American Indian & Alaska Native Youth & Returning Veteran Suicide Prevention Initiative
Web-Based Interactive Courses

1.0 Overview

The National Council of Urban Indian Health (NCUIH), the National Indian Health Board (NIHB) and Kognito Interactive has prepared this document to assist those parties interested in funding the development of a $1.72 million comprehensive training program to reduce the incidence of youth suicide in tribal and urban American Indian and Alaska Native (AI/AN) populations. NCUIH and NIHB will work with Kognito Interactive to develop numerous web-based courses that will provide training for all users that are in a position to better detect, talk to, and if necessary, make an effective referral of any AI/AN youth in psychological distress. These courses will be owned by NCUIH and NIHB and made freely available to all users within tribal and urban Indian communities. To ensure that the content and context of the courses maximize learning outcomes, NCUIH and NIHB will identify subject matter experts who are intimately connected and keenly aware of the behavioral health concerns surrounding suicide prevention in tribal and urban AI/AN communities.

A brief summary of the courses are as follows:

1. Peer-to-Peer for Tribal Youth: Tribal youth are taught how to identify and help friends in need. Based on educational gaming technology, this 25 – 35 minute resource will immerse learners in a familiar and highly engaging learning environment where they become aware of the warning signs and become proficient in how to talk with a friend in need.

2. Peer-to-Peer for Urban Youth: Similar to the peer-to-peer tribal youth but will be adapted to AI/AN living in urban environments thus the culture and context will be customized accordingly.
3. Tribal Community: This 35 – 40 minute course will mobilize the support and knowledge of tribal elders, parents, aunties, uncles and other important community members, and provide them with the type of training experiences that promote youth suicide prevention. Increasing the awareness and skills of the community as a whole will reduce the chances of those youth experiencing depression and associated thoughts of suicide going undetected.

4. Urban Community: Similar to the tribal community but will be adapted to the specific environment, culture and context of the urban population.

5. High School Teachers of AI/AN Youth: This 45-minute course will train teachers of AI/AN youth in suicide prevention. High school teachers are in a unique position of observing their students over a period of time thus with training, they can be an important resource in detecting at-risk behaviors and associated effects on academic performance, and make appropriate referrals.

6. Returning AI/AN Veterans: This 45-minute course is designed to help families of returning AI/AN Veterans by providing them with the knowledge, confidence and skills to recognize when their son, daughter, spouse or significant other is in need of help for post-deployment stress including PTSD, depression and thoughts of suicide, and to know how to speak with them to motivate them to seek professional help.

2.0 Training Benefits
Providing youth suicide prevention training and training to help returning Veterans experiencing post-deployment stress to all potential gatekeepers within AI/AN communities has several benefits as follows:
- A multi-tiered training program will optimized the impact in reducing the number of undetected youth who are experiencing psychological distress including depression and thoughts of suicide, and provide avenues of help for these youth.
- Reduce the stigma associated with mental illness and promote awareness of the mental health services available within tribal and urban communities.
- Rapidly and cost-effectively (free to users) trains all potential gatekeepers within the AI/AN communities with engaging courses that are available 24x7 via any computer with an Internet connection.
- Reduce user (e.g. family, friends, teachers, etc.) anxiety about approaching and dealing with an at-risk youth and returning Veterans with post-deployment stress.
- Learning that takes place privately to reduce fears of demonstrating limited skills.
- Augment existing youth suicide prevention efforts.
- Increase community awareness in suicide prevention.
- Increase the number of Veterans with signs of post-deployment stress who enter into treatment.

3.0 Learning Objectives
The learning objectives of the program include:
1. Identify warning signs of mental distress, including verbal, behavioral, and situational cues.
2. Manage conversations with AI/AN youth and returning Veterans to determine the need for referral
3. Develop awareness of negative stereotypes and misconceptions about psychological distress and illness in both AI/AN youth and returning Veterans.
4. Understand the process of referral and the mental health services available for AI/AN youth and returning Veterans.
4.0 Co-Principals

National Council of Urban Indian Health
The National Council of Urban Indian Health is a 501(c)(3), membership-based organization devoted to support and development of quality, accessible, and culturally sensitive health care programs for American Indians and Alaska Natives living in urban communities. NCUIH fulfills its mission by serving as a resource center providing advocacy, education, training, and leadership for urban Indian health care providers. NCUIH strives for healthy American Indians and Alaska Natives living in urban settings, supported by quality, accessible health care centers and governed by leaders in the Indian community. See http://www.ncuih.org.

