

# Arctic Suicide, Social Medicine, and the Purview of Care in Global Mental Health

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## Abstract

Youth suicide is a significant health disparity in circumpolar indigenous communities, with devastating impacts at individual, family, and community levels. This study draws on structured interviews and ethnographic work with health professionals in the Alaskan Arctic to examine the meanings assigned to Alaska Native youth suicide, as well as the health systems that shape clinicians' practices of care. By defining suicide as psychogenic on the one hand, and as an index of social suffering on the other, its solutions are brought into focus and circumscribed in particular and patterned ways. We contrast psychiatric and social explanatory models, bureaucratic and relational forms of care, and biomedical and biosocial models for care delivery. Within the broader context of global mental health, this study suggests steps for linking caregiving to the health and social equity agenda of social medicine and for operationalizing commitments to health as a human right.

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What is the purview of care in global mental health, and what is the role of health workers delivering care in settings of morbid social inequality? The syncretic frameworks of social medicine and human rights—turning to the social, historical, and structural forces that produce illness and govern its care, while directing such care toward achieving the highest attainable standard of health—offer several converging points of guidance. Social medicine refers here to the constellation of fields working to understand and organize care around the non-biologic bases of illness and disease.<sup>1</sup> Social medicine is both an articulation of, and path toward realizing, human rights—including the right to “the enjoyment of the highest attainable standard of physical and mental health,” as defined by the Constitution of the World Health Organization.<sup>2</sup> Finally, global mental health is meant to index the practice of researching, developing, and delivering mental health care on a global scale, with a health and health care equity agenda.<sup>3</sup>

Promisingly, the 21st-century scale-up of global health has seen mental health care find inclusion both conceptually and as a core service delivered by state health agencies and nongovernmental organizations on the global stage.<sup>4</sup> The rise of global mental health as a moral concern, and as a body of action to address inequities in the care of human suffering, closely parallels the development of global political commitments to the right to health—and dovetails with the twin health and social equity agendas of social medicine.<sup>5</sup> Increasingly recognized in these movements is evidence that many of the paramount predictors of mental health are social in nature; that mental health care delivery occurs within meaningful social contexts that significantly affect treatment adherence and outcomes; and that broad-scale social arrangements both define the distribution and burden of mental disorders and shape the manner in which care is extended or withheld based on the social legitimization of illness and experience.<sup>6</sup>

Yet the mental health fields (broadly, psychology, counseling, psychiatry, and clinical social work), as they extend their practice onto the equity-focused terrain of global health, have focused

primarily on the scale-up of technical interventions and systems of care developed in a small set of Western nations (that is, in comparatively affluent, biomedically oriented social and scientific contexts).<sup>7</sup> Research, policy agendas, and clinical care remain animated by a professional legacy and scientific product that focuses attention on pathological, disease-analogous processes internal to the individual, with social, political, and economic life treated as an appendix to the real work of understanding and care.<sup>8</sup> Culture, within the context of caregiving, often becomes operationalized as a technical skill or competency.<sup>9</sup> By tracking the framing and care of suicide in a remote region of the Alaskan Arctic, this study seeks to foster an action-oriented discussion of the broader meaning and purview of care in global mental health.

### Suicide care in Arctic Alaska

Perhaps nowhere is the ambiguous purview of global mental health more apparent than with respect to suicide care across the circumpolar North. In the context of the United States, Alaska Native youth suicide rates have become among the nation’s highest in the past 60 years, shaping a disturbing trend situated in public discourse as an “epidemic” that warrants broad-scale health system mobilization in response.<sup>10</sup> This takes shape through systems of surveillance, clinical intervention, and rights restriction, enmeshed in complex state regulatory environments and the bureaucracies of rural Alaska health care.<sup>11</sup> In the study region, the suicidal “patient” is typically held in the emergency room, village holding cell, or clinic until evaluated by a trained clinician for what is construed as essentially a medical event within the purview of clinical mental health care and emergency medicine.<sup>12</sup> Assessments for suicide risk and the delivery of care play out in a regimented, protocol-based system centered on clinical diagnosis, risk mitigation, and the prevention of harm—doubtless noble and worthy goals.

