The Development of a Suicide Prevention Program for American Indian Youth in Nebraskan Communities

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The Development of a Suicide Prevention Program for American Indian Youth in Nebraskan Communities

Sara Donovan, Epidemiology

Committee Chair: Keith Hansen, MBA
Second Committee Member: Regina Idoate, PhD, MA
Third Committee Member: Juan-Paulo Ramírez, PhD
Chapter 1 - Introduction

Significance and Aim

A lifelong resident of Nebraska, I approached this capstone with deep respect for the resilience of the American Indian (AI) peoples of the state in the face of generations of persecution and challenges. I strived to apply my passion and learning with humility while developing a program to reduce suicide rates among 19-24 year old AIs in the state of Nebraska.

The program, Healing Waters, is intentionally developed to be culturally humble, having respect for the unique dynamics, viewpoints, and traditions of different cultures. A culturally humble suicide prevention program will tailor efforts to the community it is intended to serve. Throughout the project, attention was given to Indigenous research methodology and ethical principles. Specific focus was given to the principles of recognition, relevance, relationship, reflexivity, responsibility, rights, reciprocity, re-storying, revitalization, and respect (Chilisa, 2011; Johnson, 2013; Kirkness & Barnhardt, 1991; Kovach, 2019; Smith, 2013).

The aim of the capstone was to design a culturally humble suicide prevention program to be implemented in community settings, with an overarching goal of reducing the prevalence of suicide in the Nebraskan AI youth population aged 19-24 years. A community-based suicide prevention program tailored to self-identified AI youth does not currently exist throughout Nebraska. It is expected that Healing Waters will be implemented in Nebraskan AI communities, with the potential for program materials to be used by leaders in existing AI organizations, such as the Nebraska Urban Indian Health Coalition, Native Futures, and the Ponca Tribe’s Fred Leroy Health and
Wellness Center. As a result of implementation, it is anticipated that the mental health status of AI youth will be improved and suicide ideations and attempts within this population will be reduced.

Chapter 2 - Background and Literature Review

Community and Partnering Organization Description

When considering the population and communities to be served, the Indigenous principles of recognition and respect were of focus, as attention was given to the history, land, language, values, traditions, and core beliefs of the tribes of Nebraska (Chilisa, 2011; Johnson, 2013; Kirkness & Barnhardt, 1991; Kovach, 2019; Smith, 2013). Additionally, the Indigenous principles of respect and recognition are evident in the naming of the suicide prevention program. The program name includes the term “waters,” as Nebraska is named after the Otoe, Omaha, and Pawnee word for “flat water.” Furthermore, water is a life force, and the program promotes life through suicide prevention.

There are four federally recognized AI tribes in Nebraska, the Santee Sioux Nation, the Omaha Tribe of Nebraska, the Winnebago Tribe of Nebraska, and the Ponca Tribe of Nebraska. In 2017, 16,012 AIs resided in the state of Nebraska, and 47.2% of the AI population was under the age of 24 (United States Census Bureau, 2019).

The Nebraskan counties with the greatest populations of AIs were Thurston (4,014), Douglas (2,629), and Lancaster (1,730) (United States Census Bureau, 2019). Thurston County is ranked the lowest in health outcomes (length and quality of life) among the 79 ranked counties of Nebraska (Robert Wood Johnson Foundation, 2019). The Santee Sioux Nation and the Ponca Tribe of Nebraska are headquartered in Niobrara,
Nebraska in Knox County; the Omaha Tribe of Nebraska is based in Macy, Nebraska in Thurston County; and the Winnebago Tribe of Nebraska is headquartered in Winnebago, Nebraska in Thurston County (Nebraska Commission on Indian Affairs, 2019).

