This paper is presented from the viewpoint of a regional state administrator for mental health services who has observed the implementation of Alaska's suicide prevention programs for several years. Other observers, or participants in those programs, might see their strengths and weaknesses in a different light. The region observed, Region III, is the most rural of the three mental health regions and has the highest percentage of Alaska Natives. It covers roughly three fourths of the state and includes only one urban area, Fairbanks. Although many Alaska Natives, like Indians in the "lower 48," have migrated to urban areas, the majority still live in rural areas (about half live in communities with less than 1,000 population). These villages are extremely isolated by the standards of the contiguous United States; however, they have been massively influenced by Western technological society in the past 50 years, particularly so in the past 20.

In the 1940s the Natives of Alaska still were the majority population; less than 50 years later, in 1988, the estimated 81,200 Natives made up only 15% of the state's residents. In spite of a high birth rate and a decreasing infant death rate, they have been overwhelmed by a tide of white immigrants. With this tide came the many mixed blessings of the technological society, among them snow machines, television, schools, welfare checks, and the cash economy. Also considered a mixed blessing by some was the 1972 Alaska Native Claims Settlement Act (ANCSA), which created 12 regional Native corporations and many village corporations. These corporations were to manage the lands and resources to which the Native claims were now recognized. They also generated sister corporations that manage health and social services funded by state and federal governments through a variety of agencies. Three fourths of Region III's Community Mental Health Centers (CMHCs) are funded through a Native corporation. The Native population's relative political and economic impact was enhanced by ANCSA, which brought 11% of the state's land under the control of Native corporations.

ANCSA was expected to raise Native standard of living and well-being. Native family incomes rose almost 40% between 1970 and 1980, educational levels rose, and the quality and quantity of housing stocks also rose. However, while the proportion of Native women working increased to equal that of Native men, the employment profile of Native
men did not change significantly (Kruse, 1984). Although the standard of living improved, Native well-being did not, as indicated by the rapid increase in violence and self-destructive behavior.

No public mental health system existed in Alaska prior to statehood in 1958. At present there are 28 CMHCs, in regional and subregional communities providing services to all of Alaska through a system of contiguous catchment areas. Size, population served, and area of responsibility vary widely among the CMHCs and funding is based more on population and historical accident than on need or the cost of delivering services. Anchorage serves a population of about 250,000, while Tanana serves a little over 1,000 persons distributed among eight villages. Wrangell serves only its small community of 2,300, while Bethel serves 36 villages spread over an area as large as Oregon. The word "serve" has a variety of meanings in different parts of the CMHC system. For the smaller villages, service often means a visit by an itinerant white professional every 3 or 4 months, and frequent staff vacancies in the smaller centers may leave a village without face-to-face service for as much as a year. Centers are almost exclusively staffed by white professionals who receive no training to sensitize them to the cultural differences and environmental challenges they will encounter. The problems associated with the delivery of mental health services to Alaska Natives are much the same as those encountered serving Indians in other western states; e.g., lack of cultural relevance and high staff turnover. In Alaska, however, the problems are exacerbated by greater isolation, higher costs, and extreme weather conditions.

The State's Response to Suicide

Recognition by researchers and public health officials that suicide was a major public health problem among Alaska Native youth began to emerge in the late 1960s, as Robert Kennedy, head of the U.S. Senate Subcommittee on Indian Education, focused national attention on Indian problems. Kraus and Buffler (1979) noted that in addition to the overall increase in suicide rates, a shift in age distribution had begun in 1965. Native suicides that had followed the classic U.S. pattern of rates rising with age shifted to a pattern with a sharp peak at the 15–25 age range. However, little public or legislative attention was paid to the rapid increase in suicide among Native youth, and research attention lagged as the state passed into the 1980s and the days of big oil revenues.

In the winter of 1983–1984, in reaction to requests from rural constituents, the House Finance Committee of the Alaska legislature held a series of public meetings on suicide. Alarmed by what it heard, the legislature provided funds for an evaluation of the extent of suicide in the state to be undertaken by the Alaska Native Health Board (ANHB). Money also was appropriated to a reluctant Division of Mental Health and
Developmental Disabilities (DMHDD) for suicide prevention demonstration projects. Unfortunately, the central office staff of DMHDD at that time was not particularly interested in services to rural areas.

