Journal of Health Disparities Research and Practice
Volume 8, Issue 4, Fall 2015, pp. 108-123

School of Community Health Sciences
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Hawai‘i’s Caring Communities Initiative: Mobilizing Rural and Ethnic Minority Communities for Youth Suicide Prevention

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ABSTRACT

Youth suicide is a serious, yet preventable, public health concern for ethnic minorities and rural communities. This paper describes the youth leadership model utilized by Hawai‘i’s Caring Communities Initiative (HCCI) and provides reflections on the important factors for success in implementing a youth and community advocacy project for youth suicide prevention. HCCI partnered with six youth and community organizations who serve ethnic minority and rural communities across the State of Hawai‘i to train youth leaders and community members in suicide prevention, in order to develop community awareness activities that are grounded in each community’s strengths and needs. The work of a youth leadership group on the island of Kaua‘i is provided as an example to demonstrate the positive rippling effects that health promotion activities can have when they are youth-driven. Important factors to consider for similar interventions that aim to engage youth to address health disparities include prioritizing relationships among all partners, building the capacity of community partners, and providing meaningful leadership opportunities for youth to serve as role models in their communities.

Keywords: Injury Prevention; Child/Adolescent Health; University-Community Partnerships; Primary Prevention

INTRODUCTION

Youth suicide is a serious, yet preventable, public health problem. The national suicide rate has more than doubled among youth between 1950 and 1990 (US Public Health Service, 1999) and has remained relatively stable over the last few decades (US Department of Health and Human Services [US DHHS] Office of the Surgeon General and National Action Alliance

for Suicide Prevention, 2012). There are approximately 4,600 youth suicide deaths every year, which is equivalent to the loss of 12 young lives every day. Suicide is becoming one of the fastest growing causes of death among American youth, with more dying from suicide than motor vehicle traffic-related injuries (US DHHS, 2012). In addition, approximately 157,000 youth receive medical care for self-inflicted injuries nationwide every year (Kochanek, Xu, Murphy, Minino, & Kung, 2011). Youth reporting suicidal ideation are at increased risk for suicide attempts, major depression, and substance use disorders that can have lasting impacts into adulthood (Hooven, Snedker, & Thompson, 2012). The exposure to suicidal behaviors of others can also heighten suicide risk among youth (Burke et al., 2010). In light of these recent trends, many communities are seeking prevention programs to increase the safety and resilience of their youth.

Executive Summary of the HCCI Youth Leadership Model

This paper proposes a youth leadership model utilized by the Hawai‘i’s Caring Communities Initiative (HCCI) to train and mobilize youth and community members in suicide prevention and develop community awareness activities. Rather than being passive targets of an intervention, this model places youth leaders in the center as active partners in youth suicide prevention. This model reflects the understanding that youth suicide can be most effectively prevented when youth themselves are involved in the efforts. Youth have the insider perspective on youth culture and are attuned to the realities that their peers face. By focusing on team-building opportunities, youth empowerment strategies, and evidence-based suicide prevention training, HCCI’s youth leaders applied their newly acquired training and skills to develop and implement suicide prevention awareness activities and events. These youth-driven and community-responsive activities and events had rippling impacts throughout their communities, as the number of trained community members increased and youth who were at suicide risk were identified and connected to appropriate mental health services.

Epidemiology of Youth Suicide in Hawai‘i

Suicide can affect all youth, but studies show that some ethnic minority groups are at higher risk for mental health disorders (Else, Andrade, & Nahulu, 2007; Rushton, Forcier, & Schectman, 2002). The State of Hawai‘i has a population of approximately 1,400,000 residents and is considered home to one of the highest percentages of ethnic minorities in the US, with three quarters of residents identifying themselves as non-white (US Census Bureau, 2012). Although the State of Hawai‘i is often portrayed as an idyllic paradise, suicide is a considerable health concern. In Hawai‘i, an average of one suicide occurs every two days, with suicide being the leading cause of injury-related death among 15-24 year olds (Galanis, 2012). Furthermore, Hawai‘i’s youth are more likely to report that they have seriously considered attempting suicide, made a suicide plan, and attempted suicide compared to national averages (Youth Risk Behavior Survey, 2013).

