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Why an alternative to suicide prevention gatekeeper training is needed for rural Indigenous communities: presenting an empowering community storytelling approach

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Abstract

The need for effective youth suicide prevention is uncontested, and is particularly urgent for Indigenous populations. The Indigenous youth suicide rates in some North American communities can be 18 times greater than for other young people. Despite the clear need, evidence in support of Indigenous youth suicide prevention strategies remain mixed. The most common approach to youth suicide prevention – gatekeeper training – may have limited effects in Indigenous communities. Based on recent work undertaken with Indigenous leaders in rural Alaska, we describe culturally grounded, practical alternatives that may be more effective for Indigenous communities. We highlight the ways in which research informed, grassroots interventions can address cultural, practical and systemic issues that are relevant when addressing risks for suicide on a community level. Built on a transactional-ecological framework that gives consideration to local contexts, culture-centric narratives and the multiple, interacting conditions of suicide, the innovative approach described here emphasizes community and cultural protective factors in Indigenous communities, and extends typical suicide prevention initiatives in ways that have important implications for other ethnically diverse communities.

Keywords

empowerment; indigenous people; prevention

Introduction

Youth suicide is a significant problem, particularly for Indigenous populations which have extremely high rates of suicide and suicidal behavior (Borowsky, Resnick, Ireland, & Blum, 1999; Centers for Disease Control and Prevention, 2005; Durie, Milroy, & Hunter, 2009; Kirmayer, Boothroyd, & Hodgins, 1998). In the specific context of Alaska, the annual suicide rate can be more than 18 times higher for Alaska Native (AN) youth ages 15–19 than for other American youth (124 vs. 6.9 per 100,000) (Wexler, Silveira, & Bertone-Johnson,

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2012). At the same time, it is important to acknowledge high levels of variation. Many Indigenous communities in Alaska and across North America have suicide rates well below the national rate (Chandler & Lalonde, 1998). Nonetheless, suicide remains one of the top two leading causes of death for AN youth (Alaska Bureau of Vital Statistics, 2012).

Although the need for Indigenous youth suicide prevention is uncontested, there is little guidance to help practitioners constructively respond to individuals who may occupy a different social location or cultural background from their own. There is even less opportunity for practitioners to consider the ways in which mainstream mental health practices are themselves steeped in particular values, cultural traditions, and ways of knowing (Wexler, 2011; Wexler & Gone, 2012). With this article, we call attention to the potential limits of standardized approaches to suicide prevention gatekeeper training for rural Indigenous communities, using recent work with Indigenous communities in Alaska as a site for exploring alternative approaches that privilege local knowledge, storytelling, and community empowerment.

In the United States, the majority of federally funded youth suicide prevention programs rely on gatekeeper training as a key strategy (Macro International, 2010; Rodi et al., 2012). This approach is designed to encourage early identification and referral of potentially suicidal youth to mental health services (Evans & Price, 2013; Rodi et al., 2012). Community gatekeepers include teachers, youth workers, coaches, and others who have regular, typically ‘non-clinical contact’ with youth. Such ongoing proximity to youth places these gatekeepers in a unique position to be able to detect potential signs of depression and suicide risk in young people in order to refer them to mental health services if needed. This approach needs to be critically examined for its cultural relevance (Wexler & Gone, 2012) as well as the kinds of contexts in which it is likely to be effective (Evans & Price, 2013). In this article, we do just that by broadly scanning the academic literature and published program evaluations, and reflecting on our own experiences working in this area. Drawing together various strands of available critique, we identify critical issues embedded in the format and content of gatekeeper training, and underscore its limitations in the context of rural Indigenous communities. In doing so, we necessarily overstate the problematics of the approach in an effort to highlight a need to go beyond typical gatekeeper training. As an example of *one* way forward, we describe an alternative approach, Collaborations for At-Risk (youth) Engagement and Support (CARES). Developed with Indigenous leaders and community members, the CARES model attempts to address some of the limits of de-contextualized and standardized approaches that characterize most gatekeeper training models.

