



HHS Public Access

Author manuscript

Am J Community Psychol. Author manuscript; available in PMC 2019 December 01.

Published in final edited form as:

Am J Community Psychol. 2018 December ; 62(3-4): 396–405. doi:10.1002/ajcp.12293.

Decoloniality as a Framework for Indigenous Youth Suicide Prevention Pedagogy: Promoting Community Conversations About Research to End Suicide

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Abstract

Indigenous youth suicide remains a substantial health disparity in circumpolar communities, despite prevention efforts through primary health care, public health campaigns, school systems, and social services. Innovations in prevention practice move away from expert-driven approaches to emphasize local control through processes that utilize research evidence, but privilege self-determined action based on local and personal contexts, meanings, and frameworks for action. ‘Promoting Community Conversations About Research to End Suicide’ is a community health intervention that draws on networks of Indigenous health educators in rural Alaska, who host learning circles in which research evidence is used to spark conversations and empower community members to consider individual and collective action to support vulnerable people and create health-promoting conditions that reduce suicide risk. The first of nine learning circles focuses on narratives of local people who link the contemporary youth suicide epidemic to 20th century American colonialism, and situates prevention within this context. We describe the theoretical framework and feasibility and acceptability outcomes for this learning circle, and elucidate how the educational model engages community members in decolonial approaches to suicide prevention education and practice, thus serving as a bridge between Western and Indigenous traditions to generate collective knowledge and catalyze community healing.

Keywords

decolonial; decolonizing community education; Alaska Native; suicide; Indigenous mental health

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Youth suicide remains a substantial and recalcitrant health disparity in circumpolar Indigenous communities (Bjerregaard, Kue Young, Dewailly, & Ebbesson, 2004; Lehti, Niemelä, Hoven, Mandell, & Sourander, 2009; Fraser, Geoffroy, Chachamovich, & Kirmayer, 2015), despite considerable efforts at prevention and intervention through primary health care, public health campaigns, and social and behavioral health services. Health systems have in many cases excelled at public health surveillance and emergent care, and can contribute in critical ways to suicide prevention (Luoma, Martin, & Pearson, 2002). However, Indigenous suicide rates remain substantially higher than those for non-Native populations (Alaska Native Epidemiology Center, 2009) and have proven difficult to affect through surveillance, referral, and clinical intervention alone (Wexler & Gone, 2012; Wexler et al., 2016).

This paper describes the theoretical and practical underpinnings, as well as preliminary acceptability and feasibility outcomes, of a community health education and mobilization model for Indigenous youth suicide prevention focused on translating research evidence into self-determined prevention practice. Promoting Community Conversations About Research to End Suicide (PC CARES) is a health intervention collaboratively developed and delivered by a research team at the University of Massachusetts-Amherst and the University of Alaska-Fairbanks, and a tribally-governed health and social services organization in rural Alaska. PC CARES draws on Indigenous pedagogy and adult learning theory to bring together regional health professionals, community health workers, tribal and city officials, and community members to work together to prevent suicide within local contexts and systems of care (Wexler et al., 2016). In this model, networks of Alaska Native facilitators utilize research evidence to spark community conversations, in which local people interpret the research and decide how they want to use the information in practice. In this way, PC CARES occupies an important bridge between Western and Indigenous epistemological and caregiving traditions by positioning scientific information as a catalyst to spark self-determined prevention practice.

PC CARES is comprised of nine independent learning circles; however, this paper will focus on the first only, called 'Where We've Been and Where We Are Going.' This learning circle starts with a film showing local people who link the contemporary youth suicide epidemic to the breakdown of intergenerational mentorship and support associated with historical and contemporary colonialism. We focus our analysis on the reception of this model across 10 rural Alaska villages, describing acceptability and feasibility outcomes of the pilot in the context of decolonial movements in research, education, and prevention practice. We describe the PC CARES model as an incremental move toward an ethics of decoloniality, situated within colonial traditions, power structures, and biases of the health sciences and scientists, their public funders, and the American health system writ large. As a foundation for understanding this effort, we begin with an analysis of how colonialism and suicide intersect in Indigenous health research, social theory, and public health practice.