The Santee Sioux Nation Society of Care is an inter-tribal initiative dedicated to partnering with self-identified young AIs, their caregivers, and strategic partners throughout Nebraska to enhance the quality of life of youth, families, and communities. The initiative is committed to serving youth and their caregivers through licensed clinical services, traditional healing, education, and outreach. The Society of Care has outreach specialists working with the Santee Sioux Nation (Santee), the Omaha Tribe of Nebraska (Macy and Walthill), the Winnebago Tribe of Nebraska (Winnebago), the inter-tribal populations in metropolitan Omaha and Lincoln, and the inter-tribal populations in the rural and frontier western Nebraska panhandle. The Society of Care provides outreach support, including educational programming and behavioral health services, available in the three counties in Nebraska with the largest populations of AIs and in the counties in which each of the four federally recognized tribes of Nebraska are headquartered.

Funding for Society of Care’s existing suicide prevention program is primarily provided through a Native Connections grant, which was awarded to the Santee Sioux Nation in 2018 (SAMHSA grant # 1H79SM081564-01). Native Connections is a five-year grant program from the Substance Abuse and Mental Health Services Administration (SAMHSA) that assists AI communities in identifying and addressing Native youth’s behavioral health needs (Substance Abuse and Mental Health Services Administration, 2019). The designed suicide prevention program was requested by the
communities that the Society of Care serves and has the potential to benefit self-identified AI youth within Nebraska as well as their caregivers and communities.

**Scientific Background, Rationale, and Description of the Health Problem**

AI youth have the highest disconnection rate in the United States, with 23.9% of AI youth aged 16-24 not being enrolled in school or employed (Measure of America of the Social Science Research Council, 2019). A high rate of disconnection is concerning, as unemployment and a lack of educational attainment can contribute to depression and poor physical health (Measure of America of the Social Science Research Council, 2019). Nationally, AIs have reported experiencing significant depressive symptoms at higher rates than the general population (Whitbeck, McMorris, Hoyt, Stubben, and LaFromboise, 2002).

In 2017, the AI population of Nebraska was twice as likely as the non-Hispanic White population of Nebraska to have felt mentally unwell for 14 or more of the past 30 days (Nebraska Department of Health and Human Services, 2017). In addition, 27% of AIs in Nebraska reported a diagnosis of depression, a proportion that was nine percentage points greater than that of non-Hispanic Whites (Nebraska Department of Health and Human Services, 2017). These statistics are of concern, as poor mental health, including psychiatric diseases and mental disorders, have been shown to be contributing factors to suicide (Brådvik, 2018).

In 2017, suicide was the tenth leading cause of death in the United States and the ninth leading cause of death in Nebraska, with suicide claiming the lives of over 47,000 people and 275 people respectively (American Foundation for Suicide Prevention, 2019; Centers for Disease Control and Prevention, 2018). Also in 2017, there were an estimated
1,400,000 suicide attempts in the United States (American Foundation for Suicide Prevention, 2019). AI youth have the highest suicide rates among all youth racial and ethnic groups (Yoder, Whitbeck, Hoyt, LaFromboise, 2006). Furthermore, AI youth aged 13 to 18 have higher lifetime suicide attempt rates when compared with all other racial or ethnic groups in the same age range (Yoder et al., 2006). In Nebraska, between 2006 and 2015, suicide was the second leading cause of death for AI youth aged 15-24 (Nebraska Department of Health and Human Services, 2017).

When looking at access to care, 30% of AIs in Nebraska report not having a personal physician or provider, indicating that AIs are almost 1.8 times more likely to not have a personal physician than non-Hispanic Whites (Nebraska Department of Health and Human Services, 2017). Furthermore, approximately one-fourth (25.1%) of AIs in Nebraska report being unable to see a physician due to financial cost (Nebraska Department of Health and Human Services, 2017). Statewide, Nebraska has a shortage of mental health providers, with 88 of Nebraska’s 93 counties being designated as mental health shortage areas (University of Nebraska Medical Center, 2019). Thurston County, the Nebraskan county with the greatest population of AIs, is a mental health shortage area, with five mental health providers serving approximately 7,300 individuals in the county in 2018 (University of Nebraska Medical Center, 2019). With scarce resources, access to care in the AI population is further exacerbated by concerns of stigma, trust, lack of cultural competency, and historical trauma (Nebraska Department of Health and Human Services, 2017; Call et al., 2006). These concerns and statistics highlight the importance of the development of culturally humble mental health programming and
services outside of a clinical setting, as licensed clinicians are not always available or accessible.

