

The Omaha Nation Community Response Team

Omaha Nation Community Suicide Prevention Plan

Established within Project "HOPE"

July 1, 2007 / June 30, 2008

The Omaha Nation Community Response Team (ONCRT) is a private, non-profit organization that serves the residents of the Omaha Reservation in Northeastern Nebraska. As a community-based coalition, the organization strives to provide quality prevention and community mobilization services and activities, emphasizing the inclusion of Omaha culture as the primary protective factor in bringing about positive changes within the community.

Over the past eighteen months, the ONCRT has collaboratively participated in the initial strategic planning process regarding suicide prevention and to help facilitate the project efforts. Over this period of time, the ONCRT has established important partnerships leading to effective community-based training regarding suicide prevention. Specifically, the ONCRT and Indian Health Services partnered to bring Dr. Clayton Small to our reservation for a four-day community training process for youth and adults. Twenty-nine (29) adult community members and Elders participated in the first two days training on the H.O.P.E. curriculum. On days three and four, 27 high schools students participated along with Dr. Small and the trained adults. From this training, a sub-committee was formed and continued to meet regularly, leading to additional training with the University of Nebraska Extension Services in providing further adult-youth training and planning with Mr. Jeff Hart. Additional partnerships were established when the Indian Country Child Trauma Center from the University of Oklahoma and Dr. Dee Big Foot and Dr. Teresa LaFromboise of Stanford University came to train delegates from the Omaha Nation and Walthill Public Schools on the *American Indian Life Skills Development Curriculum* (AILSDC).

Most recently, members of the Suicide Prevention Team (SPT) traveled to Pechanga, CA to participate in the American Indian and Alaska Native Summit on Suicide Prevention, Intervention and Healing which was held in San Diego on September 25-27, 2007. The ONCRT was invited to our Team to participate in the two and a half day working retreat to initiate and strengthen a planning and policy initiative related to youth suicide prevention, intervention, and healing. Each of the invited tribal delegations received advice and support regarding suicide prevention, intervention and healing experts throughout the working retreat. This invitation was only extended to tribes, coalitions of tribes, tribal organizations, and urban Indian organizations that had identified youth suicide as a critical issue within their communities.

Only 5 to 7 tribal communities across the country were selected to participate in the summit, which was based on tribal leaders across the country who remain seriously concerned about the escalating risk of suicide among American Indian and Alaska Native youth. The Child, Adolescent and Family Branch of the Substance Abuse Mental Health Services Administration (SAMHSA) Center for Mental Health Services partnered with the National Indian Child Welfare Association, the National Congress of American Indians, the National Technical Assistance Center for Children's Mental Health of the Georgetown University Center for Child and Human Development, the Federation Families for Children's Mental Health, Indian Country Child Trauma Center, Indian Health Service, the National Indian Health Board, and the One Sky Center to develop an organized response to the suicide crisis that is sadly affecting too many tribal communities. The Team utilized this invaluable experience to create their Community

Suicide Prevention Plan to be carried out over the next three years. The Team members of the Omaha Nation included:

Initial Omaha Nation Suicide Prevention Planning Team	
Team Member	Organization
Mr. Mitchell Parker, Chairman	Omaha Tribal Council
Mr. John Penn, Executive Director	ONCRT
Ms. Wehnona St Cyr, CEO	Carl T. Curtis Health Education Center
Ms. Miriam Kay Kearnes, Director	Project Wasko , Omaha Nation Public School
Ms. Gwen Porter, Director	Rain Maker Project, ONCRT
Ms. Elanore Baxter, Council Member	Omaha Tribal Council
Ms. Christine Burns, LMHP	Guidance & Development Center

Purpose of the Initiative:

Project HOPE is a community-based initiative focused upon the prevention of suicide among our youth. The target population for this initiative is Omaha Nation youth ages 9-19, with additional inclusion up to age 24. As an integral aspect of our suicide prevention initiative, the ONCRT has created a working sub-committee that has developed the following plan of action. The primary purpose of Project HOPE is to serve as the catalyst for preventing suicides among youth through the Omaha Nation Suicide Prevention Initiative. This long-term initiative will be achieved by promoting the following foundational prevention efforts:

