicide happens in the community, it happens sequentially, like in sequence. (The suicide) will make other really close family and friends feel really depressed and down.”

Consistent with the “circles of vulnerability” model discussed in the Background section of this report, one respondent illustrates how degree of psychosocial proximity to someone who has died by suicide can influence the degree of risk for individual community members, contributing to contagion:

“But, the closer the relatives or the friends of the individuals that have taken their own life... the level of the impact is higher than the ones that are not related. So, the risk is there for those that are closer to the family, especially the friends of the young person.”

Community members described being impacted by and responding to suicide clusters in remarkably similar ways, more as a unified group than as individuals or particular sectors of the community. Villagers noted that the community experiences a collective depression when it loses a young person to suicide. Noted one village member, *“Since we are close knitted, everyone is basically related to everybody closely or relatives or good friends. It really puts the morale down very much.”* Another said, *“People that are ‘suiciding’ are people that we grew up with...and when that happens, it really makes the whole community like dark and like sad.”* Reflecting on the trauma of past suicides, the ongoing pain of suicides and attempts, and the feeling of shared sorrow with other villages, one respondent said,

“That’s a hard thing to see when someone loses their loved one, especially through suicide. And that really affects each community because we’ve gone through so much these past years and it seems like it’s still going. And that hurts me when I hear other villages going through the same effects we have in this village.”

At the same time, a notable community strength (described further in Community-Based Resources) is that community members—within and across villages, in the case of western Alaska—collaborate in unity to support those who are closest to the youth who died by suicide. The support that community members provide for one another, often connected by shared spirituality and culture, promotes healing. One person described how community members gather with the family who lost a young person, *“talking to one another, supporting each other, comforting and during those gatherings, you have gospel singing and sometimes stories will come up of memories (of) that person. In most cases, it’s really good ... when everybody comes together and comforts one another.”* Another respondent described that villages reach out and support other villages, because community members across these villages can relate to the pain and trauma that the suicides cause.

“When a suicide occurs, I know there’s lots of support going on from our village because we know how it feels when there’s effective support for each other, like

a support system, which is good to see because that's what we do, deal with the family support and see what we can do to help and just be a support system to them."

Community Perspectives on Resources for Suicide Cluster Prevention and Crisis Response

Community members provided their perspectives about the resources critical for strengthening suicide prevention and response to suicide clusters. They also identified important resources provided from outside of their community.

Community-Based Resources (Crisis Response)

Community-based resources for crisis response range from the formal (e.g., the tribe, behavioral health services, school policies, VPSOs) to the social or cultural (e.g., elders, families, natural healers, community members), with similarities and differences across the tribe and village communities.

Formal Community Structures

Among the western Alaska communities, some have one of the villages has a subregional clinic, which gives access to a higher level of health and behavioral health care services than are available in most villages or community health aide clinics. One respondent noted, *"There's a lot of help available here at the village. We're one of the luckier villages in that aspect of getting help."* He continued, *"We have our regional clinic here and there's medical personnel, mental health personnel, two VPSOs and a police force for our village that is open 24/7, 365 days a year. And I know that's a big plus for any village."* This compares with other villages that have a single VPSO and no police, and one village that relies solely on outside resources for behavioral health services.

Schools and tribal councils take an active role in their communities, including in times of crisis. Referencing a recent incident in which a young person wrote a suicide note, one community member explained how coordination between agencies occurs:

"The school was concerned, our tribal council was concerned, and they acted on it right away.... They talked with the young individual, started different things that he can do here in the community, talked with the parents, made sure

Community-based Resources

Formal Community Structures

- Tribal council and declarations of emergency
- Schools
- Behavioral health resources
- VPSOs and first responders

Cultural/Social Resources

- Elders, traditional teachings
- Local clergy and faith community
- Community members, particularly from the schools
- Tribal medicine, natural healers
- Community gatherings

everybody was involved, so that's what they did with the last suicide note. And we've been watching the young boy for the past few weeks and just there's been a good turnaround the past few weeks."

Further, tribal councils may provide immediate financial support to families in the event of a suicide to assist with practical matters, such as funeral expenses.

"They [the tribal council] provide big support, especially with the people, family members who live out of town; they pay their fares roundtrip from where they are, be it lower 48 or around Anchorage or what have you, the other surrounding village. And they help pay for caskets and give money for food also. So it's a tremendous support financially."

Tribal courts, with a holistic approach to problems and emphasis on restorative justice⁶, also serve as an indirect formal resource for suicide prevention and response. The courts handle cases dealing with child protection, juvenile delinquency, and domestic violence, and are therefore well-positioned to work on restoring balance and harmony within family and community. Interviewees considered tribal courts to be valuable local resources in addressing the suicide crisis in Alaska. A community member noted, *"The type of services that we provide are through our Indian Child Welfare Act through our tribal court. We have three judges that meet with family member and meet with different problem areas here in the community."*

Cultural/Social Resources

In addition to the services provided by formal agencies, each community relies on a wealth of social and cultural resources such as guidance from elders for culturally rooted approaches to addressing grief, natural healers and traditional medicine, and formal or informal community gatherings. At such gatherings, community members congregate, share stories, sing gospel songs, and draw on a shared sense of spirituality and cultural history in attempting to overcome crises and impact of the suicides and suicide clusters. A community member explained,

"The purpose of the elders is to address to the community ... because when it comes to loss, again, some of the family would not have the interest in doing what they usually do. So it's to advise the community as well as the family members in the community how they should deal with their grief culturally."