Nationwide, curricula have been developed to reduce the prevalence of suicide among AI youth. Among these is American Indian Life Skills (AILS), formerly known as the Zuni Life Skills Development program, a school-based culturally-grounded program that was created to lower adolescent suicidal behaviors (Suicide Prevention Resource Center, 2007). The AILS includes between 13 and 56 lesson plans and is typically delivered over a 30-week period in a structured school or after school program environment (Suicide Prevention Resource Center, 2007). As implementation of AILS requires regularly scheduled in-person meetings in a structured environment, the program has limited applicability for community-based implementation.

While there have been interventions focused on suicide prevention in AI youth populations in Nebraska, these efforts have typically focused on members of a single tribe or specific geographic areas. For example, earlier this decade, Project HOPE was a community-based initiative focused on the prevention of suicide among youth in the Omaha tribe (Suicide Prevention Resource Center, 2011). Providing programming specifically to the metropolitan Omaha area, The Soaring Over Meth and Suicide Program (SOMS) has been developed by the Nebraska Urban Indian Health Coalition, an organization that currently collaborates with the Society of Care on other public health efforts (Soaring Over Meth and Suicide, 2019).
Chapter 3- Methods

Needs Assessment

Native Connections requires grantees to apply the Community Readiness Model. The Community Readiness Model was developed to build the capacity of communities and tribal nations to recognize and build upon strengths possessed, while simultaneously encouraging a healing process toward healthy change (Plested, Jumper-Thurman, & Edwards, 2017). Use of the Community Readiness Model for suicide prevention consists of five steps: defining community, conducting key person interviews, scoring interviews quantitatively to determine readiness, developing strategies, and furthering community change (Plested et al., 2017). The Society of Care completed the first three steps of the Community Readiness Model, and quantitative analysis of key person interviews was completed as a component of the capstone.

Based on SAMHSA guidelines, the Society of Care defined community as self-identified AI youth up to the age of 24 in Nebraska. Twenty-nine key person interviews were conducted. Interviewees included tribal elders, community members, healthcare providers, law enforcement, social services, government officials, religious officials and spiritual leaders, school administration, and educational providers in metropolitan community A (6), metropolitan community B (7), reservation community A (3), reservation community B (8), and rural and frontier community A (5). The names of all interviewees and their communities are not disclosed to maintain anonymity for those involved and to respect the privacy of involved communities. The questions asked to interviewees covered six dimensions and all concern suicide prevention. The six dimensions are existing community efforts, community knowledge of efforts, leadership,
community climate, community knowledge on the issue, and resource availability (Plested et al., 2017). Society of Care’s Director, Greg Donovan, and Lead Evaluator, Dr. Juan-Paulo Ramírez, scored the responses to the six dimensions quantitatively on a scale of stages from one to nine according to the Community Readiness Model scoring process (Plested et al., 2017). The scale used is shown in Table 1.