Although suicide was once a rare occurrence in Hawai‘i, suicide rates among Native Hawaiians have been increasing since the State began collecting suicide statistics in 1908 (Else et al., 2007). In addition to the lack of access to educational and socioeconomic opportunities, the loss of land and cultural practices of Native Hawaiians have contributed to the historical trauma that continues to devastatingly impact ethnic minority and indigenous populations across the globe (Brave Heart, Chase, Elkins, & Altschul, 2011). Native Hawaiian and Pacific Islander adolescents are now among the highest risk for suicide-related behaviors in the US (Else et al., 2007; Yuen, Nahulu, Hishinuma, & Miyamoto, 2000; Wong, Sugimoto-Matsuda, Chang, & Hishinuma, 2012). Despite these health disparities, there are many strengths and resources that

reside in these communities, with Native Hawaiian youth reporting that they receive a tremendous amount of informal support from community members (Medeiros & Tibbetts, 2008).

In addition to ethnic disparities, those living in rural communities have higher rates of suicide and suicide attempts compared to urban residents (Hirsch, 2006; Ikeda et al., 2002). Rural youth in Hawai‘i are nearly four times more likely than urban youth to use the emergency department for mental health care (Matsu et al., 2013). All five inhabited islands outside of the metropolitan center of Honolulu, as well as specific areas in O‘ahu, are considered rural and federally designated as Health Professional Shortage Areas and Medically Underserved Populations (Hawai‘i Primary Care Association, 2006). However, as with the ethnic groups discussed above, rural communities have strong social connections and are willing to come together on common concerns (Berkes & Ross, 2013). Therefore, suicide prevention programs that address ethnic and geographic disparities, as well as the unique strengths and resources that reside in these communities are needed.

National Initiatives on Youth Suicide Prevention

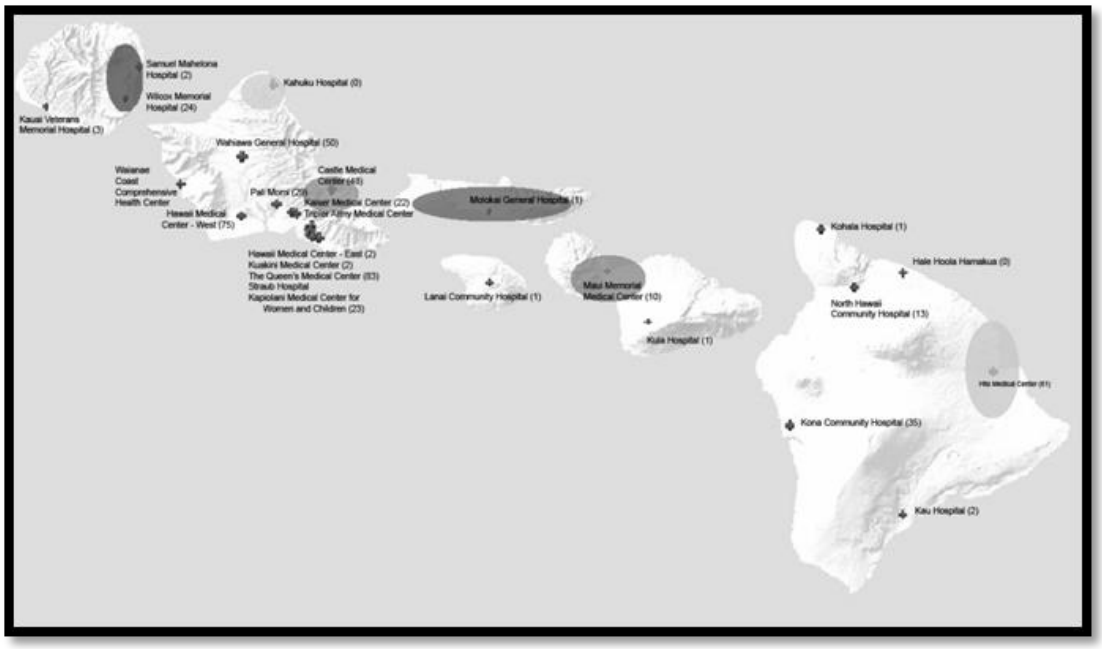
Several national movements in the past few decades have helped move suicide prevention efforts forward. The Garrett Lee Smith Memorial Act, the nation’s first youth suicide prevention bill, was signed into law in 2004, which provides grants to states, tribes, and colleges to support suicide prevention efforts. Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA) put forth a strategic initiative that highlighted the goal of preventing suicides and suicide attempts among indigenous and minority youth. To reach this goal, SAMHSA encourages the development of culturally-specific programs that promote a strong sense of self and appropriate help-seeking behaviors among youth (SAMHSA Strategic Initiatives, 2011). The 2012 National Strategy for Suicide Prevention by the Surgeon General also emphasized the need for suicide prevention efforts to take place in communities, and recognized the importance of social connectedness as a key protective factor (US DHHS, 2012).

