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Urban American Indian Community Perspectives on Resources and Challenges for Youth Suicide Prevention

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Abstract

American Indian (AI) youth have some of the highest rates of suicide of any group in the United States, and the majority of AI youth live in urban areas away from tribal communities. As such, understanding the resources available for suicide prevention among urban AI youth is critical, as is understanding the challenges involved in accessing such resources. Pre-existing interview data from fifteen self-identified AI community members and staff from an Urban Indian Health Organization were examined to understand existing resources for urban AI youth suicide prevention as well as related challenges. A thematic analysis was undertaken, resulting in three principal themes around suicide prevention: formal resources, informal resources, and community values and beliefs. Formal resources that meet the needs of AI youth were viewed as largely inaccessible or nonexistent, and youth were seen as more likely to seek help from informal sources. Community values of mutual support were thought to reinforce available informal supports. However, challenges arose in terms of the community's knowledge of and views on discussing suicide, as well as the perceived fit between community values and beliefs and formal prevention models.

Keywords: suicide, prevention, American Indians, culture, mental health services, informal supports

Urban American Indian Community Perspectives on Resources and Challenges for Youth Suicide Prevention

Youth suicide is one of the principle mental health concerns for American Indian (AI) communities. AI youth have the highest rates of suicide among all ethno-racial groups in the United States, with rates 62% above the national average for youth ages 10-25. Suicide is the leading cause of non-accidental death among AI youth of this age group (Centers for Disease Control and Prevention, 2014a). Additionally, AI high-school students are over three times as likely as their White peers to report suicide attempts requiring medical treatment, and 70% more likely to report suicidal ideation (Centers for Disease Control and Prevention, 2014b). Youth suicide has become a significant public health concern for AI communities. However, there is a dearth of research on the topic (Olson & Wahab, 2006) and on AI mental health in general (Gone & Trimble, 2012). This is especially true in urban areas, as most research on AI mental health

has been carried out in reservation settings (Hartmann, Wendt, Saftner, Marcus, & Momper, 2014).

Over 70% of people identifying as AI alone or in combination with some other racial group live in urban areas (U.S. Census Bureau, 2010). Yet, there are few reliable sources of information regarding urban AI youth suicide rates. In contrast to reservation suicide rates, which are reported by the federal Indian Health Service (IHS), urban AI suicide rates are reported by hospitals and are complicated by incorrect documentation of race and ethnicity on death certificates (Middlebrook, LeMaster, Beals, Novins, & Manson, 2001). The only existing study to directly compare rates between AI youth raised in urban or reservation settings found no significant difference in lifetime suicide attempts between the two (Freedenthal & Stiffman, 2004). Another study in Northern Arizona reported that 27% of AI adults living off-reservation had reported suicide attempts or completions among family members (Chester, Mahalish, & Davis, 1999); in Minneapolis, 18.6% of AI youth ages 9-15 reported past-month suicidal ideation, and 15.1% reported previous suicide attempts (Pettingell et al., 2008). Additionally, suicidal ideation may represent an even greater risk factor for urban AI youth, who have lower rates of ideation for the same number of attempts (Freedenthal & Stiffman, 2004).

Ecological approaches to mental health understand suicidal behavior not only in terms of personal factors, but as reflective of population-level phenomenon requiring social and structural change (Snowden, 2005). Many psychological predictors of suicidal ideation or attempt are common for AI as well as non-AI youth. These common predictors include emotional difficulties, drug and alcohol abuse, a family history of suicide attempts, physical and sexual abuse, and violence perpetration or weapon-carrying (Ayyash-Abdo, 2002; Borowsky, Resnick, Ireland, & Blum, 1999; King & Merchant, 2008; Mackin, Perkins, & Furrer, 2012; Pettingell et al., 2008). However, many AI people view suicide not as an individual problem, but rather as a community one stemming from a long history of cultural loss and collective suffering due to colonial oppression (Wexler & Gone, 2012). Thus, factors predicting suicide for AI people in particular may be social, community, and even societal in nature (Alcántara & Gone, 2007). Investigations comparing risk and protective factors related to suicide among AI youth have found variations based on gender (Manzo, Tiesman, Stewart, Hobbs & Knox, 2015; Pettingell et al., 2008), residence on or off-reservation (Freedenthal & Stiffman, 2004), and tribal culture (Novins, Beals, Roberts & Manson, 1999).

Factors that may protect against suicide among AI youth include the quality of family relationships (Borowsky et al., 1999; Cwik et al., 2015) and social support (Freedenthal & Stiffman, 2004; Novins et al., 1999). However, the significance of social support as a protective factor varies between tribes as well as between AI youth living on and off-reservation. Additional interpersonal factors of thwarted belonging, which is the unmet desire to belong, and perceived burdensomeness, which is a person's sense of being a burden on others, may help explain many of the risk and protective factors associated with youth suicide (Van Orden et al., 2010). However, these concepts have received mixed support in studies with AI individuals. Perceived burdensomeness, as well as perceived burdensomeness combined with thwarted belonging, have been found to predict suicidal ideation among AI college students (O'Keefe et al., 2014). Similarly, Hill (2009) found a negative association between sense of belonging and suicidal ideation in a national sample of AI adults. Studies specific to AI adolescents, however, have found no association between suicide attempts and connectedness to others (Pettingell et al., 2008) or between suicide attempts and connectedness to community (Mackin et al., 2012).