Mixed evidence in support of gatekeeper training

Gatekeeper trainings tend to coalesce around key content: didactic teaching about suicide prevalence, risk factors, and warning signs; encouraging participants to reach out to those who show ‘warning signs’, and referring those at risk to mental health services, if needed (Gould & Kramer, 2001). An appealing aspect of the approach is that local people can be trained to facilitate the training. This cascade training model means that workshops can

be offered in an ongoing way and the expertise remains in the community. This benefit is especially important in rural communities where sustainability can be a major challenge.

Although gatekeeper training has been adopted throughout North America (Cross et al., 2011; Macro International, 2010), the low base rate of suicide and the diffusion technique of the model create evaluation challenges that have prohibited direct evidence that gatekeeper trainings reduce suicidal behavior. Previous evaluation studies link the training to an increase in suicide knowledge, readiness to intervene, and skills for intervention in participants (Cross et al., 2011; Evans & Price, 2013; Isaac et al., 2009). At the same time however, 'the research conducted to date does not yet clearly demonstrate whether gatekeeper training has a unique and independent effect on reducing suicidal ideation, suicide attempts, and deaths by suicide' (Isaac et al., 2009, p. 266).

Additional evidence suggests that gatekeeper training may not meet the needs of Indigenous communities. A recent national evaluation of gatekeeper trainings in American Indigenous communities indicates that participants acquire information and skills, but do not often apply them, believing the practices are not aligned with local cultural and social expectations (ICF Macro, 2010). For instance, Indigenous respondents noted that referring a family member to a stranger (who happened to be a mental health clinician) did not necessarily align with their community's sense of relatedness and the interpersonal roles and responsibilities that accompany it. Other published research on gatekeeper training in Aboriginal communities in Canada found a decrease in intentions to refer to mental health services after attending the training (Capp, Deane, & Lambert, 2001). This finding was reinforced in a two-year follow-up study with the same Indigenous communities (Deane et al., 2006). In a more recent randomized controlled trial in a Canadian Indigenous context, the gatekeeper training had 'no significant impact' on intervention skills '… or on self-reported confidence, skills, knowledge or preparedness to help someone who is suicidal' (Sareen et al., 2013, p. 1025).

A key learning outcome in gatekeeper training – the increased identification and referral of suicidal youth to mental health services – may not always be viable or useful. The majority of Indigenous youth in North America do not utilize these services, even when referred. Most never receive care even when showing signs of anxiety, anger, depression, or other mental distress (Beals et al., 2005; Novins, Beals, Roberts, & Manson, 1999; Wexler, 2011) or when actively suicidal (Freedenthal & Stiffman, 2007; Wexler et al., 2012). Research from one region in Alaska suggests that mental health services are typically utilized exclusively during crises, and only after peers and family members have depleted their social reserves (Wexler et al., 2012). One reason for this underutilization of services is stigma associated with mental health services (Oetzel et al., 2006). Although this stigma is not unique to Indigenous communities, it is perhaps worse since these services can be understood as misaligned with Indigenous cultural and community values (Wexler & Gone, 2012).

In acute cases where suicidal Indigenous young people do receive treatment, some research indicates this care is often culturally inappropriate and can be further traumatizing. As Josewski (2013) puts it, '… consistent with Western bio-medical and individualised notions of health and illness … the tendency within the mental health care system has

been to interpret Aboriginal mental health problems as arising from individual pathology, dysfunction and life-style choices' (p. 224). Not only is such an orientation at odds with Indigenous epistemologies (Gone 2003, 2007; Gone & Trimble 2012), which typically emphasize holistic understandings of health and wellness, but it also ignores the role that social, historical, and political forces play in the emergence of suffering (Vukic, Gregory, Martin-Misener, & Etowa, 2011). Understanding the linkages between colonialism and self-destruction is particularly important when responding to AN suicide (Wexler, 2009). Further, once a mental health clinician is involved, the imminent risk posed by the late stage intervention often requires that the suicidal person be taken from his/her rural home community to ensure his/her safety (Wexler et al., 2012). Aside from the potential to be distressing, forced removal from one's home also represents a missed opportunity to build on the protective factors of tribal communities, and to align mental health services with the local cultural norms. Recent literature calls for comprehensive, multi-strategy, ecological-transactional approaches which are implemented across an array of settings and contexts and developed by/with local communities (Alcántara & Gone, 2007; Baber & Bean, 2009). Recent scholarship calls for interventions that create conditions that enable the development of collaborative relationships between professionals and communities (Durie & Wyatt, 2013). Paying attention to the larger organizational norms and overall practice cultures, especially the ways in which they can either enable or inhibit the uptake of suicide prevention gatekeeper skills and knowledge, is an important contextual consideration that has only recently begun to be explored (Evans & Price, 2013). Additionally, scholars and communities have called for a shift in perspectives: moving from deficit-based suicide prevention efforts to more democratic, strength-based, resilience building and wellness-oriented initiatives (Kirmayer, Dandeneau, Marshall, Phillips, & Williamson, 2012; Wexler, 2014; White, in press).