The context of youth suicide: Colonial history, colonial response, and decolonial developments.

Across the circumpolar north, Indigenous youth suicide has risen from essentially nonexistent in public record to as much as 17 times the American national all-age average in the past century (Wexler, Silveira, & Bertone-Johnson 2012), shaping a disturbing and ubiquitous trend framed in Western public and political discourse as a ‘health care crisis’ demanding broad-scale state mobilization in response (Stevenson, 2014). However, as movements toward increased Indigenous political and cultural sovereignty and self-determination gain traction in public forums (Inuit Tapiriit Kanatami, 2016), prevention science orthodoxies—including their forms of knowledge, power, and intervention—have been challenged.

Instead, attention has been drawn by indigenous and colonized people to the pervasive inequities and dispossessions that color the social and material worlds of the colonized (Fanon, 1966; Kirmayer, Gone, & Moses, 2014). This includes the manner in which colonialism operates “on and through the psyche” (Stevenson, 2014), and through structures of power and meaning that organize relationships, institutions, and knowledge itself (Foucault, 2008; Trout, 2018). For example, health systems have been criticized in arctic Indigenous communities for the medicalization of social problems such as suicide (Kral, 1994; White, 2012) and overreliance on restrictive intervention practices that desocialize care (Wexler & Gone, 2012). In some cases prevention practices may mirror welfare colonial efforts (Paine, 1977) that removed Indigenous people from their families and communities within the lifespan of current generations, for purposes such as Western education and treatment during tuberculosis epidemics (Kral, 2012; Stevenson, 2012).

Many Indigenous people point out that suicide is not readily circumscribed by medical understandings and strategies for intervention (Wexler & Gone, 2012). Across the circumpolar north, social inequity (Inuit Tapiriit Kanatami, 2016), historical trauma (Wexler, 2006), and rapid and imposed social change (Kral, 2012) are indexed as drivers of suicide risk that warrant a nonmedical, tribally-governed, and community-driven response (Inuit Tapiriit Kanatami, 2016). Yet systems of suicide care, including prevention pedagogy, rely primarily on a clinical helping infrastructure that is skeletal or absent in many arctic Indigenous communities, and often maps poorly onto local understandings of suicide and its prevention (Wexler & Gone, 2012).

Welfare colonial interventions

In this sense, clinical and public health interventions for Indigenous suicide take place within a narrative disjuncture in which suicidality is identified as both a symptom of 19th and 20th-century colonialism (Lawson-Te Aho & Liu, 2010), and subject to treatment through welfare colonial means (Paine, 1977). The common characteristics of these interventions—lack of consultation with affected people and local authorities (Wexler & Gone, 2012), epistemological and ontological ruptures (White, 2012), and the bureaucratization of ‘care’ (Stevenson, 2012)—are reflected in the use of civil rights restriction and mandatory inpatient psychiatric care for the those who are suicidal, even as

such care undoubtedly saves lives. In many cases, this involves the forceful removal of the suicidal youth from his or her village, family supports, and traditional systems of care to receive treatment 500 miles away in an Anchorage psychiatric facility.

This practice may temporarily prevent suicide—doubtless a noble goal—but can also discourage further help-seeking (Wexler & Gone, 2012). Across Alaska, mental health services are underutilized in Indigenous communities due to issues of trust and cultural relevance (Freedenthal & Stiffman, 2007), perpetuating a pattern in which services are primarily accessed under emergent conditions—precisely when rights restriction and forced displacement of the suicidal person is the last available option (Wexler, Silveira, & Bertone-Johnson, 2012). This pattern of response curtails important opportunities for more culturally-relevant and community-based care (Wexler, White, & Trainor, 2015).