While earlier models of suicide prevention focused primarily on identifying and intervening with high-risk individuals, promising population-level interventions have been developed in recent years (Isaac et al., 2009; Knox, Conwell, & Cain, 2004). An important component of such ecological approaches to suicide prevention is that they involve community members and are grounded in local culture and understandings (Trickett, 2009). Similarly, one shared feature of AI youth suicide prevention programs in particular is the emphasis on cultural education and participation as core components of, if not the primary basis for suicide prevention. Such trends are reflective of the larger and often cited need for the integration of traditional AI healing into mental health treatment (Gone, 2007, 2010; Goodkind et al., 2010; Moorehead, Jr., Gone, & December, 2015; West, Williams, Suzukovich, Strangeman, & Novins, 2012). However, most suicide prevention programs created specifically for AI populations have been designed with a specific tribal community in mind. Interventions that are tailored to a particular tribal setting may not be easily replicated in urban AI communities. With 566 federally recognized tribes across the United States, urban AI communities can be very diverse in terms of tribal affiliation, enrollment status, multiracial identity, physical distance from communities of origin, traditional world-views, and relationship to tribal traditions.

Given the need for urban AI youth suicide prevention programs, and the dearth of related research, the current study seeks to identify challenges, resources, and cultural considerations related to suicide prevention in an urban AI community. Such information can then assist community organizations and practitioners in identifying, adapting, or creating suitable interventions for urban AI youth. The current study explores the following questions: (a) What resources exist in urban AI communities that can be harnessed for youth suicide prevention?, (b) What challenges exist for urban AI youth in terms of accessing such resources?, and (c) How do urban AI community members view suicide prevention efforts in relation to traditional cultural values and practices? Previously collected interview data from a participatory research project will be used to examine these questions, with the goal of understanding the local context surrounding AI youth suicide prevention.

Method

Research Approach

The current study uses pre-existing data from a Community Readiness Assessment (CRA) conducted as part of an ongoing participatory research relationship between our academic research team and a Midwestern Urban Indian Health Organization (UIHO). Participatory approaches engage voices that have been excluded from, or been taken advantage of by mainstream approaches that view community members as subjects rather than valuable actors in the research process. By recognizing power differentials between academic and community partners, participatory research strengthens academic-community partnerships by providing a platform to prioritize indigenous definitions of health, wellbeing, and healing (Wallerstein & Duran, 2006). Additionally, qualitative analysis of pre-existing data has been posited as useful in social and health sciences research for inquiry about sensitive topics with hard-to-reach populations (Long-Sutehall, Sque & Addington-Hall, 2010), including AIs (Wendt & Gone, 2012).

Developed for use in diverse ethnic and cultural settings, the CRA framework seeks to engage community members in the design and implementation of prevention and intervention programs that are specific to the local community and cultural context (Jumper-Thurman, Edwards, Plested & Oetting, 2003). The CRA was conducted in preparation for the implementation of an urban AI youth suicide prevention program. This framework measures community readiness to address a target issue by examining six dimensions: existing prevention

efforts, community knowledge of prevention efforts, leadership, community climate, community knowledge of the target issue, and resources for prevention (Plested, Jumper-Thurman, Edwards & Oetting, 1998). Given the richness of the interview data and the potential for resources and challenges for AI youth suicide prevention to exist in each of these six dimensions, it was decided that secondary analysis of these pre-existing data was an appropriate fit for the research questions in the present study.

Setting

The community was comprised of self-identified AI youth, adults, and elders within a Midwestern metropolitan area. Approximately 48,000 people who identify solely as AI or Alaska Native, or identify as AI and Alaska Native in combination with another group, live in the UIHO's seven county service area (U.S. Census, 2010). The UIHO's service population includes AI and non-AI people, and is largely low income. Many clients are uninsured, on government-sponsored health insurance, or access a sliding-scale fees policy to pay for healthcare.

As one of four urban Indian organizations in the area—and the only one designated as a health clinic—the UIHO provides a number of services including: (a) behavioral and physical health care and referrals, (b) substance abuse treatment and prevention, (c) parental support and youth programming, (d) financial services (e) health education and programming, and (f) cultural education and traditional healing ceremonies (e.g., sweat lodges). The UIHO must refer out to other agencies if an individual needs psychiatric assessment or medication. The organization focuses on the incorporation of Western and traditional AI practices to empower individuals and families, and to enhance their physical, mental, spiritual, and emotional wellbeing. It also serves as a community center and hosts a variety of events throughout the year. With over forty staff-members, the UIHO also engages a number of community volunteers and interns from local universities.

At the time of data collection, the organization was in the early stages of implementing activities whose sole purpose was AI youth suicide prevention. Local statistics on suicide, particularly among the urban AI population, are difficult to find. Statewide, suicide is the second leading cause of death among 10-30 year-olds (Centers for Disease Control and Prevention, 2014a). Community screenings with a youth population that was 70% AI revealed that 10% of

the youth screened had *attempted* suicide in the past, all but one of whom were AI (Mueller-Williams, Tauiliili, Momper, Tuomi & Bieber, 2015).

Participants

Purposive sampling was used to select participants from among staff and community members who frequented the UIHO. The goal of this non-probabilistic sampling procedure was to identify informants who were most knowledgeable about a particular topic in a given community (Tongco, 2007). Staff members who were knowledgeable about the people that frequented or worked at the UIHO recommended participants who were familiar with the urban AI community and the UIHO. Proposed participants were then approached by the research team to gauge their interest in being interviewed. Once an initial group of participants agreed to be interviewed, others were identified and approached with the goal of balancing the sample across age, gender, community status, and amount of involvement with the UIHO.