- Prevent youth deaths due to suicide across the entire Four Hills of Life
- Reduce the rates of related suicidal behaviors among the targeted youth population
- Reduce the harmful after-effects associated with suicidal behaviors and the traumatic impact of suicide on family and friends by creating a comprehensive community response
- Promote opportunities and a safe environment to enhance resiliency, resourcefulness, respect, and interconnectedness for individuals, families, and the community

Needs of the Community:

Suicide on the Omaha Reservation is a reality that was, not many years ago, rarely even talked about within the community. Ideology concerning suicide is difficult to target, as most incidences are held in confidentiality and not reported. Attempts are often seen as severe bouts of depression or substance abuse-related issues and are generally left unrecognized and untreated or passed over until counseling, therapy or treatment can be applied. The tribal system of care is overburdened and overwhelmed, and an alarming number of youth are displaying disruptive behaviors and attitudes that are typically left untreated, risking more attempts and possible successions. Local poverty, unemployment, family deterioration, and substance only increase stress on youth. Until a successful completion occurs, suicide is not addressed as a community issue. Yet, we know that suicidal ideation among our youth is quite prevalent.

Ancient Omaha tribal organization has all but ceased to exist, owed to the changed environment and the imminent approach of Western civilization. Elders tell us that very little remains of the ancient customs as we now live in a fragmented state and much of our Omaha language, beliefs, norms, and values have given way to Western systems. English has become the predominant language, however many elders still speak fluent Omaha and are available to learn from when asked. The clan system has all but disappeared, although many members know

which clan their family belongs to and many still give their children Omaha names through ceremonies. The socioeconomic factors make the status of our communities poor, as more than half of our Omaha people live below the poverty level and the dropout rate among our youth is the highest in the State. As unemployment and poverty have increased, so have our substance abuse, diabetes, suicide, youth crime, and abuse and neglect rates.

Currently, the needs related to suicide prevention includes adding traditional mental health services (including therapists); more active involvement on the part of community healers and leaders; training on suicide prevention and early intervention for teachers, coaches, prevention staff, tribal system of care staff and other paraprofessionals who deal with youth on a regular basis; greater awareness of the signs of suicide for parents, grandparents, foster families, child care and group care providers; an effective emergency response from mental health and social work community, tribal leaders, clergy and traditional spiritual leaders when a suicide is completed. A strong media approach is also needed to not only inform and educate the community about suicide, but to provide vital information about where to get early assistance, how to get involved, and what activities are being provided through the initiative. Effective community assessments are also needed to collect important data and information to establish suicide rates, to provide indicators of the severity of problems concerning suicide ideation, to facilitate a systemic wide surveillance process to regulate delivery of services matched to the need of participants, and to help understand where to apply limited reservation resources. Additional research must also be completed in order to keep abreast of national data and effective approaches. Finally, an emergency response effort among available resources must be gathered and be ready when a successful suicide occurs. The healing process must start as soon as possible for the family and whole community.

Risk and Protective Factors:

From 2000 through 2007, information concerning the prevalence of substance abuse and gaps in the current service system has been gathered from community and school assessments. The ONCRT has utilized the Nebraska Risks and Protective Factors Student Survey (NRPFSS), which is geared towards substance abuse but does include suicide ideology, to develop strategies based on data concerning risk and protective factors. Results for 2003, 2005 and 2007 are similar and suggest the following risk factors: a.) Community - community disorganization; b.) Family - poor family management; c.) School ó low commitment to school; and d.) Individual ó early initiation of anti-social behaviors. Our youth have also identified the following protective factors as contributing to resiliency: a.) Community ó opportunities for pro-social involvement; b.) Family ó family attachment; c.) School ó opportunities for pro-social involvement; and d.) Individual ó social skills. As members of the coalition analyzed the risk and protective factor survey data, it became overwhelmingly evident that the local risk factors center around community disorganization, issues of family management, and low commitment to school. Members of the ONCRT coalition have come to the conclusion that these risk factors continue to perpetrate continued degradation of each other and the community, and contribute to our problems related to youth suicide, suicide ideation, and related behaviors.