Framing decoloniality

Colonialism—treated here as a social logic parallel to the historical events of colonization—is predicated on the disruption of Indigenous people’s ability to control and influence their worlds, including their health and wellbeing (Allen & Smylie, 2015). For this reason (among others), creating locally-governed, community-based, and culturally-responsive systems of care have been increasingly prioritized within circumpolar Indigenous communities as part of a practice and ethics of decoloniality (Lehti et. al, 2009; Inuit Tapiriit Kanatami, 2016). At the same time, evidence-based public health practice, and the production of positive health knowledge generally, appears to add value to Indigenous health interventions (Inuit Tapiriit Kanatami, 2016)—even as this positivism has often been experienced and enacted as violent, disruptive, and disempowering (Stevenson, 2014).

In this paper, we understand decoloniality to index social movements away from the forms of knowledge, power, and social order implicated in—and often outlasting—historical colonization (Mignolo, 2013), and toward futures of increased self-determination, including possibilities for social, political, and even epistemological sovereignty (Mignolo, 2011). In the context of health research, decoloniality is concerned most broadly with developing a more critical understanding of the underlying assumptions, motivations and values that inform policy and practice—and more to the point, creating a space in which Indigenous ways of knowing, interpreting, and caring can come to life (Smith, 2013).

While this inherently involves restructuring the relationships between power, knowledge production, and public health policy and practice, we stop short of identifying decoloniality with the wholesale, principled dismissal of positivism in postcolonial health research and systems of care. Instead, the intervention described seeks out a middle ground in which Western and Indigenous knowledge and experience are placed in dialogue, with Indigenous stakeholders asserting the final word in how research evidence shapes prevention practice.

Community Context

The participating region is rural and remote, encompassing 11 villages ranging in population from 90 to 1200, spread over approximately 40,000 square miles. A 12th, larger (pop. 3200) ‘hub’ community houses much of the regional health and human services infrastructure,

including most health care and social service workers who serve the region. No roads connect these villages to each other or to the rest of the state; travel is accomplished by small aircraft and seasonally by boat or snowmobile. Community health aides and their counterparts in behavioral health and dental therapy, tribal administrators, and school-based personnel are located in the villages.

Many Inupiat combine traditional subsistence lifestyles—including hunting, fishing, and gathering—with employment and engagement in a modern cash economy, including the purchase of Western foods, utilities, entertainment, and transportation (Trout, Wexler, & Moses, 2018). American health care infrastructure has been developed in multiple, rapid waves over the past century (Trout, Kirk, Erickson, & Kleinman, 2018), with regional health, social, and tribal services delivered by a tribally-governed nonprofit corporation. An additional for-profit Native corporation supports village-based workers in each community to help with a myriad of economic development and wellness initiatives. These two regional tribal organizations were essential partners in implementing PC CARES. Tribes have partial governing authority in each of the villages, co-existing with additional city and borough governments. Additional support for PC CARES came from these local institutions.

Intervention framework

Promoting Community Conversations about Research to End Suicide (PC CARES) is a community health education and mobilization model that aims to facilitate self-determined suicide prevention practice in Indigenous communities. By creating local platforms for regional and local workers and community members to work together as contributors to suicide prevention in their villages (Wexler et al., 2016), PC CARES supports local people as engaged citizens and knowledgeable drivers of change. The model emphasizes community and cultural protective factors in Alaska Native villages, while giving consideration to local contexts, culture-centric narratives and the multiple, interacting conditions that increase suicide risk. In this sense, the framework translates Alaska Native perspectives on health and wellness into a viable funding and implementation strategy for Western health research, and then returns this research to local communities to inform prevention practice.

In each participating village, teams of two to three local facilitators invite health workers, community members, school personnel, regional health workers, tribal and city officials, and others to attend regularly-scheduled learning circles. Facilitators decide how to advertise PC CARES in their communities, as well as whom to invite. Facilitators were trained by an interprofessional team consisting of academics, social workers, community health workers, and local leaders in November 2015 at a 40-hour retreat in Portland, Oregon, and demonstrated competency through observed practice facilitation and testing on research evidence content (Wexler et al., 2017).

