

Collaboratively Adapting Culturally Respectful, Locally Relevant Suicide Prevention for Newly Participating Alaska Native Communities

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Abstract

Because suicide is deeply connected to local, historical and relational contexts, effective suicide prevention strategies must balance maintaining fidelity of evidence-based practices and adapting for the unique needs of diverse communities. Promoting Community Conversations About Research to End Suicide (PC CARES) builds the capacity of local people in close-knit rural Alaska Native communities to take preventative actions based on existing relationships, roles, and priorities. In a series of learning circles, community members learn about multilevel evidence-based suicide prevention practices, apply the information to personal and cultural contexts, and develop plans for taking action—on their own terms—in their lives. Here, we describe the participatory process used to adapt PC CARES from one region of Alaska to another, aiming to maximize transferability, practicality and relevance in our partner communities. With the shared goal of promoting self-determined, evidence-informed, community-based suicide prevention, the adaptation process included negotiating between comprehensiveness and understandability; subject appeal and utility; predictability and customizability, through consensus-building with researchers and community members. Lessons learned can be helpful to others working to navigate community-specific priorities and evidence-based approaches to develop interventions that can work across many different communities.

Keywords: Community Based Participatory Research; Alaska Native; suicide; knowledge translation; implementation science

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Introduction

The current reliance on one-on-one, clinical mental health services as the main approach to suicide prevention in the U.S. does not address the highly complex intersection of related risk and mitigation factors related to suicidal behavior. The rates of suicide across the nation are increasing, and in rural and marginalized communities, the problem is growing at a faster rate than in urban communities (Crosby et al., 2013; Ivey-Stephenson et al., 2017). In rural Indigenous communities, mental health services are often inaccessible and culturally misaligned (Freedenthal & Stiffman, 2007; Stevenson, 2012; Wexler & Gone, 2012), such that the majority of people struggling with mental health do not seek or receive professional care. Ambivalence toward mental health services is not unique to Indigenous communities, and stigma has been found to be a factor that decreases this form of help-seeking in Black, Latinx as well as Asian International and Asian American people (Alegria et al., 2011; Augsberger, Yeung, Dougher, & Hahm, 2015; Cummings & Druss, 2011; Goodwill & Zhou, 2020).

The majority of suicide prevention funding in the U.S. supports gatekeeper-type programming, promotion of national suicide prevention hotlines, and direct screening for suicidal risk (Asarnow & Wang, 2016; Godoy Garraza et al., 2018; U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). These strategies rely on identifying those at highest risk for suicide and referring them to mental health services, which may or may not be accessible, appropriate or desired (Cauce et al., 2002; Nasir et al., 2016; Wexler, 2010). This approach to suicide prevention has neglected many universal and selective prevention approaches that begin before someone is at heightened risk for suicide and offer many types of support before they become a lethal threat to themselves (Wyman, 2014).

These kinds of universal prevention or wellness strategies can be deployed within communities and can reduce suicide risk and support health (Caine, 2013; van der Feltz-Cornelis et al., 2011). Wellness-oriented, universal, and even selective prevention practices can be amplified if community members—in helping roles both institution-based (e.g., community health workers, teachers, religious leaders) and community and family-based (e.g., Elders, parents, extended family)—know how best to enact and sustain them (Bean & Baber, 2011). Effective prevention strategies range from environmental (e.g., reduction/restriction of lethal means in the household) (Sarchiapone et al., 2011; Yip et al., 2012) to interpersonal (e.g., initiating a supportive conversation) (Owens & Charles, 2017), and can be done by almost anyone in daily life, not just mental health professionals and trained “gatekeepers.” In close-knit rural Indigenous communities, a variety of community members are in contact with vulnerable persons, but do not always recognize suicide risk or know how to intervene early to prevent a crisis. People in informal support systems (family and friends) noticed something was different about their loved ones in 62% of all suicidal behavior in Northwest Alaska, but do not always recognize these issues as possible warning signs for suicide (Wexler, Silveria & Bertone-Johnson, 2012). Effective, upstream interventions are urgently needed to foster the capacity of community members and community workers across multiple sectors (law enforcement, health, religious) to recognize and respond to these signs *before* an imminent crisis (Wilcox & Wyman, 2016).

This article describes the adaptation of one such intervention: Promoting Community Conversations About Research End Suicide (PC CARES), which was designed through a decades-long partnership between the principal investigator (Wexler) and Northwest Alaskan communities. PC CARES aims to shift suicide prevention from strictly crisis intervention to include community-based universal and selective prevention efforts, carried out by those who regularly interact with vulnerable young people (Wexler et al., 2016, 2017, 2019). PC CARES aims to build the capacity of local service systems (e.g. healthcare, education, etc.), family, and friends by recruiting participants from multiple sectors of the community and offering “bite-sized” pieces of information about evidence-based prevention strategies that they can enact in their daily lives. In a series of learning circles facilitated by local people, participants discuss scientific “best practices,” and explore how

they might apply them to their personal and cultural contexts. Community members who attend PC CARES learning circles use these “bite-sized” research insights coupled with their local experiences and knowledge to develop plans for initiating preventative actions collectively or individually in their communities, professional roles and/or homes. Engaging people from different social positions within communities, the approach intentionally develops “communities of practice” through dialogue and invites participants to determine for themselves how best to adapt and deploy best practices within their lives. Overall, PC CARES is anchored in educational research (popular education for health promotion and wellness), framed around Indigenous adult learning theories, with a pedagogy based on building a community of practice (Wexler et al., 2016, 2017, & 2019).

In this article, we describe the ways we adapted PC CARES, after piloting in one region (where it was collaboratively developed), to a different remote area of Alaska. In the pilot study, ten villages, ranging in population from 100 to 3000 residents, held 59 PC CARES learning circles with 535 attendees over the 15-month pilot study. Of these, 376 were unique participants (some of whom participated in more than one learning circle). Most PC CARES participants were female (64%) and 54% respondents were Alaska Native (AN), 140 did not mark their ethnicity. It is likely that many of these unknowns are AN, with more than 80% of the population being Inupiaq. Participants’ ages were 3% teens, 13% young adults, 27% adults, 16% elders, and 41% unknown. About one-third of PC CARES participants were employed as service providers: school staff, family workers, law enforcement, and mental health workers. For a more thorough description of the PC CARES pilot study, along with its process, knowledge, and behavioral outcomes, see Wexler et al. (2019).

Structured group discussions with local facilitators who implemented the pilot intervention in their home communities, recommendations from a Local Steering Committee (LSC) and pilot study results all informed the adaptation of the PC CARES intervention. Here, we describe what we did to adapt our intervention, and explain how our work fits (or not) in existing models as a contribution to the adaptation literature. We acknowledge that there are no validated theoretical frameworks for cultural adaptation of prevention programs, especially in Indigenous contexts, despite the acknowledged need (Gonzalez, 2017). The guidance from participating community members underscores key tensions within the adaptation process that required balancing between thoroughness and understandability; subject appeal and utility; ease of use and comprehensiveness; and predictability and customizability. The engaged process of adaptation highlights community-specific priorities and evidence-based approaches, which are integrated to support incremental social transformation toward self-determination within the field of suicide prevention. This adaptation process attends to the values and priorities of local communities while also clearly portraying scientific research in applicable ways. In this article, we highlight and reflect on the messiness and tensions within this process to offer navigational tools for other researchers and community members interested in balancing community and scientific priorities in practical and respectful ways.

Adapting Interventions

Implementation and prevention research acknowledge the need to address specific preferences and understandings of diverse groups (Baumann et al., 2017; Chinman et al., 2017; Yancey et al., 2018), but often do not allow for the flexibility required to do so in meaningful and community-determined ways. Building contextually and culturally-specific interventions that can flexibly be applied is especially critical in Indigenous contexts where communities have experienced systematic harms and stigma in the name of imposed “systems of care” and scientific inquiry (Barrera et al., 2016; Bernal & Rodriguez 2012; Caldwell et al., 2005; Foulks 1989; Hodge, 2012; Stevenson, 2005). Fitting a scientifically-developed intervention to a particular community context occurs by navigating among and between epistemologies and practical concerns. The process involves integrating community voices and perspectives during the construction of the curriculum (Castro & Yasui, 2017) and through its implementation and dissemination. Adapting an intervention means modifying the

program content in ways that do not distort the evidence base on which it was developed, while also reflecting the culture and context of a particular community (Ivanich, 2020). This process at once seeks to change some less critical parts, while maintaining the explanatory models and evidence-based elements at the core of the intervention to maximize impact. This tricky balancing act is rarely written about in realistic and messy terms because existing trade-offs are often ignored or glossed over. In this section, we offer guiding ideas and intentions that shaped our iterative adaptation process for PC CARES.

By relying on local and cultural knowledge, suicide prevention programs can have longevity and a stronger impact (Allen et al., 2019; Kral 2016). Thus, adaptation processes should center on working with community partners to tailor interventions to the needs, priorities, culture, and available resources of a specific context. The privileging of local and cultural knowledge can increase community commitment to a project and requires power-sharing as a matter of course. Both researchers and community members have vital contributions to make when scientific, cultural, and local knowledges are held in equal esteem. Together, the approach increases local participation, builds on and responds to different epistemologies and knowledge bases, and can support sustainability (Rapkin 2019).

The literature often focuses on the tension between fidelity of the evidence-based program core and fit of the adapted intervention to the community context (Castro & Yasui 2017; Rapkin, 2019), rarely acknowledging temporal issues that often come into play. Specifically, there are few real-time descriptions of the iterative and flexible adaptation process for translating research to social action in Indigenous communities (Ivanich et al., 2020). When interventions have a rapid and flexible use pattern, individual participants can adapt the program to meet their needs and positionality. The self-determined interpretation and application of evidence distinguishes PC CARES implementation processes from other important suicide prevention efforts. Such endeavors include the significant contribution of Indigenous community-based participatory research (CBPR) to developing health promotion and suicide prevention interventions “from the ground up” in and with Indigenous communities (Rasmus et al., 2019). The examples of CBPR co-creation of interventions highlighted in Walters, et al., (2020) are exemplars that require long-term community-university partnerships and continued investments to realize. These influential participatory researchers offer caution about the typical process of adapting evidence-based interventions (EBIs) for Indigenous communities, stating:

Often times, EBIs are supplemented with decontextualized cultural or practice add-ons (e.g., replacing English words with tribal language); thereby, they continue to operate within the Western-oriented worldview that upholds the EBI. This ‘tagging on a feather’ approach may, albeit in limited ways, support integration of culturally specific practices. However, without acknowledging the underlying deep epistemological and cosmological context that drives health and well-being in the Native community, which differ from Western worldviews, this approach may unknowingly diminish the salience and power of Native cultural practices. (Walters et al., 2020, p.3)

Instead of “putting a feather” on the PC CARES intervention to signal indigenization, the intervention invites local adaptations to offer both flexibility and structure directly to local Indigenous facilitators and participants. The re-envisioning and adaptation process of PC CARES involved discussions about how to offer local facilitators enough structure to help them take on new leadership roles about a difficult topic (youth suicide) within their communities, while also inviting them to be creative and adapt the processes used to specific community needs, preferences, and context (e.g., recruiting participants, beginning and ending sessions, organizing discussions, etc.). The balance between facilitator “choice” and structure was an on-going point of consideration in the adaptation process.