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

⁶ Restorative justice is an approach to justice that emphasizes repair of harm done by offenders through reconciliation with victims and/or the community at large. The purpose of the restorative justice approach is to restore balance in individuals and communities primarily for harm done through drug and alcohol use as well as minor criminal offenses (Drug Courts Program Office, 1999).

on wisdom and traditions—information that has allowed the villages to survive and thrive in the face of a harsh environment and threats from outsiders of cultural extinction and assimilation. For example, Elders' Councils serve the community, in part by establishing mechanisms and programs for cultural transmission. Recounting the role of elders in informing community projects, one community member explained,

“There are some teachings that are brought down orally by the elders of how the community members should help themselves.... They’re given the principles that are brought down from the elders from the past. Everything is brought down orally and traditional. It’s like cultural evidence-based teachings that promote wellness to the communities.”

The influence of elders carries into the community setting as communities consciously integrate culture into everyday activities (e.g., school, work, and play). Interview participants describe the close-knit feel of their small, rural communities as key community assets that include sincere mutual care and concern for others; shared purpose; and an active spirit of cooperation in addressing common interests and healing the community, particularly in times of crisis. One respondent stated, *“I think in terms of these social issues and the way that we’ve handled suicides in the past, community members are always involved.”* Across the board, many respondents expressed similar sentiments. One community member described,

“In the event of emergencies, our village rises to the occasion. The people here are so strong, so supportive. Over the years when kids committed suicide ... the whole community and the people who are in need, they bring food day after day after day.... We have a custom here in our village to view a body for 3 days, and in the meantime during that 3 days, people from the whole village are consistently continuously present with the family 24 hours a day for those 3 days until the burial.”

Community members also described that individuals skilled in traditional medicine and natural healers are an important community resource who are often actively engaged during a suicide crisis. In addition, prior to declaring a state of emergency in the New Mexico tribe, key community members who coordinated to aid the local community included local clergy providing community services for those in need, and community members from the schools to promote messages with a suicide prevention lens. For example, they attempted to minimize the contagion by explaining how information about the manner of death could increase risk and contagion. Faith leaders also encouraged community members to reach out for help if they needed support.

Community Perspectives on Community Connectedness

“Families look out for one another. People look out for one another. I think we’re a strong people.”

“Our village has been through so much, yet here we are still moving forth.”

Spirituality provides a way to process and heal from life’s traumas individually and in communion with others. One participant explained how spirituality often manifests in his community: *“Spirituality is one of the things that are valued in the village system.... Everybody is invited to share a song and people with talents and the ability to*

play music for the people that have the desire to share their songs. I believe people expressing their feelings through songs is some of the way of spiritual healing.”

At the societal level, traditional culture also serves to ground individuals and provide a framework to view their place in the world. As one community member stated, *“Young people need to know who they are, have a knowledge of where their ancestors came from, to be proud of who they are.”* Communities are actively taking steps to connect youth to culture because they understand the protective effects of connection that are enabled by culture and traditional practice. One respondent explained his community’s process as *“using evidence-based interventions, cultural-based interventions, like having elders involved and share stories of how they used to deal with crisis situations in the past before our generation.”*

Community-Based Resources (Prevention)

Community members discussed direct and indirect suicide prevention activities. Prevention activities range from the cultural (culture camps, elder/youth connections) to community and youth gatherings, to formal school programs (e.g., the national peer-to-peer Natural Helpers program) and school-based presentations on suicide signs and risk factors. A common aim across these resources and programs is to strengthen protective factors across the social ecology by connecting youth and community, deepening youth knowledge and practice of traditional culture, and developing and promoting prosocial adult and peer mentors and role models.

In the western Alaska community, culture camps are a key component of each of the communities’ suicide prevention strategies. In culture camps, youth learn traditional skills and interact intensively with elders and other knowledge-bearers in order to ground youth in thousands of years of place-based knowledge. Community members described camp activities that include survival camping in the tundra, beading, harpoon making, and nature walks. The camps are timed with seasonal subsistence activities, and for some youth, are the first exposure and experience with their traditional lifeways. As one community member said, *“We have had multiple cultural camps here in the community at the school level, and also at our [tribal council] level. The last one that we did was last year fall time and I think [had] six or seven—no, six or eight young individuals who had never gone to cultural camp [before] and they had a very good time.”* Another said,

“I guess what actually the community has been trying to do is reestablish the community back to their traditional evidence-based teachings and outreach activities and having the youth be connected with the community tribal members.”

Among existing resources for suicide prevention are frequent presentations in schools on suicide risk factors and warning signs, and the Natural Helpers program. Describing an approach to presenting, one respondent said, *“This past month, we met in groups, a bunch of [youth]—I talked therapy to them about suicide. I made a lesson plan yesterday, and ... it talks about the way [that] there’s no single problem in the entire universe [that warrants dying by] suicide.”* In the New Mexico community, sources described an increase in school surveys, assessments, and screenings as a result of the Natural Helpers

program. In addition, new school policies were developed to implement suicide prevention and response protocols.