In addition, information from local surveys of community stakeholders and coalition membership has identified unique risk and protective factors. They include: loss of cultural supports, depression, hopelessness, psychological symptomatology, weak cultural identity, strained interpersonal communication, limited social support, perceived discrimination, and school difficulties. Therefore, the coalition has agreed that the overwhelming emerging contributor to engaging in suicide is overall community disorganization. The protective factors

of pro-social involvement, family attachment, social skills, and belief in the moral order are areas that protect individuals from engaging in suicide ideology and need to be emphasized in planning prevention strategies. Also, pro-social involvement needs to be expanded to include pro-cultural involvement that directly targets youth as a strong protective factor in prevention strategies.

Goals & Objectives:

In support of this prevention effort and based on assessed community needs and risk and protective factors, we have established three goals, with objectives for each of these goals:

Goal 1: To promote awareness and education on the Omaha Reservation that suicide is a community problem that is preventable when the community acts in cohesion

Research has shown that communities have a greater opportunity for successful initiatives when support is strong and comprehensive across that community, and inclusive of several important community sectors. As more community members become aware that suicide ideology is prevalent among our young people and come to believe that suicide and related suicidal behaviors can truly be prevented, the further the suicide rate and related ideology can be reduced. In addition, with additional education and increased awareness, the importance of the roles that specific individuals and groups can play in suicide prevention also increases, leading to effective partnerships.

The elimination of health disparities and the improvement of the quality of life for all of our community members will continue to be the central efforts of this initiative. Some of these health disparities are attributable to differences of gender, race or ethnicity, education, income, disability, stigma, geographic location, sexual orientation, or even personality conflicts and politics. Many of these factors place individuals at increased risk for suicidal behaviors. In addition, biological, genetic, psychological, and cultural factors significantly impact the risk of suicide in any individual. Risk factors associated with suicide include serious mental illness, alcohol and drug abuse, childhood abuse, loss of a loved one, joblessness and loss of economic security, and other cultural and societal influences, while resiliency and coping skills can reduce risks. Further, social support and close relationships serve as protective factors, which play vital roles in the inclusion of cultural approaches.

Locally, the nature of suicide includes information from the 2000 Census Bureau, which indicates the death rate in Thurston County, which includes the Omaha Reservation, is 50% higher than the state average, with 84% of these deaths being related to substance abuse compared to 26% statewide. The current reservation education, unemployment and poverty rates only add to the challenge, as the 2000 Census also reported that 36% of Native Americans in Thurston County have less than a high school education; while 23% of reservation families (with children under 18) live below the poverty level, compared to 10% for the State; and 42% of all households are single-parent families.

Other barriers include equal access and affordability of health care, which is highly influenced by the financial, structural, and personal factors and challenges depicted above by the 2000 Census data. Financial barriers include not having enough health insurance or not having the financial capacity to pay for services outside an insurance program or eligibility to Indian Health Services. Structural barriers include the lack of primary care providers, medical specialists or other health care professionals to meet special needs or the lack of health care facilities. Personal barriers include cultural or spiritual differences, language, not knowing when

or how to seek care, or concerns about confidentiality or discrimination. Reducing disparities is a necessary step in ensuring that all of our community members receive appropriate physical health, mental health, and substance abuse services. One aspect of improving such health care access is to better coordinate the services of a variety of community institutions. This will help to ensure that at-risk populations receive the services they need, and that all community members receive regular preventive health services. Another aspect is addressing policies that discriminate and lead to added stress for community members.

Key community gatekeepers—people who regularly come into contact with youth in emotional distress, need training in order to be able to recognize factors that place youth at risk for suicide, and to learn appropriate interventions. Key gatekeepers in our community include teachers and school personnel, clergy, primary health care providers, mental health care providers, law enforcement personnel, and emergency health care personnel. We recognize that some of our health professionals are not adequately trained to provide proper assessment, treatment, and management of suicidal patients, nor do they know how to refer clients properly for specialized assessment and treatment. Despite our previous efforts to increase awareness of suicide as a major health problem for our youth, gaps remain in training programs for our health care professionals and others who often come into contact with youth in need of these specialized assessment techniques and treatment approaches. In addition, some of our health professionals lack training in the recognition of risk factors often found in grieving family members of loved ones who have died by suicide (suicide survivors).