The fifteen participants were all part of the organization's staff (three respondents), volunteers (three respondents), current or former youth group participants (four respondents), and current or former adult clients (five respondents). All respondents were self-identified AI individuals between the ages of 13 and 79, with a mean age of 39.33, including eight men and seven women. Six respondents reported having completed high-school, or an equivalent, and an additional four had completed some college. Six participants did not report monthly income, but of the remaining nine, five had a monthly income under $1,500. Ten were affiliated with Three Fires (Ojibwa, Potawatomi, and Odawa) tribal nations with varying tribal affiliations among the remaining five. Nine participants had personally known someone who had attempted suicide. Eight of the nine knew of multiple people who had attempted suicide, including one youth associated with the UIHO.

Measures

Interview protocol. A 35-question interview protocol was adapted, with an emphasis on suicide, from a model CRA questionnaire that had been developed for HIV/AIDS prevention in an AI community (Plested, Jumper-Thurman, Edwards & Oetting, 1998). Questions focused on available resources for AI youth suicide prevention, community knowledge of AI youth suicide, support for AI youth suicide prevention, and challenges related to AI youth suicide prevention in the community. Questions were both close-ended (i.e. "Using a scale from 1-10, how much of a concern is AI Suicide in the community?" or "How knowledgeable are community members

about AI Youth Suicide?") and open-ended (i.e. "To whom would an individual affected by AI Youth Suicide turn to first for help in our community? Why?" or "What are the primary obstacles to efforts addressing AI Youth Suicide Prevention in the community?").

Demographic questionnaire. Participants were also asked to fill out a brief demographics questionnaire, which included information on age, gender, sexual orientation, marital status, household composition, income, education level, and tribal affiliation.

Procedure

The original study was conducted as part of a larger research project on urban AI youth suicide. Research team members attended monthly meetings of both the Community and Youth Advisory councils at the UIHO, which together oversaw and provided guidance for organizational activities. Members of both councils became involved in the project, attended meetings with funders, presented posters on the project, and provided input on measures. Additionally, an AI project manager was hired and worked from the organization's offices. This study was approved by the director of the UIHO and the Institutional Review Board of the university partner.

Semi-structured interviews that were face-to-face were conducted between February and May of 2012. Interviews ranged from 45 minutes to 2 hours. The interviewer, a female Alaska Native graduate student, scheduled the sessions at times and places that were convenient for participants. Subsequently, interviews took place in private areas of the UIHO, at other local Indian organizations, and in participants' homes. Participants were informed that the researchers were interested in gathering information about respondents' knowledge of AI youth suicide as well as current prevention efforts, in order to develop new strategies of suicide prevention. Written informed consent for both the interview and the audio recording was obtained from all participants; in the case of participants under the age of 18, written consent was obtained from the parent or caregiver and assent was obtained from the youth. Participants were provided a $20 gift card for participation in the interview.

Both audio recordings and written transcripts were created for each interview. Recordings were transcribed by a third party and checked for accuracy. Due to time constraints and participant availability, transcripts were not returned to participants for review. Once transcription was complete, the first author served as the primary data analyst, using the qualitative data analysis program *NVivo* Version 10. After a preliminary reading of the

transcripts, the first author conducted a thematic analysis of challenges and resources related to AI youth suicide prevention, topics which were discussed at length by all participants.

Thematic analysis has been posited as a flexible approach to qualitative data analysis (Braun & Clarke, 2006) that can be used in psychological research. For this study, an inductive approach was used to identify themes in the data and a semantic essentialist approach was used that limited the analysis to the explicitly stated reality, meanings, and experiences of the participants. It was *essentialist* in that participants' responses were taken as a reflection of their lived reality rather than as part of an underlying discourse, and *semantic* in the sense that the themes identified were an attempt to describe and interpret participants' responses based on their own language, without theorizing underlying constructs (Braun & Clark).

Due to the large volume of data, which consisted of 750 double-spaced pages of transcript, a first round of coding was undertaken in order to identify and isolate broad portions of text that were loosely related to resources and challenges related to AI youth suicide prevention. Segments that were excluded from future rounds of coding included: conversations whose sole purpose was to establish rapport between the interviewer and the participant; discussions of environmental interruptions to the interview, and questions to which participants responded that they did not have the technical knowledge to answer, such as those related to program policies, evaluation, and funding mechanisms. The selected portions of the interviews, approximately two-thirds of the original content based on word count, were then open coded and subsequently grouped into initial themes. Any themes that were not endorsed by at least one-third of the participants, as well as themes that were not clearly linked to resources and challenges related to suicide prevention, were excluded from the final thematic structure. The final structure comprised 312 codes that were organized into three overarching themes.

Several measures were taken to ensure the fidelity of the identified themes. First, the data analyst undertook the coding before completing a review of the literature on AI youth suicide in order to avoid forming pre-existing notions based on previous research. Second, coded segments were double checked manually and with key word searches. Third, the first author kept memos of potential patterns in the data throughout the coding process in order to monitor potential bias; approximately one-third of these potential patterns were not reflected in the final thematic structure. Fourth, the first author presented the second and third authors with visual representations of the thematic structure of the data on multiple occasions and

incorporated their suggestions, a process which resulted in eight revisions to the thematic structure. For example, previously disparate themes were grouped to reflect specific community values and overarching themes were consolidated into the three principal categories.