Left adrift by the lack of administrative support, technical assistance, and monitoring from DMHDD, the eight villages involved tried a variety of projects, some successful, most not, and left no paper trail of their experiences to guide others interested in suicide prevention. The ANHB did complete its report, but it was based on erroneous data reported by the state to the federal government. That data not only greatly underestimated the problem of Native suicide but indicated a sharp reduction in suicide among Natives when just the opposite was true (Forbes & Van Der Hyde, 1986). Based on the same erroneous data, a 1986 Indian Health Service (IHS) report stated, “The Alaska crude mortality rate from suicide declined between 1972 and 1983” (U.S. Congress, 1986).

The Senate Subcommittee

When the actual suicide rate and the failure of the suicide prevention demonstration projects became known, rural legislators, led by State Senator Willie Hensley, introduced a bill establishing a Senate Special Committee on Suicide Prevention in 1987. The committee held hearings statewide that were supported by other legislators and by social service providers as well as by Native leaders. Based on their findings, in 1988 the legislature funded DMHDD to establish suicide prevention programs. Fortunately, there had been major changes in DMHDD in the years since the previous attempt to establish such programs. DMHDD leadership now supported the need for mental health services in rural areas and was sensitive to the need for culturally appropriate services and the involvement of rural residents in the design of such services.

Prior to the appropriation of the suicide prevention funds, the DMHDD had established a midmanagement position with responsibility for rural and Native services. The Rural and Native Services coordinator had previously been director of a small community mental health center in a rural area. During her employment there, she had established a very successful team of paraprofessional mental health workers and had emphasized community development. She played an active part in supporting the Senate Special Committee and in preparing the report that presented the committee’s findings. Public awareness of the problem of Native suicide and other self-destructive behavior also had been dramatically increased by a 10-day series of articles on alcohol and suicide problems in southwest Alaska that dominated the front pages of the state’s largest newspaper in early 1988.

Suicide statistics cannot provide clues as to the impact of state prevention programs, as the most recent data available from the state’s

THE STATE’S ROLE

237
Bureau of Vital Statistics are for 1988. Records of 1989 and 1990 Native suicide completions, attempts, gestures, and threats are kept by many of the rural CMHCs for the IHS. Those records suggest that suicide completions probably are continuing at the same rate as earlier in the 1980s. Figure 11–1 illustrates the fact that Alaska Native youth suicide rates (ages 15 to 24) continue the trend begun in the 1960s, with rates between 135 and 215 per 100,000 for single years for males and between 7 and 65 for females. Figure 11–2 presents the age distribution of completed suicides for Native males and Native females averaged over the past 5 years.

Community-Based Suicide Prevention

Two suicide-prevention programs are administered by the state's Rural and Native Services coordinator.

The more conventional of the two is a "natural helpers," or peer counseling, program based on the model widely used in schools elsewhere in the United States. That program funds joint applications from schools and CMHCs. The second program differs dramatically from the usual state programs in the way in which it solicits and judges proposals, awards grant funds, and administers programs. The Community-Based Suicide Prevention program (CBSP) could best be classified as a primary prevention or mental health promotion project (Neligh, 1988). Backed by
Figure 11–2
Native Suicide Rates by Sex & Age Group Average 1984–1988

![Graph showing Native Suicide Rates by Sex & Age Group Average 1984–1988](image)

the legislature’s intent language, The Rural and Native Services coordinator, Susan Soule, designed a management system for the CBSP that emphasized community decisions and control and sited the programs without regard to the community’s size. Requests for proposals (RFPs) were advertised in the major Alaskan newspapers and sent to all city governments, village traditional councils, tribal councils, and Indian Reorganization Act councils. Among the entities eligible for funding were 210 Native villages. Unlike other departmental grant programs that carefully avoid involving themselves with potential grantees, the CBSP recruited and trained a corps of “community development specialists” who were to aid any village requesting their service in planning and writing a proposal. In its RFPs, the program described “ways of thinking” about suicide prevention and the kinds of projects the villages might develop. The following are the kinds of projects listed as “possibilities” for programs:

1. Reducing “stresses caused by unmet needs” by programs such as youth projects, youth/elder projects, parenting classes, cultural pride projects, and classes in goal setting

2. Strengthening “skills needed to cope” with stresses; e.g., life skills, refusal skills, and problem-solving and employment skills
3. Building support networks; e.g., healing circles, natural helpers, Alcoholics Anonymous, and groups for parents, men, and women

4. Identifying "those who are troubled and at risk"; e.g., training village helpers, training teachers, and developing referral plans and links to CMHCs

