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Creating a Community of Practice to Prevent Suicide Through Multiple Channels: Describing the Theoretical Foundations and Structured Learning of PC CARES

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Abstract

It is critical to develop practical, effective, ecological, and decolonizing approaches to indigenous suicide prevention and health promotion for the North American communities. The youth suicide rates in predominantly indigenous small, rural, and remote Northern communities are unacceptably high. This health disparity, however, is fairly recent, occurring over the last 50 to 100 years as communities experienced forced social, economic, and political change and intergenerational trauma. These conditions increase suicide risk and can reduce people's access to shared protective factors and processes. In this context, it is imperative that suicide prevention includes—at its heart—decolonization, while also utilizing the "best practices" from research to effectively address the issue from multiple levels. This article describes such an approach: Promoting Community Conversations About Research to End Suicide (PC CARES). PC CARES uses popular education strategies to build a "community of practice" among local and regional service providers, friends, and families that fosters personal and collective learning about suicide prevention in order to spur practical action on multiple levels to prevent suicide and promote health. This article will discuss the theoretical underpinnings of the community intervention and describe the form that PC CARES takes to structure ongoing dialogue, learning, solidarity, and multilevel mobilization for suicide prevention.

Keywords: suicide prevention, indigenous, ecological approach, community education

Introduction

Youth suicide is a significant problem particularly for indigenous populations, which have disproportionately high rates of suicide and suicidal behavior.[1–4] The youth suicide rates in predominantly indigenous small, rural, and remote arctic communities are unacceptably high.[5–8] In North America, Inuit, and Alaska Native young people in some communities have suicide rates almost 20 times higher than those of other Canadian and American young people. Clearly, suicide represents a significant health inequality for arctic indigenous youth in North America, but it is important to remember that this situation is fairly recent.[9,10] Over the last 50 to 100 years, the forced social change, colonization, has led to intergenerational trauma, and the social, economic, and political inequalities experienced by these communities create conditions that increase suicide risk and can reduce

people's access to shared protective factors and processes. In this context, it is imperative that suicide prevention includes—at its heart—decolonization, while also utilizing the "best practices" from research to effectively address the issue from multiple levels.

In this article, we describe the theoretical foundations of our approach to suicide prevention as well as describing the form we developed to foster ongoing learning and mobilization within a community of practice.[11] Developed with indigenous leaders and community members, Promoting Community Conversations About Research to End Suicide (PC CARES) uses popular education strategies to create regular opportunities to share knowledge and experiences, develop a shared sense of purpose, and gain practical insights for action. These community conversations are sparked by "bite-size" pieces of research information, which can help communities, and the people within them, shape their efforts based

on research evidence. Built on current community-specific systems of care, PC CARES brings together village health and human-service providers, law enforcement, school personnel, religious leaders, respected elders, parents, aunts, uncles, and others each month to learn about "what we know" (bite-size pieces of research information) from suicide prevention and health promotion research, spend time talking about "what we think" to reflect on its relevance, and explore ways to apply the information to their lives and community. In the last section of each PC CARES monthly learning circle, participants have a chance to talk about "what they want to do" so they can develop practical ways forward that are aligned with their own personal, cultural, and spiritual preferences. The model positions participants to engage research information as active generators of meaning and analysis rather than passive recipients of not only research information but its meaning and how it is to be applied to their communities. Such an approach emphasizes both personal agency—the rights of participants to make informed decisions— and solidarity within a group of people working toward a shared goal.

These monthly community conversations are also intended to bring people together to get support and inspiration from each other. Through these learning and relationship-building processes, PC CARES aims to (a) expand participants' knowledge about the multiple ways to prevent suicide, (b) increase collaboration in noncrisis situations through the development of a community of practice, and (c) spur practical innovation to create community conditions that reduce suicide risk and promote wellness. This article will describe how we incorporated popular education theories, "community of practice" strategies, and scientific literature into PC CARES. We believe this community- based and community-driven model of reflection, learning, and doing can provide a flexible structure to community members who want to create conditions within their families and community to prevent suicide and promote health and wellness. In this article, we will first outline the theoretical underpinnings of PC CARES and will then describe how these theories structure the content and process of PC CARES. This article will conclude by describing the important implications of this approach for the field of community health education.