Additionally, evidence shows that limiting access to lethal means of self-harm may be an effective strategy to preventing self-destructive behaviors. Often referred to as "means restriction," this prevention approach is based on the belief that a small, but significant minority of suicidal acts are, in fact, impulsive and of the moment; they result from a combination of psychological pain or despair coupled with the easy availability of the means by which to inflict self-injury. Thus, a self-destructive act may be prevented by limiting the individual's access to the means of self-harm. Evidence suggests that there may be a limited time effect for decreasing self-destructive behaviors in susceptible and impulsive individuals when access to the means for self-harm is restricted. However, controversy exists about how to most effectively accomplish this goal because restricting means can take many forms and can signify different things to different people. For some people, restriction may connote redesigning or altering the existing lethal means of self-harm currently available, while to others it may mean eliminating or limiting their availability altogether.

One way shown to prevent suicide is to identify individuals at risk early and to engage them in treatments that are effective in reducing the personal and situational factors associated with suicidal behaviors (e.g., depressed mood, hopelessness, helplessness, alcohol and other drug abuse, among others). Effective programs that are undaunted in dealing with suicidal issues and able to provide effective, meaningful measures must be included in the preventive process. Assessments at the school, systemic, and community level must be included and brief intervention approaches must be available to meet special needs.

Another way to prevent suicide is to promote and support the presence of protective factors, such as learning skills in problem solving, conflict resolution, and nonviolent handling of disputes. By improving clinical practices in the assessment, management, and treatment for individuals at risk for suicide, the chances for preventing those individuals from acting on their despair and distress in self-destructive ways are greatly improved. Moreover, promoting the presence of protective factors for these individuals can contribute importantly to reducing their

risk. The ONCRT firmly believes that culture is the most important protective factor in providing prevention and early intervention milieus.

The objectives established for *Goal #1* are designed to heighten awareness of the presence or absence of risk and protective conditions associated with suicide, leading to better triage systems and to a better allocation of resources for those in need of specialized treatment. In addition, they focus on increasing the degree of cooperation and collaboration between and among programs and community members that have made a commitment to public awareness of suicide and suicide prevention. The specific objectives established for this goal are also designed to ensure that health professionals and key community gatekeepers obtain the training that will help them prevent suicide. They include:

- To develop public education campaigns for the prevention of suicide, targeting youth ages 10-24, using a culturally appropriate and community-driven approach
- To sponsor gatherings, forums, and training on suicide prevention and early intervention
- To ensure that individuals who typically provide services to suicide survivors have been trained to understand and respond appropriately to survivors' unique needs
- To offer specialized trainings for professionals providing for suicide early interventions and post-suicide services such as with grief caused by suicides
- To improve access to and community linkages with mental health and substance abuse services

Outcomes of successfully fulfilling *Goal #1* and its objectives include:

- Increased community awareness of the impact of suicide to the individual, family, community, and culture
- Increased organizational capacity to provide services
- Increased individual action for reporting suicidal discussion or behavior to service organizations
- Improved public safety (i.e. firearm safety design; safer methods for dispensing potentially lethal quantities of medications)
- Increased number of agencies involved
- Developed plan focusing on addressing gaps in prevention and early intervention services
- Refined utilization management guidelines for suicidal risk in managed care and insurance plans are implemented
- Enhanced mental health and suicide prevention integration into health and social services outreach programs for at-risk youth
- Improved access to prevention, early intervention, clinical, and support services
- Improved screening guidelines for schools, colleges, and correctional institutions, along with guidelines on linkages with service providers are implemented

Goal 2: To develop broad-based support for suicide prevention and early intervention activities that promote Omaha culture and incorporate familial participation

Because there are many paths to suicide, prevention must address psychological, biological, and social considerations if it is to be fully effective. Collaboration across a broad spectrum of our tribal communities, including Elders and youth, tribal programs, institutions, and

groups—from schools to prevention organizations to health care programs—is a way to ensure that prevention and early intervention efforts are comprehensive. Such collaboration can also generate greater and more effective attention to suicide prevention than can these groups working alone. Partnerships that evolve from such collaboration are able to blend resources and build upon each group's strengths. Broad-based support for suicide prevention may also lead to additional resources and to the incorporation of suicide prevention activities into the mission of organizations that have not previously addressed it.