5. Recognizing "warning signs of self-destructive behavior"; e.g., crisis response teams and community education

6. Providing support to those who have lost relatives and friends; e.g., support groups and educational programs

In its first year, fiscal year 1989, the program had $800,000 to distribute for community grants. In a two-phase process, 74 applications were reviewed and 48 were funded. Reviewing and recommendations for funding were done by an interdepartmental team, which reflected the program's emphasis on an integrated approach to problems of self-destructive behavior. Criteria for funding were described in the project history as open-ended and subjective. Project documents indicate that funding decisions were closely tied to evidence of community involvement. For fiscal year 1990, the program funded 55 of 69 applicants from an appropriation of $777,700. For fiscal year 1991, 46 projects were funded from funds of $688,000. Over the life of the project, 74 separate communities were funded; all but 1 were small Native communities. Twenty-seven communities were funded in all three funding cycles. Initially, the interdepartmental team that oversees the project had planned that project funding would be gradually phased out and the communities would take over support of their projects. However, by the fiscal year 1991 cycle, CBSP had shifted to a policy in which "the state will never phase out entirely. Each project will need some base level of funding" (S. Soule, personal communication, August 28, 1990).

Table 11–1 presents a typology of the programs funded. Comparing project types suggested in the RFPs with those proposed by grantees in fiscal year 1989 (Table 11–1), it appears that 46% can be classified as projects that "reduce stresses," another 9% involve support groups, and only 15% would more directly target youth at risk through crisis response, crisis lines, or training of providers. Reviewing successful proposals to CBSP over several funding cycles indicates the majority of proposals funded were of the same "wellness"-oriented types that have been funded in the past by state and federal education agencies and by the IHS. These were programs that were familiar to and comfortable for the villagers.

Little monitoring of programs occurred because funds were not sufficient to provide staff for both grants administration and monitoring of the many small projects. Some informal monitoring did occur at conferences and meetings associated with the program. However, not until 15
Table 11-1
Types of Suicide Interventions Proposed by Grantees in Fiscal Year 1989*

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Number</th>
<th>Percent of all Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elder/youth</td>
<td>29</td>
<td>33%</td>
</tr>
<tr>
<td>Recreation &amp; alternatives</td>
<td>12</td>
<td>13%</td>
</tr>
<tr>
<td>Support Groups</td>
<td>9</td>
<td>9%</td>
</tr>
<tr>
<td>Networking in the Community</td>
<td>8</td>
<td>8%</td>
</tr>
<tr>
<td>Training of community residents</td>
<td>7</td>
<td>7%</td>
</tr>
<tr>
<td>Counseling to youth</td>
<td>7</td>
<td>7%</td>
</tr>
<tr>
<td>Crisis response</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>Training of providers</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td>Develop a crisis line</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>8%</td>
</tr>
</tbody>
</table>

* Note. Most projects proposed two or more interventions.

Source. Division of Mental Health. Fiscal Year 1999 CBSP grantee files. Juneau, AK.

months after CBSP was initiated was an attempt made to require monthly reports to include specific information across all funded programs. Throughout CBSP's existence, not all grantees routinely submitted monthly reports. As a result, there is no body of information that records the implementation process, level of community participation, or possible outcomes across programs.

Evaluation

Formative evaluation of the CBSP program had been considered during the planning stage, but program administrators were reluctant to expend time and funds for evaluation that otherwise could be directed to village programs. At the end of the first year, the Department of Health and Social Services (DHSS) commissioner requested an evaluation, and a contract was let to cover fiscal years 1990, 1991, and 1992. The contract was not completed until fiscal year 1990 was in progress, and therefore reports on funded projects are not yet available.

The first year's scope of work was to include refining the evaluation process and selecting the 5 communities that would be involved in the more intensive portion of the evaluation. The selection of the 5 communities, as well as a group of 8 and another group of 15 communities to be involved in the less intensive levels of the evaluation, will be based on
suggestions from the interdisciplinary team and DMHDD staff and will be subject to approval by the communities. That procedure inevitably will introduce biases into the sample selection. As might be expected with a minimally funded ($30,000) evaluation that was not developed until the program was under way, little quantifiable information will be gathered. Most information will be self-report, and the evaluator will have little opportunity for face-to-face contact with the sites. Within the limits imposed, the evaluation plan is sound and well organized. The evaluator will seek access to nonintrusive measures of self-destructive behavior in the targeted villages. However, there is no indication in the evaluation plan that more specific questions, such as how many individuals were involved in the total number of instances of self-destructive behavior and whether those individuals were targeted by community activities funded by CBSP, will be addressed. A change in suicide incidence is mentioned in the evaluation plan as a possible measure, but the small populations involved exclude such measures as practical bases for evaluation. However, that need not mean the program’s impact on high-risk individuals could not be estimated using secondary measures. The success of pencil and paper measures in identifying Indian youth at risk of suicide suggests their use could have added an important dimension to the evaluation (Dinges, 1990). Measures of intermediate goals, particularly those that are in themselves highly valued, were recommended by Beiser (1982) in an earlier conference on prevention and have been used effectively by VanDenBerg (1988) in Alaska.