Decolonizing Approaches to Address the Roots of Indigenous Suicide

Indigenous suicide prevention or wellness needs to take account of the enduring negative effects of colonization, both historic and ongoing, in order to effectively address it.[12–16] In recognition of the sociopolitical origins of distress within indigenous communities, including, for example, residential schools, institutional abuse, policies of assimilation, and other forms of structural violence, it is imperative that suicide prevention efforts explicitly utilize decolonizing processes. Basically, suicide—as a "soul wound"[12]—requires a

"postcolonial form of therapeutic intervention" (p. 196).[17] This kind of intervention must acknowledge local wisdom and practices and rely on indigenous ways of knowing and doing. As such, it is important to reflect relational, familial, social, and spiritual dimensions of selfhood more than decontextualized, expert-driven, individualistic, biomedical understandings of distress.[18,19] Building on local resources, respecting cultural protocols, adhering to interpersonal practices, and developing procedures that allow for respectful, open dialogue are essential components in a decolonizing approach. Additionally, a decolonizing approach to learning, indigenous pedagogy, allows for reflection and storytelling and does not result in one consolidated understanding. Indigenous pedagogy relies on nuanced and personal understandings facilitated through storytelling and lived experiences.[20–26] As Bryan Brayboy[27] writes

> For many Indigenous people, stories serve as the basis for how our communities work. For some Indigenous scholars (and others), theory is not simply an abstract thought or idea that explains overarching structures of societies and communities; theories, through stories and other media, are roadmaps for our communities and reminders of our individual responsibilities to the survival of our communities. (p. 426)

Personal and narrated experiences invite locally situated, relational, spiritual, and personal knowing, which may be more aligned with indigenous suicide prevention.[28]

Popular Education for Health Promotion and Wellness

A long line of educational research has demonstrated that engaged and critically aware approaches to learning, which are experiential in nature and transformative in their aims, are more likely to foster long-term learning than approaches that rely on universal, knowledge transmission approaches.[29–31] 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 Paulo Freire[32] critically 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.[33,34] If education is to be transformative—engendering new understandings and action—it must create forums in which people find meaning in the content, can express themselves, and explore ideas and possibilities in an empowering way.

Building a "Community of Practice" on Current Systems of Care

A "community of practice" as defined by Wenger, McDermott, and Snyder[35] is deceptively simple. They define it "as

groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis" (p. 4). Communities of Practice (CoP) offer a key way for people to learn and share knowledge. A CoP develops as people deepen their relationships and learn to collaborate. They can also be intentionally designed and coordinated around specific issues to do more in-depth exploration.[36] An important element in creating and supporting a CoP is that interactions and knowledge sharing are relevant to those involved, and that they can choose how to use it, as they move forward. Acknowledgment of small successes that result from these processes supports CoP sustainability. PC CARES pedagogy is thus framed as a community of practice. The model invites community stakeholders, tribal leaders, rural providers of health and human services, law enforcement, religious heads, and others to come together each month to learn "what we know, think, and want to do" about suicide and suicide prevention. They decipher and apply the information to their understandings, and importantly, their particular community context, and experiences. The practical relevance, shared focus, and reflective opportunities of such a CoP allows for flexible developments in response to the particular needs of the group and the problem(s) they are addressing.

Indigenous Adult Learning as an Organizing Framework

Integrating ideas from CoP, popular and critical education, and decolonizing principles is a complex undertaking, and adult-learning principles provide a framework for this critical amalgamation. Toward that end, we utilize those adult learning theories and practices that allow space and consideration for a worldview not represented in the dominant discourse. These alternative conceptions can be summarized as not Eurocentric and as such emphasize an epistemology grounded within community and holistic learning processes. These include emotional components that are coterminous with cognitive understandings and informal learning. In general, these elements inform core areas of the adult learning experience for indigenous peoples.[37–40]

Critical areas for attention include how (1) content is delivered, (2) dialogue is facilitated, and (3) the learning environment is structured. In PC CARES, local—mostly indigenous—service providers are trained as facilitators whose main goal is to help people understand bite-size pieces of research framed as "what we know," explore ideas in "what do we think," and create possibilities for local prevention efforts in response to it, that is, "what we want to do". Instead of teaching specific content, the facilitators are trained to support open discussions about the research in ways that allow for multiple viewpoints. Importantly, the learning environment is structured by shared agreements between those participating about how to maintain a safe environment for dialogue especially around the topic of suicide.