METHODS

Hawai‘i’s Caring Communities Initiative (HCCI) for Youth Suicide Prevention

To build upon these national initiatives, the Hawai‘i’s Caring Communities Initiative (HCCI) for Youth Suicide Prevention was implemented through two strategic youth suicide prevention and early intervention projects entitled *Enhancing the Statewide Trauma Network* and *Mobilizing Communities At-Risk* (MCAR). The goal of these two projects was to positively impact at-risk youth and communities across Hawai‘i, as well as the statewide suicide crisis infrastructure, through community partnerships (see Figure 1).

Figure 1. Map of HCCI Community Partners



Crosses: trauma center and emergency department partners
Shaded areas: areas served by the community and youth partners

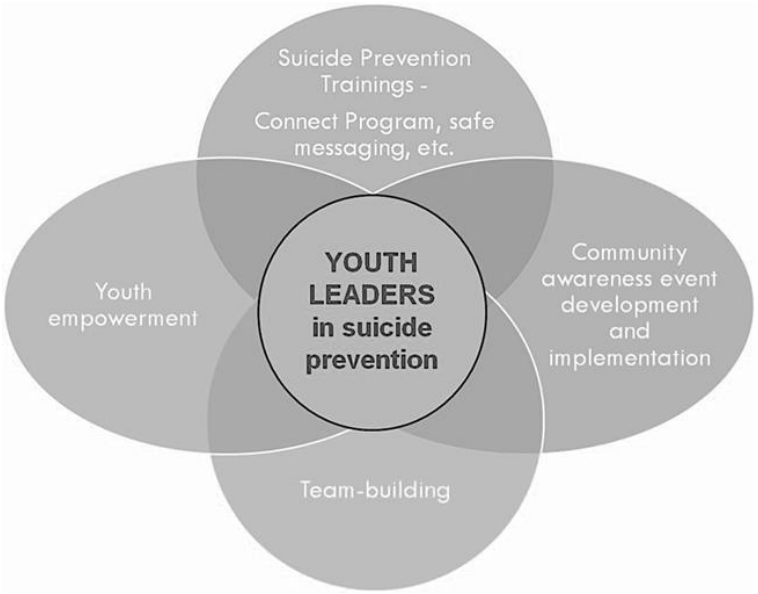
The university staff of HCCI partnered with community agencies throughout the State to translate and implement evidence-based practices of suicide prevention, while considering the unique needs and strengths of each community. This collaborative and strengths-based approach recognized the expertise of both the community and the university, which is an approach found to be effective in other rural ethnic minority communities (Rivkin et al., 2011). Both projects used a nationally-recognized best practice training program called the Connect Suicide Prevention Program developed by the National Alliance on Mental Illness-New Hampshire (Bean & Baber, 2011). Health professionals, community members, and youth were certified as Connect trainers to educate their communities to recognize warnings signs of suicide risk and to promote help-seeking behaviors. *Enhancing the Statewide Trauma Network* (Sugimoto-Matsuda & Rehuher, 2014) focused on training health professionals from over 20 trauma centers and emergency departments to reduce the suicide risk of youth patients through lethal means restriction and protocol development. This paper focuses on the MCAR project, which aimed to prevent and reduce suicide risk among ethnic minority and rural communities in Hawai‘i by training and collaborating with community and youth leaders at six community organizations to develop and implement community awareness activities in suicide prevention. The organizations were located in rural communities with high proportions of Native Hawaiians and Pacific Islanders. These communities were home to high numbers of youth (21-30%) compared to the State’s average (16%) (US Census Bureau, 2012).