Suicide is closely linked to mental illness and to substance abuse, and effective treatments exist for both. However, the stigma of mental illness and substance abuse prevents many persons from seeking assistance; since they often fear prejudice and discrimination. The stigma of suicide itself—the view that suicide is shameful or disgraceful—is also a barrier to treatment for persons who have suicidal thoughts or who have attempted suicide. In Omaha culture, it is believed that when an individual commits suicide, their spirit does not pass on to the spirit world. Many generations ago, ceremonies were not held for those who committed suicide. Even today, family members of suicide attempters often hide the behavior from friends and relatives, and those who have survived the suicide of a loved one suffer not only the grief of loss but often the added pain stemming from this unfortunate stigma.

Historically, the stigma associated with mental illness, substance abuse, and suicide has contributed to inadequate funding for preventive services and to low insurance reimbursements for treatments. It has also resulted in the establishment of separate systems for physical health and mental health care. One consequence is that preventive services and treatment for mental illness and substance abuse are much less available than for other health problems. Moreover, this separation has led to bureaucratic and institutional barriers between the two systems that complicate the provision of services and further impede access to care. De-stigmatizing mental illness and substance use disorders could increase access to treatment by reducing financial barriers, integrating care, and increasing the willingness of individuals to seek treatment.

All suicides are typically highly complex. The volume of research on suicide and its risk factors has increased considerably in the past decade and has generated new questions about why individuals become suicidal or remain suicidal. The important contributions of underlying mental illness, substance use, and biological factors, as well as the potential risk that comes from certain environmental influences are becoming clearer. Increasing the understanding of how individual and environmental risk and protective factors interact with each other to affect an individual's risk for suicidal behavior is the next challenge. This understanding can contribute to the limited but growing information about how modifying risk and protective factors change outcomes pertaining to suicidal behavior.

The specific objectives established for *Goal #2* are designed to create the conditions that empower persons in need of mental health and substance abuse services to receive them and are focused on developing collective leadership and on increasing the number of groups working to prevent suicide. They will help ensure that suicide prevention and early intervention are better understood and that organizational support exists for implementing prevention activities. In addition, the objectives established for this goal are designed to enhance inter-organizational communication to better facilitate the provision of health services to those in need of them. Finally, the objectives established for this goal are designed to support a wide range of research endeavors focused on the etiology, expression, and maintenance of suicidal behaviors across the Four Hills of Life (lifespan). The enhanced understanding to be derived from this research will

lead to better assessment tools, treatments, and preventive interventions. Specifically, the objectives for this goal include:

- To organize interagency committees to improve coordination and to ensure implementation of the Initiative's strategies
- To establish partnerships dedicated to implementing the Initiative's strategies
- To increase the number of youth (with underlying mental health disorders) who receive appropriate mental health services and cultural support

Expected outcomes for *Goal #2* and its objectives include the following:

- Increased number of professional, volunteer, and other groups that integrate suicide prevention activities into their ongoing activities
- Increased number of outside partners that adopt policies designed to prevent suicide through continuation of care issues
- Changed procedures and/or policies in certain settings, including the clinic and emergency departments, alcohol programs, mental health program, and various youth services settings, designed to assess suicide risk
- Decreased stigma for suicide prevention efforts and related services, thus increasing the number of community members seeking services
- Established singularly comprehensive suicide prevention and early intervention plan
- Assurances created that youth treated for trauma, sexual assault, or physical abuse in emergency departments receive mental health services
- Further research conducted and a formal Internal tribal Revue Board and integration plan of evidence-based suicide prevention programs for tribal programs effective in tribal communities
- Tribal suicide research agenda developed and disseminated
- Omaha-specific interventions established with demonstrated effectiveness for prevention of suicide or suicidal behavior
- Support programs implemented for youth who have survived the suicide of someone close
- Immediate therapeutic response created at local schools using a team approach
- Response plan developed for health professionals to address the affects of the suicide (i.e. counseling, medication, hospitalization, etc)
- Programs and services sustained for family and community members throughout the extended healing period
- Clinical staff are better prepared to meet the needs of the community
- Clinical staff are able to provide training to paraprofessionals and community members who will provide suicide support services and brief interventions