These educational structures allow participants to engage in *collaborative inquiry* (CI).[41] CI centralizes the importance of lived and reflected-upon experiences as foundations for new knowledge and learning. In CI, this learning is done systematically over, in the case of PC CARES, a series of nine monthly meetings. Through 3-hour monthly meetings, a group of community members can garner new information about "what we know" from suicidology research and have time to process it holistically through the telling of stories, and listening to one another framed as "what we think." Between monthly sessions, community members also have time to further reflect on the relevance and meaning of that new information in their lives, as they consider their intentions related to "what do we want to do" and the community changes they may notice result from their and fellow participants' efforts.

The Importance of a Flexible Approach to Indigenous Suicide Prevention

Flexibility in approaches to suicide prevention is important since "… 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" (p. 42).[42] What is needed is an approach that is informed by previous research but is not standardized. A consistent and strong recommendation in a recent Arctic Council report on indigenous suicide prevention states that, "one size does not fit all".[43] The differences between small, rural communities—even those within the same region—are noteworthy, stemming from diverse historic events (e.g., unevenly experienced epidemics, different church leader influences, gold rush),[44] geographies (e.g., coastal vs. inland; close to resource development sites or not), political structures (e.g., incorporation as cities or not), and family histories within communities.[45–47] The fluid approach of PC CARES allows for community members to both consider evidence from suicidology research and learn their own personal stories.

PC CARES Structure

Building on current village systems of care, PC-CARES brings together village providers such as community-health workers, law enforcement, counselors, pastor(s), school personnel, respected elders, and other stakeholders each month to learn about best practices for suicide prevention and health promotion, analyze its relevancy, and explore ways to apply the information to their lives and community. Additionally, learning circles give providers a way to get support and inspiration from each other.

All monthly PC CARES learning circles follow a similar structure (see Box 1). The session begins with prayer offered by a local elder, and each person is invited to "check-in." The check-in can be a time to briefly share what it is

like to participate in a process related to a provocative topic such as suicide or time to share why they decided to join the group and apprehensions or excitement they bring with them. This opening is followed by an overview of purpose of the meeting's topic and review of shared agreements on how to protect a safe learning environment. Next, the "what we know" piece of research is shared. The bite-size bits of research are condensed and translated into easily understood short videos, graphs, tables, pictures, or case studies that are intended to be presented in less than 10 minutes. Participants will then, in small groups or with a partner, engage in story telling, discussion, and analysis of the research presented. They will then share with the larger group for more synthesis of the material that is now interpreted through personal experiences, reflection, and community connections. Presentation of research content in "what we know" will constitute the least amount of time spent, leaving the majority of time devoted to dialogue. Learning circles offer chances to share stories relevant to the content in "what do we think," and to envision how they can apply the new information in their home community, as they discuss possible solutions and next steps in the "what do we want to do" section. All sessions will end with another closing "check-out" and prayer from an elder.

PC CARES Content

As described, of central importance to PC CARES is a process for service providers and community members to engage in ongoing wide-ranging education, reflection, knowledge sharing, relationship building, and mobilization to truly prevent suicide in under-resourced, rural indigenous communities. To be culturally responsive and to maximize impact, the content of the learning sessions need to resonate with participants, offer practical insights, and be clear and understandable. Our overarching goal is that people who attend PC CARES sessions will leave with clearer ideas about what can effectively be done, who they can rely on (and for what), and how they can prevent suicide.