Mobilizing Communities At-Risk (MCAR): A Youth and Community Project

MCAR was based on an approach piloted by a grassroots youth program called BRAVEHEART (Building Resistance Against Violent Environments thru Honorable, Empowered And Resilient Teens) that demonstrated promising results in engaging youth in suicide prevention advocacy activities (Wilcox et al., 2011). BRAVEHEART engages youth leaders by focusing on a social topic each year that is chosen by the youth. Once the topic is chosen, youth leaders seek and receive training from various organizations to guide them in developing and implementing advocacy activities. Training and program activities focus on empowering and building youth to be emerging community leaders. Advocacy activities are youth-led with the guidance of an adult facilitator. Programs that use similar youth leadership and participatory approaches in minority communities have demonstrated promising outcomes related to resiliency and mental well-being (Leff et al., 2010; Ritchie, Wabano, Russell, Enosse, & Young, 2014; Stokar, Baum, Plischke, & Ziv, 2014).

Building on BRAVEHEART's approach, MCAR developed a youth leadership model (see Figure 2) that focused on a combination of training, relationship-building, empowerment, and implementation of community awareness projects.

Figure 2. HCCI Youth Leadership Model



This model allowed for the flexibility and responsiveness that were needed to ensure that the initiative was culturally relevant and acceptable to each of the communities (Castro, Barerra, Holleran Steiker, 2010). This approach contrasts with conventional models of health interventions that often leave little room for adaptation and community input. Instead, HCCI's partnerships were built on the principles of community-based participatory research, which are grounded in the understanding that community members have valuable knowledge of the needs, strengths, and potential solutions for their community (Israel, Schulz, Parker & Becker, 2001). HCCI ensured that community partners played an active role in collectively shaping the activities and goals of each youth group by continuously assessing the needs and leveraging the strengths of each community.

MCAR also followed the understanding that youth suicide can be most effectively prevented when youth are directly and actively involved in the efforts (Wyman et al., 2010). Youth were engaged as active partners in suicide prevention with valuable skills and insights to offer. Youth have the insider perspective on youth culture and are attuned to the realities that their peers face. They also understand what types of community activities would capture the attention of and resonate with other youth. This allowed the youth to be trained to act as "bridges" for their community by identifying and connecting their at-risk peers to trusted adult resources.

Strategic Planning and Implementation

Using the youth leadership model, MCAR partnered with six community organizations across the State of Hawai‘i that are located in rural communities and serve Native Hawaiian and/or Pacific Islander populations. The six organizations were chosen based on their level of engagement in suicide prevention activities and connections to youth. Each community organization received a year-long subaward from HCCI to hire 1-2 adult coordinators to train and guide a youth leadership group in their respective communities. Coordinators were hired based on their experience in youth development and suicide prevention or related health topics. Some were internal staff, and others were subcontracted by the organization.

Table 1 outlines the general timeline of objectives and outcomes for the HCCI youth leader groups. This timeline provided the community organizations with a general framework, which they used to develop a strategic plan that was grounded in the strengths and needs of the youth and community, as well as the capacity of their organization. HCCI staff worked closely with each organization to continually assess their needs, strengths, and organizational capacity to inform and revise their strategic plan through regular check-in meetings over the phone and in-person.

Table 1. Timeline of Objectives for Youth Leader Program in Suicide Prevention

Months	Objectives	Outcomes
Preparation	Train adult coordinators in Connect Suicide Prevention Training	Coordinators certified to train others in Connect Suicide Prevention Program
1-3	Recruit youth leaders, schedule regular meetings, engage in team-building activities	Group identity formed by defining group members' roles and creating a group name
3-4	Train youth leaders and community members in Connect Suicide Prevention Program	Trusted adults and youth trained in suicide prevention to recognize warning signs and make referrals
4-5	Learn about safe messaging guidelines and how they apply to campaign activities	Safe suicide prevention campaign messages and activities developed
5-10	Develop and implement community awareness activities	Youth and community awareness of suicide prevention increased and stigma reduced
Throughout 10-12	Evaluate impact of program on youth leaders and coordinators	Community support and program sustainability for suicide prevention enhanced