Our entire community is shaken when a youth commits suicide, leaving loved ones and community members fearful and peers struggling with anger and grief. A comprehensive community response is necessary to meet the immediate needs of the family and community, providing professional support and cultural pathways that lead survivors through the healing process.

Goal 3: Develop an immediate community response and healing process to respond to completed suicides within the community

The primary objective regarding Goal #3 is designed to create a culturally appropriate, healing related response to successfully completed suicides on the Omaha Reservation.

- Develop a focused community healing plan to respond to suicides within the community to promote healing and to prevent additional suicides and/or health issues

The outcomes from *Goal #3* and its objective are expected to be the following:

- Increase the coalition partnerships to develop a singularly comprehensive suicide prevention and early intervention plan
- Integrate evidence-based suicide prevention programs in the schools, college, tribal programs, and family, youth, and community service programs

Moving Towards a Healing Process

The Omaha Initiative creates a framework for suicide prevention and early intervention for the entire Omaha tribal system of care. It has been designed to encourage and empower groups and individuals to work together to enhance collaborations in order to generate a greater chance for success. Suicide and related suicidal behaviors can be reduced as more and more sectors of the community gain increased understanding about the extent to which suicide among our youth is a problem, about the ways in which it can be prevented, and about the roles that all community members can play in contributing to the prevention efforts.

The Initiative's strategy is comprehensive so that numerous community members and partners can be actively involved in further planning and selecting those objectives and activities that best correspond to their responsibilities and resources. Under each of the plan's three goals, objectives suggest a number of roles for different community sector participation, all of which need to be involved in implementing the plan, including community members, health care professionals, law enforcement personnel, educators, and youth workers. Tribal system of care providers and institutions, such as non-profit organizations, churches, and schools all have a necessary and critical role to play. Survivors and the tribal leaders need to be partners as well, especially in re-allocating resources and providing for mandatory participation regarding public health and safety issues.

Suicide and related ideation can be treated, individually and as a community. Prevention efforts will include community education and awareness trainings, forums, and cultural gatherings. Project HOPE will continue to bring speakers and trainers into the community to facilitate planning meetings and educate professionals and project partners on providing brief interventions. A media component will also be incorporated to assist in carrying the message that "Life is Sacred" and display where the community can receive immediate and confidential assistance. In addition, both public schools will engage in providing the *American Indian Life Skills Development Curriculum* (AILSDC), an evidence-based approach, for all youth in grades 6-12. After-school and summer prevention programs such as Huthuga Project, Shonga Ska, and

Project Wasko will also provide the AILSDC participants with additional support activities, as we believe that programs that address risk and protective factors at multiple levels are likely to be most effective. A number of our current prevention programs show promise for reducing incidences of suicide and suicidal behaviors and new, innovative programs will be developed to cover current gaps in services. This is the area where many of those who display suicide ideational behaviors work with a non-mental health clinicians two-three times per week. These contacts magnify the important role prevention workers can play in identifying risk factors for suicide and in referring patients displaying suicidal ideation or behaviors for early intervention or clinical care.

Because suicide is a low base-rate event, special efforts will be taken to ensure collection of sufficient data to allow for meaningful analysis of risk factors and interventions. The Initiative will include early intervention activities by incorporating community assessments to gather key data and surveillance surveys in all clinical and direct service locations. Staff will be better trained to provide effective clinical and brief interventions at all levels of care, including in the schools, Head Start, and child care facilities. Finally, reality dictates that our plan must include an immediate community response when a suicide is completed. Experience has taught us that when this occurs, the whole community is affected. Clinical assistance must be deployed to the schools as soon as possible to provide support for students and staff. Family members must be gathered together as soon as possible for community healers to begin the healing process through counseling and ceremonies. Therapeutic services for the family and community must be made available at once and extended as needed, including emergency referrals to local hospitals when necessary. A day of prayer and ceremony will be held at the Community Tribal Building, with tribal leaders assisting family members with food and financial assistance.