Paradoxically, the rise of youth suicide across the North American Arctic closely parallels the development of colonial infrastructure, including

health systems and public services, in indigenous communities.<sup>13</sup> Suicide rates have increased in tandem with the rapid and imposed social change that has characterized the “modernization” of the Global North in various waves of colonial settlement.<sup>14</sup> A common narrative in the study region links the social, economic, and political revisions of Arctic life experienced by indigenous people over the past century to mental health disparities, mediated by increased social inequality and diminished access to community and cultural protective factors.<sup>15</sup> Rapid, imposed social change and the dissolution of shared structures of meaning are implicated frequently in public discourse, as well as some research, as drivers of contemporary youth suicide.<sup>16</sup>

For some, the welfare colonialism embodied in health bureaucracies, public health infrastructure, and “Western” forms of care is linked to the generation and maintenance of indigenous health disparities, including suicide.<sup>17</sup> In response, Alaska Native leaders have called for community-based and decolonizing approaches that emphasize the protective value of culture, traditions, and sovereign systems of care.<sup>18</sup> While we focus here on the narratives attached to suicide among health and social work professionals, elsewhere we have contributed similar efforts from community perspectives.<sup>19</sup>

More broadly, this study is intended to investigate the relationship between defining a problem and invoking its solution in global mental health. Precisely what sort of thing is suicide? What can be done to stop it? And how can this assessment inform the strategies employed in global mental health to achieve the aims of fostering health equity, securing human rights, and alleviating preventable suffering?

## Methods

This study examines the meanings that health and mental health workers assign to Alaska Native youth suicide, the broader systems that shape these workers’ practices of care, and the communities these systems serve. We conducted 14 structured interviews with health professionals in a remote, predominantly (80%) indigenous region of Alas-

ka. Participants were recruited via convenience sampling to represent the key players in suicide care across the health system, including six social workers, three community health aides, two village-based counselors, two nurses, and a family medicine physician. Informed written consent was obtained from all participants.

Our interviews asked specifically about participants’ knowledge and beliefs regarding youth suicide and suicide prevention. We administered a scripted protocol of 14 questions, including five case study questions asking health workers to consider their responses to specific hypothetical suicide events. For example, one case study question asked participants to anticipate their response if a family member of a suicidal person were to contact them and ask for help. Another asked health workers to consider their response to rumors of a suicide pact among a number of village youth after the death of one of their peers. Additional questions covered successes and failures experienced with suicide prevention in professional and personal caregiving roles, perceived causes of youth suicide, training, recommendations to other health professionals for effectively intervening to prevent suicide, and perceived health system successes and failures (as well as recommendations for improvement) broadly across the region.

Each interview was recorded and selectively transcribed (omitting full transcription only of information that we deemed to be unrelated to the topic) to capture recurring themes. Key concepts were documented from every interview; these concepts included (1) specific theories on the nature and causes of suicide, (2) consistent patterns of care and collaboration across case study questions, (3) perceived successes and failures of the health professional’s own work, as well as of the health system broadly, and (4) discrepancies between beliefs and actions as a professional and as a community or family member with respect to suicide prevention.

We employed a grounded theory approach to induce recurring themes in health professional narratives about the nature and prevention of Alaska Native youth suicide across the region, allowing for an iterative process of grouping common mean-

ings into the four categories noted previously as the analysis progressed. Grounded theory is a social science methodology that generally begins with a question—in this case, how is Alaska Native youth suicide defined by caregivers, and how does this shape the care offered in response—and progresses to assess common themes and develop theories from coded data. In this study, we annotated interview transcriptions in Word documents with a code set developed progressively from common concepts across the four domains described above. Weekly teleconference meetings allowed us to consult with each other regarding our independent findings, and only themes common to both of our analyses are presented in this paper.

We further drew on 25 combined years of clinical, research, and health policy experience in the region to corroborate our findings. However, this experience may introduce bias into the interpretation of data, as we hold perspectives as health workers and have many personal relationships in the region. Our research was approved by the institutional review board of the University of Massachusetts-Amherst, and was conducted in partnership with the region's tribal health and social services organization. All names have been fictionalized, and specific clinical roles and other personal attributes changed to protect confidentiality.