In her description of the CBSP program, the evaluator states, “The intent of the Senate Committee and DHSS was to establish . . . program . . . preventing self-destructive behavior” (Bernier, undated, p. 10). Elsewhere Bernier states, “CBSP Projects are working to change community environments. . . .” (p. ii) and “The CBSP program . . . focuses on community empowerment and community development rather than client-centered care. . . .” (p. 59). Program documents indicate that the overall objective is community development as a process, with the assumption that as a community develops more strengths, a reduction of self-destructive behaviors will occur. In an attempt to encourage innovation and increase the cultural relevance of the individual projects, the degree of Native and community control over selection and implementation of project activities was much greater than that found in most state-funded projects. The proposal process, reporting, and other requirements for funding were simplified to increase the accessibility of funds for smaller communities. The use of CBSP-supported community development specialists also increased accessibility of funds for smaller Native communities and organizations. In spite of these attempts to increase prevention effectiveness by encouraging innovation, cultural relevance, and accessibility, there is no evidence at this time that the CBSP projects, individually
or collectively, have been more successful than past projects of the same general type.

The program has some additional weaknesses. The ultimate goal of most CBSP projects was to change the behavior of adolescents and young adults, yet there was little or no involvement of youth in the planning, selection, or implementation of programs. State administrators were unrealistic about the number of staff needed to implement a program of its size. The apparent CBSP emphasis on community development and general prevention biased funding against more targeted interventions, which may have reduced its effectiveness in view of the lack of evidence of success of general prevention programs elsewhere in the nation.

Finally, and most serious in terms of the long-term survival and effectiveness of the program, was the lack of evaluation. The program's goals would have been better served by beginning with a pilot project involving a much smaller number of villages, much more and more detailed information on prevention choices to potential grantees, ongoing face-to-face monitoring, more training, and evaluation built in from the inception of the program. As has been learned in cross-cultural research projects, large-scale projects that do not take the time and the funds to implement pilot projects are doomed themselves to become very expensive pilot projects.

Other Prevention Responses

The DMHDD responses to the high suicide rate among Native youth were not confined to the CBSP program. The Rural and Native Services coordinator authored a manual for communities that included the Centers for Disease Control's plan for community organization and delineated what responses a community could (ideally) expect from appropriate agencies. The manual was distributed to all CMHCs, which have attempted to respond to a flood of suicide threats, attempts, and gestures, most of which are associated with alcohol abuse. CMHC responses to potential suicides vary widely, depending on the training of its staff members and their individual outlook.

Not all rural CMHCs have access within their catchment area to a hospital that will accept psychiatric patients for screening or evaluation. Most areas in Region III are served by IHS hospitals, the majority of which are being taken over by Native regional corporations. Until last year, the IHS hospitals often were aggressively resistant to providing care to psychiatric and/or suicidal patients. They also have resisted being designated by the state as evaluation facilities so that area residents could be involuntarily committed for a 72-hour evaluation in a facility close to their homes. As a result, rural suicidal patients were sent to facilities in Fairbanks or Anchorage, resulting in great cost to the state and a most untherapeutic effect upon the patient.
When faced with a serious suicide threat from a Native youth, most small CMHCs try to admit him or her to one of two inpatient treatment facilities in the state: Charter North, a private hospital that receives most of the Medicaid-eligible patients, and the Alaska Psychiatric Institute (API), the state inpatient facility. However, commitment statutes make it difficult to secure involuntary commitment status for suicidal persons who are unwilling to accept treatment voluntarily. The statutes allow involuntary status only when the person is “mentally ill” and “a danger to self or others.” Too often a rural CMHC will send a rural youth to API under an emergency detention order only to have him sent back to the village on the next flight because he cannot be committed. No formal study has been made of the effects on Native youth of such action or of treatment at either API or Charter North. Anecdotal reports from a number of CMHC clinicians at smaller sites suggest that treatment does have positive effects for the first 3 to 6 weeks after the person’s return to his or her village. However, without an adequate after-care plan, the effects of treatment are transitory.