Ideally, this collaborative Initiative will motivate and illuminate. It can serve as an initial model and be adopted or modified by other tribal communities as they develop their own, local suicide prevention plans. The Initiative articulates the framework for community efforts and provides legitimacy for local groups to make suicide prevention a high priority for action as part of their normal service delivery. The Initiative encompasses the development, promotion and support of programs that will be implemented in the community designed to achieve significant, measurable, and sustainable reductions in suicide and suicidal behaviors. This requires a major investment in action. Now is the time for making great strides in suicide prevention.

Implementing the plan's goals and objectives provides the means to realizing success in reducing the heavy toll from this critically important problem. Sustaining action on behalf of all Omaha community members will depend on effective collaboration because suicide prevention is truly everyone's business.

Suicide Prevention Initiative Work Plan

Goal	Objectives	Activities	Timeline	Outcomes
<p><u>Goal 1:</u> To promote awareness and education on the Omaha Reservation that suicide is a community problem that is preventable when the community acts in cohesion</p>	<p><u>Objective 1:</u> To develop public education campaigns for the prevention of suicide using a culturally appropriate and community-driven approach</p> <p><u>Objective 2:</u> To sponsor gatherings, forums, and training on suicide prevention and early intervention</p> <p><u>Objective 3:</u> To ensure that individuals who typically provide services to suicide survivors have been trained to understand and respond appropriately to their unique needs</p> <p><u>Objective 4:</u> To offer specialized trainings for professionals providing for suicide early interventions and post-suicide services such as with grief caused by suicides</p> <p><u>Objective 5:</u> To improve access to and</p>	<p>1. Educational materials developed that are culturally relevant (i.e. Omaha culture)</p> <p>2. Website developed for identifying suicide prevention resources that are culturally appropriate</p> <p>3. Implementation of a public information campaign designed to reduce accessibility of lethal means</p> <p>4. Educational programs developed for family members of youth identified at elevated risk for suicide</p> <p>5. Health care providers and health and safety officials educated on the assessment of lethal means in the home and potential actions to reduce suicide risk</p> <p>6. Individuals who provide services to suicide survivors trained to understand and respond appropriately to survivor’s unique needs</p> <p>7. Education offered for family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide</p> <p>8. Develop utilization management guidelines for suicidal risk in managed care and insurance plans</p> <p>9. Integrate mental health and suicide</p>	<p>The Suicide Prevention Work Plan will be initiated July 1, 2008 and will continue through June 30, 2011.</p>	<p>1. Increased community awareness of the impact of suicide to the individual, family, community, and culture</p> <p>2. Increased organization’s capacity to provide services</p> <p>3. Increased individual action for reporting suicidal discussion or behavior to service organizations</p> <p>4. Organization’s capacity to provide services is increased</p> <p>5. Enhanced community awareness of the impact of suicide to the individual, family, community, and culture increased</p> <p>6. Increased number of agencies involved in the initiative</p> <p>7. Developed plan focusing on addressing gaps in prevention and early intervention services</p> <p>8. Refined utilization management guidelines for suicidal risk in managed care and insurance plans are implemented</p> <p>9. Enhanced mental health and suicide prevention integration into health and social services outreach programs for at-risk youth</p>