## Results

Results are organized across three conceptual binaries: psychiatric and social explanatory models for mental health, bureaucratic and relational forms of care, and biomedical and biosocial models of care delivery. These act as useful, if wildly simplified, heuristics for understanding how mental health is understood, safeguarded, and supported within this tribal health system and among its Alaska Native and non-Native caregivers.

### *Psychiatric and social explanatory models for mental health*

Efforts at suicide prevention are necessarily animated by a set of beliefs about what the suicidal desire is to

begin with.<sup>20</sup> Answers to the question “What do you see as the root cause of Alaska Native youth suicide?” fell into the categories of psychiatric explanatory models (depression, mania, other mental health disorders, disrupted biological rhythms, inability to regulate emotion) and social explanatory models (historical and intergenerational trauma, social inequity, social logic, attachment and relationships). Alcohol use, by far the most frequently referenced associated condition, occupied a middle ground between the social and psychiatric, interwoven with notions of trauma, grief, and forgetting—but also indexing, for many health workers, a diagnosable mental health condition that leads to increased impulsivity, depression, and suicide.

**Psychiatric explanatory models for suicide.** We found a disjuncture between both Alaska Native and non-Native health workers' personal beliefs about suicide, on the one hand, and the structure of care for suicidal individuals, on the other. No interviewees endorsed the ubiquitous clinical narrative that links suicide to psychopathology, yet psychiatric explanatory models were reflected in the care delivered by every participant in the scenario questions. This course of action is unsurprising in this context, as it is a psychiatric understanding of suicide that roots intervention to health care in the first place.<sup>21</sup> Yet many health workers found this medicalized understanding of suicide to be a poor reflection of their own personal and professional caregiving experiences.

Melissa was asked about her experiences with suicide prevention in her capacity as a community health aide (a frontline provider in rural Alaska's community health worker system). Turning immediately to the Community Health Aide Manual, the book of protocols for village-based health care, she began to read:

*So page 694 in our manual is the stuff on suicide ... “Begin here if the patient seems to be having a new mental health problem such as anxiety, nervousness, feeling sad, thoughts of suicide ...” And there's a whole list of questions ... If patient is thinking about hurting self or others, say to the*

*patient, "I'm glad you came to clinic today. I am concerned about your safety or the safety of another person. I'm going to talk to the doctor, who will help you and make a plan for your safety. But first I need to ask you some more questions and do an exam to be sure the feelings ... are not being caused by a physical problem."*

Various iterations of this regimented style of intervention defined every answer to the scenario questions posed. Health workers universally turned to diagnostic manuals, clinical protocols, and psychiatric explanatory models to describe their actions in suicide care and intervention. Yet when asked about their personal beliefs, the same health workers tended toward social understandings of suicide that would seem to favor social and structural modes of intervention.

**Social explanatory models for suicide.** Social explanatory models relate suicidality to lived social conditions on one of two levels. The first focuses on the social contexts of suffering and despair—pointing to poverty, lack of opportunity, relationships, adverse experiences (especially physical and sexual abuse), marginalization, and trauma (including historical and intergenerational trauma) as causes of suicidality. The second social framework identifies the suicidal desire itself as a kind of social logic; that is, an idea to which certain individuals are more or less susceptible based on the incorporation of suicidality as a socially mediated logic of behavior into one's sense of self.<sup>22</sup> The vast majority of health workers' theories of suicide were social, focusing both on social determinants and social logic, yet this did not translate to social models for intervention.