Table 1: Stage Descriptions for Key Person Interview Scoring

<table>
<thead>
<tr>
<th>STAGE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No Awareness</td>
<td>SUICIDE PREVENTION is not generally recognized by the community/leaders as an issue (or it may truly not be an issue.)</td>
</tr>
<tr>
<td>2. Denial / Resistance</td>
<td>At least some community members recognize that SUICIDE PREVENTION is a concern but there is little recognition that it might be occurring locally.</td>
</tr>
<tr>
<td>3. Vague Awareness</td>
<td>Most feel that there is local concern but there is no immediate motivation to do anything about it.</td>
</tr>
<tr>
<td>4. Preplanning</td>
<td>There is clear recognition that something must be done and there may even be a group addressing it. However, efforts are not focused or detailed.</td>
</tr>
<tr>
<td>5. Preparation</td>
<td>Active leaders begin planning in earnest. Community offers modest support of efforts.</td>
</tr>
<tr>
<td>6. Initiation</td>
<td>Enough information is available to justify efforts. Activities are underway.</td>
</tr>
<tr>
<td>7. Stabilization</td>
<td>Activities are supported by administrators or community decision makers. Staff are trained and experienced.</td>
</tr>
<tr>
<td>8. Confirmation/ Expansion</td>
<td>Efforts are in place. Community members feel comfortable using services and they support expansions. Local data regularly obtained.</td>
</tr>
<tr>
<td>9. High Level of Community Ownership</td>
<td>Detailed and sophisticated knowledge exists about SUICIDE PREVENTION prevalence and consequences. Effective evaluation guides new directions. Model is applied to other issues.</td>
</tr>
</tbody>
</table>


Preliminary analysis of the 29 interviews consisted of calculating the mean interviewee response for the six dimensions by geographic area and as a state (all
geographic areas combined). If the mean calculation resulted in a decimal, then the value was rounded down to the nearest whole number. When calculating the means of the six dimensions across all communities, the average of the mean scores of each of the five communities was calculated. The calculated means are shown in Table 2.

Table 2: Mean Question Response for the Five Geographic Areas and All Geographic Areas Combined (All Communities)

<table>
<thead>
<tr>
<th>Community</th>
<th>Existing Community Efforts</th>
<th>Community Knowledge of Efforts</th>
<th>Leadership</th>
<th>Community Climate</th>
<th>Community Knowledge on the Issue</th>
<th>Resource Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan Community A</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Metropolitan Community B</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Reservation Community A</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Reservation Community B</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Rural and Frontier Community A</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>All Communities</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

A Kruskal-Wallis test was conducted to determine if there is a statistically significant difference in interviewee responses to any of the six dimensions across the five geographic areas. The statistical analysis showed that existing community efforts was the only dimension in which there is a significant difference in responses across geographic areas, $x^2(2) = 13.473$, $p = 0.009$. The responses for the existing community effort dimension ranged in score from two to seven, and this is the only dimension with
responses scored as a seven. All five responses scored as a seven were reported in a metropolitan area (four in metropolitan community B and one in metropolitan community A). For all other dimensions, scored responses were not significantly different, indicating that different geographic areas across Nebraska are at similar stages of readiness to address suicide. The results of the Kruskal-Wallis test are displayed in Table 3.

Table 3: Results of the Kruskal-Wallis Test Performed on Interviewee Responses

<table>
<thead>
<tr>
<th></th>
<th>Existing Community Efforts</th>
<th>Community Knowledge of Efforts</th>
<th>Leadership</th>
<th>Community Climate</th>
<th>Community Knowledge on the Issue</th>
<th>Resource Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>df</strong></td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Asymp. Sig.</strong></td>
<td>0.009</td>
<td>0.464</td>
<td>0.192</td>
<td>0.181</td>
<td>0.161</td>
<td>0.504</td>
</tr>
</tbody>
</table>

No interviewee in any of the five geographic areas gave a response scored an eight or greater for any of the six dimensions, indicating no geographic area has reached the stage of confirmation and expansion or the stage of a high level of community ownership for any question area. Additionally, aside from a median score of seven for existing community efforts in metropolitan community B, no dimension for any geographic area had a median response score of six or higher (shown in Table 4). The lack of median response scores of 6 or greater (with the exception of existing community efforts for metropolitan community B respondents), in conjunction with the scientific background and lack of statewide community-based suicide prevention programming for AI youth, confirms that further work surrounding suicide prevention needs to be done across Nebraska.
Table 4: Median Question Response for the Five Geographic Areas