The first step was to train and certify each adult coordinator in the Connect Suicide Prevention Program. Once certified as a Connect trainer, the coordinators' early efforts focused on recruiting and orienting youth leaders to suicide prevention and building a group identity. Community partners felt it was important to engage youth with natural leadership qualities, as well as disengaged youth who might especially benefit from the connectedness, support, and training provided by the group. Because recruiting a diverse group of youth was a priority for all partner organizations, each coordinator developed their own unique recruitment strategy. For example, one community coordinator worked with four other community leaders to create personalized formal invitations, which all five leaders then distributed to youth in various social settings, such as faith-based organizations, sports clubs, and cultural activity groups (Chung-Do, Napoli, Hooper, Tydingco, & Bifulco, 2014). Many youth were recruited due to their interest in youth leadership opportunities, but some were drawn to the group because of their own experiences and exposure to suicide risk factors. Coordinators screened each youth using their training from the Connect Suicide Prevention Program, and by engaging in culturally appropriate forms of talking story with the youth (Watson-Gegeo, 1988) to ensure they were not acutely at-risk for suicide.

Once youth were recruited, much time and effort were invested to build a group identity and purpose. Per recommendations from the National Strategy for Suicide Prevention (US DHHS, 2012), each community organization was encouraged to foster connectedness among the youth. Through team-building and youth leadership development techniques, each coordinator focused on increasing the level of "buy-in" and the youth's voice in the strategic plan. Coordinators also trained the youth leaders in the Connect Suicide Prevention Program, and

provided other resources related to suicide prevention and mental wellness. With their adult mentors, the youth leaders then co-facilitated Connect Program trainings with other adults and peer groups to widen the safety net for suicide prevention in their community. Using their training, the youth leaders also designed and implemented a series of community-based activities and events to raise awareness about suicide prevention and decrease stigma in their community. Throughout this process, the youth leaders learned about safe messaging (Suicide Prevention Resource Center, n.d.), which they applied to their awareness materials and events to avoid unintentionally increasing suicide risk among vulnerable individuals. In the safe messaging training, youth leaders learned how to avoid glamorizing or normalizing suicide as an everyday occurrence, and to promote local and national suicide prevention resources such as the National Suicide Prevention Lifeline (1-800-273-TALK [8255]). While the ideas were primarily driven and implemented by the youth, the adult coordinators and HCCI staff provided ongoing guidance to ensure that activities were done safely with appropriate resources and support in place. All youth groups engaged in regular discussions to reflect on their challenges and successes as suicide prevention youth leaders. The HCCI staff worked with the coordinators to ensure regular evaluation data were collected through a mixed-methods approach that included tracking sheets, surveys, focus groups, and interviews.

RESULTS

KLAS: An Example of a Suicide Prevention Youth Leadership Group

Kauaʻi Leaders Against Suicide (KLAS) is a youth leader suicide prevention group based on the Island of Kauaʻi. There are 64,529 people living on Kauaʻi, including 20,183 families. About 20% of the population fall below the poverty level, and 23% are under 18 years of age (US Census, 2012). KLAS was established under Life's Bridges Hawaiʻi in 2012, a bereavement program that bridges the gap between grief and healing by meeting the special needs of those dealing with the sudden death of a loved one by suicide, homicide, and accidents.

The coordinator selected by Life's Bridges worked with a group of youth from one of three high schools on the island. All students were invited to join the group through Connect Program trainings held at the high school. This resulted in 15-20 students from grades 9-12 joining KLAS, which was officially recognized as a school club. Early stages of group development included team-building activities, leadership development, and assigning specific roles to each group member. The group chose to name themselves KLAS—Kauaʻi Leaders Against Suicide— and created a logo to be used on community awareness materials and events. KLAS also launched a t-shirt campaign at their school where they distributed wallet cards and other educational materials to raise awareness and decrease stigma around the topic of suicide. This visibility led the group to be invited by other teachers and counselors to conduct Connect Program trainings on campus. As the Kauaʻi community became more aware of KLAS, the group began receiving invitations to host booths at community fairs around the island. Additionally, KLAS partnered with the local radio station to create three Public Service Announcements, which provided local statistics, promoted the National Suicide Prevention Lifeline hotline, and encouraged help-seeking behaviors. Figure 3 provides an example of one of the scripts written by the youth leaders (with guidance of the adult coordinator and HCCI staff). Local statistics were used to frame the topic of suicide as a serious and relevant issue while providing a hopeful message with local and national resources.