Finally, all researchers had some prior connection to the UIHO. The interviewer was Alaskan Native and had conducted a prior research project at this UIHO. The second and third authors are members of non-local tribal nations and had been working for a combined total of 16 years with the UIHO on a number of research projects. The first author is a non-Native graduate student who had previously completed a year-and-a-half long clinical internship with the UIHO. In this way, the research team brought a mix of familiarity with the UIHO, its programs, and the local community context to the project. This study also adheres to the *Consolidated Criteria for Reporting Qualitative Research* guidelines (Tong, Sainsbury & Craig, 2007) as well as Braun & Clarke's (2006) *15-Point Checklist of Criteria for Good Thematic Analysis*.

Results

Three overarching themes were induced from the interview data, all of which were mentioned by each of the fifteen participants. These were: a) Formal Resources, b) Informal Resources, and c) Community Values and Beliefs. Both "Formal Resources" and "Informal Resources" included two subthemes related to kind of resources available and challenges associated with such resources.

Formal Resources

Available services. One of the major recurring themes discussed by respondents was that of available services for AI youth. Formal services are defined here as services offered both by licensed professionals and by unlicensed paraprofessionals operating within the purview of a non-profit organization or government agency. Available services included professional mental health services, collateral services, and paraprofessional suicide services.

Professional mental health services are defined as those services provided by professional mental health practitioners, such as licensed social workers or psychologists. These practitioners can conduct screenings to identify youth who are at-risk for suicidal behavior. They can also implement individual treatment plans aimed at reducing individual risk factors, such as depression, or increasing protective factors, such as social support. Ten participants discussed the availability of such services for AI youth largely in the context of counseling and referrals provided by the UIHO's behavioral health department. Two of these participants mentioned

additional mental health clinics that could be utilized for formal mental health services, but whose target populations were another ethno-racial group or low-income individuals in general.

Thirteen participants mentioned collateral services as resources for AI youth suicide prevention. These services are provided in settings whose primary focus is not mental health, but which nonetheless interface with the mental health system and may assist youth in times of crisis. For example, school counselors were mentioned by nine participants as individuals that youth could go to if they were contemplating suicide. The youth group at the UIHO, along with youth groups at two other urban AI organizations, were mentioned as resources for suicide prevention. To a limited extent, medical doctors were also mentioned as individuals who could be approached for information or services related to suicide prevention.

Another type of service mentioned by seven participants were paraprofessional suicide services, which may not be staffed by licensed professionals but are provided by individuals with specialized training. The principle resources that participants mentioned were suicide prevention hotlines such as the National Suicide Prevention Lifeline or the Native Youth Crisis Hotline. There was, however, no consensus on whether AI youth would use these services. Finally, three respondents were aware of youth suicide prevention "classes" or "programs" offered in the UIHO's service area, although these were not specifically for AI youth.

Challenges to access. Despite the presence of some professional services for AI youth in the city, all fifteen participants reflected on challenges related to accessing these services. These included challenges related to the urban environment, the invisibility of the urban AI population, the potential for negative consequences in service settings, a history of negative institutional experiences, a general lack of accessible services, and a lack of government support.

The most frequently cited challenges to accessing suicide prevention resources were related to the urban environment itself. As seven participants pointed out, the AI population is geographically dispersed and is far from homogeneous. All but one of the participants also discussed transportation as a potential barrier for accessing suicide prevention services. This was explained not only in terms of distances but because of a lack of reliable public transportation and the fact that police and emergency personnel are known to not respond to 911 calls in the city, especially in poorer areas. Transportation was mentioned as being a particular challenge for youth who depend on adults to get from one place to another, and although the UIHO does have

a van to assist with transportation, this service is bound by limited resources and is shared among all of the UIHO's programs.

Participants also suggested that the AI population in this urban setting is largely invisible. Related to this idea, eleven participants discussed their own experiences of being mistaken for other ethnicities as well as having to confront stereotypes that AI people no longer exist. Stephan (a pseudonym), a 17-year old youth, summed up these responses with the following reflection: "[People] don't think [AI youth suicide] is urban because [in the urban setting] there's no Native Americans. We're just not visible . . . if you're a tiny person living amongst giants, you know, it's hard to get help sometimes."

Another challenge to accessing existing services was related to the potential negative consequences for disclosing suicidal ideation or intent in such contexts, which leads to anxiety and ambivalence among those seeking services. This was discussed by eleven participants. Seven participants suggested that AI youth would not want their parents to know if they were contemplating suicide, as they might "get in trouble" or parents might "jump to conclusions" or youth could be "put away." For these reasons, youth might be reluctant to share feelings with professional helpers who would be required by law to report potential self-harm to the youth's guardians. Other negative consequences that youth might perceive for disclosing suicidal intent in a formal setting included having the police called, being made to go to the hospital, being suspended from school, getting their parents in trouble, and being removed from the home. Johnnie, a 16-year-old youth, discussed his school's approach to dealing with youth who are struggling with suicide: "In school if [a youth] struggled, they would have to see a counselor and they couldn't come to the school . . . because they don't want to bring that type of negativity around other students."