<table>
<thead>
<tr>
<th>Community</th>
<th>Existing Community Efforts</th>
<th>Community Knowledge of Efforts</th>
<th>Leadership</th>
<th>Community Climate</th>
<th>Community Knowledge on the Issue</th>
<th>Resource Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan Community A</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>1.5</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Metropolitan Community B</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Reservation Community A</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Reservation Community B</td>
<td>3.5</td>
<td>3.5</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Rural and Frontier Community A</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Program Description

Healing Waters was developed with input from the University of Nebraska Inter-Tribal Exchange (UNITE) at the University of Nebraska-Lincoln (UNL). UNITE is a student organization developed to promote the academic prowess and professional development of Native American students at UNL, to aid in personal growth and social well-being, and to facilitate participation in UNL community life (University of Nebraska-Lincoln, 2016). All members of UNITE were invited to attend a focus group about suicide prevention, and one student attended. The student in attendance identified as a female, and she has previously resided in and currently resides in a metropolitan area.

The UNITE member was provided with statistics on suicide in the youth AI population of Nebraska and the rationale for a community-based suicide prevention program. The Community Readiness Model proposes strategies for suicide prevention programming based on the perceived stage of community readiness.
The student was shown the mean for each of the six dimensions for the state (all geographic areas combined, shown in Table 2). Stage-appropriate strategies from the Community Readiness Model were presented for each of the six dimensions. The student was asked to select which, if any, of the strategies she believed would be effective, with an understanding that the strategies could be tailored for individual communities with higher or lower perceived stages.

As shown in Table 2, the mean statewide perceptions for leadership and community climate are equal to two, indicating denial and resistance. The goal of stage two is to raise awareness that suicide exists in the community (Plested et al., 2017). The UNITE member suggested the usage of posters to engage youth. Specifically, she recommended placing educational posters with AI suicide statistics in highly trafficked areas, such as restrooms. In response to learning the findings for the dimension of leadership, the student recommended conducting one-on-one visits with community leaders from different sectors in an effort to increase support. She emphasized the importance of collaboration among leaders to ensure that young adults are receiving support and guidance in multiple settings.

For three dimensions, community knowledge of the efforts, community knowledge of the issue, and resources related to the issue, the mean statewide perceptions are equal to three, indicating vague awareness. The goal of stage three is to raise awareness that the community can do something (Plested et al., 2017). For community knowledge of the issue and community knowledge of efforts, the UNITE member suggested a strategy of presenting relevant suicide-related information at community and cultural events and to unrelated community groups. Specifically,
she spoke about the importance of discussing stigma at presentations, as she believes that youth are often scared that there will be repercussions or consequences resulting from seeking behavioral health support. With regard to the dimension of resources, she said that posters, flyers, or billboards could be helpful in raising awareness of resources available.

The only question area that has a mean score of four is existing community efforts. A perceived stage of four indicates preplanning, with a goal of raising awareness with concrete ideas (Plested et al., 2017). For this stage, the student recommended using social media to reach the age demographic of interest. She believes that Twitter and Instagram are the most commonly used applications among individuals aged 19-24. These applications can be used in conjunction with existing efforts to reach a larger audience.

In addition to incorporating the suggested strategies from the Community Readiness Model, Healing Waters will include educational outreach provided by community leaders under the guidance of Georgiana Ausan, the Society of Care’s Director of Suicide Prevention. Community leaders will include individuals interviewed (tribal elders, community members, healthcare providers, law enforcement, social services, government officials, religious officials and spiritual leaders, school administration, and educational providers) along with other individuals in these sectors. Outreach will include discussions about suicide in the AI youth and young adult populations, including the sharing of statistics, protective factors, and community dynamics. Additionally, information on community-specific and statewide suicide prevention resources, including behavioral health services and supports available through
the Society of Care, will be provided. Also, community leaders will work with the target population to develop skills, including the development of healthy coping mechanisms. Ausan will work closely with identified community leaders to assure that materials developed alongside and shared with program participants are culturally relevant and tailored to the needs of the population of focus in that community.