DMHDD has not taken action to systematically provide training in suicide prevention, effective after-care planning, or treatment of suicidal youth to all the CMHCs in the state system. Some training has been provided at an annual training conference, but conference attendance by rural clinicians is erratic.

One resource often requested by villages threatened by suicide is a local mental health worker. To date, use of like-ethnic paraprofessionals has been optional for CMHCs. Some employ such like-ethnic paraprofessionals in the regional CMHC and have them work as itinerates in the villages with or without professional backup. Some have one or two paraprofessionals stationed in a particular village either because of the village’s status as a subregional center or because of the level of need. Some try to have volunteer village response teams, with varying degrees of success. With the exception of Nome’s program, which is exceptionally stable, using like-ethnic paraprofessionals has had mixed success.

Discussion

The state of Alaska derives 85% of its total revenues from oil. Although conflict in the Middle East has produced higher oil prices for the moment, the state's supply of oil is dropping rapidly and even Saddam Hussein can only delay briefly the state’s coming budget crisis. In view of the approaching budget shortfall, the most crucial question for suicide prevention in Alaska is whether it will continue long enough to provide evidence of success or failure. Suicide prevention programs may not survive the cutthroat competition in a revenue-poor state legislature without evidence of their effectiveness. State statutes place crisis response and services to the severely mentally ill ahead of prevention in the priorities for
state-funded mental health services. Only direct legislative funding, like the funding supporting CBSP, can make suicide prevention a priority.

Lack of data regarding primary, secondary, and tertiary efforts in preventing youth suicide by Alaska Natives cripples efforts to obtain support for programs and deprives decision makers of a rational basis for allocating resources. The limited CBSP evaluation effort is not likely to produce strong evidence of success or failure because of its belated involvement and sparse funding. The evaluation effort is further hampered by the number and variety of projects within CBSP, the lack of records, and the mixture of primary, secondary, and tertiary prevention within and among projects.

Examining past programs targeted on preventing suicide and other self-destructive behavior in American Indian communities outside Alaska does not encourage optimism about the effectiveness of CBSP projects. Neligh (1988) reports that primary preventions attempted in Indian communities have objectives similar to those of CBSP; i.e., “to effect a major social and attitudinal change in the entire community such that the problem of suicide... will vanish completely...” (p. 16). He also notes, “Prevention programs are aimed at an entire population rather than a defined subgroup, making the prevention efforts inefficient and perhaps ineffective. ... There is lack of evidence that these general 'prevention' programs are effective in Indian communities” (p. 5).

Secondary and tertiary prevention efforts by the professionals in the CMHCs have not been tracked, so no supporting evidence will be easily available. Information on comparative outcomes for those who attempted suicide but were not institutionalized versus those hospitalized at API or Charter North remains buried in the files.

Other important information awaits further research. For example Levy, Kunitz, and Henderson (cited by Thompson, 1989) found that Hopi suicides often were clustered within families. Elders in several Alaska Native communities claim this also is true in communities in their regions. Additionally, a few providers have expressed the opinion that in Alaska it is the brighter and better adjusted Native youth who commit suicide. If this is true, many prevention efforts are focusing on the wrong group. Dozens of questions come to mind, the answers to which might help target resources: What percent of attempters and what types of attempts are associated with later completion? What are the interactive effects on risk of tribe, level of education, and exposure to settings outside the village? Were adolescents and youth in southwest Alaska villages aware of the sensational Daily News story on suicide?

There seems to be general agreement that the rate of social change in the past 25 years is a root cause of the increase in self-destructive behavior seen among youth, minority and majority, in many settings around the world. Too often the reasoning, which begins with identifying social change as the cause of individual or social dysfunction, leads to the
assumption that the exclusive solution is a return to ways of the past. Unfortunately, as Mohatt and Blue (1982) have reported, "Traditionality does not appear to be the panacea that many people hope" (p. 114). If, as May (1987) reports, those Indians who are the least likely to wind up as statistics in any major category of deviance are well grounded or well situated in both the traditional Indian and the modern mainstream societies, then we might expect successful prevention to emphasize grounding in both traditional and mainstream societies. Berry (1984) has presented a model of change accommodating both traditionality and acculturation as healthy states that could guide program design.