Seven participants shared negative institutional experiences related to AI people's reluctance to utilize formal services. These included the histories of family members who had been removed from their homes and forced to go to Indian boarding schools (where physical, emotional, and sexual abuse of children was widespread); experiences with government relocation policy (a program that promised jobs if AI people moved to urban areas, where they encountered few resources, discrimination, and weakened ties to tribal communities); and experiences of being profiled or harassed by law enforcement. The reluctance to use formal services at times could extend even to the UIHO, as was mentioned by Gladys, a 50-year-old

staff member, when discussing the process for referring youth to behavioral health services: "A lot of times the parent will say 'go ahead,' make the referral. . . . but then it's that same parent that says that they won't let their youth go and get that help because they're afraid of whatever."

Six participants directly mentioned the dearth of accessible services for AI youth, saying that there were "not enough places" for AI youth to go in a crisis. The only organization that offers formal mental health services targeted at AI individuals is the UIHO itself; of the participants that mentioned non-profit organizations aside from the UIHO, none mentioned the same organization, suggesting that these resources were either not well known or there was no consensus as to their utility. Participants noted that individuals seeking services may not have the financial resources to access available services, and that organizations such as the UIHO that do offer services are also strained by limited resources.

Finally, the lack of professional resources devoted specifically to addressing the mental health needs of AI youth was attributed to the inadequacy of government support by eleven participants. Local and state governments, they suggested, either do not think about or do not care about the urban AI population, a fact which increases the difficulty of accessing additional resources such as grants to develop services.

Informal Resources

Sources of informal support. Informal sources of support included family members, friends, and non-professional supports available through the UIHO such as youth leaders and mentors. Such individuals were described as being more comfortable for AI youth, as well as fitting with the values, beliefs, and practices of the community.

Eleven participants suggested that friends would be the first point of disclosure for youth who were contemplating suicide. Friends were described as individuals that AI youth could talk to if they were having trouble, and as supportive, accepting, and better able to understand the struggles of their fellow youth. Friends were also described as being trustworthy and less likely to report personal information to others. As Johnnie stated: "Some [youth] show they're happy, but what's on the inside is what they're holding in and they won't let it out in front. Some of them won't tell their parents, and they'll tell their friends rather than tell their parents."

Nine participants discussed family as a source of assistance for youth, either in general or as specific individuals to turn to if a young person was contemplating suicide. Included in this category were not only parents, but also members of a youth's larger family network, such as

grandparents or cousins. Dale, a 79-year-old community member shared: "We normally bring it up in our family, the problems we've been having. Sometimes just you and your dad or your mom. . . . that's what I would do if I had a problem. I'd talk to my children."

In addition to friends and family members, nine participants discussed informal assistance available through the UIHO. This was offered by volunteers or staff who do not hold formal roles related to mental health or suicide prevention. Such individuals were described as people to "touch base with," people who had been through similar situations, and those who were considered as mentors. Douglas, a 14-year-old youth, stated: "I don't think they would recognize [the signs and symptoms of suicide], but someone would ask, 'Are you okay? Is there anything going on?' They'll get it out of you some way. They'll notice something is wrong." Eight participants also mentioned that youth would feel more comfortable talking to youth leaders. Youth leaders were described as young AI individuals who serve as mentors and role models for young people in the community, especially through teaching traditional values.

Challenges to informal support. A number of challenges were said to arise when trying to rely on informal methods of support for suicide prevention in an urban AI setting. These include: a lack of knowledge about suicide in the community, the potential for home environments to be a source of stress for youth, the tendency of people in the community to keep silent about their personal problems, and reluctance to discuss the issue of suicide.

Fourteen participants suggested that the community was not knowledgeable about suicide, with eleven citing a lack of local information about the prevalence of suicide among urban AI youth and nine mentioning the lack of accessible materials related to suicide prevention such as stickers, pamphlets, flyers, and posters. Eight participants suggested that community members would not be able to recognize the signs and symptoms of suicide, which could complicate the ability of individuals to provide assistance outside of professional settings. Harland, a 48-year-old community volunteer: shared the following in relation to a question about obstacles to AI youth suicide prevention:

> Obstacles [are] the people themselves not knowing what to do, what they need to be taught about suicide and what are some of the signs. . . .we've never been taught that as Native people. . . . we'd say "Oh, they're down and out again," you know, instead of "you know what? Let's go to the Indian center and go see somebody."

Although family members were listed as potential resources for AI youth, ten participants suggested that youth's home environments might not be the ideal place to seek assistance. Nine of these participants suggested that the home environment may be a contributing factor to stress for some youth. Additionally, six participants said that parents may not be in a position to provide support. Participants noted that parents are often times dealing with their own struggles, which prevent them from recognizing that their children are also struggling. At other times, parents may not know exactly how to help in a crisis situation. Participants also discussed the tendency of youth to "keep things bottled up" or "hide their feelings," a pattern which extended to adult respondents as well. For example, one mother mentioned that she would never let her difficulties show in front of her children because she did not want them to worry, and another mentioned that AI people are supposed to be "stronger-minded."

Ten participants stated that in general, people in the community would prefer to keep to themselves rather than speak openly about personal difficulties. This was discussed in terms of youth not wanting people "in their business" or that "people talk." Two participants also specifically discussed the tendency for people to avoid talking about the loss of loved ones. Teresa, a 30-year-old staff member at the UIHO, shared the following: "I don't know that we really address it when anyone dies for any reason. . . . I think that might be another old school way, too. You know, when my dad passed away, none of us went to counseling or anything like that. We just stopped talking about it."

Eight participants mentioned that the issue of suicide, in particular, was something that is not discussed openly in the community. Reasons for this included fear that talking about suicide may lead youth to contemplate attempting suicide and people being afraid to talk about the issue of suicide because it is a "touchy subject" or brings up difficult feelings. For example, one respondent alluded to the idea that talking about suicide could bring it "into someone's influence" and thereby lead to suicidal ideations or attempts.