**Logic Model**

<table>
<thead>
<tr>
<th>INPUT</th>
<th>ACTIVITIES</th>
<th>OUTPUTS</th>
<th>OUTCOMES</th>
<th>IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current community resources</td>
<td>Documenting current potential resources</td>
<td>Development or refinement of community-based suicide prevention coalitions in AI communities</td>
<td>Increased awareness of suicide prevention approaches</td>
<td>Increased community engagement in the lives of youth and young adults</td>
</tr>
<tr>
<td>Time and effort of community members and leaders</td>
<td>Documenting historical/traditional healing approaches</td>
<td>Adoption of evidence-based and practice-based approaches most relevant to each community</td>
<td>Increased community leader engagement in suicide prevention efforts</td>
<td>Increased quality of life among youth and young adults</td>
</tr>
<tr>
<td>Current community understanding of issue &amp; readiness to act</td>
<td>Identifying protective factors through key person contact and analysis of prior research</td>
<td>Metrics measuring success of marketing campaigns [change in perception during interviews]</td>
<td>Reduced self-reporting of suicidal ideation and depression among Nebraska AI youth aged 19-24</td>
<td>Reduced number of suicide attempts among Nebraska AI youth aged 19-24</td>
</tr>
<tr>
<td>Society of Care resources [professional staff, time, supplies, networks]</td>
<td>Key person interviewing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAMHSA Native Connections funds</td>
<td>Statistical analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNMC College of Public Health [program development]</td>
<td>Plan development [statewide commonalities and community-specific]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Marketing campaign [print and social media] focused on Nebraska AI youth &amp; young adults, caregivers, and communities</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Chapter 4- Results

Implementation Plan

Ausan will oversee the implementation of identified suicide prevention strategies and programming. She will guide community-based coalitions comprised of tribal elders, community members, healthcare providers, law enforcement, social services, government officials, religious officials and spiritual leaders, school administration, and educational providers to implement strategies and programming. The schedule of events and the types of activities to be performed will be determined individually within communities, and strategies will be tailored according to specific community resources and needs and to be culturally relevant. For example, activities will be focused on community climate, leadership, and community knowledge of efforts in metropolitan community A, as these dimensions were scored the lowest.

Evaluation Plan

Evaluation of Healing Waters will occur both quantitatively and qualitatively. Quantitative evaluation will occur in the years following implementation of programming, as statistics related to suicide (suicide rates and attempts and self-reported youth behaviors) can be compared between the years before implementation and the years following implementation. Qualitative evaluation will be completed after program implementation, as another round of key-person interviews following the Community Readiness Model protocol will be conducted. If perceived stages across a community increase, this would be indicative of an improvement in suicide prevention efforts.
Chapter 5- Discussion

Expected Outcomes

It is anticipated that Healing Waters will reduce the number of suicide attempts and suicides in the 19-24 year old AI population of Nebraska. It is expected that the communities involved will gain awareness, understanding, and engagement in suicide prevention efforts. As a result of program implementation, it is believed that higher stages of readiness will be achieved when compared to the initial assessment, which according to the Community Readiness Model, will lead to an expansion in services and reach within communities (Plested et al., 2017).

Strengths and Limitations

A strength of Healing Waters is that it maximizes collaboration across many sectors in a community. Through encouraging collaboration across sectors, numerous individuals with multiple perspectives in a community can provide education and support. Additionally, the programming does not require a structured environment. Programming can occur in numerous settings within a single geographic area or community.

Another strength of the program is that the quantitative and qualitative data collected allows for a true statewide approach benefitting Nebraskan AI reservation, metropolitan, and rural and frontier communities. When looking at the quantitative analysis performed (Kruskal-Wallis), no literature was found that analyzed data from the Community Readiness Model assessments in the same way, indicating that the methods used are novel.
In addition, the suicide prevention strategies to be implemented were developed with input from an individual in the demographic group of interest (AIs aged 19-24 in Nebraska). The Indigenous principle of relevance was acknowledged through acquiring data for the scientific rationale of the program and through meeting with the student, as the student was able to relate the strategies suggested within the Community Readiness Model to the issues surrounding suicide being faced. Additionally, through meeting with a student in UNITE, the principle of relationship was of focus, as the Society of Care did not have a formal contact within UNITE prior to this interaction, and now a relationship between the two organizations has been developed.