Intervention implementation in all disciplines, but especially mental health and suicide prevention, must grow beyond clinical and Eurocentric settings (Glasgow et al., 2012; Woodward et al., 2019) and into more

upstream community environments to promote health equity, which requires earnest dialogues with community members and within the community settings where research takes place. This article begins to unpack the real-life tensions that exist with a focus on negotiating the priorities of fidelity and flexibility. Navigating this dilemma is critical to developing frameworks and approaches which balance different values, epistemologies and ontologies rather than superficial “rebranding” of business-as-usual intervention implementation. We hope that documenting our cross-cultural sharing of perceptions, experiences, and knowledge related to the collaborative adaptation of the PC CARES curriculum contributes to the development of theory and strategies for implementing wholly adapted interventions that can contribute to social transformation for community health (Caulfield, 1979).

Methods

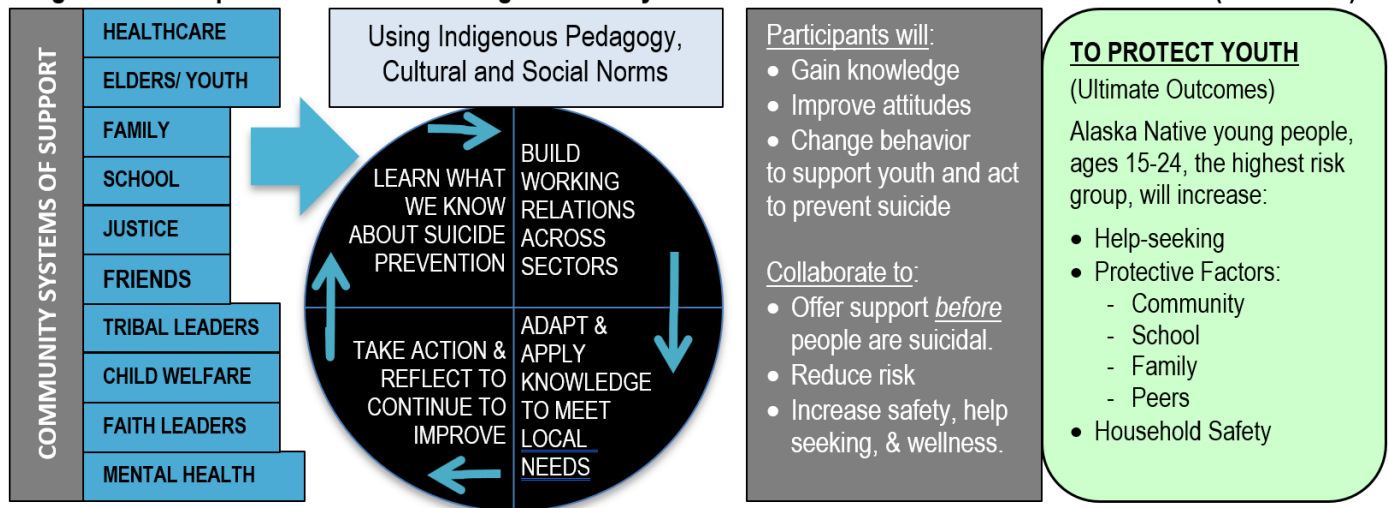
Community-Based Participatory Research and Participants

As community-based participatory research, this project relies on community stakeholders’ partnership and co-learning with the research team. One mechanism for community leadership is the Local Steering Committee (LSC), which is a group of Alaska Native Elders, local leaders, and interested community members who guide the project during periodic meetings. The LSC met with the research team telephonically every 1-2 months and in-person annually to share local priorities, review progress, and to ensure research artifacts such as new recruitment materials, regular community communications, (e.g. emails, newsletters) respect and adhere to cultural norms. At least half of the members of the LSC were involved in the development of the original PC CARES intervention and participated in the debrief with local facilitators of the pilot. Additional members from the new region were invited to join the LSC early on to ensure that local Indigenous perspectives shaped the adaptation process.

Materials

The original PC CARES curriculum was developed in partnership with Alaska Native community leaders and included a series of 9 learning circles that reflected different levels (universal, selective, and indicated) of culturally-specific wellness and suicide prevention information. This reality is in contrast to most of the literature on adaptation (Whitbeck, 2006). Our intervention was built from research reflecting both majority and Iñupiaq culture, and content was specifically chosen and tailored for relevance in a rural and remote Alaskan context. Additionally, the process of interpreting research evidence is designed to be a self-determined and community-based one that situates lived experience and knowledge as important for understanding and applying research evidence. In this way, PC CARES integrates locally and culturally-specific understandings of risk and protective factors and practices into the content and structure of our intervention. The approach is intended to build on both the scientific literature and the knowledge and practices of the community participants (see Figure 1: PC CARES Conceptual Model). The series engages people representing community and family and institutional supporters within remote and rural small AN communities. The learning circle content moves from curriculum focused on familiar and foundational topics such as historic and ongoing cultural trauma (Wexler, 2006), to less commonly understood topics that may challenge participants’ ideas about suicide (e.g. postvention as prevention) (Cox et al., 2012). The pilot curriculum included 8 distinct content areas, with the ninth as a review of the 8 topics plus discussions about how (or if) they wanted to continue collective suicide prevention efforts (Wexler, et al., 2019).

Figure 1: Conceptual Model of Promoting Community Conversations About Research to End Suicide (PC CARES)



Adaptation Process

Adapting the intervention for use in a neighboring, culturally-distinct region involved unpacking the process and outcome indicators from the pilot with community members from the new region, hosting group discussions among pilot facilitators, and modifying the curriculum and research model/methods in order to reflect the realities of the newly participating region. This process involved an assessment of the most important aspects of the curriculum that needed to be preserved, identifying the integral interpersonal elements as well as content. Table 1 summarizes the events of the pilot and adaptation process in a timeline.

Table 1 *Timeline of events from the pilot through the adaptation process*

<i>Time period</i>	<i>Event</i>
November 2015	First “train the trainer” with pilot curriculum
April 2016	Refresher training for facilitators
November 2015 through January 2017	PC CARES pilot implementation facilitated by 23 community volunteers, delivered to 495 local people in 10 villages to participate in 64 PC CARES learning circles
January 2017	Half-day debrief with pilot facilitators
March 2017	Implementation concludes, survey data collection begins
September through December 2018	Recruiting Local Steering Committee (LSC) members from newly participating communities and key organizational partners
October 2018	Planning meeting in with organizational partners tied to newly participating communities to review process and behavioral outcomes of the pilot study
October 2018	Ideas for condensing the curriculum from 8 learning circles to 4 collected and compared
December 2018	Revision rubric created and content areas scored
January 2019	LSC 3-day meeting previewing draft curriculum and research artifacts and discussing feedback
March, May, June 2019	LSC meets and discusses further changes to curriculum, measurement, and plans for implementation

April 2019	Tribal and institutional review boards approve protocol and measures
June 2019	Village-based counselors preview learning circles; Final adjustments are made based on their reactions
October 2019	Training of Facilitators week-long training begins new cycle of implementation

Following the pilot study, the research team conducted a half-day “debrief” with the most active facilitators after all 9 learning circles were complete. Though ten facilitators were invited, seven participated based on their availability, representing five communities in the pilot region. These discussions took place in 30-minute blocks focused on different questions, and groups swapped topics for the next time period, so that all facilitators discussed all of the topics.

Facilitators reflected on their experiences, talked about what was challenging about facilitating learning circles and what content seemed most engaging and useful for learning circle participants. Facilitators discussed elements that contributed to their success, like having a co-facilitator to rely on, food at the meetings and building trust with learning circle participants. They walked through each learning circle to evaluate the value of the content for each. The groups came together at the end of the debrief to reflect on their shared assessments about how the project could be improved. A research team member took notes on each group’s discussions and shared the notes with participants to ensure accuracy. These notes were referred to when prioritizing changes to be made in the intervention to increase cultural responsiveness and improve feasibility and practical use.

The Local Steering Committee (LSC) discussed broader questions needed to condense the curriculum content, such as “Does this information generate new and useful ways to talk about suicide prevention?” and “How might we group different subject areas together?” and “Does combining more content undermine the idea of using ‘bite-sized’ scientific knowledge to spark extended knowledge-sharing and action-planning among participants?” During monthly meetings, LSC decisions were made through consensus, with detailed meeting notes capturing which decisions were made and why.

After gathering the pilot facilitators’ feedback on what worked and what could be improved in the PC CARES pilot and discussing these findings with the Local Steering Committee, the research team—in consultation with community partners— developed a set of priorities for the next iteration of the curriculum. These considerations were integrated into a rubric to negotiate editing decisions about the curriculum. The rubric offered a way to integrate feedback from multiple sources and balance competing interests. Additionally, the research team reviewed implementation science and adult learning theories and literature (Damschroder et al., 2009; Dearing & Kreuter, 2010; Rogers, 2002; Wexler et al., 2016).

After editing the curriculum to a usable level, the revised learning circles were presented to eight Local Steering Committee members and four regional organization leaders based in the hub community over the course of a 3-day, in-person meeting. This meeting was held in a local cultural center, and time was spent walking through each draft learning circle, including both the content and the research protocols (e.g., group agreements, consent forms, surveys, recruitment scripts). Each learning circle was followed by a 45 to 75-minute debriefing session where the research team asked for feedback and addressed specific activities, asking what people liked and how might it be improved. Experiencing the learning circles in-person also allowed the group to identify times when the instructions were unclear and hone activities and discussion questions when they saw they were not quite functioning as designed.

Implementation Considerations

Facilitator focus group results and process outcomes demonstrated that the locally-facilitated learning circle approach was feasible. Facilitators liked the facilitator's guidebook with specific instructions and scripts, because it made facilitation easier. They also appreciated that the "tool kits" had all necessary materials, paper, and handouts to carry out the learning circles. Facilitators liked having a set pattern of learning circle flow. Facilitators reported that stating the purpose of the meeting, setting "safe talk" guidelines, and developing shared agreements for group discussion at the beginning of each learning circle gave participants clear expectations. Facilitators reflected that it was helpful having familiar opening processes coupled with the consistent pattern of activities, moving from 'what does the research show,' 'what do we think' and 'what do we want to do' before closing.

The biggest shared challenge across villages was maintaining consistent learning circle meetings and attendance over time. Only half of the participating 10 communities completed all of the 9 learning circles, and local facilitators told us that it was difficult to keep community members interested and engaged in monthly sessions over a 9-month period, following the recommended timeframe of one learning circle per month (Wexler et al., 2019). Suggestions for addressing this issue included offering continuing education credit (CEUs) for community workers, holding learning circles over a shorter time span (3-5 months instead of 9), allowing a different order of learning circles depending on emerging community needs, personally inviting people to attend learning circles (as opposed to only posting a flyer), and reducing the overall number of learning circles: nine was uniformly considered too many.