In the Alaska villages, community gatherings and youth centers—where available—provide another venue for positive youth connection with community and caring adults. Describing the impact of community gatherings, one respondent stated *“Community gathering is what I have been focusing on because it is a lesson that can be used as a tool to connect elders, youth, family, leaders [in] the community, resource members together to implement empowerment for the spiritual wellness of the community.”* Youth centers in two of the villages are venues for positive social interaction and activities for youth. One villager described, *“[The] youth center has people working on weekends to try and motivate the young people from getting into alcohol and drugs by giving them healthy activities on Fridays and those are some of the things that they have set up in regards to prevention.”*

Amidst all of the efforts of these communities to positively engage youth and reconnect to *Yuuyaraq*, the traditional way of life known in Alaska, participants understand that suicide prevention does not happen overnight. As one community member noted, prevention takes time and effort: *“And it takes effort for a tribe to bring back—have [youth] regain back their core values.”*

In the New Mexico tribe, sources also suggested that formal tribal action that promotes the development of suicide prevention resources and programs has been a critical support. A source suggested, *“The tribal administration finally understands that our community-based services are not connecting in a vital way to meeting the challenges of children and youth with serious mental health needs and their families.”*

External Resources

In addition to the local resources, both communities receive outside help in responding to and preventing suicide. In the Alaska setting, the community received help from other villages, regional corporations based in Bethel (e.g., YKHC), and even, at times, from the “lower 48” (the contiguous United States, as it is referred to in Alaska). This outside support often takes the form of agency provision of behavioral health services, and mission trips from visiting churches to engage youth or (re)build local infrastructure.

In the New Mexico community, after the administration declared a state of emergency, outside help included deploying mental health service providers and other crisis workers from IHS. Crisis workers were available in the school and the community at large. In addition, individuals from a large, urban university came to the community to provide counseling, crisis services, and postvention services for the community in general and for the student population.

In western Alaska, because villages are small and relatively close together, the region itself takes on a community feel. Thus, when one of the villages experiences a crisis, community members from other villages step forward to assist the affected community and family. One community member explained, *“The villages are so small that we know most of each other. So when a community is going through a crisis, the other communities will come over and just be a support of that family.”*

In the Alaska villages, the regional health corporation, YKHC, located in Bethel, provides on-call crisis support in the form of debriefing teams that fly into communities following a violent death or trauma (e.g., suicide or homicide). When such an event occurs, the community notifies the YKHC Behavioral Health Department, which mobilizes a crisis response team. One respondent noted,

“[The] debriefing that YK[HC] provides, that really made a big difference when a lot of other people want to help total strangers, even organizations like YK[HC], that’s such a tremendous support for villages and for individual families or individuals.”

In addition to providing postvention or intervention after a suicide, YKHC supervises the local BHAs and has a team of itinerant behavioral health clinicians who travel monthly or bimonthly to the villages for 1–2 days at a time. As the BHAs are limited in scope, the itinerant clinicians help to round out the behavioral health services available within the village. One respondent described an increase in village behavioral health services provision as a result of assistance from the YKHC: *“YKHC has provided a whole bunch of behavioral health services after, I think, 2007 and they’re getting more people involved in trying to get behavior-type issues understood.”*

Mission trips from visiting churches can also be forms of external support. Mission trips are regarded as a suicide prevention resource because of the positive engagement they provide, particularly for young people. One participant cited an ongoing relationship his community has had with a church group from “the lower 48.” For the past several years, the church sent a group of members to the village during the summer to support youth service projects and to provide positive activities and engagement for youth. This participant describes, *“they were here working with a whole bunch of kids, giving them a whole bunch of activities to work on.”*

As valued as all of these external resources are, several respondents in western Alaska voiced concern over the limitations and lasting impact of temporary help coming in from the outside. Noted one community member,

“Once they leave, even though they came, it needs to be the community that can work together as a community alone. Because they’ll just come in and help us, but that’s where it begins that the community needs to understand that they need to work together as a team to help each other out.”

Barriers and Facilitators to Suicide Cluster Prevention and Response

Community members reflected on the factors that hindered or facilitated suicide cluster prevention and response efforts in their own communities. Respondents reported leadership, capacity (e.g., human capital, funding, and services), and implementation challenges affecting community-level prevention and response/recovery efforts. Respondents also identified shifts in perceived self-sufficiency and social norms (e.g. increased role of elders, decreased individual complacency) to explain the community’s response to suicide.

Barriers

Respondents identified the following barriers to suicide prevention:

- **Lack of a standardized or community-based reporting and surveillance system.** Such a system is needed to help communities understand the nature of suicide clusters and how to best address the problem.
- **Lack of coordination across grant and tribal programs.** Lack of coordination results in missed opportunities to streamline and maximize the impact of services, resources and programs. One source noted, *“There were definitely a lot of service issues in terms of which community programs wanted to provide which services to different populations ... it seems like there was a competitiveness in terms of who wanted to provide services to whom, and nobody knew how each program should go about doing that.”*
- **Access to appropriate evidence-based services.** Evidence-based suicide prevention services for tribal populations are limited. One community member explained that, while adaptation may often be necessary across tribes, the tendency to encourage a “tribal adaptation” that can be applied to all AI/AN populations is inappropriate. Fidelity to the evidence-based program may be lost as each community makes their own adaptations, and a “one-size fits all” approach cannot account for the unique factors that distinguish one tribal community from another (Wexler & Gone, 2012).
- **The role of the media and media messaging.** Lack of coordination on media messaging during the suicide cluster in the New Mexico resulted in inaccurate reporting about the event. In addition, media sources released graphic details about the deaths and *“were reporting these numbers about the devastating life conditions on the reservation, the negative lifestyles that were taking place”* said one community member. Community members believed this to be irresponsible. Eventually, community members reached out to news outlets (television stations and newspaper/print journalists) and invited them into the community to correct inaccurate reporting, as well as to discuss the type of information that needed to be withheld from the public.
- **Ongoing shame.** Shame around seeking behavioral health resources, or even discussing suicide and prevention approaches, is pervasive in these communities. Nearly every respondent identified ongoing embarrassment, fear, and shame as an impediment to accessing behavioral health resources. One respondent noted,

Community-Level Barriers

- *Limited human capital, funding, and services*
- *Need for surveillance*
- *Lack of coordination*
- *Lack of an evidence-base for suicide cluster prevention in tribal populations*
- *Role of the media during a suicide cluster*

Community Perspectives on Shame and Suicide Prevention

“It’s like the word suicide is poisonous or something.”