Figure 3. Script of a KLAS Public Service Announcement on youth suicide prevention

> ***Person 1:*** *Did you know that one out of every 6 teenagers in Hawai'i consider suicide?*
>
> ***Person 2:*** *That teen can be a friend, or even your brother or sister.*
>
> ***Person 3:*** *Luckily, 85% of those considering suicide will tell someone.*
>
> ***Person 1:*** *Talking to someone is crucial, so call 1-800-273-TALK, the National Suicide Prevention Lifeline, or speak with a trusted adult.*
>
> ***Person 2:*** *If you or someone you know is considering suicide, don't be afraid to ask for help. This message has been brought to you by KLAS, the Kaua'i Leaders Against Suicide.*

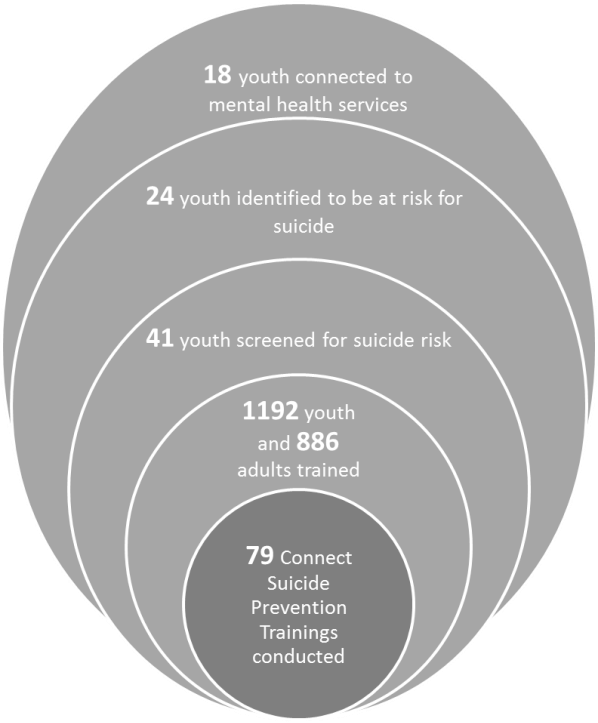
In addition, KLAS youth leaders were interviewed on local television shows to publicize their suicide prevention efforts. They also partnered with members of the Prevent Suicide Kaua'i Task Force and the Kaua'i Police Department to hold multiple sign-waving campaigns throughout the island. Through these activities, KLAS has directly reached more than 230,000 people on island of Kaua'i. Their extensive work has been recognized by the local newspaper and organizations, and other schools have expressed interest in creating similar youth leadership groups. Group meeting agendas are now developed and driven by the youth leaders who continually work on evaluating and strengthening their group and activities through regular retreats and reflective activities.

DISCUSSION

Evaluating the Impact

Evaluation efforts of MCAR's activities used a mixed-methods approach. Tracking sheets were used to record the number of people reached by community activities, as well as the number of people identified to be at risk for suicide and connected to appropriate mental health services. During HCCI's three-year project period, a total of 79 Connect trainings were conducted throughout the State of Hawai'i, resulting in 1,192 youth and 586 adult community members being trained in suicide prevention. Figure 4 illustrates the rippling effects of these efforts, which have led to 41 youth being screened for suicide risk, 24 youth being identified as potentially at-risk for suicide, and 18 of those youth being connected to appropriate mental health services. Youth at risk were primarily identified by youth leaders and community coordinators who recognized the warning signs of suicide, such as loss of interests in hobbies, withdrawing from friends and families, and engaging in reckless behaviors. Pre and post surveys were collected at Connect Program training to evaluate changes in knowledge and attitudes. The six youth leader groups developed and implemented a total of 31 community awareness activities. By counting the number of people in attendance at their events and estimating media readership and listenership, HCCI staff estimated that these youth-led awareness activities have reached over 643,000 people throughout the State of Hawai'i. Additionally, focus groups and interviews were conducted with youth leaders and coordinators to understand the impact of the HCCI approach, as well as lessons learned (Antonio et al., 2015).