Deborah, a non-Native social worker who has been in the region for close to a decade, explained her view of the social-relation cause of suicide as follows:

*When I first got here I remember my supervisor telling me to be very careful about the diagnoses I gave to people ... She said, "What you see is not what is happening." And I didn't get that ... I saw clients and was quick to give them diagnoses in my*

*own mind, like dependent personality disorder. And then I remembered what she said, and tried to remind myself of this. I realized it was more about their relationships and connections with other people, and when those relationships are gone or change there's no outlet ... to deal or process what they are experiencing.*

Deborah also addressed Linehan's parasuicidogenic expectancies, or the set of narratives, social constructions, and practices that shape a social logic of suicidal behavior.<sup>23</sup>

*To me, suicide ... can be glorified, because when somebody dies there are gatherings, and people come together to eat, there's food at the cookhouse in the villages, the whole town is busy-busy-busy for one person. And how that plays in the person's mind ... A lot of villages are scared that that promotes suicide. They see all of this stuff going on for this one person and they are afraid someone will think, "I want that attention, too."*

A public health nurse, Clarissa, expanded on the social logic of suicide and the legitimization of suicide as a viable outlet for pain:

*Suicide seems to be acceptable. It seems to be an acceptable alternative when you're kind of down and drinking. In my neighborhood ... in the last two years, three young men have committed suicide. In the last 10 years, many, many more. I think people do things when they're drinking that they normally wouldn't do. And I don't know where the idea that that's an acceptable thing to do, or is an alternative ... But it does seem to be. As you know, it's very, very common here.*

**Alcohol as middle ground.** Every health worker referenced the association of suicide with alcohol use, though the relationship was described in varied ways. Non-Native health workers were more likely to think of alcohol in a causal relationship to suicidality, whereas Alaska Native community health aides tended to describe alcohol as an intermediary between historical and personal trauma, social suffering, grief, and suicide. (In the study region, there is a dearth of Alaska Native physicians, advanced practice providers, and mental health

counselors, yet most community health aides are Alaska Native.) Social worker Deborah spoke to the confusing role that substance use plays in suicide:

*I thought at first ... that the suicidal thoughts were there and that the alcohol just brought them to light. As I worked more with people, I have learned that is not necessarily the case at all. It doesn't mean that just because you took a bunch of pills, that thought was always there.*

Deborah views the suicidal person's experience as often disjointed from their sober experience, noting that the sober "version" of the person may not feel suicidal at all. It is common for intoxicated, suicidal people, she noted, to become medical patients in the emergency department for a night—only to be released the next morning when they are sober and categorically deny any suicidal ideation. It is important to clarify, however, that many people with experience—either firsthand or through friends or family—know that expressing suicidal ideation can result in rights restriction and displacement for inpatient psychiatric care several hundred miles away. As Katie, a nurse, stated of her patients' attitudes, "What do I really say? I don't want to be Title 47-ed [have my rights taken away]. I don't want to be told what to do."

#### *Bureaucratic and relational forms of care*

A second fault line in suicide care relates to the meaning of care itself, as either a fundamentally relationship-driven act or a prescribed and professionalized system. These qualities correspond to the designations of relational and bureaucratic care, respectively.

While there are important cultural dynamics at play in how care is felt and expressed, the disparity between personal and professional caring roles was described as the key point at which bureaucratic and relational care diverge.<sup>24</sup> Especially for Alaska Native health professionals and those who have spent significant amounts of time in the study region, a disjuncture was often noted between personal and professional roles in suicide prevention. That is, the expectations and regulations that shape one's professional approach to suicide prevention

sometimes bore little resemblance to the personal attitudes and beliefs held by the same person. The cultural gap between clinical roles at the village level (Alaska Native community health aides) and in the regional hub hospital (generally non-Native providers, nurses, and social workers) compounded and confused these dynamics, as professional roles are often further bifurcated along these lines.

While the discretion "allowed" in these professionalized caregiving relationships is shaped by an unwaveringly bureaucratic interface, community health aides are necessarily caring for friends and family in both formal and informal capacities as the sole health care providers in village communities.<sup>25</sup> Melissa, a community health aide, captured this disjuncture succinctly. When asked what she would do if confronted with a suicidal patient at the clinic, she responded:

*I would go to the [Community Health Aide Manual] section that, you know, asks those questions ... [She finds the section and begins reading:] "CHAP is not expected to make a specific assessment and plan for mental health problems. You will report to your referrals doctor who will make the assessment. The next two to three steps will help you with your report. Use 'Chart A: Signs that a mental health problem may be caused by a physical illness' to decide if patient's problem may have a physical cause. If needed, use index in this manual to find the problem ... If you think this patient has a mental health problem, use chart B to help you decide what might be wrong with the patient."*