When discussing the specific content of the curriculum, facilitators reported that participants were particularly engaged in the learning circle that focused on "Listening Well" and developing skills in reflective listening. They also reported that the content regarding historical trauma opened some space for talking about the tragedy of suicide in a way that is respectful and situated within local people's understanding (Wexler, 2006). Starting the learning circle series by acknowledging the role of historical and ongoing colonization as a key driver of Alaska Native youth suicide was an important starting point because it framed the issue outside of the traditional mental health treatment paradigm, and into a societal context.

In practical terms, local facilitator feedback from the pilot intervention and partner discussions led to changes in the delivery, recruitment and content of the curriculum. We reduced the number of learning circles (from 9 to 5) and the timeline to complete them from 9 months to 4-6 months. This change intended to increase consistent participation for busy local people. Additionally, the revised iteration of PC CARES included a 3-credit University of Alaska Fairbanks college course for facilitators, starting with the 40-hour Training of Facilitators (ToF) and providing continued support through on-going virtual cohort meetings each month. Social workers and village health aides who participate in learning circles were also offered continuing education credits (CEUs) to encourage consistent attendance. Based on feedback that learning circles often discontinued when facilitators moved, left their jobs, or had other changes in their lives, the number of facilitators per community went from 2 to 4, with a community coordinator/lead facilitator identified who recruited 3 others. The team worked with local organizations to recruit tribal organization employees who could serve the role of lead facilitator in each community and use work time to organize and recruit for PC CARES sessions.

Procedure

Revising the Original Curriculum

Since there were many different kinds of considerations to manage as we revised the curriculum, the research team created a list of criteria to use throughout the revision process informed by conversations with

local facilitators, members of the LSC, and stakeholders from the partnering communities. These considerations helped the team systematically consider many overlapping issues as we made decisions about what to keep, what to change and what to cut from the curriculum. The following list of criteria was both an outcome of many hours of discussion, and a process to help us identify and apply different criteria in our decisions:

Strength of the evidence in the literature. The information shared in the learning circles should have strong evidence as health promotion or suicide prevention strategy.

Local data is available. It was important to participants and local facilitators that the source of information shared in learning circles be as local as possible. This preference lends credibility to the knowledge shared.

Information is realistically actionable at multiple socio-ecological levels. The information shared should be actionable, as opposed to information shared for symbolic or instructive reasons. We also noted the levels of the social ecology where these actions could be enacted, aiming for maximizing usefulness at interpersonal, family, institutional and community levels (Alcántara & Gone, 2007).

Improvement in the pilot. We wanted to preserve what was already working in the curriculum, so this criterion captured which subject areas improved during the 5-year pilot study (Lisa Wexler et al., 2019).

Universal and selective (including postvention) prevention at interpersonal and community levels. We wanted to ensure a mixture of these categories would be included in the final curriculum because the curriculum aims to support multilevel suicide prevention efforts (Wexler et al., 2016).

Iterative Modifications to a Revised Curriculum

As we revised the curriculum to meet the needs of a new region in Alaska, we aimed to build on the social and learning outcomes of the pilot, while also condensing the content to fit into fewer sessions and to reflect the needs and realities of the new region. The curriculum revision goals included: a) reducing the number of learning circles, b) utilizing topics of priority in the new region, c), keeping information salient to Alaska Native community members (parents, uncles, aunties, Elders) and service providers' scope of practice (behavioral health, child welfare, justice, mental and physical health), and d) using data from the pilot study to prioritize content areas that were shown to be helpful in promoting community wellness and suicide prevention.

To reduce the total number of learning circles, consideration of the value of each content area was based on the five criteria described above. We removed sessions that covered highly localized information that was not relevant to other regions. For instance, we dropped the seasonal patterns of suicidal behavior from the pilot region because these data were not available (and may not apply) for other regions in Alaska. In other cases, we kept research not directly done in the participating region because the Local Steering Committee (LSC) thought it would elicit productive community conversations. For example, survey data about the role of adults in preventing suicide originated from the pilot region (Learning Circle 2, see Figure 2), but the LSC suggested we retain the graph (Wexler & Goodwin, 2006). The LSC suggested we present the graph in combination with regional data from the Alaska Youth Risk Behavior Survey (YRBS) and School Climate and Connectedness Survey (SCCS) to give their community members more insight into how youth local to their region report experiencing adult support.

Learning circle content was adapted based on its perceived usefulness and measured outcomes. In the pilot curriculum, Learning Circle 4 presented a graph describing an inverse relationship between the number of community-level protective factors (e.g. enforcement of local option laws, schools respecting the local culture, village leaders working to improve the village) and suicide rates (Berman, 2014; Chandler & Lalonde, 2008; 1998). Facilitators reported that learning circle participants during the pilot—from many different backgrounds and social positions—had more trouble coming up with ideas about how to use this information than other information shared in other learning circles. (See graph at www.pc-cares.org/community-protective-factors) They did not find the Community Protective Factor graph compelling or actionable.

Information that was considered relevant, and highly actionable, but had yielded no significant changes in behavioral outcomes, was reframed, explained differently and presented using different teaching tools/visual aids in the adapted curriculum. For example, the pilot curriculum used a case study about a “Jane Doe” character returning home after a suicide attempt, highlighting that people who habitually received short, supportive, and non-demanding notes after a suicide attempt were more likely to seek help (Luxton, June & Comtois, 2013; Motto & Bostrom, 2001; Whitlock et al., 2014). In our debrief after the pilot study, facilitators shared that the story of “Jane Doe” did not resonate with participants: they had little to say about the generic case and did not readily apply the information to their lives. Rather than predicating non-demanding contacts on a suicide attempt, in the revised curriculum, the information was reframed as “small acts of kindness.” Research evidence was explained simply and directly, rather than through a case study example. Learning circle participants are then invited to discuss their connections with youth and situations in which such small acts of kindness might make a positive impact on young people’s lives.

Our revision process involved a fine balance between providing enough information to compel in-depth discussion, while also making the research information understandable in ten minutes or less. This time limit is intended to “allow room” for local wisdom and interactive knowledge-building alongside scientific information sharing. The curriculum needed to be scientifically-grounded, useful, interesting, and understandable, which is especially difficult given the diversity of lived experiences and education of participants. PC CARES intentionally invites people with institutional roles (teachers, therapists, community health workers, child welfare, justice, tribal leaders) to learn alongside parents, uncles, aunties, Elders who are vitally important community and family supporters of youth. The adult education model relies on bi-directional learning, which means that participants come to each session with information and perspectives to share that can inform each other’s practice (Wexler et al., 2016). To invite this kind of sharing, the curriculum needs to inspire discussion and new ideas that are relevant for all participants’ lives and/or scope of practice.

Results

The resulting curriculum includes four learning circles, each with content that addresses a time points on a spectrum of prevention, including universal (cultural wellness), selective (support for youth, prevention) and postvention (grief and healing, reducing risk after a suicide occurs), and a final learning circle that reviewed the groups’ insights and “takeaways” from previous learning circles in order to discuss next steps (5 in total). Although we present the curriculum with this order in mind for predictability and building of knowledge, sometimes experienced facilitators do use particular learning circles to respond to local events (e.g. grief and healing learning circle after a traumatic event in the community). Interested parties can compare the pilot and adapted curriculum materials on pc-cares.org.

Local Steering Committee Feedback

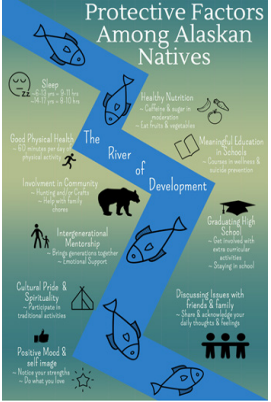

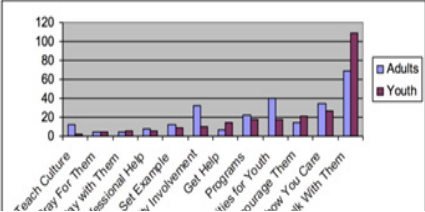
The revised draft curriculum was tested out during a three-day in-person Local Steering Committee (LSC) meeting in January 2019, with the research team members and curriculum co-authors on the LSC playing the role of “facilitator.” The LSC suggested improvements and asked questions that helped us clarify our purpose and approach, and led to changes in the curriculum. These edits included ensuring that jargon such as “postvention” or “lethal means” be changed or removed from the curriculum. They advised that materials be as localized as possible. Any quotes or examples should be from local youth, handouts and imagery should reflect regional landscapes, Alaska Native themes and language, and local settings. In particular, organizational partners and LSC members underscored the importance of Native pride, cultural expression, and continuing traditions as protective for Alaska Native youth. This was key in understanding how PC CARES “fits in with” many of the wellness-focused activities already being promoted in the region, which celebrate a deeply held

narrative that “culture *is* prevention” (Kirmayer, Simpson & Cargo, 2003; Wexler, Joule, Garoutte, Mazziotti & Hopper, 2014).

Learning Circle 1: Cultural Wellness. During the in-person demonstrations of the newly adapted curriculum, the LSC members’ reactions to the “Cultural Wellness” learning circle were captured via detailed meeting notes. Before showing a video of community members’ thoughts and feelings about healing from historic trauma, facilitators highlighted the fact that there were no recorded Alaska Native youth suicides before the 1960s. Discussion questions underwent several iterations, one of which asked, “What do you think was different for youth in the 1960s as compared to now?” The phrasing of the question inadvertently focused discussion on participants’ associations with the decade, such as civic unrest related to the Vietnam War, drug culture, and civil rights, rather than universal suicide prevention. The question was replaced by inquiries that helped relate the information to community members’ understandings and experiences (e.g., “What did the video make you think about the history of Native people in our community?” and “What did the video make you think about what it is like now for young people?”). Additionally, Learning Circle 1 was expanded to include information about positive youth development. With immense input from the LSC, we developed and revised a “River of Development” handout (Figure 2, or for larger resolution see: <http://www.pc-cares.org/cultural-wellness>) which highlights elements necessary for positive youth development using a visual metaphor of rivers converging. Figure 2 shows the results of our collaborations from pilot versions to current drafts of the “River of Development” where the final product was informed by our discussions with the LSC to be more polished and culturally relevant, including the addition of important cultural imagery like fish racks and berry picking and people in relationship with the water and the land.

Figure on next page. Figures appear in a supplemental file available for download from <https://openjournals.bsu.edu/jsacp>

Figure 2. Side-by side comparison of pilot and revised curriculum materials.