“Most youth won’t go to the mental health clinic. The stigma and shame keeps people away.”

“Nobody just wants to talk about it; they just want to ignore it and hide it and not talk about it.” In one community, some suggested that shame is rooted in a *“culture of silence”* on the topics of death and dying that ultimately contributes to lives lost. One community member suggested that youth experience a combined sense of hopelessness and shame that prevents them from seeking behavioral health care: *“they feel so hopeless, there’s no hopeThere’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.”*

- **Lack of existing behavioral health services and funding.** Even when an individual overcomes shame and self-identifies as “at risk,” the available services in rural communities are often insufficient. Inadequate capacity in the form of funding, human capital, and service availability impedes suicide prevention and response/recovery efforts. In the New Mexico community, there is a mental health clinic with one full-time psychologist to provide mental health services to thousands of youth and adults. Insufficient funding for services was also identified as a barrier. One community member reported, *“To provide services, it takes either volunteer work or somebody that wants to help the community but they want compensation.”* Even when communities request assistance from outside, it costs time, effort, and money. As one villager explained, *“Trying to get others to see what the community is going through, they have to go out and travel, talk with others, provide capacity building training. If you want services to come out here, you have to provide travel for them to come out. You have to give them a place to stay.”* Respondents reported a lack of behavioral health and law enforcement personnel trained in suicide prevention or as gatekeepers. One of the villagers in a community without a subregional-level clinic, shared, *“We haven’t had a behavioral health worker for a while.”*
- **Lack of sustained interest and engagement in suicide prevention as a priority.** Community members described that turnover in tribal leadership often meant the end of suicide prevention efforts that were no longer considered to be a priority. In western Alaska, respondents saw current village leadership as a hindrance to prevention, and response and recovery efforts. A member of one community explained that tribal leadership was too reactive. Whereas leaders provided support during a crisis, they did not anticipate needs, plan, or implement upstream approaches to prevention. An upstream approach, which typically involves collaborative assessment, planning, and implementation, would address the underlying roots of problems, often by providing opportunities for cultural learning and connectedness. Some suggested that some leaders engaged in self-destructive behaviors resulting in high turnover in the tribal administrator position. According to one community member, the lack of leadership has been a problem in one community for, *“give or take about the past 10 years.”* In different tribal communities, lack of leadership can be both literal (i.e., vacancies in tribal administration due to turnover) and figurative (i.e., lack of greater commitment by tribal leaders related to suicide as a priority).

Community Perspective on Grants

The shelf life for grants are pretty low. You only have a handful of years to make an impactful change. And it’s hard to really do that, especially in communities where maybe their readiness level just are not—they still need to be built up.

Sources noted that once funding for a suicide prevention grant ends, the people involved in any given program seek out new sources of employment: “[They think] ‘We’ve done it, the money is gone, let’s move on to something else that we can get employment with.’” One source explained that having a grant is no assurance that a tribe will make suicide prevention a priority. Priorities change with tribal elections and the ebb and flow of grants: “The grant is gone, the people are gone, the people that were trained are gone, and let’s move on to something else.” Fowler and colleagues noted similar barriers in their epidemiological investigation of a youth suicide cluster in Delaware (2013).

Facilitators

Community members identified factors that facilitate the prevention of and response to suicide clusters: familiarity and closeness between families and villages and culturally congruent and positive messaging. Related to messaging, one person shared, “All of our families want to hear something positive when we’re feeling down and out and depressed [during a suicide cluster event].”

To facilitate response/recovery efforts (and echoing CDC’s recommendations), respondents described the importance of coordination among local entities (e.g., regional health clinics, VPSOs, and community members) and having substance use and mental health services available in the community. When describing the benefits of coordination, one respondent shared, “YKHC has provided behavioral health services after 2007 and they’re getting more people involved.” Another respondent described the advice he received: “We should not keep this big issue to ourselves, but try to get more people involved at the regional and state level.”

Respondents reflected on their communities’ growth as a result of responding to and recovering from suicides. In doing so, they identified spirituality as a key asset in the recovery process. One respondent described gatherings after a suicide: “They have meetings at their personal house ... to try to help our community in times of tragic moments, like suicides. They do it spiritually by singing.... The group gets bigger and bigger, so the gathering [is accepted] and I don’t see anything wrong with that.” Another respondent described: “I’ve noticed our community has grown a lot more spiritually.”

Facilitators of Suicide Cluster Prevention and Response/Recovery

- Familiarity and closeness between families and villages
- Culturally congruent and positive messaging
- Coordination between local, regional, and state-based health service providers
- Availability of subregional behavioral and mental health services
- Increased communication about suicide
- Coordination between community-based and external prevention programs
- Availability of cultural activities
- Support from the tribal council

In the New Mexico community, one of the most significant facilitators spurring recovery was the willingness of the tribal council to declare a state of emergency to secure needed resources for the community. The tribal council also sent leaders to every department head to ensure presence and representation at tribal meetings where the suicide cluster was discussed.

Respondents identified (1) increased communication about suicide and (2) increased willingness to talk about personal problems in general, as characteristics that strengthen suicide prevention efforts. One community member reflected, *“The biggest help is getting the message out.”* Communication is still a major problem, yet respondents note that there have been inroads. One respondent commented, *“You think Eskimos don’t talk about their problems a lot, but in these few years things are starting to change, people are starting to talk more.”*

Respondents described the importance of integrating cultural activities into the village life to keep youth engaged and to spread suicide prevention messages. Examples of such activities included beading, making harpoons, making parkas and mukluks (fur boots), picking berries, going on camping trips, and taking nature walks. These activities served as an opportunity for community members and youth to talk about suicide as well as reestablish ties to cultural traditions. One community member reflected, *“There was a suicide in August and that was about the time that they were having the annual tundra festival.... They brought up the subject of suicide during the festival, which was good.”* Community members from surrounding villages attended some of the larger events, thereby increasing the potential to spread suicide prevention messages.