Suicide is an act with many meanings

Suicidal behavior among Indigenous youth is not easily addressed through formal service systems for a variety of other reasons. An important factor is that 'youth suicide does not carry a single meaning, nor is it a stable, certain or 'tame' problem. As such, it cannot be solved or contained, through an exclusive reliance on predetermined, standardized, decontextualized interventions' (White, 2012, p. 42). Training gatekeepers to refer all potentially suicidal youth to formal service systems is one example of a predetermined, standardized, and decontextualized intervention. While we do not dispute that professional help may provide a much needed and useful response to a young person in distress, what is at issue here is the uncritical way in which 'professional help' is conceptualized as a neutral, culture-free intervention and promoted as the most appropriate response within many gatekeeper training programs.

Professional help is generally assumed to be a relevant, useful, and logical solution for those identified as 'at risk', and referrals to mental health agencies quickly become a kind of generic response. Evidence from a recent review of gatekeeper referral patterns for youth identified as at risk for suicide seems to bear this out. Specifically, a review of referral patterns among those who recently participated in a gatekeeper training program suggested that in the large majority (73%) of cases, youth who were identified as at risk for suicide

were referred for a mental health assessment (Rodi et al., 2012). Our concern is that standardized gatekeeper training programs appear to place minimal emphasis on exploring context-specific, collaboratively generated solutions that are in keeping with young peoples' cultural and/or spiritual preferences. This kind of response could include: family and community gatherings; online support; healing ceremonies; nature-based activities; social activism; and/or other responses that could provide hope, solidarity, and sustenance to young people experiencing various forms of distress (White, in press). These approaches acknowledge participants' knowledge, meaning systems and practices, creating a more collaborative and democratic learning environment.

Since suicide does not adhere to a particular pattern at the individual level and because it is rare even in communities with high rates, it is difficult to detect. Even when identified, many 'at risk' people forego mental health services because of stigma and embarrassment (Gulliver, Griffiths, & Christensen, 2010; Rickwood, Deane, & Wilson, 2007). According to a recent review, the number of youth in the general population who access community-based mental health services following a suicidal crisis is relatively low: about 50% (Michelmore & Hindley, 2012). For those youth who do seek mental health treatment following a suicidal crisis, the dropout rate is very high, with half of all youth attending less than five sessions. Clearly, there are inherent limitations to prevention efforts that narrowly focus on referral to mental health services.

Meanwhile, it is important to recognize that many of the biggest threats to well being among Indigenous youth arise from existing structural inequities that simply cannot be addressed through the provision of mental health services (Kirmayer, 2012). Thus, any approach to suicide prevention or healing needs to take account of the enduring negative effects of colonization and the unique role of historical trauma in the lives of Indigenous youth, families, and communities. These include the forced removal of children from their homes, institutional racism, assaults on culture, theft of land, disruptions to family life, and attempts at assimilation (Kral, 2012; Vukic et al., 2011).

With the broader historical and socio-political view in mind, suicide prevention efforts might best be directed towards strengthening social and familial support, addressing multiple forms of trauma, and providing culturally grounded healing practices (Kirmayer, Simpson, & Cargo, 2003). These kinds of initiatives focus on developing critical consciousness and community activism (Horton & Freire, 1990) as a driver for empowerment and wellness. These approaches will require multiple strategies and community-wide approaches, which simultaneously engage individuals, families, communities, social policies and structures, and reposition community members as knowledgeable drivers of change rather than recipients of information and skills.