The interviewer then asked Melissa if she could recall another time that she had intervened in a suicide event. Melissa spoke in a measured voice about how one of her children had died by suicide and that after this, another child had attempted suicide several times. She explained:

*And then I realized, after his third attempt ... I figured I wouldn't just take him to the hospital. I would take him out in the country. So we got in the boat and left. But that was the last time he attempted ...*

*After that I decided to move my family to camp. We homeschooled our ... little kids for three years*

*in subsistence camp. And that's where we regained ... how we associate with our family, you know? We had to work out a lot of things at camp ... But that's what it took.*

Melissa's statements point to a fissure between two culturally mediated forms of care—the bureaucratic and the relational. This fissure is also structured through the tension between professional role-obligations and personal relationships. On the one hand, Melissa cares for her patients at the village clinic through the strictures of medical standing orders and clinical protocols, themselves authored by non-Native policymakers and administrators enmeshed in the ethos of a bureaucratic “care delivery system.” Within her professional role, Melissa is responsible for providing a prescribed form of care that does, in fact, prevent suicide events.

At the same time, Melissa recognizes the insufficiency of clinical care for suicidality when it comes to her own family. She takes a seemingly antithetical approach to supporting her own children by removing them from clinical care and embedding them in a specific form of cultural and family life. This care centers on strengthening relatedness among family members, the land, and culture.

It is well argued that the space occupied by family members and health professionals ought to be distinct, along precisely these lines. However, the point we seek to illustrate is that bureaucratic forms of care often come to *supplant* relational ones, as the health care system legitimizes itself as the primary vehicle for addressing suicidality. Moreover, on the small scale of village-based care, friends, family, neighbors, and patients are far from distinct. This same health aide told a story of abandoning her post at the clinic to go to the cemetery when she had a “bad feeling” about a patient. She found him there, unconscious on top of his brother's grave after a prescription drug overdose. Melissa saved his life but violated the rules defining her professional role by leaving the clinic.

**Bureaucratic forms of care.** Bureaucratic care describes the systematization of care “delivery” and the professionalization of caregiving roles. This

form of care deeply informed responses to suicidality throughout the study region. Intense concerns over fault and agency characterized the experiences of mental health counselors especially, who saw their role as one protective both of their patients' lives and of the interests of the health system broadly. In response, clinicians turned to the clinical protocol to describe and rationalize their care. Deborah, a mental health counselor, explained her role thus:

*Now I am to the point where if they say A, I know we have to do that, and if they say B, C—I know that is what we have to do. And if they say they don't want to do A, then here's what comes next. So I am pretty comfortable with how things work and I know how to get people here, still not violating their rights, and making sure they are safe.*

Such statements, highlighting the role of the clinician as a navigator of a preordained decision tree, were pervasive throughout interviews, where health workers felt their agency to be defined and circumscribed both by explicit protocols and by the expectations and norms of their professions. Even when personal beliefs about effective and moral forms of care diverged from bureaucratic ways of proceeding, it was bureaucratic care that typically defined what was offered.

**Relational forms of care.** Where in bureaucratic care the object of care comes to matter abstractly, rationally, and as an instance of a broader population, the opposite is true of relational care, where the individual matters specifically, emotively, and contextually. Acts of care emerge in this sense from an active relationship that itself establishes one's capacity to help.