Pilot Curriculum	Revised Curriculum
<p>Learning Circle 1: Historic and Cultural Context Film: historical trauma & youth suicide started in 1960s Chart: Protective Factors among Alaska Natives</p> 	<p>Learning Circle 1: Cultural Wellness Film: historical trauma & youth suicide started in 1960s Chart: River of Youth Development</p> 
<p>Learning Circle 2: The Role of Adults Chart: Protective factors for youth suicide prevention</p> <p>Guess what Inupiaq youth & adults think is most helpful in preventing suicide? (These ideas came from 355 local people)</p> <ul style="list-style-type: none"> ○ Teach culture ○ Pray for them ○ Stay with them ○ Get professional help ○ Set a good example ○ Being involved in the community ○ Getting them help ○ Programs ○ Activities for youth ○ Encourage them ○ Show you care ○ Talk with them <p>What will help prevent Inupiaq youth suicide?</p> <p>On a Survey representing 355 people in Northwest Alaska, youth & adults wrote: (Wexler & Goodwin, 2006)</p> 	<p>Learning Circle 2: Support for Youth Graph: What Youth and Adults Say Prevents Suicide</p> <p>Chart: School Survey Results (not pictured) Role play: Listening for Wellness</p>

Learning Circle 5: Supportive Counseling and Listening Well

Film: Supportive counseling as prevention – Just listen



[Above: video thumbnail - Talking and Listening for Wellness]

Role play: Listening for Wellness

CHEAT SHEET FOR LISTENING FOR WELLNESS

Talker: Tells the listener about the stressor

Listener:

1. Invite conversations from the heart
→Show acceptance and willingness to listen.
“Tell me about what is going on for you.”
“Talk to me about your stress.”
“Want to talk about it?”
2. LISTEN
DO NOT interrupt,
DO NOT give advice,
DO NOT try to cheer them up...just listen.
3. Reflect back what you heard
“It sounds like it is really hard for you when....”
“You get really stressed when...”
“Sounds like [XYZ] is really hard to deal with.”
4. Ask open-ended questions about next steps:
“What do you want to do about it?”
“How have you handled this before?”
“What can you do to get through this?”

Chart: School Survey Results (not pictured)

Role play: Listening for Wellness

Cheat Sheet for Listening for Wellness

SLIDE

1. Invite conversations from the heart
→Show acceptance and willingness to listen.
“Tell me about what is going on for you.”
“Talk to me about your stress.”
“Want to talk about it?”
2. LISTEN
DO NOT interrupt,
DO NOT give advice,
DO NOT try to cheer them up...just listen.
3. Reflect back what you heard
“It sounds like it is really hard for you when....”
“You get really stressed when...”
“Sounds like [XYZ] is really hard to deal with.”
4. Ask open-ended questions about next steps:
“What do you want to do about it?”
“How have you handled this before?”
“What can you do to get through this?”

[Click Support for Youth and Elders by Using Active Listening with Friends](#)

Learning Circle 6: Restricting Lethal Means

Image: 10 Minutes Can Save a Life



Research shows that making it harder for someone to find a loaded gun, a private place, pills, a bridge, alcohol, a snow machine keys... **CAN SAVE A LIFE!**
 --Even a few-minute delay can prevent suicide.

New Material: Safe Homes



Learning Circle 3: Prevention

Flyer: Safe homes

What we know about effective prevention...

- #1 10 MINUTES CAN SAVE A LIFE. Research shows that making it harder for someone to find a loaded gun, a private place, pills, a bridge, alcohol, a snow machine keys... **CAN SAVE A LIFE!** Even a few-minute delay can prevent suicide.
- #2 SIMPLE CHANGES TO THE HOME can help someone we're worried about. Here's how...

REMOVE ALCOHOL: Alcohol tends to make things worse. Removing alcohol from the house helps reduce risk.

LOCK AND LIMIT: Medications are the most common method used by teens who attempt suicide.

NO LOCKS: Keep doors open or unlocked when you're worried about someone.

SUN-BLOCKING SUNGLASSES: Better sleep during sunny summer nights.

HAZARDS: Look for rope or other hazards in the room. Consider getting a collapsible curtain rod.

TAKE KEYS AWAY: If people are driving, take their house, snow machine, or car keys away.

RESOURCES IN PLAIN SIGHT: Remind people that getting into a sign of strength, not weakness. You can help them call the Alaska Careline at 1-877-258-4337.

GUN SAFETY TRIGGER LOCKS, LOCKED AMMO BOXES: Make it harder to get a loaded gun. 87% of suicide deaths in the United States from 1999-2014 were from firearms.

LC 3: Prevention ACTIVITY | What We Know About Effective Prevention Handout

Learning Circle 7: Support After an Attempt

Case study: Following up after suicide attempts

When 'Jane Doe' came home from Kotzebue after attempting suicide, she was embarrassed and still had to deal with the problems that made her feel bad in the first place. It was hard. 'Jane Doe' felt alone and sad. She didn't know how to talk about what happened, and she wasn't sure she wanted to because of her shame.

When she received a short text message a day after saying, "You are special." 'Jane Doe' felt supported, even though it was from someone she isn't close to. A few days later, when she got a text saying, "Thinking of you today," she smiled and thought about those people in the community who care about her.

Weeks later, when she gets a text message, "wishing you a good day," she gets a warm feeling. When she is down, she thinks about this feeling and it helps.

Now, many months later, 'Jane Doe' sometimes gets a supportive text from this same person, and it reminds her that people care about her, even if she isn't close to them. It gives her a way to get help if she needs it in the future.

Flyer: Small Acts of Kindness

What Works? Small Acts of Kindness!

Research note: In studies, people who received short, supportive and *non-demanding* notes or acts of kindness after feeling suicidal and low were much more likely to seek help, not attempt or die by suicide, when compared to people who didn't get these (Matto & Bostrom, 2001; Ranney, Pisani, & Chernick, 2018; Reger, et al. 2017).

What does 'non-demanding' mean? It means to do something without expecting the other person to do anything. For example:

- Ø **Demanding act:**
 "Call me if you want to talk."
- ⇒ **Better to do Non-demanding:**
 "I am thinking of you and want you to know I care."
 "I really appreciate the way you _____."
 "I baked some cookies and wanted you to have some."

Suicide prevention can mean making sure to send someone who is having a hard time random, small, non-demanding notes and acts of kindness over a long time. And, research shows that **you don't need to be close to the person to make a big difference to someone.**

"Whatever it is you want from young people, you must give them."
 - Anonymous Alaskan

"Kindness is a gift everyone can afford to give."
 - Unknown

"Love is what makes you smile when you're tired."
 - Terri, age 4 (From Helping Little Kids Succeed - Alaska Style).

"A healthy village is a circle whose people are safe within its fold. Love, understanding, kindness, culture, history, goals, and truth make the circle strong..."
 - Harold Napoleon, Yu'pik author and activist

"Love and kindness are never wasted. They always make a difference. They bless the one who receives them, and they bless you, the giver."
 - Barbara De Angelis

Learning Circle 8: Postvention: Talking Safely About Suicide

Chart: Postvention: What to do /not to do to

POSTVENTION	
After a suicide happens, everyone—especially young people—are at higher risk for suicide. This is what we know about actions and words that can either protect them or increase suicide risk:	
Protective	Riskier
<ul style="list-style-type: none"> Let those who are grieving talk about whatever they are going through (anger, guilt, sadness, numbness...). Share ways of getting help: "If only he knew that it feels better after talking." "There are other ways to get help, even calling a hotline can make someone feel a sense of relief." Tell basic facts (no details on how), only: "[Name] was 19, from X village and died yesterday." Share the hurt caused by the person's passing: "Suicide hurts". 	<ul style="list-style-type: none"> Blaming someone else for the suicide increases risk because... <ul style="list-style-type: none"> ...People listening may feel angry and desperate, and could think about suicide as a way to get revenge or as a way to hurt someone else. Talking about the person who died as a "successful suicide" or being "in a better place" or "at peace" can increase suicide risk because... <ul style="list-style-type: none"> ...Suicide could seem desirable for those who are having a hard time finding peace or believing things can get better in their life. Dedicating a tournament or making T-shirts in honor of a person who died by suicide can increase suicide risk for youth because... <ul style="list-style-type: none"> ...Young people who feel overlooked may see suicide as a way to attention and love.

Learning Circle 4: Grief and Healing

Poster Activity: Stages of Grief Chart: What Can Hurt and What Helps Healing

How to Help After A Suicide	
After a suicide happens, everyone—especially young people—are at higher risk for suicide. Families, communities, and institutions can respond in ways that can help and hurt.	
CAN HURT	HELPS HEALING
<ul style="list-style-type: none"> Individuals can hurt by: <ul style="list-style-type: none"> Blaming someone else for the suicide. This increases risk because... <ul style="list-style-type: none"> ...people listening may feel angry and be looking for a way out, and could think about suicide as a way to get revenge or to hurt someone else. Talking about the person who died as a "successful suicide" or being "in a better place" or "at peace" because... <ul style="list-style-type: none"> ...suicide could seem desirable for those who are having a hard time finding peace or believing things can get better in their life. Not talking about it. Not talking about it doesn't happen. What it may seem like the right thing to do is to "protect" youth, ignoring a suicide is risky because... <ul style="list-style-type: none"> ...if people, especially young people, need a strong and clear place to talk about their feelings when a friend or family member dies by suicide. Communities can hurt by: <ul style="list-style-type: none"> Talking about the suicide as if it were a "normal" incident. For example, "This girl just took up and hit and killed herself?" <ul style="list-style-type: none"> ...Youth may hear their friends and think of suicide as something to do if they break up with their boyfriend. Dedicating a community event, or making a t-shirt in honor of a person who died by suicide because... <ul style="list-style-type: none"> ...young people who feel overlooked may see suicide as a way to get attention and love. Institutions can hurt by: <ul style="list-style-type: none"> Not taking action to prevent another suicide <ul style="list-style-type: none"> ...Talking about suicide does not increase risk, and youth need adults or school to acknowledge the tragedy to help them get through it. Ignoring community protocols <ul style="list-style-type: none"> ... This emergency communities limit the people in hand at a time when they most need their strong traditions, culture and sense of control in order to heal. 	<ul style="list-style-type: none"> Individuals can help by: <ul style="list-style-type: none"> Sharing ways of getting help: "If only he knew that it feels better after talking." "There are other ways to get help, even calling a hotline can make someone feel a sense of relief." Talking safely about suicide by telling only the basic facts (without details of how or why): "[Name] was 19, from X village, and died by suicide." Sharing the hurt caused by the person's passing: "Suicide hurts" Making time to listen well: "I'm here to listen and support you." Letting those who are grieving talk about whatever they are going through (anger, guilt, sadness, numbness...). Communities can help by: <ul style="list-style-type: none"> Hosting weekly support groups for people to share whatever they are going through. Reminding everyone to look up their guns (or make sure the bullets are out), just away about guns after a suicide. Making sure that the funeral, memorial service, and services are the same as they would be for a non-suicide death. Reaching out to the survivors of suicide: "It's no one's fault" Institutions can help by: <ul style="list-style-type: none"> Partnering the event with law enforcement, law enforcement, and healthcare providers. Schools having a plan for what to do after a suicide death, which includes talking to students about the suicide safely, teaching about grief, and making time for healing. Following community guidance and leadership

Learning Circle 9: Review and Moving Forward

Posters: Review and moving forward – What do communities want to do next?