Critically examining the gatekeeper training model includes considerations about its educational methods, learning outcomes, cultural universality, and underlying assumptions about the nature of suicide. The critique that follows is not meant to be comprehensive, but rather is designed to establish potential problematics for Indigenous communities. We address the content and the educational strategy of gatekeeper training, as well as the larger social context within which gatekeeper training has been envisioned as a

solution. Following this, an alternative to expert-driven and didactic educational strategies is described. Specifically, the CARES, which is an engaged, storytelling approach that was developed with Indigenous community members for a rural, AN context is presented.

Problematics of current gatekeeper training for indigenous communities

When suicide is viewed exclusively as a private, individual problem that is directly linked to psychopathology or intrapsychic experiences, there is very little opportunity to see its relational, social, historical, cultural, or political dimensions (Wexler & Gone, 2012). Such a narrow conceptualization often invites professional responses that target the individual person for change, while neglecting many of the socio-political processes and structural forces that confer suicide risk, including, for example, social inequity, racism, homophobia, or colonization (Wexler, DiFluvio, & Burke, 2009). In this section, we explore some of the specific implications of this 'one-size fits all' approach.

Gatekeeper training content—The conception of suicide associated with psychological illness and certain risk factors and identified by particular 'warning signs' may not apply to communities universally. Generalized risk factors and warning signs are based on population-level data and may or may not conform to an individual's etiology or a group's epidemiology. The rendering of suicide in one particular way can, thus, limit the possibilities for prevention. The presumed factors and signs can lead to missed opportunities for identification of those at risk if they do not adhere to these population-based descriptors, signs, and trajectories. This limitation is particularly salient for marginalized groups, such as Indigenous people.

The etiology and demographics of suicide vary considerably in different populations (e.g. Dorgan, 2010; Rebholz et al., 2011; Wexler et al., 2012; Zhang, Xiao, & Zhou, 2010). The differences in patterns for different groups underscore the multiplicity, complexity, and variance surrounding suicide. Yet, gatekeeper training typically presents population-specific suicide knowledge in ways that obfuscates the cultural, gendered, and even place-based specificity of the act. Presenting suicide 'facts' that are based on population statistics risks undermining the knowledge of people – particularly those from marginalized and minority communities – who know differently, epistemologically, and ontologically (Kirmayer, 2012). Given that the aim of gatekeeper training is to encourage gatekeepers to notice vulnerable others and motivate them to intervene with identified persons, this form of universal training could be problematic.

Importantly, an overarching goal of most gatekeeper training curricula is not only to identify and intervene with those at risk of suicide, but to refer suicidal persons to mental health services. This aim is not always a viable one, particularly in underserved, rural Indigenous communities. Foremost, as stated above, few young people (and even fewer Indigenous youth – see Freedenthal & Stiffman, 2007; Oetzal et al., 2006) seek and engage in mental health treatment (Hunt & Eisenberg, 2010). Some scholars have considered certain unspoken cultural understandings of mental health interventions, including suicide risk assessment and treatment practices (Rogers & Russell, 2014), which may explain this underutilization of services. Being verbally articulate, emotionally expressive, rational, self-disclosing of

personal information, and cognitively congruent are just a few of the expectations embedded in much mental health treatment (James & Prilleltensky, 2002; Rogers & Russell, 2014). Rather than conceptualizing mental health interventions as objective, universal, or value-free, it can be helpful to see them as culture-bound products which have arisen within specific disciplinary traditions and may not be appropriate for all clients in every context (Kirmayer, 2012; Rogers & Russell, 2014; Wexler & Gone, 2012).

Gatekeeper training pedagogy—While some gatekeeper programs make a concerted effort to be locally responsive (see for example LivingWorks), there is often a reliance on standardized, de-contextualized, and didactic teaching of risk factors and signs, which can be at odds with people's everyday experiences. This incongruity is particularly true for ethnic groups whose traditional pedagogy relies on nuanced and personal understandings facilitated through stories and experience (Cruikshank, 1990; Howard, 1991; Hurd, Muti, Erwin, & Womack, 2003; O'Nell, 1996; Panikkar, 1992; Rosaldo, 1986). Personal storytelling invites locally situated, relational, and/or spiritual communications, which may be more aligned with Indigenous suicide prevention (Vukic et al., 2011).