The National Health Board
The National Health Board (NIHB) is a 501(c) 3 not for profit, charitable organization providing health care advocacy services, facilitates Tribal budget consolation and provides timely information and other services to all Tribal Governments. Whether Tribes operate their own health care delivery systems through contracting and compacting or receive health care directly from the Indian Health Services (IHS), NIHB is their advocate. NIHB also conducts research, provides policy analysis, program assessment and development, national and regional meeting planning, training, technical assistance programs and project management. These services are provided to Tribes, area Health Boards, Tribal organizations, federal agencies, and private foundations. The NIHB presents the Tribal perspective while monitoring, reporting on and responding to federal legislation and regulations. It also serves as conduit to open opportunities for the advancement of American Indian and Alaska Native health care with other national and international organizations, foundations corporations and others in its quest to build support for, and advance, Indian care issues. See http://www.nihb.org.

5.0 Subcontractor - Kognito Interactive
Kognito is a NYC-based developer of interactive training simulations and educational games. The simulations improve learning outcomes by providing users with virtual practice environments that simulate challenging situations similar to ones they face in real life. In these simulations, users learn by making decisions, viewing their consequences, and receiving personalized feedback.

Kognito Interactive has developed a proprietary and award-winning training simulation platform to create simulated conversations like those described above. The platform is based on research in social cognition, learning theory, and neuroscience. As a result, it provides superior learning results and unique technological features, which reduce development cost and further enhance impact on behavioral change. The platform is entitled “Human Interaction Simulation Platform™”, and provides learners with an opportunity to enter a virtual environment and engage in conversations with virtual, fully animated characters that possess emotions and memory. As a result, learners become more capable and confident to handle similar situations in real life. Kognito’s technology has received numerous awards, including the 2007 Learning Leader Award from Bersin & Associates and the 2009 Training Product of the Year from HR Magazine. To learn more about Kognito and their gatekeeper training simulations go to www.kognito.com.
6.0 Technology Features
The Human Interaction Simulation Platform™ used in course development has many unique features as follows:

1. Virtual, fully animated characters that respond through body language, facial expressions, and audio dialogue. These characters have their own emotional state and memory, which drive their reactions to users’ decisions during the conversation.
2. The ability to record the users’ decisions throughout the conversation, so they can be analyzed to provide feedback on how effectively they handled certain points in the conversation.
3. Conversations built around a behavioral model which dictates the cause-and-effect relationship between users’ decisions and the responses of the virtual characters. This ensures that learners are repeatedly exposed to conversation patterns as a way to develop skills.
4. Dynamic and open-ended conversation architecture which adjusts to the decisions and tactics made by users during the conversation, impacts the character’s emotional states, and dictates the character’s subsequent response.
5. Use Flash-based animated characters instead of videos in order to substantially reduce cost for development and subsequent updates. Also, the advantage of using animated characters is the ability to easily change their appearance, enabling additional conversations to be created at a low cost without videotaping additional actors.
6. Virtual characters are dynamically animated and lip synched (as opposed to coded), which allows quick integration of changes and movements for each character and ensures that body and face movements are consistent.
7. Do not rely on simple decision tree architectures, where users are asked to choose from three possible answers. This limited and unnatural conversation structure results in lower levels of learning and engagement.

The Human Interaction Simulation Platform™ was used to develop At-Risk for University Faculty, an online course to develop similar gatekeeper skills in university faculty and staff. This course is the first simulation-based training program to be added to SAMHSA’s Suicide Prevention Resource Center Best Practices Registry (SPRC/AFSP). To view a demo of At-Risk and the results of a national survey at 72 universities that have used the resource, please go to www.kognito.com/atrisk (for more info about At-Risk see Appendix I).