A limitation of the needs assessment conducted was a low sample size. For example, in reservation community A, only three individuals were interviewed. Although this sample size was less than that desired for a representative viewpoint, all results for this sample were reported, as this sample still provides insight into the community.

Another limitation of the needs assessment is that perceptions are subjective, and involvement, familiarity, and exposure to existing suicide prevention efforts could vary from individual to individual, even within the same employment sector and working experience. For example, two law enforcement officers in the same community could have vastly different perceptions of suicide prevention efforts based on personal experiences that are not dictated by the established role they serve.

**Sustainability**

The Society of care has a demonstrated record of sustaining activities beyond the lifetime of a specific grant. Additionally, the Santee Sioux Nation is committed to
furthering the work described in this capstone. Ausan will be given all information contained within this capstone, along with a list of contact information for all individuals engaged throughout the process of developing the suicide prevention program.

**Recommendations**

It is recommended that the Society of Care continue conducting interviews within AI communities across the state to gain a larger sample size for analysis and representation purposes. Also, additional interviews would lead to the engagement of a greater number of individuals who will assist in the provision of outreach services. Additionally, it is recommended that the Society of Care sustain a relationship with UNITE at UNL. Members of UNITE can provide near-peer suggestions and ideas for future efforts, and after input is obtained, developed programs can be shared with UNITE. Through sharing implemented efforts, the Indigenous principle of reciprocity will be achieved.

Young AIs in Nebraska have endured and experienced significant hardship and trauma, yet demonstrate remarkable resilience. It is hoped that the suicide prevention program will build upon the resilience of the population of interest and reduce suicidal ideations, attempts, and completions.
References


University of Nebraska-Lincoln. (2016). *UNITE brings the Native American powwow back to UNL*. https://newsroom.unl.edu/announce/rso/5239/29894


Biography

Sara Donovan received a Bachelor of Arts from Drake University, with a major in Biochemistry, Cell and Molecular Biology, a concentration in Leadership Education and Development, and a minor in Biology. She is presently a Master of Public Health student in the Department of Epidemiology at the University of Nebraska Medical Center. Sara is employed as a Student Research Assistant at the Global Center for Health Security in Omaha, Nebraska, where her work primarily focuses on supporting trainings for federal disaster and public health services teams. Her primary research interests include health disparities and emergency preparedness and response. Outside of academic and professional pursuits, she enjoys spending time with family and friends, traveling to new and familiar destinations, and playing recreational sports.
Curriculum Vitae

SARA DONOVAN
Omaha, Nebraska | (402) 890-2054
saradonovan29@gmail.com

EDUCATION

<table>
<thead>
<tr>
<th>Degree</th>
<th>Field</th>
<th>Institution</th>
<th>City, State</th>
<th>Years</th>
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<tbody>
<tr>
<td>MPH</td>
<td>Epidemiology</td>
<td>University of Nebraska Medical Center</td>
<td>Omaha, Nebraska</td>
<td>2018-Present</td>
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<td></td>
<td></td>
<td>Cumulative GPA: 4.0</td>
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<tr>
<td>BA</td>
<td>Biochemistry, Cell &amp; Molecular Biology</td>
<td>Drake University</td>
<td>Des Moines, Iowa</td>
<td>2014-2017</td>
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<tr>
<td></td>
<td></td>
<td>Minor: Biology</td>
<td>Concentration: Leadership Education and Development</td>
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PROFESSIONAL EXPERIENCE