During each learning circle, facilitators share straightforward research evidence (presented via film, case studies, infographics, or charts) on Indigenous youth suicide prevention. Through structured dialogue, facilitators create space for interpreting the research evidence, considering its local relevance, and discussing its applications (or lack thereof) to their particular community context. PC CARES utilizes a consistent template for each learning

circle that includes discussion of (1) ‘what we know’ based on the evidence presented, (2) ‘what we think’ about this finding and its relevance to local contexts and prevention practice, and (3) ‘what we want to do’ based on the ensuing community dialogue. The discussion framework for each of the nine PC CARES learning circles works to build prevention efforts around local understandings and knowledge, to grow a sense of collective responsibility and capacity, and to translate research evidence into a “simple, useable, and systematic form” (Gawande, 2009, p. 133) for community-based prevention practice.

Each learning circle begins with a prayer, address from Elders, and time to review the participant-developed agreements for how to interact during the meeting. The presentation of research evidence follows, typically taking seven minutes or less. The bulk of each learning circle involves analysis, discussion, and storytelling/sharing experiences in small and large groups. After a closing ceremony or prayer, participants often share a meal together. The entire learning circle lasts approximately two hours.

The first learning circle, ‘Where We’ve Been and Where We Are Going’, uses a short film produced at an Arctic Institute wellness gathering in Fairbanks, Alaska to spark conversation about the social context and history of suicide in Alaska Native communities. This film can be viewed at www.pc-cares.org. The research evidence shared consists of the simple fact that no Inupiaq youth suicides were documented in this region before the 1960s (Chance, 1990), in stark contrast to the ubiquity of suicide today. The film captures a talking circle during which a group of Alaska Natives (many of whom are from villages participating in PC CARES) discuss the history, cultural context, and effects of suicide in their communities. The drivers of Indigenous youth suicide, as discussed in the film, include the breakdown of intergenerational mentorship and support; colonialism and its present-day manifestations in drug and alcohol abuse, dependency on Western institutions, and culture loss; and rapid social changes, such as shifting subsistence practices and the death of Elders, that may be contributing to the issue. After viewing the short film, participants discuss its meaning in the context of their lives and experience, and how this information can inform local efforts to prevent youth suicide.

Methods

This paper tracks community responses to the first learning circle, held in 10 villages across Northwest Alaska, in order to assess both the acceptability of the PC CARES model in local contexts, and the extent to which the model is mobilized specifically as a decolonial process, pedagogy, and practice. This serves as a case study to document the implementation and reception of the PC CARES model within and across rural Alaska communities. We hypothesize that PC CARES will empower local people to engage in suicide prevention in a manner that is both evidence-informed and responsive to local contexts and needs, thus serving as a bridge between Western and Indigenous epistemological and caregiving traditions.

With unanimous participant consent, facilitators audiorecord each learning circle and mailed these recordings to the research team for verbatim transcription and coding. We used MAXQDA software and modified grounded theory analysis to track thematic content in

community conversations and assigned codes to prevalent concepts. Each code is tagged with a definitional memo, and code categories are modified in an iterative way as analysis progresses to reflect and consolidate repeated themes and emerging concepts and categories of meaning.

Groups of related codes were then grouped into sets. For example, one code set includes participants' stated theories about why suicide happens, including specific codes such as alcohol and substance abuse, culture loss, and mental illness. These sets are used to identify broader categorical understandings within the dominant learning circle narratives. Our analysis identifies dominant themes found in the narratives across participating communities and describes how these themes relate to teaching and practicing decoloniality. Results illustrate how the PC CARES framework worked as both a decolonial process and pedagogy, leading to decolonial practice through community-based action. Ethics approval was provided by the Institutional Review Board of the University of Massachusetts-Amherst.