With the recognition that schools are an ideal setting for reaching youth, the communities have worked with the schools to formally integrate cultural programming, including Native language classes, Native studies, and traditional arts and crafts, into the school curriculum.

One community identified law enforcement as a potential resource and facilitator of prevention. As the first responders to every attempt and death by suicide, officers have a wealth of service/call data on factors that can inform prevention. One respondent noted, *“They record tons of information about the actual event itself. So they have a lot of really rich event level data in terms of say, demographic information.”* They added that law enforcement knows whether drugs or alcohol were involved and they collect historical information from family members. This information could be used to identify patterns in ideation, attempts, and deaths by suicide, to better identify at-risk youth and families.

Community Recommendations to Enhance Suicide Cluster Prevention and Response

Recommendations to enhance suicide cluster prevention and response are summarized below.

Prioritize Collaborative and Culturally-based Suicide Prevention Efforts

Prioritizing suicide prevention and related activities was a strong theme across communities. Community members suggested that progress related to suicide prevention—such as the degree of

community emphasis and awareness about risk factors for suicide—seemed to ebb and flow based on the funding for prevention programs and current tribal leadership priorities. While advocating that suicide prevention should be a consistent priority within the tribal leadership, one source noted,

“We need more leadership activities to inspire youth to change their life course. Sometimes I think our community forgets that a tribe’s legacy rests in its children and not in how well tribal enterprises operate.”

Participants suggested that there is a critical need to educate community members about the risks for suicide and to build awareness of programs and resources for suicide prevention. Community members reflected that education and awareness building are important to address the shame surrounding suicide that prevents help-seeking. One person said, *“It’s time to break the silence and totally bust that taboo. That’s my firm belief. And educate young kids, youth, and young adults.”*

Community members underscored the importance of involving youth in prevention efforts. One community member who attended a statewide youth leadership summit in Anchorage with a young person from her community suggested that young people need many more such opportunities, so that they could *“get ideas on how to use their thinking caps.”* Others stressed the importance of involving youth in prevention planning. A villager noted, *“If they would involve the youth Natural Helpers and student council, if they would invite that group to the meeting, I think it would be helpful because those youth would help bring out the awareness to the other students.”* Another described the value of involving youth, *“[This is] the first time that the community actually asked the youth. I think this is going to go a long way.”* Another respondent described an approach to conducting suicide prevention presentations for youth:

“I tried to go through every scenario I could [as to] why kids committed suicide over the years, the ones that stood out and why kids might have done this...[I] reiterate to the kids if they see their family or friends in suicidal mode, not to leave them and seek further help and not to feel like a tattletale about asking for more help ... I ask them to look out for one another and not feel like a tattletale if their family or friend is feeling suicidal.”

More generally, several respondents voiced a need for community members to come together and work cooperatively for the benefit of the youth. As one respondent said, *“Community leaders and the elders are needed to come together to assist and help the young people so that suicide can be prevented.”* For some, this involves strengthening leadership and communication channels. As one community member said, *“We need more rich leadership involvement and communications, everybody communicating more.”* Another, too, saw the need for leadership to step up: *“I guess it’s the policymakers that have to do their part in trying to help, also assist in solving the problems in the community, along with the resources that are available that are willing to help as a whole.”* In part, this was seen as an issue of tribal self-determination: *“The community must come together and acknowledge their capabilities and strengths to solve problems relating to some things that need to be addressed, like violence.”* Village respondents had clear recommendations about which community members should come together and be involved in communitywide planning for suicide cluster prevention and response. One person

suggested, *“We would need our tribal council, our school, public safety, and our communities, I think that that’s all we need to make our suicide prevention plan, and it would work fine that way with lots of communication with each other.”*

Community members repeatedly emphasized the importance of ensuring that suicide prevention programs be developed and implemented with a clear understanding of the specific cultural context of a given tribal community. For example, one participant noted, *“The construct of death and dying [is] really different in Native communities versus mainstream.”* Another source from the same community noted that his community did not speak of death and dying and, thus, effort must be made to collaborate with and engage tribal leadership and elders in developing suicide prevention approaches that could be successful in this cultural context.

Increase Access to Behavioral Health Services

Community members advocated for expanded access to behavioral health services, including increasing the availability of behavioral health workers, programs, and services, and building awareness of such programs. One respondent explained, *“We need to be identifying where [youth] can go, [who youth] can talk to ... or just go to a place where you can talk to [someone] who you trust can be helpful or a benefit for you for calming yourself.”* In the villages, some suggested that the solution may be to ensure that there is a BHA in every village. Overall, participants provided mixed responses regarding whether the BHA needs to be someone who is a community member. While some suggested this was not necessary, others suggested that it is critical for behavioral health services to be provided with a clear understanding of community values and culture; thus, it would be useful and important for the BHA to continue to be someone in the community. The challenge, one respondent said, is that confidentiality can be hard to maintain:

“It doesn’t have to be someone we know because some people are—I don’t know how to come up for a word for it, but they don’t really trust that worker and they don’t want to go over to them and talk to them because they know them, you know what I mean?”