Learning Circle 5: Review and Next Steps

Posters: What do we want to do next? Handout: Learning Circle Summary

Learning Circles 1-4 Review

<p>Learning Circle 1: Individual</p> <ul style="list-style-type: none"> Share how you feel about suicide and how it affects you. Share your own experiences with suicide. Share how you feel about suicide and how it affects you. Share your own experiences with suicide. 	<p>Learning Circle 2: Support</p> <ul style="list-style-type: none"> Share how you feel about suicide and how it affects you. Share your own experiences with suicide. Share how you feel about suicide and how it affects you. Share your own experiences with suicide. 	<p>Learning Circle 3: Stages of Grief</p> <ul style="list-style-type: none"> Share how you feel about suicide and how it affects you. Share your own experiences with suicide. Share how you feel about suicide and how it affects you. Share your own experiences with suicide. 	<p>Learning Circle 4: Review</p> <ul style="list-style-type: none"> Share how you feel about suicide and how it affects you. Share your own experiences with suicide. Share how you feel about suicide and how it affects you. Share your own experiences with suicide.
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Handout: Individual and Community Change Discussion questions

Individual/Family Level Questions

DISCUSSION QUESTIONS (10 mins)

1. What do you think helped you keep participating in PC CARES?
2. What kinds of prevention or wellness actions have you taken?
3. What helped you remember to do those things?
4. If/for do you think you could pass on some of what you learned to others?

Community/Organization Level

DISCUSSION QUESTIONS (10 mins)

1. What community groups and organizations in this community (for example, Norton Sound, Kaniwuk, BSSJ, Traditional Council, etc.) should be part of prevention and wellness?
2. What kind of support from organizations (Norton Sound, Kaniwuk, BSSJ, Traditional Council, etc.) do you think mattered most in making PC CARES happen here?
3. What should these organizations or community groups know about how they can work effectively to prevent suicide and promote health?
4. If/for might these community groups and organizations be involved in prevention and wellness moving forward?

Learning Circle 2: Support for Youth. In the original iteration, to introduce the Learning Circle 2 handout, the research team conceptualized a teaching moment where the participants would be asked to guess what adults and youth in their region said they can do to prevent suicide, and then reveal the answer—which is different from what most participants would be likely to guess. Feedback from curriculum co-authors and trainers was that this came across as a “gotcha” experience for participants which hindered the trust-building needed to facilitate communities of practice. The curriculum was subsequently changed to simply demonstrate the discrepancy in answers between adults and youth on the handout instead of reproducing it in real time with participants. This was an important learning experience for the research team where a learning strategy that might have been engaging in a Western context was not the best strategy for local people in our community partner context.

The second learning circle in the adapted curriculum begins by presenting graphs and figures from the original curriculum (Learning Circle 2: “Role of Adults”), integrated with region-specific results of statewide youth surveys. Early drafts of the handout included different kinds of data, including quotes from youth focus groups and interviews. However, this draft was busy and potentially confusing, with extra information that diluted discussion and took up too much time discussing where each piece originated. Trying the data handouts in the learning circle format, it became apparent that the more information that was included, the more explaining was needed about how the information was collected and what the handout was “saying.” When the Local Steering Committee previewed this learning circle, there was substantial discussion about who was surveyed, and how the wording of survey questions might be interpreted differently, (e.g., the difference between teaching a culture and actually living it). Most questions and discussion revolved around the methods of the research more than the overall meaning, and the potential for confusion further diluted the possibility of meaningful knowledge exchange. In subsequent meetings, when a revised handout was shared, members agreed that “less is more”—less information made the handout clearer overall and allowed time for participants to discuss meaningful questions in greater depth. This was a trade-off, since the Local Steering Committee members stated early on that they wanted to share as much research information on this topic as possible (and there was a lot of information available) with the people in their region.

This experience with the Local Steering Committee taught us that the more survey data we bring in to the curriculum, the more questions about methods (e.g., subject recruitment, inclusion criteria) and research (e.g., who conducts this survey and why?) facilitators may have to be prepared to answer during the learning circles. We decided to equip facilitator toolkits with FAQ pages from the statewide surveys and other supplemental resources like the current article. If questions arose, a facilitator could provide supplemental information to the person who was asking without having to memorize methodology.

“Support for Youth” in the new curriculum is a combination of Learning Circle (LC) 2 and LC4 from the pilot curriculum (Table 2). LC4 in the pilot was about building active listening skills. In the new curriculum, with the engrossing discussion of data precipitated by the first handout, it became clear that the accompanying 5-minute movie with interviews from people from the region about Supportive Counseling and Listening Well (LC4) in the original curriculum would be challenging to cover in the time allotted. We subsequently removed the video (which also reduced additional burdens of preparation for facilitators in villages with limited internet and video-viewing equipment).

Learning Circle 3: Prevention. The third learning circle focuses on selective/secondary prevention and features an activity designed to call awareness to signs of suicide risk. The focal message of this learning circle in the pilot curriculum was the message that “10 minutes can save a life”—delaying someone’s ability to impulsively act on suicidal ideation by restricting their access to lethal means of suicide is an effective prevention strategy (Sarchiapone et al., 2011; Yip et al., 2012).

This content in the pilot curriculum did not regularly lead to participants' intention to take preventative actions (like ensuring guns, pills, and vehicle keys are not easily accessible to someone in distress), and the curriculum committee thought this information could be broadened to focus on what someone, could do in their home after the training, without waiting for a crisis.

To illustrate the ways that families could make their homes safer, we presented several options to the Local Steering Committee, including the original handout used in the pilot, materials from the Center to Prevent Youth Violence (CPYV) "Is your home Suicide-Proof?" campaign, and a graphic with region-specific data on suicide fatalities. The LSC felt that the imagery of gun/bullets and loose medications in the first draft of the handout (Figure 1, Learning Circle 6) was triggering and may reduce engagement. Furthermore, they encouraged a visual and overall message focusing on what families *can* do, rather than means of suicide deaths, as the most acceptable and engaging approach. Holding the CPYV flier in one hand, a Local Steering Committee member said, "*Our houses just don't look like this.*" The home in the CPYV flier was two-stories, with a brick chimney, home office, and a handgun depicted as an example of the only firearm in the house. While many Alaska residents own handguns, hunting rifles are more common in small subsistence-reliant communities.

This comment was the inspiration to create a drawing of a different house: single-story, built on pilings, Honda four-wheeler out front, as a backdrop for a menu of simple changes a community member could make to their home that could help suppress someone's risk of dying by suicide (Beautrais et al., 2005; Caetano et al., 2013; Mann et al., 2005; van der Feltz-Cornelis et al., 2011). The picture allowed curriculum authors to populate the flier with information about many different risk factors, including alcohol and medications in the home, access to motorized vehicles including snowmobiles, the importance of good sleep, and making resources easily available (Caetano et al., 2013; Craig & Hull-Jilly, 2012; Hill, Perkins & Wexler, 2007; Mann et al., 2005).

The third learning circle also features an activity designed to call awareness to signs of suicide risk. During one activity from the pilot curriculum, participants would receive a list of warning signs they might notice if a friend or family member was having a hard time. Participants would then be asked to brainstorm further signs of risk. LSC members felt that the activity should be prefaced by an acknowledgement that sometimes there are no visible warning signs before a suicide occurs. "*Part of the healing is not to blame yourself or not to blame other people,*" one LSC member said.

They were concerned that showing members of the community a large list of "warning signs" would send the message that suicides are predictable and it is the responsibility of others to stop them (and induce guilt if they did not). It was suggested that community members begin with a blank page, but as the curriculum was developed further, the activity entailed 6 pre-filled signs of risk and short dyadic discussions to supplement the list. It also emerged from this discussion that highlighting things people can do around their home that is not contingent on suicide warning signs or an attempt (e.g., have a regular practice of safe gun and medication storage), made the suggestions much more actionable.

Learning Circle 4: Grief and Healing. Very early in the adaptive process, the LSC reflected that in order to break the cycle of youth suicide, there needed to be space for grief and healing from suicide death, since virtually everyone in the region is a suicide survivor. They said the new curriculum should acknowledge the complicated grief that occurs when someone dies by suicide. We added in content related to stages of grief and included a discussion about how an individual might support someone who is grieving.

Additionally, the fourth learning circle highlights best practices after a suicide happens. Suicide postvention is a triggering and painful subject in tight-knit communities with high rates of suicide. This handout (Figure 2, Learning Circle 8 in the pilot) was developed through an intensive iterative process in the pilot study. It features "what helps" and "what hurts" in two columns and offers locally-relevant explanations for scientifically supported assertions. The LSC considered the table to be appropriate and respectful, but suggested changes in language, including changing headers from "Protective/Risky" to "Can Hurt/Helps Healing" and

“What institutions (e.g., health care organizations and schools) can do to ‘help healing’ is to honor local protocols and follow community guidance and leadership.”

They also increased the balance of suggestions between institutional, individual, and collective community actions by including more examples at different levels (interpersonal, institutional and community).

Learning Circle 5: Review and Next Steps. As in the pilot, we wanted to culminate the series of learning circles with an opportunity for participants to review their previous discussions and decide how (or if) they wanted to continue to meet, learn, and take local action together. The pilot curriculum included a review of the content, an activity for participants to talk about the actions they took, changes they saw, and to participate in a relatively unstructured discussion of what they want to see happen next. The unstructured approach, however, did not lend itself to continuing to mobilize as a “community of practice” since learning circles ended when the intervention did. In the revision, we provided additional scaffolding to prepare participants to continue to work on wellness issues in their community after the official (funded) five PC CARES learning circles ended.

We considered introducing a Community Development Model during the last learning circle, which would present information on what factors need to be in place to sustain positive community change. Such a model would also serve as a primer for discussion about what participants need in order to continue wellness work on a personal and community/organizational level and guide discussions on the next steps they can take individually or as a group to support positive community change. After writing new activities and creating draft handouts with this information, we were reminded by some community partners about the complexity of starting a different area of content (the community development model). We could see that the introduction of a new model to the final learning circle was a complicated subject area and created expectations that burdened some and that did not align closely enough with suicide prevention. Thus, in the fifth and final learning circle for the adapted curriculum, participants review the content from Learning Circles 1-4 and discuss changes they would like to see in their own communities. In consultation with the LSC, we decided to style discussion questions to be balanced around different ecological levels of action (individual, community, and organizational; see Figure 1). Discussions in this session focus on local accomplishments, and what made them possible. The session ends with an open-ended discussion about how they want to move forward, including 1) holding a potluck to sustain the relationships among participants, 2) continuing PC CARES with a new group of participants, 3) reaching out to PC CARES researchers to identify a new focus for continued PC CARES meetings, or 4) making commitments to follow through on some personal/community action ideas.