Jane, a social worker, discussed her role in supporting distressed and suicidal students in the school system. She emphasized the importance of coming to understand, from her students' perspectives, the nature and origins of their suffering. Jane also understood the primary vehicle for addressing students' problems to be the relationship itself. When asked about what she finds most meaningful about her job, Jane replied:

*[Laughs] Actually helping the students. All the other stuff, I'm pretty sure it's not meaningful. But when I have an opportunity to help the students, that's really what I signed up for this job to do. And that goes anywhere between helping them out in family or relationship situations, or helping them through a struggle with drugs or alcohol, or just connecting with them because they've been bullied in class. Or even in situations of suicide, the whole gamut.*

*[Researcher: And what do you feel in those scenarios helps you be helpful?]*

*Especially in this region, one of the first things ... I know it seems trivial, but simply just knowing their name, to start out with. Just being able to call them their name.*

Being able to recognize and call a student by name is, for Jane, the beginning of the act of care. To name is to call a specific and definite relationship into being, and Jane characterizes her relationship with youth as the core of her ability to help.<sup>26</sup> In doing so, Jane resists many of the bureaucratic forms of care that define her professional role. Under special circumstances, for example, Jane gives her personal cell phone number to youth when they are having trouble at home. She also describes leaving the school to search the streets for a youth about whom she is concerned. If a student's parents were drinking and fighting the night before, leading to the student's dismissal from class due to inattention or disruptive behavior, Jane habitually provides a quiet place for the student to sleep at the school. If food shortage was the origin of distress, the student is fed. All of these forms of care extend beyond the prescriptions of Jane's professional capacity, yet she describes them as by far the most important elements of her work and care.

### *Biomedical and biosocial systems of mental health care delivery*

We found specific acts of caregiving to both shape and be shaped by broader systems of care delivery. That is, explanatory models for suffering structured the broader context in which mental health challenges were addressed, just as these contexts contoured caregiving at the most local and immediate levels.

Biomedical care systems tend to construe mental health care delivery as primarily a matter of accurate and timely diagnosis of a discreet category of disease, whereas biosocial perspectives strive to organize care around the social forces that affect the distribution and burden of mental distress or disorders, the manner in which these forces become embodied in personal suffering, and the social dynamics that mediate access to, compliance with, and efficacy of treatment.<sup>27</sup> This kind of practice may involve engaging the broader social and structural determinants of health, or simply inform the use of biomedical therapeutics to maximize efficacy. As Kasper and colleagues write, "Even when biomedical interventions are the best option, patients' ability to benefit from them are embedded in social, economic, and political systems that impact the outcomes of medical care."<sup>28</sup>

**Biomedical systems of mental health care delivery.** The arc of treatment for suicidal youth in remote Alaska often begins and ends in an improvised room in the local village clinic. "High-risk patients" are transported by aircraft to the regional hub city to be admitted the emergency room and then inpatient ward of a small hospital as they await the opening of a psychiatric bed in Anchorage, more than 500 air miles away. Wait times for psychiatric beds run into the weeks, and many rural and remote communities provide little by way of care beyond restricting access to lethal means through physical restraints. Perhaps unsurprisingly, skepticism is widespread regarding many forms of mental health care—from psychotherapy to psychiatric care.

Once a youth is "stabilized," referrals to a community behavioral health program are generally provided; however, mental health care is widely underutilized in the study region. In the study region, only 8% of people who die by suicide have accessed mental health care over the course of their lives.<sup>29</sup> Carol, a village-based counselor, addressed the delivery gap in mental health care, which she sees as maintained through local frustrations with the bureaucratic process of intake and clinical care—symptomatic of a biomedical system that



fails to reflect local values, including the rejection of bureaucratic care:

*If you look at how many people who are screened for suicidal behavior and how many actually go on to sign up for [behavioral health services] and receive services, there is a huge gap. The system isn't working for people who need help the most due to paperwork requirements and policy and procedure requirements and red tape.*

Melissa, a community health aide, built on Carol's narrative:

*I know there's way more ideation in these small communities than what's reported. There's a lot of them that go unreported—probably half of them ... Because people know, if they call the cops or go to the clinic, they're going to get put in the hospital in that one room where it's all padded.*

As Melissa notes, *avoiding* clinical care can become a priority for people who are suffering. Many health professionals noted that the poor fit of clinical mental health care, relative to Alaska Native traditions and social expectations, creates a significant barrier to care. On the broadest level, framing suicide within the discursive registers of medicine and mental health strikes many in the study region as fundamentally poor logic. Instead, calls for engaging traditional healers and tribal doctors, family members, and broader social networks are widespread throughout rural and remote Alaska.