In the tribal community, participants suggested that having more full-time behavioral health in the schools and community would promote suicide prevention as a priority. One source noted that greater awareness and cooperation is needed, and recommended *“helping the mental health clinic become fully staffed, getting faster hiring approval for these clinicians, and ensuring faster Medicaid approval for persons referred to residential treatment centers.”*

Develop Community Youth Centers

In the western Alaska community only, participants indicated the need for an indoor central gathering space or hall where youth and community members could meet and hold events or organize activities. Indoor space for such

Respondent Recommendations

- *Prioritize collaborative, culturally-based suicide prevention*
- *Improve behavioral health services*
- *Develop community youth centers*
- *Improve surveillance*

activities, especially highly valued during the long winter months, is severely limited across communities. For example, in one community, youth activities that are not school-related are usually organized in the community's laundromat, a cramped and crowded space ill-suited for youth events. One respondent explained,

“If the community had a community hall where we could hold the suicide prevention gatherings, everything would be much more accessible and reasonable, just because especially during the long winter days...the community tends to get bored and because there’s not really any other things to do.... There’s just nothing to do for youth unless school starts and you go to school.”

Improve Surveillance

Some community members suggested the adoption of mandatory surveillance or tracking systems to help the community understand the nature of the problem and how to best address the problem. The White Mountain Apache surveillance system—a nationally recognized surveillance system—was identified by a New Mexico tribe community member as a model to be emulated. The White Mountain Apache Tribe implemented a community-based Suicide and Self-injury Reporting System. The tribe mandates reporting of all known incidence of suicide ideations or attempts or deaths by suicide as well as other intentional self-injury (e.g., cutting) and life-threatening incidences involving drug or alcohol intoxication (IHS, 2013). This community member went on to explain that, while some community members have advocated for this type of surveillance system, no formal system has been instituted or supported by the tribal council.

DISCUSSION

The tragedy of youth suicide and youth suicide clusters in indigenous communities continues to be a critical public health issue, adding new layers of trauma in communities already living with the impact of historical trauma. Information gathered in this report sheds some light on barriers and facilitators to prevention, needed resources, and strength-based approaches to prevention, response, and recovery. Based on information guiding this report, the key barriers to progress in these communities include the following.

Insufficient Community and Clinical Behavioral Health Resources

Numerous suicide prevention programs have been implemented across tribal communities. In September 2012, 10 of 23 grants awarded by the U.S. Federal Government to prevent youth suicides were awarded to NA/AN tribes or organizations (Woodward, 2012). Such programs reach only a small proportion of the communities that could benefit from their assistance. Interview participants recognize that there have been inroads in addressing the problem of youth suicide clusters and many suicide prevention programs have been useful to communities. However, these stakeholders suggest that progress has been insufficient to address the magnitude and complexity of the problem or yield sustainable, lasting change. Interview participants note 2–3 years is not long enough to establish

sustainable change. Examples of lasting change may include change in community readiness to address the problem of suicide; change in capacity or ability to identify and refer a youth for suicide; more services or infrastructure to respond to youth in crisis; or expansion of telebehavioral health capabilities (e.g., phone and internet capabilities).

In addition, many suggest that IHS is chronically underfunded (Dorgan, 2010; USET, 2014), resulting in a host of health care delivery problems. These include vacancies in behavioral health care provider positions; insufficient behavioral health care specialists; referrals for services great distances off reservations or out of villages that are often costly; and complicated regional office administrative structures that may inhibit creative solutions (e.g., Belluck, 2009; Dorgan, 2010; Young, 2010). Some suggest that the combined effect is “full-scale rationing of critical health services, including mental health care services” (Dorgan, 2010, p. 215) in AI/AN communities. Community members attest to the significant issue of access and adequacy of health care, particularly in rural or remote tribal communities. Such communities are often based hundreds of miles from an urban area, making adequate care and outreach to Native youth problematic. These divides can also make it difficult to recruit sufficient behavioral health support staff. Finally, emergency health services, such as those needed to respond to suicide attempts, suicide clusters, or other violent deaths, can be especially difficult. Transportation to and from rural areas can be challenging because of weather or terrain and expensive because of distance—both conditions making timely emergency health services uncertain.

Insufficient Cultural Tailoring in Suicide Prevention

Some suggest that widely used approaches to suicide prevention may not appropriately or sufficiently reflect an understanding that *“suicide in indigenous communities is frequently identified as the terminal outcome of historical oppression, current injustice, and ongoing social suffering”* (Wexler & Gone, 2012, p. 801). According to a literature review by the Research Prioritization Task Force of the National Action Alliance for Suicide Prevention, models of suicidal behavior have evolved over the past 25 years, but many are psychologically based and assume some type of cognitive dysfunction in the suicidal process (Action Alliance, 2014). Some tribal experts suggest that the assumption of cognitive dysfunction as the primary symptom for suicide prevention efforts is flawed. The assumption is culturally incongruent for indigenous communities, in which suicide may be more appropriately framed as a way of expressing social distress and despair (Wexler & Gone, 2012). In addition, localized responses to youth in crisis are needed to ensure culturally congruent approaches to support young people. For example, best practice suggests that suicide prevention programs that use suicide risk screenings should have community-based services to address the needs of identified at-risk youth. However, for rural and remote communities, support for youth in crisis often requires that the youth leave the village or tribe for treatment. This approach may have devastating effects at the individual, family, and community levels, as youth are removed from settings and people that provide protective social relationships.