Results

PC CARES as decolonial process: Mobilizing communities for prevention

Across villages, participants voiced appreciation for the process of coming together to take collective action, and for the fact that local people were leading the effort in a manner both respectful of local culture and responsive to local need. After watching the video, one participant commented on how it oriented her, and perhaps others in the community, toward actively participating in prevention:

I know if we want to do something that has to do with suicide, this video was really helpful in building, you know... After watching it, it helped us in understanding what this group is for. Now we'll be involved. That video says a lot. It's in the right tone, the message is right, and I think it will reach our people the right way.

Numerous participants responded to the nontraditional experience of being supported as leaders in preventing suicide. One participant relayed:

I really like that this let us come and express ourselves in confidentiality and also it doesn't say, "Here, go take this and go talk to these kids." It doesn't tell you what you got to do. We are talking and coming up with solutions ourselves.

The content of this first learning circle invites people to consider the role of history and colonialism in the contemporary youth suicide epidemic, which both underscores local understandings and invites critical dialogue. A participant summarized:

Every little piece of history, no matter where we're from—this is what made up this program. It's all hard fact that we need to look at. It's what's going to help us understand why we are having these problems like we're experiencing now and how we're going to address it.

Coming together as a community around the issue, participants developed a sense of aptitude and collective responsibility in order to mobilize and coordinate across sectors of the community. One participant addressed the cultural empowerment and community mobilization dimensions of PC CARES:

With this information, I like how it is not just prevention work but promoting our people. A lot of people who are coming are volunteering and how meaningful that is. People working, tired at the end of day, but they are still coming. I appreciate that. It speaks volumes in itself, people willing to be part of that change for the betterment of their selves and our community. We are promoting our people and lifting them higher.

PC CARES as pedagogy: Making sense of suicide in social context

PC CARES makes the interpretation of research evidence a personal and participatory activity, utilizing theories of engagement, interdependence and active participation to support learning as personal, meaningful, and experiential. Participants noted this sense of interdependence, with one community member stating, “I am not alone and we could all do this as a community. For all of us to heal and for everyone else to also.” Another noted:

I was pleased to see different people from the sections of the region getting together and trying to rely on each other to talk about the monster in the room... The support and conversations beginning to say, “You are never alone. You can come out of any situation because you want to.”

PC CARES legitimizes many people’s understandings and experiences of oppression, cultural violence, and rapid, imposed social change. Additionally, this critical lens fosters dialogue on how colonialism works in the lives of Indigenous youth, which opens a variety of possibilities for community-based prevention, advocacy, and resistance. A participant reflected on how people in the film inspired him to consider how to move forward in a self-determined way:

[Indigenous people in the film] can choose what they wanted to do with their communities; they can choose how they want to interact and be part of the community; they didn’t have to just go along with how it was or how they thought it was all the time; instead of assimilation or being pushed with the drift; they are going to choose. [In reflecting on his own conversations], we talked about how the Elders got together and determined, “This is what we choose. This is where we want to go with our culture.”

Of the epistemological orientation of PC CARES, one participant stated:

It’s not coming from anybody else. It’s coming from me that our ancestors and our aanas [grandmothers] and Tatas [grandfathers]. Our moms created us and God created us, too—and this is what they set before us, a table so we could learn from what they said.

The learning circle fostered an environment where local people related suicide to social determinants that are both new, as part of Alaska’s colonial legacy, and modifiable, as they relate to actionable concerns over intergenerational mentorship, culture loss, social suffering, and identity. The intersection of historical trauma, alcohol abuse, and culture loss was another prevalent theme throughout the learning circles:

A long time ago our people never used to have alcohol or drugs in them days. Their parents and their parents before them have this knowledge about life. I think this is what you guys are doing – is doing the right thing.

Another participant noted that “In the 70s when alcohol was brought in and we thought it was ok, there was a lot of sexual abuse. And many of them, or many of us, are scarred from [that].”