Answers to the questions listed earlier will contribute to planning effective prevention programs. However, understanding youth suicide demands an understanding of the context in which it occurs from the perspective of the youth involved. Unfortunately, as Condon (1990) points out, our knowledge of adolescence is deficient because it is limited primarily to the observation of adolescents in Western industrialized societies. Most studies of adolescence in traditional cultures do not reflect the realities being experienced by young people today. Family structure, mode of economic exchange, number of specialized adult roles, subsistence adaptation, and sexual division of labor are among the many aspects of cultural institutions that influence how the adult members of a society manage young people who are entering puberty. All of these have changed drastically in the Arctic in the past 25 years, altering the context in which adolescence occurs. Condon's (1990) work involved Inuit adolescents in the Canadian Arctic, making it particularly relevant to Alaskan concerns. In Alaska, as well as the Canadian Arctic, no longer are the roles and responsibilities of Native youth entering adulthood predetermined by the harsh environment. Ethnographic studies such as Condon's are needed in a variety of settings to identify "structural correlates and psychosocial aspects of adolescent development" (p. 268) as they exist today.

The conference for which this paper was prepared, with its rich mix of experience and disciplines, seems an ideal setting for the development of multidisciplinary and multidirectional approaches. The person-by-situation approach suggested by Manson, Tatum and Dinges (1982) at an earlier prevention conference is a good example. Analyses of Alaskan settings merging Condon's ethnographic and the person-by-situation approaches could provide direction for prevention that even a state bureaucracy would find difficult to ignore.

References

Indian and Alaska Native communities. Portland, OR: Oregon Health Sciences University.


Discussion

Dr. Neligh: You highlighted very nicely some issues of service delivery that have not been the targets for prior research. Appropriately, they should be and may work in ways that no one expects in rural areas. You're thinking about things which many of the states with large Indian populations really do not. The issue of the separation of Indian service delivery programs and community mental health centers pervades the West. In most places there's no interface between those systems at all. At least, there seems to be an interface where you are.

The other thing that I wanted to touch on which you alluded to are issues of funding and health care fads related to suicide prevention. This is an avenue whereby local communities are able to secure funds. In places with 80% or more unemployment rates, any funding mechanism becomes significant. What's the message that's sent by those of us who are health care intervention providers? In order to get funds, a community needs a suicide epidemic. What is that message at a metalevel? It seems a double message.

I think your point about the need for studies of suicide prevention intervention is very acute. Others have made the point that the health care fad du jour seems to be primary prevention intervention. Looking at the drug abuse prevention literature, it shows that educational intervention and self-esteem building intervention actually cause a paradoxical increase in the behavior that's trying to be extinguished.

The other thing I wanted to mention are the service delivery issues. A technology gap exists throughout the West, and particularly in the remote areas of which many Indian and Alaskan Native programs obviously are located. Is there a gap between what's known in the mainstream and what can actually be put into practice at the local level? We see ideas that are good in the research literature get translated and handed down from many different retellings. They become impressionistic as they get further and further from the literature. Many times when things reach the level of the village or the small town, they may have no relationship to the actual intervention that was suggested in the literature at all.
It is nice that the Native villages have satellite television. One only wishes that there was a more extensive telecommunications network that could train people in children's mental health. It could allow case conferences and consultations over the same satellite networks. I understand some villages are connected up that way.

**Dr. Forbes:** They have now cut the funding for educational television, but kept the commercial.

**Dr. Neligh:** In my past experience there were few people in rural areas that had training in adolescent mental health. This provides a huge gap in what they're able to do. That's an area that we don't know how to do yet — how to get information out to the actual service provider.

I think the reporting of suicide rates is another thing we have to somehow take into account. It seems to depend on how suicide is regarded by the local governments. You may get a very active political suppression of reporting of suicides or an encouragement of it. If there's money as there was in the 1980s, then one would expect suicide rate reporting to go up. On the other hand, other places had been stigmatized as being heavily suicidogenic reservations. The tribal councils would actively suppress actual suicide rates. I know of probably three or four reservations with significant epidemics where the tribal council had frankly told local workers that if they reported that, they were fired. It got leaked to me by mental health providers. I think our picture of what goes on in those areas is much less clear than even heroic descriptive epidemiology efforts would have us believe.

I wonder if anyone has investigated the different drug cultures and their beliefs in Alaska. For example, in the 1960s, marijuana, LSD, and amphetamines in the Anglo culture were associated with peace and love. Today the same drugs in the Anglo culture are associated with violence. I don't know if anyone has investigated the Alaskan beliefs about suicide and drinking together in the culture of adolescent males.