Historical trauma has been described as rooted in a long and present history in that the cumulative cultural stresses are unresolved. It has been suggested that “without resolution, indigenous people can be seen as sometimes misattributing their present struggles to personal and collective failings rather than to oppressive systems and structures . . . [which] leaves some AI/AN people with a pervasive sense

of having no future, a sentiment that can be strongly linked to suicide.” (Wexler & Gone, 2012, p. 802). This view is consistent with one community member’s suggestion that hopelessness, in combination with shame surrounding discussion of suicide, prevents Native youth from seeking behavioral health care: *“They feel so hopeless, there’s no hope . . . There’s no tomorrows.”* Thus, prevention and responses to high-risk youth that don’t contribute to ongoing trauma are essential.

Lack of Basic Steps and Consistent Support

Tied to the issues noted above, the interviews suggested that limited progress has been made to formalize prevention and response to suicide clusters. For example, CDC recommends that as an elemental first step, communities must develop a plan to prevent and contain suicide clusters (CDC, 1988). None of the cluster settings in this report had a formal community prevention or response plan prior to the cluster events. However, each of the communities is currently collaborating with federal and regional partners to develop a local community plan, which may help to ensure culturally congruent prevention and response. Looking forward, other AI/AN communities will need consistent support and partnerships to develop their own community plans for suicide cluster prevention and response.

RECOMMENDATIONS

The following recommendations are informed by interviews with AI/AN community members as well as literature on best practices for preventing and responding to suicide clusters, including “CDC’s Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters” (CDC, 1988). These recommendations are intended primarily for local, state, and federal agencies and organizations that may collaborate with AI/AN communities in developing suicide cluster prevention and response plans, or assisting during a cluster event. Additional recommendations and supports for tribal communities follow.

- **Partner With AI/AN Communities to Develop Culturally Specific Community Plans.** Many tribal communities, including the communities interviewed for this report, may need assistance in developing community plans for suicide cluster prevention and response. For effective plan development and implementation, communities need technical assistance to support the following components of plan development: culturally competent needs and resource assessment, priority mapping, coalition development, identification of locally tailored strategies, and integration of the plan within the community’s current infrastructure. As suggested by interview participants and researchers (Wexler & Gone, 2012) and recommended by CDC (1988), community prevention and response plans for suicide clusters must be adapted to the particular needs, resources,

There are more than 560 federally recognized AI/AN tribal groups. Of these, 231 are in Alaska. These tribal groups have different social structures, individual and gender expectations, support systems, and conceptualizations of death (Novins, Beals, Roberts & Manson, 1999; Olson & Wahab, 2006). Support provided to AI/AN communities must be guided and informed by each unique cultural and geographic context.

and cultural characteristics of the community. This is particularly relevant for AI/AN communities, given the resources, diverse cultural contexts across tribal communities, and historical trauma discussed above. At the invitation of tribal communities, local, state, and federal partners with this expertise should collaborate with AI/AN populations, and building on community strengths, provide technical assistance to help the community develop a plan that reflects its own traditions and culture.

- **Support Research to Improve Understanding of Suicide Clusters in AI/AN Communities.** The findings in this report are consistent with recommendations from the Research Prioritization Task Force of the National Action Alliance for Suicide Prevention. In particular, the recommendations call for research that focuses on understudied, hard-to-reach, and/or high-risk communities and care settings, including AI/AN rural settings. Additional recommendations include a focus on studies designed to improve understanding about suicide mitigation strategies and how to sustain progress that reduces suicide risk (Action Alliance, 2014). Since some AI/AN communities suffer higher suicide burden than others—including frequent youth suicide clusters—research is needed to understand the differences between these communities, especially strength-based factors that may translate to other communities. The findings in this report also suggest the need for research examining the particular mechanisms of suicide clusters, which are not well understood within any population. Such research may result in models that better explain contagion, resilience, and protective social connections within AI/AN communities.
- **Support the Development and Enhancement of Surveillance Systems.** Community members and others have pointed to the need for data on the mental health of tribal communities and the prevalence of suicide clusters in general, to inform prevention (Dorgan, 2010). The dearth of data presents a serious barrier to understanding the contextual issues and key variables that may influence suicide clusters and inform cluster prevention and response planning. Emerging surveillance systems (such as those supported through the SAMHSA’s Native Connections grant program [SAMHSA Request for Applications SM-14-013]) may be useful to local, state, and federal partners in improving understanding about AI/AN subpopulations with particularly high suicide rates and related needs.
- **Ensure an Inclusive and Coordinated Planning Process Involving Multiple Community Sectors.** Local, state, federal agencies and others that partner with AI/AN communities should consider CDC’s recommendation for inclusion across all sectors of the community (e.g., public health, behavioral health, education, parents, community members, etc.) in planning and implementing suicide cluster prevention and response efforts (1988). Community members in this report had clear ideas about whom should be included. One interviewee suggested, *“We would need our tribal council, our school, public safety, and our communities, I think that that’s all we need to make our suicide prevention plan, and it would work fine that way with lots of communication with each other.”* Moreover, CDC guidance urges that *“Every effort should be made to promote and implement the proposed plan as a community endeavor ... no single agency ... has the resources or expertise to adequately respond to an evolving suicide cluster”* (CDC, 1988, p. 3).

Lack of advanced coordination may result in delayed elements of the response may be delayed or opportunities for prevention missed. Thus, it is critical for all relevant locally based participants, programs, and external partners (e.g., local, state, or federal agencies, organizations, or universities) to have a clear sense of their respective roles and responsibilities in advance. In addition, regular communication among partners (e.g., the local community and outside partners) should occur so that all partners are kept apprised of the status of available resources, plans, and protocols. Effective suicide prevention requires a sustained and coordinated response. Partners must commit to and organize themselves in such a way that ensures ongoing coordination of efforts and that suicide prevention remains a priority.