Although vignettes are sometimes sprinkled into content, the typical gatekeeper curriculum emphasizes knowledge based on population-derived statistics and retrospective suicide studies. This approach to suicide prevention can be characterized as 'teaching as telling', where experts transmit the 'facts' to passive recipients. White, Morris, and Hinbest (2012), suggest that '… youth suicide prevention education is by no means a straightforward technical task of information dissemination. On the contrary, it is a site where multiple identities, ethical relations and possible future worlds are constructed' (p. 341).

The reliance of gatekeeper training on probability risk frameworks, distinctions between truth and 'myths' and (decontextualized) risk and protective factors can be antithetical to Indigenous epistemologies. For instance, many gatekeeper training programs include an emphasis on estimating levels of risk as a way of determining the most appropriate follow-up plan for keeping the suicidal person safe. The underlying assumption is that there is a 'one-size-fits-all' approach to crisis intervention and risk assessment (Rogers & Soyka, 2004). A more culturally informed approach might include some of the following dimensions: recognition of the role of culture in conceptualizations of distress and well being; placing value on understanding the particular meaning of suicidal behavior to the young person and his/her family, and exploring personal beliefs about suicide (Rogers & Russell, 2014).

Conceptualizations of distress—As these examples suggest, it is important to recognize the socio-political origins of distress, including, for example, residential schools and institutional abuse, historical policies of assimilation, and other forms of structural violence. The enduring negative legacy of colonization contributes to high levels of suicidal despair among many Indigenous peoples. This type of 'soul wound' requires a 'postcolonial form of therapeutic intervention' (Duran, 2006; Gone, 2010, p. 196). Healing strategies which honor Indigenous ways of knowing and which reflect relational, familial, social, and spiritual dimensions of selfhood are more likely to be effective than those which are predicated on decontextualized, expert-driven, individualistic, biomedical understandings of

distress (Wexler & Gone, 2012). Building on local resources, respecting cultural protocols, valuing the spiritual dimension, and strengthening family and community relationships are critical components of any prevention endeavor (Gone, 2010).

Empowering and culturally responsive alternatives to gatekeeper training

Educational research demonstrates that engaged and critically aware approaches to teaching are more likely to be effective than approaches that rely on universal, knowledge transmission approaches (Fuller, 2007; Gay, 2010; Kolb & Kolb, 2005). Experiential, engaged, and critical pedagogies invite learners to bring their experiences to bear on what is being taught, and grant significance to the cultural identities and assumptions of teachers and learners in the overall learning process. Moving beyond what Freire (2003) referred to as the 'banking concept' of education – where knowledge is deposited into the heads of individual learners – an engaged pedagogy emphasizes interaction, collaborative learning, storytelling, creativity, and joint action (Hooks, 2010; White et al., 2012). These principles are consistent with the work of Indigenous scholars who have written extensively about Indigenous knowledge systems and pedagogies (Battiste, 2002; Battiste & Youngblood Henderson, 2000), de-colonizing methodologies (Tuhiwai Smith, 2012) and Indigenous ethics (Ermine, 2007). For example, Battiste (2002) notes that Indigenous epistemologies are rooted in the values of interconnectedness and holism, inter-generational transmission of knowledge, stories, ceremonies, and responsibility to future generations. An example of an empowering and culturally responsive alternative to gatekeeper training, which is inspired by these frameworks, is described below.

Instead of emphasizing knowledge and skills for detecting suicide risk and referring to mental health, CARES facilitators (local people) aim to empower local people to better support people in their lives. The community training focuses on generating ideas and readiness of participants to help others who may need some extra caring as well as those who may be suicidal. In broadening the scope, CARES aligns well with recent calls in the suicide literature (Caine, 2013). Focusing on vulnerability (not suicide) makes it appropriate for natural helpers of all kinds: youth, family members, and typical gatekeepers who come in contact with youth regularly. Additionally, the training is appropriate for communities that are underserved by mental health systems because it does not aim to increase referral to mental health services. Rather, CARES aims to strengthen the local support network so that community members – parents, friends, family members – are better able to reach out to persons-in-need *before* a crisis. The training encourages participants to show they care through a variety of means that have worked in that particular community. Table 1 summarizes some of the key principles that distinguish the two different approaches.