3.0 Built for AI/AN Communities by AI/AN Communities
NCUIH and NIHB will work with Kognito to develop the training simulations to ensure that each course meets the exact needs of the population that it is targeting (e.g. youth, community members, families of Veterans, etc). It is critical that learners are immersed in a virtual environment that represents their surroundings and culture. When learners are placed in contextually relevant situations and are faced with realistic and engaging challenges, the level and transfer of knowledge and skills associated with best practices in youth suicide prevention will more effectively transfer into real life situations. To accomplish this NCUIH and NIHB will identify several AI/AN subject matter experts (SME’s) to be involved in the needs analysis and in developing the appropriate scenarios/profiles that are culturally relevant and engaging. NCUIH and NIHB will also recruit groups of representative end-users for each course to be involved in this iterative process including beta testing, for they are the recipients of the training.
In addition to creating the simulations for NCUIH and NIHB, Kognito will also customize the training in the following ways:

1. Providing each tribe and urban association with access to a link within the simulations that will lead the user to an agency supported website that will provide information about available behavioral health services. This will require NIHB, NCUIH or another agency to gather and update the information.
2. Kognito will help integrate pre-launch marketing materials that NIHB, NCUIH and SME’s develop to promote the training within tribes, urban communities and high schools.
3. There will be a printable certificate of completion for each user.

4.0 NIHB – NCUIH Webinar Survey
NIHB, NCUIH and Kognito held two nationwide webinars to ascertain the interest for the proposed training simulations within AI/AN communities. The results of the survey are seen below:

In what setting do you currently work?

- Tribal Org.
- Indian Health Service
- Urban Indian Health Program
- Other

What is your primary work role?

- Community Member
- Community Outreach/Wellness
- Provider
- Clinic/Program Administrator
Do you feel that AI/AN suicide gatekeeper training simulations will be helpful to your Community?

![Bar Chart]

If AI/AN specific gatekeeper training resources were available, would you introduce these to your community?

![Bar Chart]

In Appendix II you can view a list of organizations that webinar participants were from.

In Appendix III you can view a list of comments made by webinar participants.

5.0 Kognito Simulation Development Process

Appendix IV includes a detailed description of the development phases. Overall, we estimate that it will take 12 – 18 months to complete all six courses with several of the courses delivered after the initial 8 months of development. A detailed schedule with milestones and deliverables will be developed following the needs analysis phase.
6.0 Development Cost
The total cost for developing and delivering the six courses for youth suicide prevention is estimated at $1.4 million in accordance to the following breakdown:

<table>
<thead>
<tr>
<th>Course</th>
<th>Length in Min</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer-to-Peer for Tribal Youth</td>
<td>25-35</td>
<td>$225,000</td>
</tr>
<tr>
<td>Peer-to-Peer for Urban Youth</td>
<td>25-35</td>
<td>$120,000</td>
</tr>
<tr>
<td>Tribal Community</td>
<td>35 - 40</td>
<td>$275,000</td>
</tr>
<tr>
<td>Urban Community</td>
<td>30-35</td>
<td>$150,000</td>
</tr>
<tr>
<td>High School Teachers of AN/AN Youth</td>
<td>45</td>
<td>$325,000</td>
</tr>
<tr>
<td>Returning AI/AN Veterans</td>
<td>45</td>
<td>$325,000</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$1,420,000</td>
</tr>
</tbody>
</table>

NCUIH and NIHB - $300,000
1. Staff
2. Hosting two face-to-face meetings for subject matter experts
   a. Event One – Overview and Needs Analysis
   b. Event Two – Content Production
3. Subject Mater Experts for the courses (about 4-5 per course each spending about 30 hours)
4. Assessment
5. Hosting of courses on NCUIH and NIHB websites

Total project cost - $1.72 million

7.0 Next Steps
As evidenced by webinar survey data and numerous discussions with interested parties there are a significant number of tribes, associations and government agencies strongly interested in seeing the proposed youth suicide prevention resources made available to AI/AN communities. The next steps involve approaching possible funding sources so development can begin.