Community Values and Beliefs

Through their responses regarding the resources and challenges related to AI youth suicide prevention, participants touched upon relevant values and beliefs related to the urban AI community and AI communities in general. Issues discussed include: culture of mutual support, important characteristics of helpers, a concern about the erosion of AI identity and sense of community, ways of teaching and learning, and the use of culture in healing and prevention

A core concept related to providing support for AI youth was the expectation that "Native people help each other." This was discussed by all fifteen participants. Participants suggested that this norm of mutual support is an important part of Native identity and traditional culture. The importance of helping children in particular was discussed, with participants suggesting that it is "everyone's duty" and that people would be supportive of prevention efforts to "save their children." Similarly, all but one respondent stated that the urban AI community would support youth suicide prevention efforts. Although time and economic resources are limited, respondents generally thought that community members would donate money toward such efforts if they had it. Respondents also suggested that community members would donate their time by volunteering to assist in suicide prevention efforts.

Twelve participants discussed important characteristics of helpers for youth. Rather than placing emphasis on professional training or knowledge about suicide prevention, participants described helpers as individuals with whom youth feel comfortable and understood. Importance was placed specifically on the ability of youth to trust a potential helper, as well as on the value of a person's individual experience rather than formal training. Respondents suggested that people who had "been there" or had had similar experiences would be best able to provide assistance to youth who were struggling with suicide.

Despite the presence of a culture of mutual support, eleven participants felt that urban AI people may be losing their identity or sense of community. Examples given by participants included loss of culture due to past government policies such as the removal of children to boarding schools, relocation, or prohibition of traditional ceremonies. Others discussed AI people not knowing who they are or not having had access to traditional teachings. Nine, however, suggested that there has been a loss of community in the urban setting, that there may be divisions within the urban AI community, and that some people "just don't care." The juxtaposition of traditional values of mutual support with the contemporary loss of community and culture was summed up by Harland:

> We need to reach out to each other and help each other as Native people because that's the way we are as people. We're good people, we helped before the White man came here … and we need to get that back, that care for each other and help for each other. That's our biggest problem right now. We lost it and we're still losing it.

Another cultural component that participants discussed in relationship to AI youth suicide prevention was the need to respect traditional ways of learning and teaching. Formal ways of presenting information, such as presentations, workshops, and manualized programs, were seen not only as boring and likely to dissuade people from participating, but as representative of ways of teaching and learning that were not appropriate for the community. Ways of learning that were posited as being more appropriate for the community included storytelling by Elders, learning through one's own experiences and those of others, and, finally, including small amounts of information related to suicide during community gatherings. Teresa summarized these positions in this way:

> I think listening to stories and learning about the seven grandfather teachings and the types of medicines we use and why . . . speaks way more than having little workshops where we do funny little skits about "hey, don't take drugs" or "hey, how you feeling today?" I think that speaks way more than putting kids into awkward situations and making them do something they don't want to do, you know?

The importance of other facets of Native identity and culture in the promotion of individual wellbeing was also mentioned by ten participants. This included the mention of the use of culture in healing, specifically the inclusion of traditional healing as part of services through the UIHO, and the possibility of using traditional practices as a means of suicide prevention. Participants mentioned that practicing a traditional way of life means that youth will live a healthy lifestyle and be better able to understand themselves, the world around them, and their purpose in life. Rolland, a 65-year old volunteer discussed the importance of traditional culture in understanding oneself and in helping others.

> The people who're trying to help [the youth] have to learn more about their culture … because some of these kids don't even know what's bothering them and the people who are trying to help them have no idea what's bothering them. It boils down to a cultural thing, really. . . . I see that most of the people who do really get back to the culture have a better understanding of themselves, who they really are, not people telling them who they are, you know. They have a better understanding, and that's what they need.

Discussion

The purpose of this investigation was to examine the resources and challenges in an urban AI community that could be harnessed for AI youth suicide prevention. Specific attention

was given to differences in formal and informal resources, as well as the relationship between suicide prevention efforts and traditional AI values and practices. Based on the results of this study, we offer the following four recommendations.

Increase Financial Resources for AI Mental Health Services

The analysis presented here suggests that urban AI youth have extremely limited access to professional mental health services, despite having some of the highest rates of suicide in the country. The main source for suicide prevention for AI youth in this region, and the only organization offering services designed specifically for the AI population, is the UIHO itself. Its service area includes seven counties and a service population of over 40,000 (U.S. Census Bureau, 2010). As already mentioned, AI individuals in need of psychiatric evaluations or medication must be referred to other clinics, which may also require psychological care at that facility; this means that AI individuals wishing to incorporate these services into their treatment are unable to receive individual mental health services at the UIHO. Additionally, the UIHO serves tribal members, non-tribal members self-identifying as AI, and (owing to its portfolio of funding arrangements) people who do not necessarily identify as AI. Although this takes into account the diverse nature of the urban AI population, it also means that not all of the UIHO's limited resources go to services for individuals who identify as AI.

