Project Title

The Helping Our People End Suicide Study: Developing a Native American Culture-Based Suicide Risk Assessment Tool

Project Narrative

Suicide is the leading cause of non-accidental death among Native American peoples aged 10-24 years old, as approximately two deaths by suicide occur every day (Drapeau & McIntosh, 2020; CDC, 2021). The age-adjusted suicide rate for Native American youth (20.4 per 100,000 deaths) is over one and a half times higher than the general US population (12.1 per 100,000 deaths) (Indian Health Service, 2019; Olson & Wahab, 2006). Additionally, this suicide rate has increased by nearly 35% over the past 20 years as an alarming health disparity (Curtin & Hedegaard, 2017; Warne & Lajimodiere, 2015; Sarche & Spicer, 2008).

The Helping Our People End Suicide (HOPES) Study aims to develop a culture-based suicide risk assessment tool for use at the Sacramento Native American Health Center (SNAHC). The study focuses on the empirical (re)centering of Native American voices to prevent suicide among tribal youth by promoting culturally responsive mental healthcare through clinical interventions developed by, with, and for the Sacramento Native American community (Atalay, 2012). The study hopes to prevent suicide among Native American youth in the Sacramento community by promoting culture-based risk assessment practices that can optimize care coordination and treatment planning for high risk youth.

The HOPES Study is a three-phase, community-based participatory research project integrating a transformative, convergent mixed methods research approach. The HOPES Study is invested in accomplishing the following three empirical objectives: 1) explicate conceptions regarding suicide including how to best implement prevention efforts; 2) ascertain perspectives

regarding culturally relevant care including opinions on current suicide screening protocols; and 3) quantify suicide stigma including related associations for delivering effective care.

Project Description

The HOPES Study involves three phases: Phase One is exploratory; Phase Two is developmental; and Phase Three involves implementation. As the exploratory stage, Phase One focuses on mixed methods data collection to guide the study. Phase Two is the developmental stage featuring data analysis and community-engaged processes to design the culture-based suicide risk assessment tool. Phase Three operates implementation science frameworks to produce a strategic plan for integrating the suicide screener at SNAHC.

Two theoretical concepts direct the study's community-based research efforts. First, Indigenous Wholistic Theory frames holistic health to include spiritual, mental, physical, and emotional domains. Subsequently, holistic healing occurs when these domains align with responsive political, economic, historical, and sociological contexts situating oneself within the larger interconnectedness of "self, individual, family, community, nation, society and creation" (Absolon, 2006, p. 74). Second, the Transactional-Ecological Framework for Understanding Suicidality operationalizes these domains and contexts for a relevant application to understand and effectively prevent suicide. This second framework predicates effective prevention efforts require targeted processes to occur across the socio-ecological environment because suicide results from discordances beyond an individual's biological or psychological pathways (Alcántara & Gone, 2007, 2008). The nexus of these two theoretical concepts guides the entire study.

The HOPES Study's proposed study population includes all members of the Sacramento Native American Community including people currently employed at SNAHC. As such, the HOPES Study stratifies its sample population into three strata: Youth; Community Members; and SNAHC staff. The stratified sampling technique will structure comparative analysis to elucidate findings in conjunction with the study's three empirical objectives. Study recruitment is not contingent on previous experience with suicide-related behavior nor suicide screening protocols.

For Phase One, the HOPES Study operationalizes convergent qualitative and quantitative mixed methods. The qualitative strand involves semi-structured interviews and focus group interviews across the study's three strata. Qualitative data collection will gather information across five across five thematic domains. These domains include: 1) Native American Mental Health and Culture; 2) Implementation of Culture-Based Screeners; 3) Opinions on the PHQ-9; 4) Opinions on the AIHFS Hope & Wellness Survey; and 5) Confidence in Addressing Suicide. The quantitative strand administers survey methods for the SNAHC Staff, and Community Member populations. Surveys are utilized to measure variables concerning provider bias and suicide stigma to understand correlations between strata membership and other identitarian covariates concerning participants 'positionalities.

Phase Two is the developmental stage and will focus on analyzing the data gathered in Phase One through collaborative and participatory processes. The first goal of Phase Two includes finalizing results from the parallel qualitative and quantitative strands through an intentional collaborative and participatory process. The second goal builds upon this to further interpret these results through a process of mixed methods integration (Fetters et al., 2013;

Scammon et al., 2013). The developmental component for this second phase centers the collaborative and participatory processes that will guide the drafting of the culture-based suicide risk assessment tool. Community participation will define the development of the concepts, questions, practices, and protocols of the new culture-based suicide risk assessment tool as explicated through the HOPES Study's results and interpretation process.

For the implementation stage, Phase Three seeks to best incorporate the screener for use at SNAHC. This stage builds upon the previous development of the culture-based suicide risk assessment tool to finalize the tool and design effective strategies for implementing it in culturally aligned ways relevant for the community and healthcare setting. Community participation also defines this phase to ensure successful implementation in a real world setting. The goal for Phase Three includes finalizing the culture-based suicide risk assessment tool for use at SNAHC and developing an effective implementation plan. Collaborative and participatory processes will specify how the assessment tool will be utilized, who will administer it, and where the tool will be administered. These components represent key features related to the development and implementation of the culture-based suicide risk assessment tool as defined by the community.

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