<p><u>Goal 2:</u> To develop broad-based support for suicide prevention and early intervention activities that promote Omaha culture and incorporate familial participation</p>	<p>community linkages with mental health and substance abuse services</p> <p><u>Objective 1:</u> To organize interagency committees to improve coordination and to ensure implementation of the Initiative's strategies</p> <p><u>Objective 2:</u> To establish partnerships dedicated to implementing the Initiative's strategies</p> <p><u>Objective 3:</u> To increase the number of youth with underlying</p>	<p>prevention strategies into mental health and social services outreach programs for at-risk youth</p> <p>10. Specialized trainings for professionals providing for suicide early interventions and post-suicide services such as with grief caused by suicides</p> <p>11. Specialized trainings for professionals providing for suicide early interventions and post-suicide services such as with grief caused by suicides</p> <p>12. Utilization management guidelines for suicidal risk in managed care and insurance plans are implemented</p> <p>13. Mental health and suicide prevention are integrated into health and social services outreach programs for at-risk youth</p> <p>1. MOU's established to outline the responsibilities and commitment of each partner</p> <p>2. Plan increased preventative and early intervention services currently nonexistent in the community</p> <p>3. Suicide-risk screening incorporated in all youth primary care and services Increased numbers of youth with mood disorders will receive and maintain treatment</p> <p>4. Formal acceptance and implementation of evidence-based suicide prevention program in both public schools on the</p>	<p>10. Improved access to prevention, early intervention, clinical and support services</p> <p>11. Improved screening guidelines for schools, colleges, and law enforcement, along with guidelines on linkages with service providers are implemented</p> <p>1. Increased numbers of professionals, volunteers, and other groups that integrate suicide prevention activities into their ongoing activities</p> <p>2. Increased number of outside partners that adopt policies designed to prevent suicide through continuation of care issues</p> <p>3. Changed procedures and/or policies in certain settings, including the clinic and emergency departments, alcohol programs, mental health program, and various youth services settings, designed to assess suicide risk</p>
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	<p>mental disorders who receive appropriate mental health services and cultural support</p>	<p>Omaha Reservation</p> <p>5. Technical support center developed to build the capacity to implement and evaluate suicide prevention programs and initiative activities</p> <p>6. Screening guidelines defined and implemented for schools, agencies, and service institutions, along with guidelines on linkages with service providers</p> <p>7. Committee developed to develop the referral systems and policies reflecting specific protocol</p> <p>8. Committee meetings held to assist in transform community attitudes to view mental health and substance use disorders as real illnesses, equal to physical illness that respond to specific treatments, in the context of Omaha culture, and to view persons who obtain treatment as pursuing basic health care</p>	<p>4. Decreased stigma for suicide prevention efforts and related services, thus increasing the number of community members seeking services</p> <p>5. Established singular comprehensive suicide and early intervention plan</p> <p>6. Assurances created that youth treated for trauma, sexual assault, or physical abuse in emergency departments receive mental health services</p> <p>7. Further research conducted and a formal tribal Internal Revue Board (IRB) and integration plan of evidence-based suicide prevention programs for tribal programs effective in tribal communities</p> <p>8. Tribal suicide research agenda developed and disseminated</p> <p>9. Omaha-specific interventions established with demonstrated effectiveness for prevention of suicide or suicidal behavior</p> <p>10. Support programs implemented for youth who have survived the suicide of someone close</p> <p>11. Immediate therapeutic response created at local schools using a team approach</p> <p>12. Response plan developed for health professionals to address the affects of the suicide (i.e. counseling,</p>
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<p><u>Goal 3:</u> To develop an immediate community response and healing process to respond to suicides within the community</p>	<p><u>Objective 1:</u> Develop a community healing plan to respond to suicides within the community to promote healing and prevent additional suicides and/or health issues</p>	<ol style="list-style-type: none"> 1. Extended service hours expanded for families and community members 2. Spiritual and tribal leaders engaged to provide cultural ceremonies and support for family and community members for healing once a suicide occurs 	<p>medication, hospitalization, etc)</p> <ol style="list-style-type: none"> 13. Programs and services sustained for family and community members throughout the extended healing period 14. Clinical staff are better prepared to meet the needs of the community 15. Clinical staff are able to provide training to paraprofessionals and community members who will provide suicide support services and brief interventions <ol style="list-style-type: none"> 1. Increase the coalition partnerships to develop a singular comprehensive suicide prevention and early intervention plan 2. Integrated evidence-based suicide prevention programs are established in schools, college, tribal programs, and family, youth, and community service programs
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