**Biosocial models of health care delivery.** Every health worker interviewed made reference to the importance of understanding the social context of Alaska Native communities, be it through knowledge of culture, communication styles, idioms of distress, patterns of service utilization, gaps in services, or the colonial history of the North. Many also noted that health professional training should be adapted to fit local contexts. Katie, a nurse, explained:

*I think there should [be] a lot more cultural training. You know, you only get 30, 45 minutes ... they really should expand on that, especially for people who are not from Alaska, so they're not aware of*

*a lot of the cultural differences ... You're coming to a community that is 80% or better Alaska Native. And you're not.*

*If you've never been around an Indian culture or a community where you are the extreme minority ... I think there needs to be a lot more training on how to identify ... subtle signs and symptoms of people who may be suicidal. And it's different here than it is in the Lower 48, where I come from, because the reasons that people kill themselves here are different. I've been here a year—I'm finally figuring out the "why."*

Perhaps ironically, the reasons Katie cites for Alaska Native suicide relate to daylight exposure and mania, rather than specific social or historical forces; yet she feels strongly that social health and care represent essential aspects of health promotion in Alaska Native communities. Along with every other health worker interviewed, Katie noted that "culture"—used colloquially in the study region to index a constellation of racial and ethnic identity, shared social life, and geographic solidarity—bears heavily on both the causes of illness and the meanings attached to care.

Many Alaska Native health professionals invoked critiques of biomedical care related to history and rights: specifically, the relationship among colonial social violence, tribal sovereignty, and systems of care. While there was a notable lack of consensus regarding what a truly biosocial care system might look like in the context of mental health, key recommendations included addressing the social determinants of health at the root of mental, emotional, and social suffering; attending to cultural safety in existing care systems; and supporting community- and culture-based healing initiatives in addition to formal clinical care.

## Discussion

### *The meaning of care*

In this study, "care" is taken to mean both "the way someone comes to matter and the corresponding ethics of attending to the other who matters."<sup>30</sup> As Arthur Kleinman and colleagues note, care spans moral, emotional, and enacted dimensions.<sup>31</sup> How-

ever, the turn in contemporary medicine—and, by virtue of their relationship, global mental health—has been toward a near-exclusive focus on technical aspects of care, to the point of disregard for the “coming to matter” part of care.<sup>32</sup>

Arctic anthropologist Lisa Stevenson notes this absence in her description of the failures of caregiving in the neocolonial north.<sup>33</sup> Framed through Michel Foucault’s concept of biopolitics, which describes the politicization and governance of citizen health through enacted state power and control, Stevenson describes the role of biopolitics in terms of the “maintenance of life itself.”<sup>34</sup>

*[B]iopolitics as a logic of care informs not only the way policies concerning the population are enacted, but also how individuals engage with other individuals while adhering to the logic of biopolitics that treats individuals as members of a population.*<sup>35</sup>

Stevenson sees biopolitics in individual acts of care, describing such care as “anonymous”—that is, “one cares, but indifferently,” without specificity, context, or relation.<sup>36</sup> One cares for the individual, as a representative instance of a population, *because* of one’s role as a professional charged with their care. This ethos is justifiably central to global mental health, with its focus on population health, professional care, and universal rights. Yet biopolitics as a logic of care, made manifest in the individual and specific interactions between caregiver and care recipient, can be experienced as uncaring, disingenuous, and violent. Within these tensions, the “health care crisis” of Alaska Native youth suicide plays out.

### *Redefining suicide care*

Suicide care involves navigating within caring relationships through the most practical and exigent of risks, the prescriptive nature and practicalities of care systems, and the complex social conditions that give rise to the level of suffering that suicide inherently marks. In the neocolonial context of many circumpolar indigenous communities, the movements of power throughout history—and within contemporary life—bear further on both

the meaning and causes of suicide, and the meaning and purview of care.