If you are interested in more information or have questions please call:

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Appendix I

University At-Risk Learning Objectives & Walkthrough

The learning objectives of the program include:

1. Identify warning signs of mental distress, including verbal, behavioral, and situational cues
2. Manage conversations with students to determine the need for referral
3. Develop awareness of negative stereotypes and misconceptions about mental distress and illness
4. Understand the process of student referral and the counseling services available for students

The following walkthrough provides information on the experience to be taken by users as they engage in the interactive course.

Step 1: The classroom

In the course, users assume the role of a teacher who is teaching a class where several students are at-risk. The goal of the teacher is to identify, approach, and refer the ones who are at-risk for mental distress.

In identifying these students, users first view information about each student’s academic performance (i.e., grades, participation, and attendance), behavior in class, and appearance. If they believe there is sufficient information to suggest the student might be at-risk, they can choose to “Talk to Student” to engage in a simulated conversation and better determine the need for a referral.

The symptoms exhibited by the students in their profiles and during their conversations with the user reflect those that are often indicative of the most common and most severe psychological illnesses among young adults:

- Alcohol/Substance Abuse
- Bipolar Disorder
- Borderline Personality Disorder
- Depression
- Eating Disorders
- Panic Disorder
- Post Traumatic Stress Disorder
- Schizophrenia
- Social Phobia
- PTSD

On average, users spend 45 minutes to complete the training. The course is hosted on Kognito’s secure web server. The Kognito Learning Management System tracks and records the progress of each user thereby allowing users to complete the program in multiple sittings and for the program administrator (i.e., CCCS) to view reports on who has launched and completed the program.

Step 2: Approach & Referral
Each conversation takes 5-7 minutes to complete. The user controls the conversation by choosing what topic(s) to discuss and what specific things to say or ask. The available topics depend on the student’s profile and on the decisions made by the user throughout the conversation (i.e., new topics appear and others disappear as the conversation unfolds).

The virtual student is an animated character who responds to the user’s decisions via voice and body language. Some statements and questions make the student more comfortable and increase the likelihood that they will open up to the user. Other statements and questions make the student more defensive, reducing the opportunities to make a successful referral.

Throughout the conversation, users receive encouragement and constructive criticism on their decisions to reinforce best practices. In addition, the student’s body language and verbal responses are strong indicators to the user about the effectiveness of their actions. As the conversation unfolds, users determine whether the student needs to be referred. If so, they must refer the student and use appropriate language to convince/motivate him/her to seek help. In certain situations, the simulation suggests that the teacher take a more active role and contact the support services themselves.

3. Feedback
Upon concluding each conversation, users receive narrated and animated feedback, which includes an analysis of the student, a review of their symptoms in class and in conversation, advice on how to refer other students with similar symptoms, and a reminder to follow up with the student.

4. Completion
Once users successfully identify and refer the at-risk students in their class, they will be notified that they have successfully completed the training. At that point, users are asked to complete the online survey and are provided with access to a printable summary of best practices and a printable certificate of completion.
Appendix II

Webinar participants were from the following organizations.

Alaska Native Tribal Health Consortium
Aleutian Pribilof Islands Association
Northwest Portland Area Indian Health Board
Soule Consulting
Suicide Prevention Resource Center
Child & Family Support Services Center
Methamphetamine & Suicide Initiative
Winnebago Tribe of NE
Oklahoma City Area Inter-Tribal Health Board
Winnebago Counseling Center
San Manuel Band of Mission Indians
Four Directions
South Dakota Urban Indian Health, Inc
Indian Health Board of Minneapolis, Inc
Navajo Area IHS
Winslow Indian Health Care Center
AI/AN Head Start Collaboration Office
Magellan Health Services of Arizona
National Indian Women's Health Resource Center
San Felipe Pueblo Behavioral Health Program
FirstPic, Inc.
Indian Health Board of Minneapolis, Inc
Winnebago Tribe of NE
Northwoods Coalition for Family Safety
Teen Lifeline
South Dakota Urban Indian Health
Aleutian Pribilof Island Association
San Manuel Band of Mission Indians
The Confederated Salish and Kootenai Tribes
Tribal Behavioral Health Association