Table 2 *Summary of how learning circle subjects were cut and combined*

Pilot Curriculum	Adapted Curriculum
LC1 - Historic and Cultural Context	LC1 - Cultural Wellness
LC2 - The Role of Adults	LC2 - Support for Youth
LC3 - Seasonal Influence	<i>Cut</i>
LC4 - Community Protection	<i>Cut</i>
LC5 - Listening Well	<i>Combined with LC2</i>
LC6 - Reducing Access to Lethal Means	LC3 - Prevention
LC7 - Support after an Attempt	<i>Combined with LC3</i>
LC8 - Postvention	LC4 - Grief and Healing
LC9 - Review and Moving Forward	LC5 - Review and Next Steps

Discussion

The learnings from PC CARES align with much of the existing research and theories on program adaptation in Indigenous mental health, and this article built upon existing work (Allen et al., 2018; Harder et al., 2015; LaFromboise & Pitney, 1995) to describe the co-creative processes and dynamics in the adaptation of an Alaska Native suicide prevention program alongside community partners. The lessons from our adaptation of PC CARES emphasize that collective negotiation is key in a co-creative adaptation process. The adaptation of the PC CARES curriculum was an iterative process based on a shared vision of promoting self-determined, evidence-informed, and community-based suicide prevention. Using the themes laid out by Ivanich and colleagues (2020) as a starting point, we examine six key aspects of this work, and discuss our experience building partnerships, taking time, integrating guidance from community partners and evidence-based literature. This iterative process maintained familiar aspects of the intervention, while incorporating structural adaptations, innovative methods and designs.

Building partnerships. The process of adaptation needs to engage many voices and diverse expertise. The core of the intervention of PC CARES was built on community consensus and several trials with feedback from Alaska Native knowledge-holders who represented tribal organizations and interested stakeholders outside of formal roles associated with employment. Recruitment of these collaborators was based on previous relationships, perceived interest and availability. The vast majority of these partners were women, and most occupied wellness-related positions within their community. It is important to note that several of the LSC members participated in both the pilot and the revision of PC CARES. These key members from both the new and pilot region participated in implementation of the pilot program, listened to facilitator feedback, and added insights in an on-going manner to the revision process. This continuity across time was important for deciphering which components and content to keep and which needed revision. These decisions were influenced by our community partners' intimate knowledge of the local realities for the pilot and new PC CARES regions.

Taking time. Time is essential to foster trusting relationships and on-going community engagement, which formed the basis of curriculum adaptations. We worked alongside facilitators and the Local Steering Committee, with whom a strong partnership was established before and during the first iteration of PC CARES. Building authentic partnerships with local collaborators in a "research enterprise" context is difficult because of the power structures that underlie such endeavors. They are typically characterized by a hierarchy whereby the researchers are considered "experts" and community members as "less informed" participants. To address this power imbalance, it is important to pay attention not only to interpersonal dynamics, but also taking time to attend to spaces and processes that might cue or reinforce this dynamic (Cheung, 2020).

Our team contended with these by carefully evaluating activities considered business-as-usual in academic culture but might be unfamiliar and alienating to others, such as introductions centering on professional credentials. During our in-person meetings, we attended to relationship-building to foster open communication and accountability. Our LSC meetings included opening and closing with a prayer, time for breaks, taking walks and eating food together, reflections, giving gifts, inviting personal sharing or song. In the virtual space, we attended to these factors by inviting all participants to check in before starting, balancing between video conferences and phone-only calls, and taking care to tend the virtual space, (e.g. pace of meetings). We intentionally held space in meetings for feedback via discussions where consensus and attention to everyone's contribution can be prioritized rather than asking our group for individualized feedback to drafts via email. We paid attention to what community partners prioritized over time, and proactively raise those issues in an ongoing manner. This approach stands in contrast to asking for comprehensive review of every detail of materials. Instead, we were taught over time which materials are most important to review.

Creating relationships and working spaces for authentic feedback from both community partners and researchers facilitated more authentic conversations and brought revisions closer to important factors

needing balance throughout the adaptation process. Taking time also reflects the progressive process of ideas and changes in curriculum adaptation. Community-based participation takes time to ensure a safe negotiating space.

Integrating guidance from community partners and evidence-based literature. Adaptation is also about integration to create an adjustable hybrid program (Castro, Barrera & Martinez, 2004). We consider the term “hybrid” to describe the dynamic and always-evolving processes and perspectives that shape the elements within an intervention. Adaptations are feedback-relayed processes that happen throughout the multiple deliveries (Rapkin 2019). Adaptation explores community perspectives and evidence-based research in a balance between contextual and theoretically-rooted elements.

The very core of PC CARES emphasizes this approach to adaptation on a micro scale, as learning circles present evidence-based research (what does the research show) and ask community members to reflect on this (what do we think) before fostering conversations about what they determined best for their own local applications (what do we want to do). Likewise, the curriculum adaptation process was led by input from the facilitators and the Local Steering Committee. This integration is not a linear process and needs several discussions and negotiations around the appeal and utility of different content. Working alongside facilitators, Elders and other knowledge-holders allows PC CARES to try new materials and have important discussions around comprehensiveness and understandability, maximizing flexibility while maintaining evidence fidelity. A large part of the adaptation literature focuses on the tension between fidelity of core evidence-based elements and the fit to community’s perspectives (Castro & Yasui, 2017). This tension was resolved in PC CARES through our participatory design, which brings together the “evidence-based” elements, rooted in existing research, and the local knowledge of community members, to foster dialogue and planning for future action (Wexler et al., 2016).

Making the intervention familiar. During an adaptation process, it is important to contextualize the program to fit to the community’s culture (Barrera et al., 2013). Customizability of a program to local culture and context is expected to positively affect flexibility and outcome predictability. One of the major adaptation elements that PC CARES focused on was coordinating the evidence-based research to appropriately represent the context- specific realities of the new delivery region. This process included integration of local data when possible, and when it wasn’t, making sure that the scientific information represented the realities in the newly participating region. Additionally, we created localized materials that fit the imagery, language, and the setting of the new PC CARES communities.

Incorporate structural adaptations. Structural or deep adaptations are changes to address core values, beliefs, and norms of participating communities (Bernal & Rodriguez 2012). Culturally adapted interventions increase engagement, program efficacy and community ownership of the program (Barrera, Berkel & Castro, 2017). Culture is an important protective factor for Alaska Native suicide prevention (Rasmus et al., 2019). The Local Steering Committee was instrumental in rooting elements of the program in continuing traditions and cultural expression of the local region. Furthermore, the iterative process of adaptation led to structural changes of the program that incorporate local priorities (e.g. adding grief and healing) and ways of understanding and addressing the complex issue of suicide (e.g. changes made to learning circles 3 and 4).

Bring in innovative methods and design. PC CARES is an innovative program combining health education and community mobilization (Wexler et al., 2016). Elements of the program are supported by teaching materials such as videos, graphs, charts, and pictures, but the central element in the curriculum is a process of community education and dialogue whereby people respond to scientific evidence and share their experiences and knowledge in order to deepen understanding, relationships and possibilities for action. In the revised curriculum, the last learning circle is a structured way to invite reflections from community participants about what they learned and did as a consequence of their PC CARES experience. They are then invited to

innovate: to decide how (or if) they want to continue to meet, learn and act as a community of practice. This “open-ended” and self-determined invitation to innovate is novel.

Overall, these six themes reflect key aspects of curriculum adaptation. The themes are intricately related and feed one another, illustrating how complex and deeply social an adaptation process is. Curriculum adaptation depends on existing relationships with community partners, (whether facilitators, Local Steering Committee members, or learning circle participants), and relies on social relationships of participants and the communities that structure this engagement. At its center, curriculum adaptation is a social exercise involving trade-offs and negotiations that are never finished. This process involved navigating between comprehensiveness and understandability, subject appeal and utility, and predictability and customizability. Adaptation was an ongoing, communal negotiation to ensure that perspectives from community members and evidence-based elements form a dynamic hybrid, context-led program that fit the understandings of local participants, while keeping the theoretical core of the program. By providing a safe place for this back-and-forth dialogue to happen, we ensured that the new iteration of the program mobilizes culturally-grounded community actions to prevent youth suicide in our partner communities.

Limitations

The process we followed involved product testing and gathering feedback on what we presented. LSC members often shared openly and honestly about how the information made them feel or what it made them think about. However, the downside of feedback is that it must always be in response to a proposed idea, product, etc.—and it is seldom a generative mode of creation. We were limited by our own ideas and ability to be creative.

We learned that “trying it out” was the best way to find flaws in the adaptation. Ideally, we would have tested our adaptations with people in the region beyond our Local Steering Committee and organizational partners. Trying it out with less-invested audiences (or those similar to who the facilitators would be interacting with) would offer more critical perspectives about the curriculum.

Importantly, since the majority of Local Steering Committee (LSC) members and program facilitators were mostly women, men were relatively underrepresented during collaborative meetings and opportunities to collect feedback. This does not reflect the communities where PC CARES will be implemented, nor the learning circle attendance during the pilot where many men participated (Wexler et al., 2017). During our discussion with the LSC, members noted that social roles and gender were impacted by colonization and thus, more efforts would be needed to include men in facilitator or LSC positions. Men could have offered different perspectives on the curriculum and its adaptation—for example, activity types that would increase or inhibit their desire to participate in learning circles. In the future, we aim to address this by asking existing Local Steering Committee members to invite male collaborators to serve on the committee. We also recruited a higher proportion of males for learning circle facilitators in the next iteration of PC CARES in the newly participating region (about a quarter of 40 new facilitators were male).

Last, we relied heavily on existing trust, relationships, and infrastructure to build a communal process for reviewing and adapting the curriculum. The processes used to adapt our curriculum might not be generalizable or transferrable to settings where partnerships between local leadership and academic scholarship are newly forged.

Conclusion

Research indicates a need for multi-level, culturally-responsive, “upstream” suicide prevention that extends community safety, works within cultural and local systems of care, and reduces population risk (World Health Organization, 2018). In small, rural, under-resourced Alaska Native villages, collaboration is both

key to accomplishing this, and a cultural value. As such, co-creating, implementing, and adapting programs should reflect true reciprocity between community and university partners (Holliday et al., 2018). Within this process, it is important to understand who defines research evidence, and, if not the communities themselves, if the definition reflects communities' own priorities. PC CARES sought to create a digestible, actionable model to translate scientific knowledge to self-determined practices aimed at preventing Alaska Native youth suicide. Developing scientific content to spark community conversations involves balancing among competing interests, iterative collaborations between academic and AN community partners, and negotiating the tensions of curriculum adaption in ways that attend to power, mutual respect, and a shared vision of promoting self-determined, evidence-informed, community-based suicide prevention.

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Declaration of Interest Statement

The authors of this article have no financial conflicts of interest.