Figure 4. Impact of HCCI's Training and Awareness Activities



Successful Factors in Implementing Youth Leadership Programming in Suicide Prevention

Several factors were instrumental in HCCI successfully meeting its goals. Being aware of these factors could be helpful to similar youth and community-driven initiatives related to stigmatized health issues. By reflecting on the ongoing reports provided by coordinators and youth leaders, along with our own observations, the HCCI staff recognized that making the concerted effort to prioritize relationships has been a key factor to success. In addition, focus groups conducted with youth leaders suggest that they formed valuable relationships with trusted adults and their peers and increased their self-efficacy (Antonio et al., 2015), which is an important protective factor for increasing resiliency (Werner & Smith, 1992). It took more time than initially expected for each youth group to build these relationships and trust with one another and their adult coordinators. Because most of the communities were relatively small in size, it was assumed that these relationships already existed. However, during the discussions at regular check-in meetings among the HCCI staff and community coordinators, we realized that the youth still needed time and ongoing opportunities to build their identity as a group to feel mutually invested in the group's goals of suicide prevention. At first this process was perceived to slow down the grant timeline. After collective reflection, the staff realized that prioritizing relationship-building was essential to meeting the goal of building youth leaders. This was validated by the coordinators' reports during the regular check-in meetings that the youth were more engaged in the group and motivated to take an active role when more time was provided and invested to build trust and relationships within the group. Although the estimated time needed for relationship-building varies by each community, it is recommended that all future

program planners who are working with youth provide ample time for relationship-building opportunities up front, provide ongoing and responsive team-building opportunities throughout the program, and pay close attention to the ever-changing needs and dynamics of the group.

In addition, the relationships between university staff and community organizations were crucial to the success of the project. The time investment for relationship-building to take place should not be underestimated in community-university partnerships (Chung-Do et al., in press; Minkler, 2004). The HCCI team directly interacted with youth leaders by facilitating many of the initial trainings. The team also worked closely with the coordinators to ensure that all the awareness activities followed safe messaging guidelines, especially at the beginning of each group's timeline. This required numerous air flights to reach isolated areas in the State and an extensive amount of staff time, which need to be factored into funding mechanisms for similar initiatives in geographically isolated communities (Pinto, 2013). Balancing between funding requirements and ideas from multiple stakeholders was an ongoing process that was made possible because of the level of trust we were able to build with community partners (Seifer, 2006). Community coordinators reported that having the HCCI staff physically present and actively engaged in the youth's lives and group activities helped establish relationships and communication channels that were crucial to achieving the goals of the project. It also allowed the HCCI staff to gain a better understanding of each community's unique contextual factors and dynamics firsthand. This allowed all partners to reach a mutual understanding when revisions to the strategic plan were necessary, which progressively strengthened the partnerships.

Efforts were also made to build relationships among the six youth leader groups across the islands. Because of the funding structure, MCAR was initially designed so the timelines of the six communities were staggered across the years, with each community having different starting and end points. However, the HCCI team realized that building a wider sense of community *across* the islands increased the effectiveness of the work *within* each community. Therefore, in-person trainings and workshops, monthly webinars, and conference calls with all partners were established to allow the coordinators to share their successes, challenges, and ideas with one another. Cross-island meetings also encouraged collaboration among the youth leaders themselves. For example, a partnership was initiated between KLAS and a youth group on the island of Molokaʻi to coordinate a joint youth leadership retreat, where both youth groups trained one another. Coordinators and youth reported that allowing the time and space for communities to meet and share tools and ideas helped them see how their work connects to the bigger picture, which further motivated them (Antonio et al., 2015). Thus, similar efforts to engage youth in addressing health and social concerns should aim to connect youth to other youth groups working on similar initiatives.