Winslow Indian Health Care Center
Tohono O'odham Nation -- Behavioral Health
Oneida Indian Nation
NM Human Services Department
Yavapa Prescott Indian Tribe
National Indian Women's Health Resource Center
Chickasaw Nation Behavioral Health
Absentee Shawnee Tribe of Oklahoma
Salt River Pima-Marcopla Indian Community
FirstPic, Inc.
Office of Minority Health /HHS
Reno-Sparks Tribal Health Center
Oneida Children and Family Services
Eastern Shawnee Tribe of Oklahoma
Leupp Schools, Inc.
Tribal Law & Policy Institute
Northwest Portland Area Indian Health Board
University of Arizona
U.S. Department of Education
Fort Peck Tribal Court
Mental Health America-Board member
Winnebago Counseling Center
Winnebago Counseling Center
Soule Consulting
Indian Family Health Clinic
Tohono O'odham Nation -- Behavioral Health
Chickasaw Nation Behavioral Health MSPI
Bearskin Healthcare & Wellness Center
Appendix III

Comments made by webinar participants are as follows:

One area in Alaska had 17 suicides in 18 months so I could use all the tools I can put on my toolbelt. Each community should have one or each of the tools.

We have had QPR training and are planning to host ASIST community gatekeeper training, but would be very interested in having this AIAN online training available for free 24/7.

As a mother of a child who completed his suicide 12/14/97 and my husband of 25 years losing his battle to cancer on 12/16/97 (he was in a coma so he did not know of our son's suicide), I am glad to see other tools being researched as different levels of training can be useful in any community. The mere fact that it is "ok" to talk about it is my message for this year's MSPI Conference Presentation in Oklahoma. Thank you and I hope I can provide some insight to future promotion.

I think it would be very beneficial to the youth gatekeepers and the professionals. I do think that there would be a segment of the community that would be receptive however the natural leaders of Indian communities still believe personal contact and listening to each other regarding learning. There would be a segment that would have to possibly be offered in a group setting using interaction and face to fact time.

I work with Boys & Girls Clubs in Indian Country and it would be helpful to have a way to train staff in recognizing suicide warning signs. Our direct service staff are trained as youth development professionals, but they do not typically have a background in counseling or mental health services. This opportunity would be valuable to them and meet an unmet training need.

The Suicide Prevention Modules can be successful if the Tribes work directly with trained professionals (teachers, leaders, parents, students) to implement specified modules focusing on different groups. In order for a community to be healthy, everyone must provide input to succeed.

I think this can be a powerful tool. My concern is that we take care of all in our communities and not create a second or third risk. We had a peer come forward about another peer following a peer-peer training. The suicidal youth was taken by the police and hospitalized. The reporting youth didn't know what happen and became fearful, guilty, wanting to die. Let's see this issue for the inclusive sphere it is and not just look at it from one direction.

I think inviting AI/AN participation in this webinar was a fantastic idea. Not only that but the idea of the curriculum itself is genius. It would save time, and I think a greater response from the youth in using technology to learn something new pertaining to suicide will help be very effective. Great Job!

So glad we have people like you looking out for the tribal youth. I agree that the youth would respond for peer-to-peer. We did QPR with 5 summer youth interns. Four of them indicated that they knew someone they were concerned about. They joked through the seminar; however, when it came down to it, they recognized the importance of taking action. If I can be of assistance, please let me know. I have an undergrad English major and just short of a master's degree in communication.

I think this is a great tool, I am versed in safeTALK and ASIST and this is a good addition. Not everyone is "willing" to commit and with the population shift, this can be used anywhere. I travel through Alaska and this is certainly an answer to my prayer as my son did not feel he could talk to anyone 13 yrs ago.
Appendix IV

Kognito Simulation Development Process
Overview

Phase 1: Needs Analysis
During the needs-analysis phase, Kognito meets with NCUIH and NIHB team, subject-matter experts, and representative end users to determine the principal project objectives and learner needs. This information is summarized in two documents, the Management Plan and Needs Analysis. Once the NCUIH and NIHB team has reviewed and approved these two documents, Phase 1 is completed.