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References

- Alcántara, C., & Gone, J. P. (2007). Reviewing suicide in Native American communities: situating risk and protective factors within a transactional–ecological framework. *Death Studies*, 31(5), 457–477. <https://doi.org/10.1080/07481180701244587>
- Alegria, M., Carson, N. J., Goncalves, M., & Keefe, K. (2011). Disparities in treatment for substance use disorders and co-occurring disorders for ethnic/racial minority youth. *Journal of the American Academy of Child and Adolescent Psychiatry*, 50(1), 22–31. <https://doi.org/10.1016/j.jaac.2010.10.005>
- Allen, J., Rasmus, S. M., Fok, C., Charles, B., Henry, D., & Qungasvik Team (2018). Multi-level cultural intervention for the prevention of suicide and alcohol use risk with Alaska Native youth: a nonrandomized comparison of treatment intensity. *Prevention Science: The Official Journal of the Society for Prevention Research*, 19(2), 174–185. <https://doi.org/10.1007/s11121-017-0798-9>
- Allen, J., Rasmus, S. M., Fok, C., Charles, B., Trimble, J., Lee, K., & and the Qungasvik Team (2019). Strengths-based assessment for suicide prevention: reasons for life as a protective factor from Yup'ik Alaska Native youth suicide. *Assessment*, 1073191119875789. Advance online publication. <https://doi.org/10.1177/1073191119875789>
- Asarnow, J. R., & Wang, P. (2016). Does community-based suicide prevention decrease suicide attempts? Strategies for reaching zero suicide. *Evidence-Based Mental Health*, 19(4), 126–126. <https://doi.org/10.1136/ebmental-2016-102378>
- Augsberger, A., Yeung, A., Dougher, M., & Hahm, H. C. (2015). Factors influencing the underutilization of mental health services among Asian American women with a history of depression and suicide. *BMC Health Services Research*, 15, 542. <https://doi.org/10.1186/s12913-015-1191-7>
- Barker, B., Goodman, A., & DeBeck, K. (2017). Reclaiming Indigenous identities: culture as strength against suicide among Indigenous youth in Canada. *Canadian Journal of Public Health = Revue Canadienne de Sante Publique*, 108(2), e208–e210. <https://doi.org/10.17269/cjph.108.5754>
- Barrera, M., Jr, Berkel, C., & Castro, F. G. (2017). Directions for the advancement of culturally adapted preventive interventions: local adaptations, engagement, and sustainability. *Prevention Science: The Official Journal of the Society for Prevention Research*, 18(6), 640–648. <https://doi.org/10.1007/s11121-016-0705-9>
- Barrera, M., Jr, Castro, F. G., Strycker, L. A., & Toobert, D. J. (2013). Cultural adaptations of behavioral health interventions: a progress report. *Journal of Consulting and Clinical Psychology*, 81(2), 196–205. <https://doi.org/10.1037/a0027085>
- Baumann, A. A., Cabassa, L. J., & Stirman, S. W. (2017). Adaptation in dissemination and implementation science. In R. C. Brownson, G. A. Colditz, & E. K. Proctor (Eds.), *Dissemination and Implementation Research in Health: Translating Science to Practice* (2nd ed., pp. 286–300). Oxford University Press. <https://doi.org/10.1093/oso/9780190683214.003.0017>
- Bean, G., & Baber, K. M. (2011). Connect: an effective community-based youth suicide prevention program. *Suicide and Life-Threatening Behavior*, 41(1), 87–97. <https://doi.org/10.1111/j.1943-278X.2010.00006.x>
- Beautrais, A. L., & New Zealand. (2005). *Suicide prevention: A review of evidence of risk and protective factors, and points of effective intervention*. Wellington, N.Z: Ministry of Health.

- Bernal, G., & Domenech Rodríguez, M. M. (2012). *Cultural adaptation in context: Psychotherapy as a historical account of adaptations*. In G. Bernal & M. M. Domenech Rodríguez (Eds.), *Cultural adaptations: Tools for evidence-based practice with diverse populations* (p. 3–22). American Psychological Association. <https://doi.org/10.1037/13752-001>
- Caetano, R., Kaplan, M. S., Huguet, N., & McFarland, B. H. (2013). Acute alcohol intoxication and suicide among United States ethnic/racial groups: findings from the National Violent Death Reporting System. *Alcoholism: Clinical and Experimental Research*, 37(5), 839–846. <https://doi.org/10.1111/acer.12038>
- Caine, E. D. (2013). Forging an agenda for suicide prevention in the United States. *American Journal of Public Health*, 103(5), 822–829. <https://doi.org/10.2105/AJPH.2012.301078>
- Caldwell, J. Y., Davis, J. D., Du Bois, B., Echo-Hawk, H., Erickson, J. S., Goins, T., Hill, C., Hillabrant, W., Johnson, S. R., Kendall, E., Keemer, K., Manson, S. M., Marshall, C. A., Wolf, P. R., Santiago, R. L., Schacht, R., & Stone, J. B. (2005). Culturally competent research with American Indians and Alaska Natives: Findings and recommendations of the First Symposium of the Work Group on American Indian Research and Program Evaluation Methodology. *American Indian & Alaska Native Mental Health Research: The Journal of the National Center*, 12(1), 1–21. <https://doi.org/10.5820/aian.1201.2005.1>
- Castro, F. G., Barrera, M., Jr, & Martinez, C. R., Jr (2004). The cultural adaptation of prevention interventions: resolving tensions between fidelity and fit. *Prevention Science: The Official Journal of the Society for Prevention Research*, 5(1), 41–45. <https://doi.org/10.1023/b:prev.0000013980.12412.cd>
- Castro, F. G., & Yasui, M. (2017). Advances in EBI development for diverse populations: towards a science of intervention adaptation. *Prevention Science: The Official Journal of the Society for Prevention Research*, 18(6), 623–629. <https://doi.org/10.1007/s11121-017-0809-x>
- Cauce, A. M., Domenech-Rodríguez, M., Paradise, M., Cochran, B. N., Shea, J. M., Srebnik, D., & Baydar, N. (2002). Cultural and contextual influences in mental health help seeking: a focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology*, 70(1), 44–55. <https://doi.org/10.1037//0022-006x.70.1.44>
- Caulfield, M. D. (1979). Participant observation or partisan participation. *The Politics of Anthropology: From Colonialism and Sexism toward a View from Below*, 309–318.
- Cheung, I. (2020 September 25). *Co-creating dissemination materials with patients* [Webinar]. KT Connects Knowledge Translation Webinar Series.
- Chinman, M., Woodward, E. N., Curran, G. M., & Hausmann, L. (2017). Harnessing implementation science to increase the impact of health equity research. *Medical Care*, 55 (Suppl 9 2), S16–S23. <https://doi.org/10.1097/MLR.0000000000000769>
- Craig, C. J., & Hull-Jilly, D. (2012). Characteristics of suicide among Alaska Native and Alaska non-Native people, 2003–2008. *State of Alaska Epidemiology Bulletin*, 15(1), 22.
- Crosby, A. E., Ortega, L., & Stevens, M. R. (2013). *Suicides—United States, 2005–2009*. In: CDC. *CDC health disparities and inequalities report—United States, 2013*. CDC.
- Cummings, J. R., & Druss, B. G. (2011). Racial/ethnic differences in mental health service use among adolescents with major depression. *Journal of the American Academy of Child and Adolescent Psychiatry*, 50(2), 160–170. <https://doi.org/10.1016/j.jaac.2010.11.004>
- Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for

- advancing implementation science. *Implementation Science*, 4, 50. <https://doi.org/10.1186/1748-5908-4-50>
- Dearing, J. W., & Kreuter, M. W. (2010). Designing for diffusion: how can we increase uptake of cancer communication innovations?. *Patient Education and Counseling*, 81 (Suppl), S100–S110. <https://doi.org/10.1016/j.pec.2010.10.013>
- Foulks, E. F. (1989). Misalliances in the Barrow Alcohol Study. *American Indian and Alaska Native Mental Health Research*, 2(3), 7–17. <https://doi.org/10.5820/aian.0203.1989.7>
- Fountoulakis, K. N., Gonda, X., & Rihmer, Z. (2010). Suicide prevention programs through community intervention. *Journal of Affective Disorders*, 130(1), 10–16. <https://doi.org/10.1016/j.jad.2010.06.009>
- Freedenthal, S., & Stiffman, A. R. (2007). “They might think I was crazy”: young American Indians’ reasons for not seeking help when suicidal. *Journal of Adolescent Research*, 22(1), 58–77. <https://doi.org/10.1177/0743558406295969>
- Glasgow, R. E., Vinson, C., Chambers, D., Khoury, M. J., Kaplan, R. M., & Hunter, C. (2012). National Institutes of Health approaches to dissemination and implementation science: current and future directions. *American Journal of Public Health*, 102(7), 1274–1281. <https://doi.org/10.2105/AJPH.2012.300755>
- Godoy Garraza, L., Peart Boyce, S., Walrath, C., & Goldston, D. B. (2018). An economic evaluation of the Garrett Lee Smith Memorial Suicide Prevention Program. *Suicide and Life-Threatening Behavior*, 48(1), 3–11. <https://doi.org/10.1111/sltb.12321>
- Gonzales N. A. (2017). Expanding the cultural adaptation framework for population-level impact. *Prevention Science: The Official Journal of the Society for Prevention Research*, 18(6), 689–693. <https://doi.org/10.1007/s11121-017-0808-y>
- Goodwill, J. R., & Zhou, S. (2020). Association between perceived public stigma and suicidal behaviors among college students of color in the U.S. *Journal of Affective Disorders*, 262, 1–7. <https://doi.org/10.1016/j.jad.2019.10.019>
- Harder, H. G., Holyk, T., Russell, V. L., & Klassen-Ross, T. (2015). Nges Siy (I love you): A community-based youth suicide intervention in northern British Columbia. *International Journal of Indigenous Health*, 10(2), 21–32. <https://doi.org/10.18357/ijih.102201514309>
- Hill, R., Perkins, R., & Wexler, L. (2007). An analysis of hospital visits during the 12 months preceding suicide death in Northern Alaska. *Alaska Medicine*, 49(1), 16–21.
- Hodge, F. S. (2012). No meaningful apology for American Indian unethical research abuses. *Ethics & Behavior*, 22(6), 431–444. <https://doi.org/10.1080/10508422.2012.730788>
- Holliday, C. E., Wynne, M., Katz, J., Ford, C., & Barbosa-Leiker, C. (2018). A CBPR approach to finding community strengths and challenges to prevent youth suicide and substance abuse. *Journal of Transcultural Nursing*, 29(1), 64–79. <https://doi.org/10.1177/1043659616679234>
- Ivanich, J. D., Mousseau, A. C., Walls, M., Whitbeck, L., & Whitesell, N. R. (2020). Pathways of adaptation: two case studies with one evidence-based substance use prevention program tailored for Indigenous youth. *Prevention Science: The Official Journal of the Society for Prevention Research*, 21(Suppl 1), 43–53. <https://doi.org/10.1007/s11121-018-0914-5>
- Ivey-Stephenson, A. Z., Crosby, A. E., Jack, S. P. D., & Haileyesus, T. (2017). Suicide trends among and within urbanization levels by sex, race/ethnicity, age group, and mechanism of death—United States, 2001–2015. *MMWR. Surveillance Summaries*, 66(18), 1–16. <https://doi.org/10.15585/mmwr.ss6618a1>