Toward these aims, we have identified scientific findings about effective suicide prevention approaches that are relevant to rural indigenous communities. First, multilevel approaches to suicide prevention are more likely to be effective.[48–50] With content that targets the multiple conditions that increase (and reduce) suicide risk[51–54] and disseminates scientific information relevant to suicide prevention,[55–59] PC CARES offers practitioners and community members ongoing opportunities to understand, translate, and apply scientific knowledge to their daily practice, collaborations, and institutional protocols. This information is the basis of each of the nine learning circles (see Box 2), which is a feasible yearly goal according to community partners. The content of these learning sessions includes community-level and environmental conditions (e.g., cultural continuity, seasonality), evidence-based approaches (e.g., lethal means restriction,

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Box 1. PC CARES Session Overview.

Set up for 3-hour monthly session: Create a hospitable space (safe, private) where traditional practices are respected (e.g., elders always present, sit in a circle, food, etc.)
1. Beginning ritual (based on local traditions: prayer)
2. Agreements (confidentiality, respect, includes SafeTalk) to remind attendees
3. Reflections about last meeting or new preventative actions taken between last time we met and now
4. Articulate why people are coming together (purpose):
　　→ In general: learn from research how to prevent suicide, and
　　→ For each particular session: specific content learning objectives
5. Learning Foci (follows this format a, b, c, but the content changes):
　a. What We Know?: Increase understanding about effective suicide prevention.
　　→ Clearly share relevant information using culturally responsive methods
　b. What Do We Think?: Invite reflection on applied meaning of information for these people & this community through active processes (e.g., storytelling)
　c. What Do We Want To Do?: Mobilizing or taking personal or collective action
6. Closure—post-survey and short exercise for all participants (e.g., six word "take away")
7. Ending ritual (based on local traditions: prayer)

Box 2. Learning about "What We Know" to Prevent Suicide.

1. Where we have been and where we are going (historical and current trauma and suicide)
2. The role of adults for youth suicide prevention
3. Seasonality trends
4. Community protective factors
5. Supportive counseling as prevention
6. Restricting lethal means
7. Support after a suicide attempt
8. Postvention, includes talking safely about suicide
9. What we have learned in PC CARES and moving forward

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safety planning) and protective factors (i.e., sleep, culture, intergenerational relationships), inter- and intra-personal knowledge, and skills that can prevent suicide and promote well-being. The focal content of sessions will vary, but each session will follow the same pattern of activities to aid facilitation (see Box 1). The empirically supported suicide prevention content will spark and anchor community discussions and help participating service providers and village members effectively answer (and act in response to) the question, "What can be done to prevent suicide in our community?" Such ongoing community learning processes have been effective in other under-resourced communities.[60–62]

Integrating Key Theories Into the PC CARES Approach

Although structured around suicide prevention research put into "bite-size" formats of charts, diagrams, five-minute films and activities, most of the PC CARES content is generated

from participants' experiences and stories. The approach includes 5 to 10 minutes of information sharing through various means, while the rest of the 2 to 3 hour learning session is spent making sense of it, drawing linkages, and exploring the relevance of it to participants' understandings and experiences (see Box 1). This approach intends to promote people's faith in their personal and local wisdom and to draw attention and emphasis to community resources as a primary safety net. Sharing and listening to stories are a way indigenous communities have shared knowledge for generations and are important pedagogical and empowerment tools. 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. (p. 53)[33]

As participants make sense of the suicide research information, they begin to take responsibility for dissecting, integrating new information, and developing, over time, a collective knowledge base with current suicide and prevention research as the focal point. This approach is a marked departure from the myriad of workshops, certification modules, and trainings that indigenous communities are often offered and sometimes mandated to attend. Those scenarios tend to package information with the expectation that the participant absorb the material and comply with already developed procedures or outcomes.[18] This kind of didactic education is antithetical to developing a CoP. As Lave and Wenger[63] wrote, "… communities of practice are engaged in the generative process of producing their own future" (pp. 57, 58) and as such allow for fresh insights and applications to communities seeking approaches to suicide prevention.