Participants shared stories during the first learning circle that linked their experience to broader discussion of the relationship between historical and cultural trauma and youth suicide. Stories participants’ shared ranged from the tremendous grief of loved ones lost by suicide to the recollection of childhood and the joy of being taught traditional ways and connection with Elders. Historical memory of the impacts of colonization were also shared throughout the learning circles, referencing primarily the impact of boarding schools, the loss of language and traditional ways, challenges posed by living ‘between two worlds’, and struggles with the current school system that continues to marginalize traditional ways (Trout, Wexler, & Moses, 2018).

Throughout the learning circles, people expressed hope and made calls on the broader community to teach traditional ways and to find strategies to bridge the gaps between youth and the older generations. Touching on the issue of intergenerational mentorship and support, one participant stated:

Even when you look at our age, today, we are the Elders now because we are losing so many of our Elders. It’s our turn to do something to our grandkids now. We live with what the Elders used to tell us what to do. They are slowly leaving us now. We are here. We have to do something for our people. It’s our turn to do what they taught us. We look at each other, we are older. Hallelujah, we are getting old, but we have to help our people. We have to. It’s already in us, all of us, to step up.

Many participants indicated that the pedagogical structure helped them to use their experiences and knowledge as tools for making sense of youth suicide. This structure legitimizes people’s histories and knowledge, while creating a community platform for electing relevant and responsive strategies for addressing youth suicide.

PC CARES as decolonial practice: Translating critical dialogue to action.

The primary purpose of PC CARES is to invite community action. The framework does not direct the ‘next steps’ of participants or the community, but rather positions them as best able to determine the appropriate actions for their community, institution, and family. This structure assumes participants to be knowledgeable and capable of determining how to use the research to craft personal and collective suicide prevention practices, disrupting colonial hierarchies of knowledge and capacity.

In every learning circle, people talked about activities, community changes, and cultivating a renewed focus on helping young people. Common action steps identified throughout the region included talking to youth and letting them know how much they are loved; getting youth engaged with PC CARES itself; reaching out to Youth Leaders (a region-wide youth

leadership and prevention program built on peer-to-peer support and intervention); having more community activities such as games, potlucks, and movies; connecting youth with Elders; teaching youth traditional ways, such as hunting and sewing, in order to promote a sense of purpose and pride in their culture; the need for more prayer; and involving the whole community with this issue, as opposed to just those in traditional helping professions. One participant noted:

I was pleased to see different people from the sections of the region getting together and trying to rely on each other to talk about the monster in the room... The support and conversations beginning to say, "You are never alone. You can come out of any situation because you want to."

Participants thought of actions they could take based on their shared present-day struggle surrounding youth suicide and affirmations of collective strength and resilience. A central theme was the need to weave together the interpersonal, community and cultural to support youth straddling bifurcated cultural worlds, for example by showing youth love and care, getting involved in community events, and teaching traditional ways. One participant stated:

You know when you spark a match, you see a little spark, but when it burns it gets bigger. We continue to do that, we'll have kids that want to come too, and listen, and feel loved by us!

Another participant reflected, "Coming to this, is like that; it's a spark of encouragement. I was happy you reminded me to [come to the learning circle]... Little things go a long way. We might think it doesn't but it does."

A consistent theme was the ability for participants to open up and talk about suicide in an environment that was, by design, safe and supportive. Many participants expressed feeling less alone by being able to share with other community members, and people talked about how this collective sharing was healing. "I am not alone," one participant asserted, "and we could all do this as a community. For all of us to heal and for everyone else to also." A connection made frequently at learning circles centered on suicide prevention beginning with personal and community healing from historical and intergenerational trauma. As one participant stated: "We heal ourselves and help the people around us heal also. That's the way to stop it."

Discussion

As an education model, PC CARES frames and promotes prevention practice among participants through collective inquiry into the colonial roots of contemporary youth suicides. As a decolonial framework, we consider PC CARES across three dimensions.