<table>
<thead>
<tr>
<th>Position</th>
<th>Years</th>
<th>Employer and Location</th>
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<tbody>
<tr>
<td><strong>Student Worker</strong></td>
<td>January 2020-Present</td>
<td>Global Center for Health Security</td>
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<td></td>
<td>• Design educational infographics for National Disaster and Medical System teams on key considerations for a COVID-19 response deployment</td>
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<td>• Conduct literature reviews on ethical concerns and obligations surrounding the COVID-19 pandemic and provide organizational support for an international Ethics Advisory Committee</td>
</tr>
<tr>
<td><strong>Communications Designer</strong></td>
<td>2019-2020</td>
<td>Nebraska Medical Association and Nebraska Department Health of Human Services</td>
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<tr>
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<td>• Designed educational materials on opioid weaning and overdose response for clinicians, patients, and first responders</td>
</tr>
<tr>
<td><strong>Graduate Research Assistant</strong></td>
<td>2018-2019</td>
<td>University of Nebraska Medicine College of Public Health</td>
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<td>• Collected and processed physical activity data obtained from youth in rural Nebraskan communities to study the impact of evidence-based ideas on implemented practices</td>
</tr>
<tr>
<td><strong>Respite Service Assistant</strong></td>
<td>2016-2018</td>
<td>ChildServe</td>
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<tr>
<td></td>
<td></td>
<td>• Planned and engaged in appropriate activities with a child with developmental delays</td>
</tr>
</tbody>
</table>
RESEARCH EXPERIENCE

Investigating Childhood Obesity in Omaha, Nebraska 2019
Center for the Child & Community | Lincoln, Nebraska
• Performed resource mapping to provide insight into the obesogenic environment of Omaha, Nebraska
• Wrote SAS code to update Children’s Hospital & Medical Center’s electronic health records to contain z-scores for patients’ body mass indexes

Best Tourniquet Holding and Strap Pulling Technique 2018-2019
Drake University | Des Moines, Iowa
• Used different two-handed techniques to apply five different tourniquets to determine which technique achieved the highest secured pressure

Sociodemographic Factors Associated with Low Birth Weight 2017
Pravara Institute of Medical Sciences | Loni, India
• Conducted interviews with mothers who had given birth within the past 24 hours
• Performed statistical analyses to determine the significance of exposures in predicting birth weight

Effects of Distance Between Paired Tourniquets 2017
Drake University | Des Moines, Iowa
• Examined occlusion pressures for single tourniquets and for tourniquets applied at varying gap widths to determine effectiveness

Expression and Purification of Tetrahymena Calcium-Binding Protein (TCB2) 2016
Drake University | Des Moines, Iowa
• Performed experiments to provide insight into how the intact TCB2 protein forms contractile filaments

Pulse Oximetry Versus Doppler for Tourniquet Monitoring 2016
Drake University | Des Moines, Iowa
• Investigated the possible usefulness of pulse oximeters for monitoring extremity tourniquet arterial occlusion

AFFILIATIONS AND MEMBERSHIPS

Public Health Association of Nebraska- Student Member
Beta Beta Beta Biological Honors Fraternity
Kappa Alpha Theta Fraternity

PUBLICATIONS

POSTER PRESENTATIONS


Wealthier R, Donovan S, Cowan A, Johnannson C, Mahajan P, Bangal V. Study of incidence and sociodemographic factors associated with low birth weight infants born at Pravara Rural Hospital, Ahmednagar district of Maharashtra, India. Poster presented at Nelson Institute for Diplomacy and International Affairs- Undergraduate Conference on Global Affairs; 2017 April 8; Des Moines, Iowa. [Drake University Conference on Undergraduate Research in the Sciences; 2017 April 13; Drake University: Des Moines, Iowa.]

ORAL PRESENTATIONS

Donovan S, Dingman H, Lester K. Resource mapping of the obesogenic environment of Omaha, Nebraska. Presented at: LiveWell Omaha Kids Meeting; 2019 August 28; Omaha, Nebraska