These local challenges are representative of larger issues of healthcare equity for AIs in the United States. The Indian Health Service (IHS), which is the principle provider of both physical and mental health services for AI people, is notoriously underfunded. Estimates suggest that $29.96 billion would be needed in order to achieve health care equity for AI's, including $145 million to expand behavioral health services and $10 million for UIHOs; currently only 6.1% of the IHS budget is reserved for mental health and substance abuse services (IHS Tribal Budget Workgroup, 2015). The results from this study demonstrate that AI individuals in an urban community attribute the lack of resources for AI youth to a larger structure of invisibility in society and neglect by government authorities. AI youth suicide is a prominent problem that must be addressed both in reservation and urban communities. Considering that the vast majority of AI people live in urban areas (U.S. Census Bureau, 2010), an increase in the amount of funds dedicated to these populations is especially warranted.

Improve Access to Traditional Healers

One way of re-conceptualizing access to support for AI youth is to recognize that for AI communities, access to traditional healers may be just as important as access to professional mental health services. This was reflected in respondents' emphasis on the importance of traditional AI culture in promoting wellbeing among youth, and this supports previous research related to AI service preferences and the relationship between AI culture and suicide prevention. In interviews with Alaska Native university students who had migrated to the city from rural areas, DeCou, Skewes, and Lopez (2013) found that students believed that traditional practices were important in preventing suicide. At the community level, the presence of cultural centers and autonomous indigenous institutions has been correlated with reduced suicide rates among First Nations communities (Chandler & Lalonde, 1998). Cultural connectedness has been found to predict an increase in reasons for living among AI youth (Mohatt, Fok, Burket, Henry, & Allen, 2011). Orientation toward AI spirituality is also inversely related to self-reported suicide attempts (Garroutte, Goldberg, Beals, Herrell, & Manson, 2003).

Although traditional healers are generally categorized as informal supports, such definitions privilege dominant understandings of mental health and wellbeing. Traditional healers may not be professionally trained in the provision of services, but in many cases their training and experience goes beyond that of trained professionals. For example, Ojibway and Cree women healers have described their healing gifts as developing over the course of their lifetimes through varying sources such as family members, serendipitous acquaintances, dreams, visions, and spirits (Struthers, 2000). These women healers commented that traditional healing necessitates not only an understanding of how to incorporate the mind, body, and spirit into healing practices, but also requires dedication to a lifestyle that exemplifies traditional values such as balance, respect, honesty and humility. Future prevention efforts should emphasize respect for traditional healers and healing practices and explore ways to increase access to traditional healing for urban AI youth, while also keeping in mind the inherent tensions and trade-offs of doing so within the context of formal mental health services (Gone, 2010; Hartmann & Gone, 2012).

Promote a Culture of Mutual Support

This study supports previous work that suggests that both AI adults and youth demonstrate a strong preference for informal supports above professional services when it comes to issues of mental health (Freedenthal & Stiffman, 2007; Walls et al., 2006). Such preferences

are based not only on cultural tenants of mutual support, but on distrust of formal institutions rooted in personal and historical experiences of stigma, discrimination, and institutional violence. This phenomenon of cultural mistrust has also been documented as a barrier to suicide prevention in other ethno-racial minority populations in the United States (Joe, Canetto & Romer, 2008). Youth reluctance to seek help from professional sources for suicidal ideation is also common in studies of help-seeking behavior, but appears to be especially prevalent among youth from these groups (Michelmore & Hindley, 2012).

Respondents suggested that urban AI community members felt ambivalence toward receiving professional services even at the UIHO, the organization which is specifically designed to work with this population. And yet, most suicide prevention programs target increased access to professional services as a primary tenant of their approach (Wexler & Gone, 2007). This is true even for empirically supported gatekeeper programs that teach individuals outside of the mental health profession to identify at-risk individuals and refer them to treatment (Isaac et al., 2009). Given the significant challenges in accessing formal health services, the strong preference for informal supports among this population, and the importance of social support as a protective factor, promoters of suicide prevention efforts for urban AI youth might consider conceptualizing their intervention approach to focus on getting support *to* people rather than on getting people into services.

One potential resource for increasing access to informal support in an urban AI community is the presence of a culture of mutual support. Although mutual support is often discussed in terms of mutual support "groups" for treatment of mental health issues (Pistrang, Barker, & Humphreys, 2008), participants referred to this concept in terms of cultural expectations that "Native people help each other." Participants discussed mutual support not only as the preferred method of assistance for youth struggling with suicide, but as an integral part of AI identity and culture. Participants also suggested that at least some mutual support is provided through the UIHO youth group, from youth leaders, and from informal interactions with UIHO staff. This complements prior research that found that peer support can benefit the emotional wellbeing of youth (Hirsch & DuBois, 1992), as can social support from non-parental adults (Sterrett, Jones, McKee, & Kincaid, 2011).

Given the large body of research suggesting that social support from family and peers are some of the strongest protective factors against suicidal behavior, developers of suicide

prevention programs might consider an emphasis on increasing AI youth's access to mutual support. This could include community building as well as identifying individuals such as youth mentors and elders who seem to be "natural helpers" (May, 2005) and providing them with training in suicide prevention. Interventions that involve a wide swath of community members in addressing youth suicide can also serve to reduce the stigma surrounding suicide and build a supportive community for both individuals struggling with suicide as well as suicide survivors (Mohatt et al., 2013).

Finally, older respondents expressed the concern that mutual support among AI community members is currently disappearing, as is a local sense of community. This begs the question of what mutual support looks like in an urban AI setting. While such values may be easily expressed in tight-knit, geographically centered reservation communities, it is less clear how AI community members practice a culture of mutual support in an urban community that is physically spread out and with significant transportation challenges. Future research might explore the concepts of community identity and mutual support among urban AI individuals to determine how this cultural tenant is expressed in an urban environment.