First, PC CARES as *process* emphasizes decoloniality by bringing community members together to acknowledge their collective strength and abilities. It creates a Native-led platform for local people outside of clinical settings and formal health policymaking spheres, to "assert, collectively, control over a mutual area of interest" (Johnston, 1991, p. 25) and to act as suicide prevention leaders based on their capacity to affect meaningful change linked to lived experience in local contexts. At the same time, this intervention takes

place within a prescriptive format, mobilizes health knowledge conducted by university researchers, and embraces a process of rational discernment of that research. In this way, the process of PC CARES seeks to facilitate a dialogue which balances the tension between local knowledges and scientific epistemologies.

Second, PC CARES as *pedagogy* supports a decolonial process by inviting participants to use their own knowledge to determine if and how the research evidence relates to their experiences and community. By inviting dialogue about the intersections of suicide and colonialism, PC CARES legitimizes many people's understandings and experiences of oppression, cultural violence and rapid, imposed social change. Additionally, this critical lens fosters dialogue on how colonialism works in the lives of Indigenous youth, which opens a variety of possibilities for cultural and community-based prevention, advocacy, and resistance. Still, PC CARES is a translational space and not a purely decolonial intervention; its innovation regards the interpretation and translation of research evidence into self-determined prevention practice, and not the wholesale decolonization of epistemologies, pedagogy, or prevention practice.

Third, PC CARES as *practice* emphasizes decoloniality by inviting community-based action. The framework does not direct 'next steps' of participants, but rather understands them to be best able to determine the appropriate actions for their community, institution and family. This structure acknowledges that participants are knowledgeable and capable of determining how to use the information provided—while still relating practice to this research—to craft personal and collective suicide prevention practices. While stopping short of a full departure from the Western health research tradition, PC CARES challenges colonial structures of power by democratizing access to knowledge and deployment of resources, and by supporting local people as experts capable of determining the best avenues for prevention. Yet unquestionably, orienting such practice within the context of research-driven community conversations frames and circumscribes the debate in consequential—and colonial—ways. This 'middle ground' attempts to diminish colonial imperatives for particular actions that the community might be expected to enact, and instead seeks to generate space for participants to reject research findings, use the evidence as a tool to explore their unique community context, or to generate new knowledge and ideas for action.

Applying local lessons to prevention practice.

Thus far, we have focused primarily on the deployment of existing health knowledge in community contexts. However, the production of potentially generalizable *new* knowledge to reframe public health discourse is a critical aspect of the intervention, and a fourth level on which PC CARES attempts to assert an ethics of decoloniality. In this case, participating communities promoted the idea that indigenous youth suicide is not just a matter of distressed individuals, but of a complex history reflected in the fundamentally social act of suicide—and that effective interventions require community-level change. We have worked to incorporate these perspectives throughout this paper.

Dominant Western approaches to suicide prevention emphasize the idea of suicide as the outcome of some form of psychopathology or severe personal forms of suffering (White, 2012), with clinical intervention held as the ultimate aim of care. This construction

conscribes the issue of suicide in ways that can be understood as reflecting colonial understandings embedded in prevention science, public health, and medicine (Wexler & Gone, 2012; White, 2012). By professionalizing suicide care, the assessment and management of the suicidal mind becomes a responsibility of the select few, and the broader contexts of community and cultural support fade from view.

In calling for a departure from the “hegemonic and subjugated knowing” (Gone, 2016, p. 314) of colonial structures of power and knowledge in Indigenous communities, prevention practice can be refocused onto the varied forms of knowledge derived from lived experience of Indigenous stakeholders. From this standpoint, scholarship can follow suit, turning to the construction of social logics of suicidal behavior (Kral, 1994), social suffering (Kleinman, 1996), and cultural oppression and violence (Wexler & Gone, 2012; Kirmayer, Gone, & Moses, 2014) as drivers of risk. From this perspective, if “political power and social violence coerce subjectivity” (Kleinman, 1996, p. 288), then attention to the broader social context of suicide—and the social production of prevention science and intervention—is critical to spurring effective prevention practice. This kind of context-driven, interdisciplinary, and meaning-centered approach to health disparities has additionally been called for by scholars in public health and community psychology (Kral, 2012), anthropology and cultural psychiatry (Kleinman, 1988), social medicine (Farmer, Nizeye, Stulac, & Keshavjee, 2006), and global health (Kasper, Greene, Farmer, & Jones, 2016). To this end, PC CARES aims to occupy a middle ground between epistemological and caregiving traditions, bringing forth ‘other knowledges’ through critical engagement with research evidence. Mignolo (2014) refers to this process as decolonial thinking and as a kind of “epistemic de-linking” (p. 36) from dominant discourses.