Needs:
- Launch meeting with NCUIH and NIHB team to gather additional project information
- Interviews with relevant subject-matter experts
- One-hour focus group with 5-10 representative end users, to discuss their needs, motivations, and preferences pertaining to training.

Deliverables:
- Management Plan Document (draft version)
  - Roles & Responsibilities – Identification of key members of the Kognito and NCUIH and NIHB teams
  - Project Communication – Communication protocols for keeping everyone informed and up-to-date regarding project news and deliverables
  - Tentative Schedule/Milestones – A tentative schedule and corresponding milestones/deliverables
  - Focus Group / User Testing Needs – Requirements for upcoming focus group and user testing sessions (e.g., number of participants, type of participants, session lengths, etc.)
  - Change/Risk Management – Protocols for handling changes and managing risks
- Needs Analysis Document (draft version)
  - Compatibility/Accessibility Requirements – Technical requirements
  - Project Objectives – Learning outcomes and content requirements
  - Learner Analysis – The target audience’s motivation, current knowledge, and attitudes regarding the subject matter
  - Focus Group Summary – An overview of end-user comments and suggestions gathered during the focus group, including their attitudes and motivations regarding the training and their suggestions for its content, design, and interactivity
  - Assessment/Tracking Requirements – Metrics that tap the established outcomes
- Management Plan Document (final version)
- Needs Analysis Document (final version)

Phase 2: Instructional Design
During the instructional-design phase, Kognito plans the learning experience in-depth, determining what content, interactivity, and simulated scenario it will contain. This plan is then submitted for review in the form of the Instructional Design Document, or IDP. Once this IDP is reviewed and approved by the NCUIH and NIHB team, Phase 2 is completed.

Needs:
- One-hour prototype testing session group with 5-10 representative end users, to discuss the intended instructional design and gather feedback from the user perspective

Deliverable:
- Instructional Design Document (draft version) – describing in detail:

NCUIH and NIHB Youth Suicide Prevention Summary Proposal
Phase 3: Content Production
During production, all materials are created by Kognito’s production team, using the IDP as a blueprint. The first step in production will be to generate the various project and conversation scripts. Kognito’s instructional designers will work with the SMEs and write/storyboard all narrated pieces, all on-screen text, and all interactive activities and conversations. Once written, the content will be refined and finalized through review cycles with the NCUIH and NIHB team. Once the scripts are approved, Kognito’s production team will begin production. During this time, Kognito will provide weekly or bi-weekly project updates to the NCUIH and NIHB team to keep them informed regarding the design and development of the materials.

Deliverables:
- Rough draft of scripts – the scripts of the course and its conversation simulations will be submitted to the NCUIH and NIHB team
- Revised scripts for final approval – based on the feedback from the NCUIH and NIHB team, Kognito will submit a revised script for final review and approval
- Design of virtual characters and 3D environments – Kognito will submit snapshots of the virtual characters and environments for review and approval by the NCUIH and NIHB team.
- Narrators – Kognito will submit audio samples of the optional narrators for review and approval by the NCUIH and NIHB team
- Interface design – Kognito will submit a snapshot of the proposed interface design for the program for review and approval by the NCUIH and NIHB team
- Beta version of training materials – once the development of the media is completed, Kognito will post the training on its secure web server for the NCUIH and NIHB team review

Phase 4: Testing
Once production is complete, Kognito tests the beta version with representative end users and generate a report for the NCUIH and NIHB team, summarizing the user-testing results and suggesting improvements. In this phase the NCUIH and NIHB team also reviews the beta version and generates a list of changes.

Needs:
- 5-10 representative end users for user testing

Deliverables:
- User Testing Report – summarizing the results of user testing
  - User Feedback – An overview of end-user comments and suggestions gathered during the user testing session
Phase 5: Content Revisions and Final Delivery
Once Kognito and the NCUIH and NIHB team determine the necessary changes, those changes are implemented. At this stage, Kognito also work with the NCUIH and NIHB IT team to integrate the modules within its Learning Management System (if necessary).

Deliverables:
- Final version of training accessible via the NCUIH and NIHB’s LMS or on their website.