Another instrumental factor was the capacity of the coordinator. Being an effective coordinator required the ability to work with youth in a way that allowed them to take true ownership of the group and efforts, while maintaining appropriate boundaries and providing consistent guidance. In addition, the coordinator's social capital was paramount in pulling in resources and forming other partnerships to further support the youths' efforts (Woodall, White, & South, 2013). The coordinators were well-connected in their communities and often received informal and formal support from their families and communities (Antonio et al., 2015; Portes, 1998). These support channels often led to an increase in partnerships and the youth group's visibility. For example, KLAS used community-based partnerships to bring in sponsorships and financial support to sustain their activities beyond the funding received from HCCI. Therefore,

investing in an adult coordinator who understands youth empowerment principles and has high social capital in the community are important factors for similar initiatives.

Future Directions and Limitations

Analysis of the evaluative data is underway to better understand the impacts of HCCI. Findings from focus group and interview data suggest that youth leaders and community coordinators' perspectives align with the reflections of the HCCI staff (Antonio et al, 2015). These findings will be used to strengthen the programs and partnerships, and to seek funding and resources to sustain the efforts. It is important for future evaluation of similar efforts to measure the programmatic impacts on the youth leaders by obtaining multiple perspectives from those who are involved in the youth leaders' lives, such as parents, family members, teachers, etc. Similarly, it may also be fruitful to obtain community-level outcomes beyond the direct participants. For example, Allen, Mohatt, Fok, Henry and the People Awakening Team (2009) used community readiness assessments to measure community-level outcomes in Alaskan Native communities. This would provide a clear way to measure whether the youth leaders' efforts have an effect on the suicide risk of the broader community.

Youth-led suicide prevention efforts may be an effective strategy to help alleviate stigma around suicide. Coordinators reported that more people seemed willing to approach a booth or attend an event that was hosted by youth leaders rather than adults (Antonio et al., 2015). Coordinators reported that adults also tended to respond more positively to a suicide prevention training that was facilitated by the youth leaders. Many community members commented that the youth's involvement brought a sense of hope to the suicide prevention messages. The community members expressed that this strengths-based approach helped reduce the stigma around the topic of suicide, which reflects the findings from similar studies (Millstein & Sallis, 2011; Winkleby, Feighery, Altman, Kole, & Tencati, 2001).

Notably, many youth leaders shared that they had a personal connection to the topic of suicide, often through family members and close friends who had attempted or died by suicide (Antonio et al., 2015). Moreover, the majority of the youth leaders shared that the HCCI group was their first leadership opportunity. Because youth advocacy and empowerment approaches have been found to enhance positive outcomes for youth (Chinman & Linney, 1998) well into adulthood (Chan, Ou, & Reynolds, 2014), using the HCCI model to address a stigmatized topic may have promising impacts for individual youth and the wider community.

CONCLUSION

Increasing evidence is emerging regarding the effectiveness of community-based prevention programs for youth that use a youth leadership approach, especially in ethnic minority and marginalized communities (Towner & Dowswell, 2002; Wexler, Gubrium, Griffin, & DiFulvio, 2013). In addition, questions have risen around the feasibility and ethical implications of placing "cookie cutter" evidence-based programs in minority communities (Castro et al., 2010). The HCCI model demonstrates that by prioritizing relationship-building and recognizing community expertise, program implementation can be grounded in a community's strengths and needs while adhering to evidence-based practices of suicide prevention. Interventions centered on a strengths-based model of youth leadership may promote healing and enhance prevention strategies to address persistent health disparities in minority communities (Guerra & Bradshaw, 2008). The HCCI model provides a promising framework to address youth concerns by recognizing and promoting their voices in the community.

ACKNOWLEDGEMENTS

We would like to thank the youth leaders, community partners, and university staff of the Hawai‘i’s Caring Communities Initiative for their dedication to suicide prevention and mental wellness. This manuscript was developed, in part, under grant number 1U79SM060394 from the Substance Abuse and Mental Health Services Administration (SAMHSA). The views, opinions and content of this publication are those of the authors and contributors, and do not necessarily reflect the views, opinions, or policies of CMHS, SAMHSA, and U.S. Department of Health and Human Services, and should not be construed as such.

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