Popular education methods aid the PC CARES process by drawing out what people already know from their lived experiences and positioning those experiences in relation to a larger social and historical reality (Freire, 2000). Its pedagogical practice invites learners to critically think about the power they have to transform their lives (Wiggins, 2011). By amplifying community narratives relative to the epistemology ubiquitous in psychiatric and mental health care, the learning circle legitimizes popular understandings of suicide, and supports local people in articulating their ideas for prevention based on community logics and forms of care.

Limitations and concerns

Although we highlighted important ways that PC CARES reflects decolonial prevention practice, there are many limitations and concerns. First, while facilitated by Alaska Native leaders and co-sponsored by a tribally-governed health care organization, PC CARES was developed in large part by a university-affiliated team of public health experts in consultation with tribal service providers. The resulting materials are prescriptive in their step-by-step format, with a facilitators’ manual that can be literally read from if facilitators so choose. Designed to be easy-to-use by local facilitation teams, these materials also reflect a restrictive format that structures the learning circle process in an unequivocally Western learning tradition. The use of research evidence itself promotes a process of codified rational discernment that some may consider at odds with a truly decolonial approach. The simple

fact of involvement and investment of non-local and non-indigenous program developers and researchers may further challenge our notions of decoloniality.

In response, we note that the possibilities for a pure decoloniality in suicide prevention practice seem quite limited under present circumstances, whether in relation to funding strategy, program design, or implementation. Moreover, it is far from clear to us what such a “pure” decoloniality might look like, even under the most optimal of circumstances. Generations of social, cultural, and political interplay have left us with poorly bifurcated Western and indigenous traditions, creating instead a social world defined by a continual process of evolving, borrowing, and appropriating categories of meaning and action (Geertz, 2001). In addressing youth suicide, distinctions between Western and indigenous, social and personal, clinical and community are ambiguous, artificial, and perhaps unhelpful. It is our hope that PC CARES supports responsible consideration of these issues, generative collaboration, and change in the right direction.

Conclusions

As the sovereignty and self-determination of Indigenous communities have become focal points of public and health policy debates, (Inuit Tapiriit kanatami, 2016), Western prevention science approaches which medicalize social problems such as suicide (Kral, 1994; White, 2012) have been widely criticized for the perpetuation of colonial power dynamics (Paine, 1977). Understanding Indigenous youth suicide as complex and socially-negotiated problem tied in public discourse to a history of colonial social violence, it is imperative that prevention efforts incorporate decolonial and community-based approaches in tandem with best practices from research to effectively address the issue on individual and community levels.

PC CARES seeks to foster a decolonial process based on the generation of collective knowledge, coordinated and self-determined action, and community healing. Using the results from the first of nine PC CARES learning circles, we have described how this approach facilitates dialogue and planning for suicide prevention by utilizing research evidence, while also supporting local people in articulating their own ideas for personal and collective suicide prevention. The results support our hypothesis that this educational model is both feasible and acceptable as a framework for incorporating both research evidence and Indigenous ways of knowing. In this way, PC CARES builds the capacity, confidence, and collective commitment to self-determined suicide prevention practice among Alaska Native people.

Acknowledgments

Research reported in this publication was supported by the National Institute of Mental Health of the National Institutes for Health under Award Number R34MH096684.

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