Incorporate Local Understandings of Wellness into Prevention Models

Finally, the results of this investigation uphold previous work suggesting that tensions exist between suicide prevention models and AI understandings of health and wellbeing. While the former often construes helpers as trained and licensed professionals, the latter places importance on personal experience and trust. While one construes youth suicide prevention primarily in terms of help-seeking for mental health concerns, the other places more importance on social and community support. Whereas silence may be seen by professionals as psychologically unhealthy and prohibitive of benefit from talk therapy, circumspect communication may make sense in the context of tense interracial relationships and limited community confidentiality. And, whereas reluctance to speak about suicide may be construed within mainstream cultural paradigms as a result of the stigma surrounding the issue, it may also reflect a general reluctance to give thought and voice to negativity and thereby risk bringing on harmful states of being.

With regard to this latter concern, some AI people believe that talking directly about negative phenomena may invite such phenomena into a person's life (Robinson, Sandoval, Baldwin, & Sanderson, 2005). As one respondent said, prevention programs should avoid

"putting [suicide] into someone's influence" by discussing it. Even though research has shown that asking mainstream youth about suicide does not cause an increase in suicidal ideation (Gould et al., 2005), these findings may not assuage AIs whose concerns are grounded in sacred traditional cosmologies rather than in secular theories of social contamination. Moreover, when respecting the assumption that traditional AI culture both promotes a healthy lifestyle and aids in healing, one might view the clinical conceptualization of suicide prevention as forming part of a mainstream culture that is in itself, unhealthy for AI youth. If prevention is viewed only as increasing access to clinical services and educating community members about suicide, it leaves little room for prevention strategies that are more culturally appropriate.

Multiple respondents mentioned the Seven Grandfathers teachings as a potential avenue for helping youth to understand how to deal with difficult emotions or situations. Specifically, the Seven Grandfathers teachings exemplify living one's life according to the values of wisdom, love, respect, bravery, honesty, humility, and truth (Ziibiwing Center of Anishinabe Culture and Lifeways, n.d.). Such traditions respect individual autonomy while at the same time providing youth with culturally appropriate resources that can be called upon in times of difficulty. For example, youth might use truth to recognize their own struggles in life and bravery to seek the assistance of others even when it may seem very difficult. In this way, the use of the Seven Grandfather's teachings could also help to reduce internalized stigma regarding mental health issues. This, in turn, could serve to improve mental health outcomes, self-esteem, hope, and social support, all of which are related to such internalized stigma (Livingston & Boyd, 2010).

Additional approaches to community change may include training advocates to promote collective action that addresses suicide as a social rather than individual problem, and funding local efforts that are based in AI cultural norms and values (Wexler & Gone, 2012). Community-academic research partnerships are also in the unique position of being in touch with community voices while also having access to structures of power. Such partnerships can promote indigenous understandings of mental health and wellbeing among mainstream professional and funding organizations. Finally, current research provides conflicting evidence regarding the relationship between cultural connectedness, sense of belonging, connectedness to others, connectedness to community, and suicidal ideation and behavior among AI youth. Further research should be conducted to understand the dynamics of cultural and interpersonal factors

among urban AI youth, in order to strengthen culturally-appropriate support systems in a way that addresses the pressing social and mental health needs of this population.

Limitations

The principle limitations of this study stem from its reliance on pre-existing interview data that were gathered as part of a Community Readiness Assessment. When relying on pre-existing data for qualitative analysis, it is recommended that, as in the present study, the secondary analyst is familiar with the context in which the data were obtained and is either part of or able to consult directly with the original research team (Hammersley, 2010). Still, there are limitations relating to fit of the data with the present study that are worth considering further.

First, the goal of the CRA interview protocol was not to collect data for thematic analysis, but rather to analyze a community's level of readiness to address an issue by examining existing prevention efforts, community knowledge of prevention efforts, leadership, community climate, community knowledge of the target issue, and resources for prevention. While challenges and resources for AI youth suicide prevention can be found in each of these domains, there may be additional challenges and resources that fall outside of these six areas of interest. Additionally, the CRA model relies on the identification and interviewing of key informants who are knowledgeable about a particular community. In the present study, this meant that individuals who had no contact with the UIHO were excluded from the sample.

Finally, only four of the fifteen individuals interviewed were under the age of 25. AI youth, and particularly those who have not already been involved in the UIHO, may have differing understandings of the challenges and resources related to suicide prevention, as well as the roles that traditional AI culture plays in promoting wellbeing. Future studies could thus focus on engaging urban AI youth voices on this topic, especially those who may not already be involved with local community health organizations.

Conclusion

In this study, resources and challenges for urban AI youth suicide prevention were investigated. A thematic analysis of interviews with fifteen self-identified AI staff and community members from a UIHO revealed three principle themes: formal resources, informal resources, and community values and beliefs. Formal services such as those provided by mental health professionals or paraprofessionals specializing in suicide prevention were reported as limited in availability or inaccessible, in part due to invisibility of the urban AI population,

negative expectations of such services, and a lack of governmental commitment. Respondents suggested that youth would be more likely to seek help from informal sources, such as friends, family, or youth leaders and mentors at the UIHO. Community values of mutual support, ways of teaching and learning, and traditional healing were discussed. Participants expressed concern not only for the loss of such traditional values and sense of community, but also for the incompatibility of mainstream clinical approaches to suicide prevention with values held by the community.

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