Linking suicide prevention and care to an explicit and actionable human rights agenda, realized through social medicine, is a critical step. The 2019 statement on suicide prevention issued by the United Nations Special Rapporteur on the right to health summarizes this frame succinctly:

*Providing holistic support for individuals and populations as a whole, particularly those who are most vulnerable, enables the attainment of the right to health by addressing the structural and psychosocial determinants of distress, such as childhood trauma and abuse, social inequality and discrimination. A focus on locating problems and solutions within individuals obscures the need to address the structural factors that make lives unliveable.*<sup>37</sup>

Within this context, we propose a reframing of global mental health to include a focus on what makes lives livable through social medicine and the broader human rights that such care must deliver, including political participation, work, and a standard of living adequate for health and well-being.<sup>38</sup> Such an effort further entails reframing suicide care to foreground the social explanatory models, relational care, and biosocial care systems described in this paper. Priorities under this social care agenda include redefining the problem of suicide; centering caring relationships, both between patient and caregiver and between community members; and building care systems around the right to health, with moral clarity and practical understanding that all human rights are health rights.<sup>38</sup>

First, suicide should be described, defined, and addressed within meaningful social, historical, and political contexts—especially by those whose lives are affected by this tragedy. Examples of this include the National Inuit Suicide Prevention Strategy of the Inuit Tapiriit Kanatami, the national representational body of Canadian Inuit, which invokes the social history of the problem and contextualizes care within the broader project of fostering healthy conditions and meaningful livelihoods for indigenous people by realizing a full range of human rights.<sup>39</sup>

Second, we must again create space in the clinical encounter for the “coming to matter” part of care. Global mental health allows for little by way of universalisms—but if there is one that works, it is that healing occurs within meaningful relationships.<sup>40</sup> Community health worker programs, longitudinal academic partnerships, and local training programs all work to promote this agenda.<sup>41</sup> Broadly, it is essential that health resources, from payment models to clinical roles, be brought in line with the expectation that relationships between health workers, care recipients, and community caregivers are the foundation for global mental health.

Third, care systems must incorporate a fuller understanding of the drivers of health and illness—beginning with a rejection of exclusive reliance on neuropsychiatric treatments to accommodate social inequality.<sup>42</sup> If we are to accept the role of state intervention for the maintenance of life itself, parallel demands must be made on the human rights that such a system supports.<sup>43</sup> This process includes supporting locally governed development agendas; facilitating the horizontal integration of government, social, and health services; and decentralizing authority in global mental health to include indigenous knowledge and healing traditions, community and peer supports, and sovereign systems of care.<sup>44</sup>

### *Promoting social medicine and human rights in global mental health*

Broadly, social medicine and human rights can advance several complementary perspectives in global mental health. First, both disciplines, at their best, look beyond the biologic bases of mental disorders and the biopolitics of technical intervention for their remediation.<sup>45</sup> They create vibrant environments for understanding how social, political, and historical forces affect mental health—and for structuring interventions that act across multiple strata of social determinants of health.<sup>46</sup> This in turn raises important questions regarding who provides global mental health care, what that care looks like, and how it is paid for.

Second, human rights and social medicine

inevitably engage with issues of political economy, human rights, and health and social equity.<sup>47</sup> General awareness of the social, economic, and political forces affecting the distribution and burden of mental disorders is a poor guarantee that such understandings will be positioned to influence health and social policy, without explicit and intentional negotiations to wed global mental health to an equity plan that seeks to reduce social stratification for its own sake and as an avenue to better health outcomes.

Finally, social medicine and human rights invoke the moral and emotional aspects of care, alongside the technical requirements of care delivery.<sup>48</sup> These fields can advance a human and relational approach to mental health care that takes seriously the first-person perspective, its social location, and the patient-caregiver relationship as essential domains of care.

## Conclusion

This study explores the meaning and purview of care in global mental health by contrasting practices of suicide care in a remote region of Alaska. We offer an alternative to notions of cultural competence as a technical skill, instead reconsidering health workers as engaged observers of the social arrangements that both produce and are propagated by poor health. Social medicine and human rights shape approaches to understanding and redressing mental health disparities that advance the intellectual and moral scaffolding of global mental health. By wedding these perspectives to each other and to an advocacy and equity agenda that holds central the claim to health as a human right, a hopeful future for global mental health is in sight.

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