Project Title

The Helping Our People End Suicide Study: A Transformative Mixed Methods Study for Preventing Suicide among Urban Native Americans in Sacramento, California

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 Hope Our People End Suicide (HOPES) Study aims to prevent suicide among Native American youth by promoting culturally responsive mental healthcare through clinical interventions developed by, with, and for the community (Atalay, 2012; Smith, 2012). The study focuses on the empirical (re)centering of Native American voices to develop a culturally responsive suicide screener for use at the Sacramento Native American Health Center (SNAHC)— an urban Native American health center in Sacramento, California. The HOPES Study is a three-phase, community-based participatory research project integrating a transformative, convergent mixed methods research approach to answer the following three research questions: 1) How are suicide, and the ways to most effectively prevent it, conceptualized by youth, community members, and SNAHC Staff?; 2) How does the youth and community members' vision of a culturally relevant suicide screener contrast with SNAHC's

culture of care?; and 3) How does suicide stigma and provider bias impact the understanding of how to implement a culture-based suicide screener at SNAHC?

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 culturally responsive suicide screener. 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 is comprised of a community sample population encompassing all community members affiliated with SNAHC including patients, nonpatients, employees, and all other relations. Study recruitment is not contingent on previous experience with suicide-related behavior nor suicide screening protocols. The HOPES Study stratifies its sample population into three strata: youth; community members; and SNAHC staff. The stratified sampling technique will approximate cross-sectional analysis throughout the study.

For Phase One, the HOPES Study operationalizes convergent qualitative and quantitative mixed methods. The qualitative strand involves semi-structured interviews across the study's three strata. Interviews are used to gather data across three domains: 1) community opinions on current suicide screening protocols; 2) ideas concerning culturally responsive care including how to best implement change; and 3) suicide stigma including related assumptions concerning suicide-related behavior. 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 of the HOPES Study engages focus group methods to bolster community engagement in analyzing and interpreting Phase One's data. Community input will design the culturally responsive suicide screener actualizing the participatory research process. Focus groups are held to incorporate the generative insight held in collective. Phase Three configures implementation science's Active Implementation Equation to the context of SNAHC (Fixsen et al., 2010). This phase's focus will investigate the effective implementation (How) of the culturally responsive screener (What) in an enabling context (Where) to yield effective suicide prevention efforts for Native American youth in Sacramento, CA (Desired Outcome). The Active

Implementation Equation will guide the development of a strategic plan for integrating the suicide screener at SNAHC.

The HOPES Study serves to advance critical discourse concerning anti-Indigenous racism as a social issue implicating the development of effective suicide preventive interventions. The HOPES Study will provide novel insight valuable for the social work profession as well as the discipline of suicidology. Knowledge discourses will illuminate: 1) how mixed methods research can align with Indigenous research methodologies to promote health equity and foster social change; 2) how Native American community members perceive "whitestream" suicide screening protocols (Grande, 2004); 3) how suicide stigma can manifest in an urban Native American community; and 4) the organizational tensions in implementing a community-defined best practice within a complex health care delivery apparatus. These insights yield implications for social work and suicidology as both fields embody new missions in eliminating racism as a pressing social issue (American Association of Suicidology, 2020; Teasley et al., 2021). The HOPES Study ventures to advance decolonial and anti-racist objectives by fostering community-led suicide prevention efforts in urban Native American communities.

Works Cited

Absolon, K. (2010). Indigenous Wholistic Theory: A Knowledge Set for Practice. *First Peoples Child and Family Review*, *5*(2), 14.

Alcántara, C., & Gone, J. P. (2007). Reviewing Suicide in Native American Communities: Situating Risk and Protective Factors within a Transactional–Ecological Framework. *Death Studies*, *31*(5), 457–477. https://doi.org/10.1080/07481180701244587

Alcántara, C., & Gone, J. P. (2008). Suicide in Native American Communities: A Transactional-Ecological Formulation of the Problem. In F. T. L. Leong & M. M. Leach (Eds.), *Suicide Among Racial and Ethnic Groups: Theory, Research, and Practice* (1st ed., pp. 173–199). Routledge.

American Association of Suicidology. (2020). *Equity & Anti-Racism* (p. 1) [Statement]. American Association of Suicidology. https://suicidology.org/about-aas/equity-anti-racism/

Atalay, S. (2012). *Community-Based Archaeology: Research with, by, and for Indigenous and Local Communities*. University of California Press.

CDC: US Centers for Disease Control and Prevention. (2021). *10 Leading Causes of Death, United States 2019, Am Indian/AK Native, Both Sexes*. Web-Based Injury Statistics Query and Reporting System (WISQARS). www.cdc.gov/ncipc/wisqars

Curtin, S. C., & Hedegaard, H. (2019). Suicide Rates for Females and Males by Race and Ethnicity: United States, 1999 and 2017. *National Center for Health Statistics (NCHS) Health E-Stat*, 6.

Drapeau, C. W., & McIntosh, J. L. (2020). *U.S.A. Suicide: 2019 Official Data* (pp. 1–2) [Suicide Data Page]. American Association of Suicidology. http://www.suicidology.org

Fixsen, D. L., Blase, K. A., Duda, M. A., Naoom, S. F., & Van Dyke, M. (2010). Implementation of evidence-based treatments for children and adolescents: Research findings and their implications

for the future. In *Evidence-based psychotherapies for children and adolescents, 2nd ed* (pp. 435–450). The Guilford Press.

Grande, S. (2004). *Red Pedagogy: Native American Social and Political Thought*. Rowman & Littlefield Publishers.

Indian Health Service. (2019). *Indian Health Disparities* (Disparities) [Fact Sheets]. Indian Health Service.

Olson, L. M., & Wahab, S. (2006). American Indians and Suicide: A Neglected Area of Research. *Trauma, Violence, & Abuse*, *7*(1), 19–33. https://doi.org/10.1177/1524838005283005

Sarche, M., & Spicer, P. (2008). Poverty and Health Disparities for American Indian and Alaska Native Children: Current Knowledge and Future Prospects. *Annals of the New York Academy of Sciences*, *1136*(1), 126–136. https://doi.org/10.1196/annals.1425.017

Smith, L. T. (2012). *Decolonizing Methodologies: Research and Indigenous Peoples* (2 edition). Zed Books.

Teasley, M. L., McCarter, S., Woo, B., Conner, L. R., Spencer, M. S., & Green, T. (2021). *Eliminate Racism* (Work Paper No. 26; Grand Challenges for Social Work, p. 30). American Academy of Social Work & Social Welfare.

Warne, D., & Lajimodiere, D. (2015). American Indian health disparities: Psychosocial influences. *Social and Personality Psychology Compass*, *9*(10), 567–579. https://doi.org/10.1111/spc3.12198