- Kirmayer, L., Simpson, C., & Cargo, M. (2003). Healing traditions: culture, community and mental health promotion with Canadian Aboriginal peoples. *Australasian Psychiatry*, 11, S15-23.
- Kral M. J. (2016). Suicide and suicide prevention among Inuit in Canada. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, 61(11), 688–695. <https://doi.org/10.1177/0706743716661329>
- LaFromboise, T., & Howard-Pitney, B. (1995). The Zuni life skills development curriculum: Description and evaluation of a suicide prevention program. *Journal of Counseling Psychology*, 42(4), 479–486. <https://doi.org/10.1037/0022-0167.42.4.479>
- Lee, H.-W., Melson, M., Ivanich, J., Habecker, P., Gauthier, G. R., Wexler, L., Khan, B., & Dombrowski, K. (2018). Mapping the structure of perceptions in helping networks of Alaska Natives. *PLOS ONE*, 13(11), e0204343. <https://doi.org/10.1371/journal.pone.0204343>
- Luxton, D. D., June, J. D., & Comtois, K. A. (2013). Can postdischarge follow-up contacts prevent suicide and suicidal behavior? A Review of the Evidence. *Crisis*, 34, 1, 32-41.
- Mann, J. J., Apter, A., Bertolote, J., & Beautrais, A. (2005). Suicide prevention strategies: A systematic review. *JAMA*, 294(16), 2064.
- Motto, J. A., & Bostrom, A. G. (2001). A randomized controlled trial of postcrisis suicide prevention. *Psychiatric Services*, 52, 6, 828-833.
- Nasir, B. F., Hides, L., Kisely, S., & Ranmuthugala, G. (2016). The need for a culturally-tailored gatekeeper training intervention program in preventing suicide among Indigenous peoples: A systematic review. *BMC Psychiatry*, 16(1). <https://doi.org/10.1186/s12888-016-1059-3>
- Owens, C., & Charles, N. (2017). Development and evaluation of a leaflet for concerned family members and friends: ‘It’s safe to talk about suicide.’ *Health Education Journal*, 76(5), 582–594. <https://doi.org/10.1177/0017896917706601>
- Rapkin, B. D. (2019). Resolving the rigor versus respect dilemma in community-based research: Commentary on Bess and colleagues. *Progress in Community Health Partnerships: Research, Education, and Action*, 13(4), 397-400.
- Rasmus, S. M., Trickett, E., Charles, B., John, S., & Allen, K. (2019). The qasgiq model as an Indigenous intervention: Using the cultural logic of contexts to build protective factors for Alaska Native suicide and alcohol misuse prevention. *Cultural Diversity and Ethnic Minority Psychology*, 25(1), 44-54. <https://doi.org/10.1037/cdp0000243>
- Rivkin, I. D., Lopez, E., Quaintance, T. M., & Trimble, J. (2010). Value of community partnership for understanding stress and coping in rural Yup’ik communities: The CANHR Study. *Journal of Health Disparities Research and Practice*, 4(3), 2.
- Rogers, E. M. (2002). Diffusion of preventive innovations. *Addictive Behaviors*, 27(6), 989–993. [https://doi.org/10.1016/S0306-4603\(02\)00300-3](https://doi.org/10.1016/S0306-4603(02)00300-3)
- Sarchiapone, M., Mandelli, L., Iosue, M., & Andrisano, C. (2011). Controlling access to suicide means. *International Journal of Environmental Research and Public Health*, 8(12), 4550.
- Silveira, M. L., Wexler, L., Chamberlain, J., Money, K., Spencer, R. M., Reich, N. G., & Bertone-Johnson, E. R. (2016). Seasonality of suicide behavior in Northwest Alaska: 1990-2009. *Public health*, 137, 35–43. <https://doi.org/10.1016/j.puhe.2016.02.010>
- Stevenson, L. (2012). The psychic life of biopolitics: Survival, cooperation, and Inuit community. *American Ethnologist*, 39(3), 592–613. <https://doi.org/10.1111/j.1548-1425.2012.01383>
- Stevenson, M. E. (2005). *Life in question: Inuit youth, suicide and the Canadian state* (Publication No. 3211780)

[Doctoral dissertation, University of California, Berkeley with San Francisco State University].
ProQuest Dissertations Publishing.

- Trout, L., McEachern, D., Mullany, A., White, L., & Wexler, L. (2018). Decoloniality as a framework for Indigenous youth suicide prevention pedagogy: Promoting Community Conversations About Research to End Suicide. *American Journal of Community Psychology*, 62(3–4), 396–405. <https://doi.org/10.1002/ajcp.12293>
- U.S. Office of the Surgeon General, & National Action Alliance for Suicide Prevention. (2012). Brief history of suicide prevention in the United States. In *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention*. US Department of Health & Human Services (US). Retrieved from: <https://www.ncbi.nlm.nih.gov/books/NBK109918/>
- van der Feltz-Cornelis, C. M., Sarchiapone, M., Postuvan, V., & Volker, D. (2011). Best practice elements of multilevel suicide prevention strategies. *Crisis*, 32(6), 319–333. <https://doi.org/10.1027/0227-5910/a000109>
- Walters, K. L., Johnson-Jennings, M., Stroud, S., Rasmus, S., Charles, B., John, S., Allen, J., Kaholokula, J. K., Look, M. A., de Silva, M., Lowe, J., Baldwin, J. A., Lawrence, G., Brooks, J., Noonan, C. W., Belcourt, A., Quintana, E., Semmens, E. O., & Boulafentis, J. (2020). Growing from our roots: strategies for developing culturally grounded health promotion interventions in American Indian, Alaska Native, and Native Hawaiian communities. *Prevention Science: The Official Journal of the Society for Prevention Research*, 21(Suppl 1), 54–64. <https://doi.org/10.1007/s11121-018-0952-z>
- West, R., Stewart, L., Foster, K., & Usher, K. (2012). Through a critical lens: Indigenist research and the Dadirri method. *Qualitative Health Research*, 22(11), 1582–1590.
- Wexler, L. (2006). Inupiat youth suicide and culture loss: Changing community conversations for prevention. *Social Science & Medicine*, 63(11), 2938–2948. <https://doi.org/10.1016/j.socscimed.2006.07.022>
- Wexler, L. (2010). Behavioral health services “don’t work for us”: cultural incongruities in human service systems for Alaska Native communities. *American Journal of Community Psychology*, 47, 157–169. <https://doi.org/10.1007/s10464-010-9380-3>
- Wexler, L. M., & Gone, J. P. (2012). Culturally responsive suicide prevention in indigenous communities: Unexamined assumptions and new possibilities. *American Journal of Public Health*, 102(5), 800–806.
- Wexler, L., & Goodwin, B. (2006). Youth and adult community member beliefs about Inupiat youth suicide and its prevention. *International Journal of Circumpolar Health*, 65(5), 448–458. <https://doi.org/10.3402/ijch.v65i5.18146>
- Wexler, L., Hill, R., Bertone-Johnson, E., & Fenaughty, A. (2008). Correlates of Alaska Native fatal and nonfatal suicidal behaviors 1990–2001. *Suicide and Life-Threatening Behavior*, 38(3), 311–320.
- Wexler, L., McEachern, D., DiFulvio, G. T., Smith, C., Graham, L. F., & Dombrowski, K. (2016). Creating a community of practice to prevent suicide through multiple channels: Describing the theoretical foundations and structured learning of PC CARES. *International Quarterly of Community Health Education*, 36(2), 115–122. <https://doi.org/10.1177/0272684X16630886>
- Wexler, L., Rataj, S., Ivanich, J., Plavin, J., Mullany, A., Moto, R., Kirk, T., Goldwater, E., Johnson, R., & Dombrowski, K. (2019). Community mobilization for rural suicide prevention: Process, learning and behavioral outcomes from Promoting Community Conversations About Research to End Suicide (PC CARES) in Northwest Alaska. *Social Science & Medicine*, 232, 398–407. <https://doi.org/10.1016/j.socscimed.2019.05.028>

- Wexler, L., Trout, L., Rataj, S., Kirk, T., Moto, R., & McEachern, D. (2017). Promoting Community Conversations About Research to End Suicide: learning and behavioural outcomes of a training-of-trainers model to facilitate grassroots community health education to address Indigenous youth suicide prevention. *International Journal of Circumpolar Health*, 76, 1.
- Wexler, L., Silveira, M. L., & Bertone-Johnson, E. (2012). Factors associated with Alaska Native fatal and nonfatal suicidal behaviors 2001–2009: Trends and implications for prevention. *Archives of Suicide Research*, 16(4), 273–286. <http://dx.doi.org/10.1080/13811118.2013.722051>
- Wexler, L., Joule, L., Garoutte, J., Mazziotti, J., & Hopper, K. (2014). “Being responsible, respectful, trying to keep the tradition alive:” cultural resilience and growing up in an Alaska Native community. *Transcultural Psychiatry*, 51, 5, 693-712.
- Wilcox, H. C., & Wyman, P. A. (2016). Suicide prevention strategies for improving population health. *Child and Adolescent Psychiatric Clinics of North America*, 25(2), 219–233. <https://doi.org/10.1016/j.chc.2015.12.003>
- Whitbeck, L. B. (2006). Some guiding assumptions and a theoretical model for developing culturally specific preventions with Native American people. *Journal of Community Psychology*, 34(2), 183–192. <https://doi.org/10.1002/jcop.20094>
- Whitlock, J., Moore, S. R., & Wyman, P. A. (2014). Connectedness and suicide prevention in adolescents: Pathways and implications. *Suicide and Life-Threatening Behavior*, 44, 3, 246-272.
- Woodward, E. N., Matthieu, M. M., Uchendu, U. S., Rogal, S., & Kirchner, J. E. (2019). The health equity implementation framework: proposal and preliminary study of hepatitis C virus treatment. *Implementation Science*, 14(1), 26. <https://doi.org/10.1186/s13012-019-0861-y>
- World Health Organization. (2018). Live life: preventing suicide. *Department of Mental Health and Substance Abuse, World Health Organization*. Retrieved from: https://www.who.int/docs/default-source/mental-health/suicide/live-life-brochure.pdf?sfvrsn=6ea28a12_2&download=true
- Wyman, P. A. (2014). Developmental approach to prevent adolescent suicides: Research pathways to effective upstream preventive interventions. *American Journal of Preventive Medicine*, 47(3), S251–S256. <https://doi.org/10.1016/j.amepre.2014.05.039>
- Yancey, A., Glenn, B. A., Ford, C. L., & Bell-Lewis L. (2018). Dissemination and implementation research among racial/ethnic minority and other vulnerable populations. In R. C. Brownson, G. A. Colditz, & E. K. Proctor (Eds.), *Dissemination and implementation research in health: Translating science into practice* (2nd ed., pp. 449-470). Oxford University Press. <https://doi.org/10.1093/oso/9780190683214.003.0027>
- Yip, P. S., Caine, E., Yousuf, S., & Chang, S.-S. (2012). Means restriction for suicide prevention. *Lancet, The*, 379(9834), 2393–2399. [https://doi.org/10.1016/S0140-6736\(12\)60521-2](https://doi.org/10.1016/S0140-6736(12)60521-2)
- Young, T. K., Revich, B., & Soininen, L. (2015). Suicide in circumpolar regions: An introduction and overview. *International Journal of Circumpolar Health*, 74. <http://dx.doi.org/10.3402/ijch.v74.27349>