PC CARES has developed a learning curriculum[63] that is defined as "a field of learning resources in everyday practice viewed from the perspective of learners" (p. 97). This approach is contrasted with Lave and Wenger's[63] depiction of a teaching curriculum whereby an instructor not only provides learning resources but also mediates the meaning and structure the direction that learning takes. The PC CARES CoP model positions learning as dynamic, with research data as a catalyst for developing shared understandings and responsibility for information interpretation. CoP members, through story telling and CI, designate the application and relevancy of what they learn to their home community. This iterative process can be transformative for participants who move from passive learning into a participatory and collaborative epistemology.

Initiating a CoP model for exploration of research information, PC CARES seeks to employ particular concepts from the fields of adult learning and indigenous studies, especially those that dovetail with indigenous ways of learning and knowing. When disseminating small pieces of research findings on suicide, the PC CARES model refrains from providing the meaning of the data but instead relates content. In line with a translational research approach, the PC CARES model seeks to partner with a community and solicit their responses to the research findings as well as to put application of the research in their hands.[64] The meaning of the data, how it might be applied to the community, and level of relevance it holds are sorted out through a CI process. The environment for this dynamic learning is one that needs to be safe and respectful. Having a consistent process for providing the research data and a structure for sharing is pivotal to ensuring genuine sharing, learning, and developing strategies for application.

Assessing Outcomes

Our pilot sessions, conducted in six village communities in August and September 2015, suggest that these aims are supported by the PC CARES approach, and ongoing evaluation efforts will track learning and action outcomes through surveys for those participating in PC CARES learning sessions before the first session, after the fourth and ninth session, and three months after the last session. Additionally, we will track PC CARES's network effects; specifically the collaborative networks of village and regional providers. We will track these social networks through both interviews with village service providers and members of the larger health services and through community-wide social network data.[45–47]

Interviews with regional and community service providers will track changes in collaborations among mental health providers and document the interactions that are mobilized in support of vulnerable youth before and six months after the intervention. Questions will focus on frequency and mode of interaction (emails and phone calls, shared casework, requests for information, or assistance), evaluative questions concerning the quality and effectiveness of interactions, and hypothetical interaction questions such as, "If you received information about a community member engaged in X, whom would you be most likely to contact?".[45–47,65] Pre-post provider data will show whether and how interactions within these formal helping systems change after implementing PC-CARES.

In two communities, social network data will reveal the informal supportive structures within each community and will show the interaction between these and the formal systems that exist outside the community.[66] In the community-wide data collection, we will also solicit the respondents' impressions of other network patterns in the community (such as age cohort clustering, family associations, interaction patterns with health services organizations). Ego network questions will focus on support relationships (friendship, housing, advice, food, information about health and related services), while third-party network questions will focus on the larger community structures of association (who works with whom on issues of subsistence production, church membership, jobs assistance, recreation, and

substance use).[45–47] By comparing the results before and after our intervention, we evaluate the effectiveness of the program in altering, intensifying, or broadening the interaction of these distinct formal systems. These effects would indicate that the ongoing, monthly popular education model focused on reflection, generating ideas, and creating critical consciousness of participants is a viable way to inspire and empower community members and service providers to create conditions that prevent suicide and promote health in their community.

Conclusions

PC CARES was developed with indigenous leaders and service providers from rural Alaska and creates conditions for people to work together to prevent the complex issue of suicide on multiple levels: community, family and interpersonal, and on their own terms. White, Morris, and Hinbest,[67] 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). To do this, our approach utilizes adult learning theory, indigenous protocols, and ways of knowing; offers new information from the scientific literature; and fosters CoP within communities in order to apply and deploy these insights and tools to various aspects of their own communities. PC CARES offers a clear way to address locally identified gaps in understanding and collaboration through (a) engaging key community members in ongoing learning about suicide prevention based on scientific research, (b) applying this knowledge to their villages and lives, and (c) supporting a broad range of actions to prevent suicide and promote wellness, on participants' own terms. Our assessments target community level, professional, and interpersonal changes in collaboration and support to actively prevent suicide crises. In this way, PC CARES translates research to practice with the aim of reducing suicidal behavior, a complex, multifactorial issue.

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