- **Partner With AI/AN Communities to Improve Youth Screening.** Screening can identify individuals early in a suicide trajectory, before a suicide attempt or suicide occurs. Suicidal thoughts in youth do not increase as a result of such screening (Gould et al., 2005). Individuals at heightened risk for suicide should be identified and screened, and the literature is clear that people who have previously attempted suicide and those who have lost a family member or friend to suicide are at heightened risk. Qualified behavioral health care professionals should oversee the screening process and conduct interviews to determine level of risk for all youth who screen positive on the initial screen (SPRC, n.d.). Tribes and villages with few available providers may require support in identifying professionals to oversee the process. Similarly, before the screening begins, the community needs to ensure (1) that response protocols for youth in crisis are well established and (2) that appropriately trained behavioral health providers are available for youth who screen positive and require followup (SPRC, n.d.). Rural and frontier tribal communities may need to reach out to local, state, or federal partners to collaborate in finding available providers. Coordinating follow-up services for youth at-risk or in crisis is critical.
- **Promote Youth Employment and Engagement.** 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 tribal communities and the need for economic development. Researchers find that work and job satisfaction are second only to personal relationships in determining quality of life. Based on such findings, employment can contribute to a more fulfilling life, particularly given its positive impact on identity, social support, purpose, and challenge (Linley, 2004; Snyder et al., 2011). For youth who are still in school, some community members talked about the need for a community/recreational center as a healthy place to hang out. Community members have also stressed the importance of engaging youth and involving them in prevention planning. Another community member noted, *“If they would involve the youth Natural Helpers and student council, if they would invite that group to the meeting, I think it would be helpful because those youth would help bring out the awareness to the other students.”*
- **Increase Availability of and Enhance Behavioral Health Services.** As described in this report, the availability of behavioral health care services has improved in rural tribal communities in the

last decade—particularly in remote Alaskan villages—with the advent of the BHA program, traveling clinical counselors, and telebehavioral health capabilities. In Alaska, these advances may have resulted in an increase in the use of mental health services. According to the State of Alaska's "Casting the Net" report focused on suicide prevention, the number of Alaskans who received mental health services grew 17 percent between Fiscal Years 2009 and 2011. The number of Alaskans who received substance use disorder treatment also grew 5.7 percent during this period. While the increase in the number of Alaskans seeking treatment and recovery services is promising, the resources available to the behavioral health system are unchanged (CTN, 2013). Despite progress in some communities, behavioral health care is still largely unavailable or insufficient for many rural and frontier tribal communities.

- **Update National Recommendations for the Development of a Local Community Plan to Prevent, Contain, and Respond to Suicide Clusters.** While CDC's "Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters" (1988) is a seminal resource, updating it to include research findings and lessons learned over the last 25+ years would be of immense benefit to the field. Attention must be given to unique characteristics of suicide clusters in diverse communities and populations, especially among AI/AN youth.

Looking Forward

Tribal communities can benefit from developing and implementing community plans to prevent and respond to suicide clusters. However, strong and genuine barriers to plan development exist, such as cultural taboos around talking about death or suicide; shame about seeking mental health treatment; suicide and mental health not being community priorities; and inadequate formal resources/structures for developing the plan (e.g., vacancies in crucial tribal agencies such as education, mental health, local government; or lack of behavioral health and crisis services). Through support offered by a range of federal programs, including SAMHSA's Tribal Training and Technical Assistance Center and Suicide Prevention Resource Center, tribes and villages can access best practices on plan development and how to build an infrastructure for community suicide prevention.

In addition, SAMHSA's Suicide Prevention Branch oversees the Garrett Lee Smith Youth Suicide Prevention and Early Intervention Program, a 5-year grant program intended to support tribes and states in implementing comprehensive suicide prevention programs grounded in public/private partnership. The programs provide support to tribes (and states) to implement programs that include coordination across youth-serving organizations to expand the capacity to identify, refer, and serve youth in crisis and at risk for suicide. In part, these grants are intended to ensure continuity of care for youth at risk for suicide. In addition, these funds can be used to implement tracking systems to monitor suicide attempts as well as deaths by suicide to identify patterns of risk and prioritize prevention efforts.

In 2014, SAMHSA released an RFA for a new grant program—Native Connections—designed to support AI/AN grantees in their efforts to reduce the impact of substance misuse, mental illness, and trauma in their communities through a public health approach. The purpose of this program is to prevent and reduce suicidal behavior and substance abuse and promote mental health among AI/AN young people

through age 24. These 5-year cooperative agreements are designed to allow for tribal specific-goal generation and planning based on Community Readiness Assessments (CRAs) conducted annually across the lifespan of the program. Tribes, working in close collaboration with SAMHSA and their Tribal Training and Technical Assistance Center contractors, will develop and implement plans specific to their community's needs and reflective of their community's level of readiness.

The community readiness model (CRM) is a nine-stage model that assesses a community's level of readiness to develop and implement prevention programs. The model is a progressive assessment of a community's ability to implement systematic change of key public health issues. A community can increase and decrease their readiness level for an issue depending upon the appropriateness and strength of local efforts. The CRM has five dimensions that, together with the stages, provide a comprehensive community assessment and serves as an information guide as to what type of local efforts is needed in which area (Jumper-Thurman et al., 2003). The five dimensions are Community Knowledge of Efforts, Community Climate, Community Knowledge of Issue, Leadership, and Resources. Each dimension receives a community readiness score and each can be at a different readiness level. The dimensions are correlated therefore one aspect of community readiness is not usually more than two stages apart from the other dimensions (Jumper-Thurman et al., 2003). The dimensions are not specific to culture; however they can be interpreted within the context of the culture of each community (Jumper-Thurman et al., 2003).

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