Although shaped by suicide prevention research, most of the CARES content is generated from participants' experiences and stories. This approach promotes people's faith in their personal and local wisdom and draws attention and emphasis to community resources. Telling stories is an effective and empowering way Indigenous communities have shared knowledge for generations. As bell hooks, an educational scholar and community activist, notes,

> Stories help us to connect to a world beyond the self. In telling our stories we make connections with other stories. … These stories are a way of knowing. Therefore, they contain both power and the art of possibility. We need more stories. (Hooks, 2010, p. 53)

CARES begins with a consensus-building exercise that identifies how the group wants to conduct the session. This process engages the participants in active learning from the start, and gives them control over the ground rules of the session. Typically, the group agrees upon basic guidelines that involve respect, confidentiality, and particular sharing procedures such as a talking stick. The facilitators contribute information by outlining key aspects of talking safely about suicide (e.g. no information about methods, emphasize hope not inevitability, and confidentiality) (Chambers et al., 2005).

Once the ground rules are agreed upon and understood, one of the facilitators – a person from the local community partnered with a mental health professional – tells an exemplar story. These practiced vignettes are taken from personal experience, and describe: what the narrator noticed to flag a need for support; did to reach out to the person and show care (or encouraged someone else with a closer relationship to do so); and how they followed up to support the person and maintain their safety. This three-part story serves as a framework to build understanding about (i) signals of distress/vulnerability, (ii) local resources and acceptable practices for offering support, and (iii) safety tips and continued involvement. With that story as an example, participants are asked to share similar stories in pairs. After paired storytelling, participants and facilitators reflect on the shared stories and describe what signaled a need for help (signs of distress), the actions taken to help, and how participants followed up with the person. Answers in each of these three content areas are listed for all to see and discussed in a large group forum. If key content is missing, the facilitators are trained to identify and discuss it. For instance, if no one mentioned the importance of maintaining sobriety (and reducing access to alcohol and drugs) for people who are sad and/or depressed, the facilitator would talk about this in the context of keeping people safe. Building on local stories, the facilitators will also initiate a discussion about local resources to help and how to access them.

Learning is re-enforced through practice. Role playing is often a part of gatekeeper training, and is often appreciated by Indigenous participants (ICF Macro, 2010). Maintaining this aspect of gatekeeper training, CARES initiates the role play with a local and culturally situated scenario derived from the experiences of the local facilitators. The role play invites participants to explore their feelings in relation to suicide specifically, and provides time in the training to reinforce and practice reaching out to someone in distress. CARES concludes with participants making a personal commitment to show someone they care and to do something that they know is good for their own spirit and health. Ending the CARES training in this positive, social, and engaging way encourages the transfer of knowledge into action (Rock, 2008).

Conclusion

The paper draws from existing research and Indigenous scholarship to critically examine the mainstream gatekeeper training model, questioning its cultural universality, challenging the didactic approach, and accompanying learning outcomes. This discussion illustrates key problematics of gatekeeper training for Indigenous communities, and underscores a need for a new approach. To offer an example of an alternative way forward, the paper describes CARES, an approach to community outreach and training that emphasizes local ways of knowing, interaction, and empowerment. The engaged and storied approach respects the role of history, tradition, cultural protocols, stories, and local community norms as important resources to include in any educational endeavor, including gatekeeper training. Instead of relying on referrals to formal mental health services as the primary goal of gatekeeper training, we recommend placing more emphasis on the important role that stories and communities play in providing stability, hope, cultural connectedness, and a sense of belonging for young people.

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Table 1.

Comparing two models: CARES and gatekeeper.

CARES	Gatekeeper training
Start with stories of support, reaching out	Start with general ‘facts’ about suicide
Expertise located in the group	Expertise located in the facilitator
Inductive style	Deductive style
Participatory throughout	Some participation
Drawing lessons from stories of participants	Decontextualized information re: risks (protective factors) and signs of distress
Emphasizes process, i.e. the value of relationships, cultural interpretations/values, local ways of knowing	Emphasize rational assessment of risk, ‘testable’ knowledge
Promote personal commitment and social action	Promote crisis intervention
Joint learning and action	Individual mastery of knowledge and skills
Generative and emergent	Standardized and pre-determined