# CULTURE-BASED INTERVENTIONS:

# THE NATIVE ASPIRATIONS PROJECT

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# PREFACE

The Native Aspirations Project was intended to support existing or innovative indigenous models of prevention (in addition to adapting and implementing existing evidence-based interventions). It was recognized that federal funding is increasingly dependent upon the evidence-based status of an intervention while the appropriateness of the evidence-based model is problematic for tribal communities (Native Aspirations draft End of Contract Report 280-05-0139 p.17).

The Native Aspirations Project conducted Community Mobilization and Planning (CMP) Events and then provided technical assistance to complete community prevention plans. A menu of Evidence-Based Interventions (which is outside the scope of this document) was offered to tribes. KAI also invited tribes to include pre-existing and innovative CBI and PBI as part of the project.

One Sky Center reviewed the *End of Contract Report* for mention of Culture- and Practice-Based Interventions in the community stories (between pp.41 and 42) and plans (Appendix W). We looked at existing efforts, barriers, mobilization efforts, technical assistance, and next steps and found 38 mentions of what appeared to be CBI or PBI goals and activities.

One Sky Center and Kauffman & Associates, Inc. discussed these findings and planned this document on 24 April 2007 in Spokane, Washington. Culture- and Practice-Based Interventions (CBI and PBI), with their safety and efficacy, would be identified and articulated within a scientific framework. One Sky Center would develop a scientific framework and marshal the evidence supporting CBI and PBI.

One Sky Center conducted telephone interviews with six of the nine sites. In view of the limited development and implementation of CBI and PBI at the sites, One Sky Center reviewed world-wide literature on indigenous CBI for youth suicide, bullying, and violence. One Sky Center also reviewed literature on the theory and practice of Evidence-Based practice in order to facilitate translation from the tribal reality. This work yielded a series of manuscripts the last of which was entitled *Describing Culture-Based Interventions for Suicide, Violence and Substance Abuse* (11 June 2008).

The present document now summarizes and applies *Describing…* to the CBI and PBI of the Native Aspirations Project.

## ACKNOWLEDGEMENTS

Preparation of this document was partially supported by a subcontract from Kauffman & Associates, Inc., for which we are very grateful. One Sky Center wishes to thank Kauffman & Associates, Inc. staff, Kauffman's grants project officer at the Substance Abuse and Mental Health Services Administration, Dr. Cynthia Hansen, and professor Ben Camp, MS Ed, Eastern Washington University School of Social Work and Alcohol/Drug Studies Program, who reviewed earlier drafts and made very helpful suggestions. The subject matter of this document is vast, sometimes ambiguous, and controversial. Opinions and errors found in this document are solely the responsibility of the authors.

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## INTRODUCTION

Interventions for youth suicide, violence, and substance abuse in Indian Country are conducted in a tribal environment in which “culture-based” interventions (CBI) are valued whereas the federal, state, and insurance industry emphasizes “evidence-based” interventions (EBI). The difference between the two perspectives creates some difficulties for American Indian/Alaska Native (AI/AN) entities when they seek regulatory approval and funding for services. Therefore, it is useful to describe CBI and supporting evidence in concepts and terms recognized and accepted by the scientifically oriented professional service and government community where regulatory approval and funding lie.

The purpose of this manual is to translate CBI into the language and scientific framework used in EBI and to apply the existing scientific knowledge base on youth suicide, violence, and substance abuse to CBI. The goal is to facilitate communication with a scientifically oriented professional service and government community, particularly when preparing grant applications or seeking reimbursement.

## YOUTH AND YOUTH DEVELOPMENT

“Youth” are between childhood and maturity phases of life, about 15-16 to 24-25 years of age. The “youth” phase of life is associated with developmental opportunities and challenges (e.g., family-making, training for employment, employment, and military service), as well as some notable social phenomena such as socio-political activism and gangs.

Youth are the parents, productive people, and leaders of tomorrow who are, today, in the process of developing social, moral, emotional, physical and cognitive competence to thrive and succeed. Young people build essential skills and competencies and feel safe, cared for, valued, useful, and spiritually grounded when their families and communities provide them with the needed supports and opportunities. Specifically, the outcomes of successful youth development are a sense of safety and structure; high self-worth and self-esteem; feeling of mastery and future; belonging and membership; perception of responsibility and autonomy; a self-awareness and spirituality; health; employability; together with civic and social involvement.

While normal youth development succeeds in the vast majority of cases, it does not always succeed. There are quite a few bumps along the road of normal youth development and a few disasters as well. Among the disasters are youth suicide, violence, and substance abuse.

## YOUTH SUICIDE, VIOLENCE, AND SUBSTANCE ABUSE

Youth suicide, violence, and substance abuse are a subset of many psycho-social ills with many shared causes and consequences besetting Indian Country.

**Suicide and Suicidality**. "Suicidality" consists of feeling depressed, thinking about suicide, taking a few very preliminary steps toward suicide, taking risks, and hinting at suicide. While milder forms of suicidality, violence, and substance abuse are pretty common characteristics of growing up, more severe forms require intervention.

Suicide is intentionally causing one's own death by such means as prescription drug overdose, illegal drug overdose, poisoning, hanging, drowning, jumping, shooting, cutting, piercing, immolation, etc. In addition there are fatal accidents which are, in effect, intentional self-destruction. There is exposure to high risk with intent to self-destruct, including police-assisted suicide. And there is long-term gradual self-destruction. Suicidal death is usually an end-point in a longer-term process including instigation, contemplation, checking the idea, desensitization, rehearsal, failed attempts, distress, and disinhibition (by alcohol, drugs, etc.).[1] Suicide typically has traumatic effects on family and friends or admirers—an estimated six persons per suicide.

For all ages world-wide, World Health Organization figures indicate that the rate of suicide is about 15 suicides per 100,000 people per year. The incidence is greater in some AI/AN communities and less in others.[2] For example, the 8-year

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[1] Joiner TE, Brown JS, Wingate LR. (2005). The psychology and neurobiology of suicidal behavior. *Annual Review of Psychology, 56*, 287-314,

[2] Chandler MJ, LaLonde C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry, 35*, 191-219. (Drs Chandler and LaLonde are leading Canadian researchers on this topic. See lists of related publications at: http://www.psych.ubc.ca/faculty/profile/index.psy?fullname=Chandler,%20Michael%20J.&area=Developmental&designation=emeritus http://web.uvic.ca/psyc/lalonde/research.html

incident rates for suicide among Aboriginal communities in British Columbia varied from zero to 120 per 100,000.[3]

**Violence: Teasing, Bullying and Harassment**. Youth violence ranges from "teasing," "bullying" or "harassment" through "assault and battery" to "homicide."

Harmful teasing, harassment or bullying (we'll call them all "bullying") is vastly more common but not as amenable to counting as are suicide, assault and battery, and homicide. There are many forms of bullying, a wide range of severity, and no coroners' or police reports from which to get counts (incidence and prevalence rates).

Bullying may involve disability-, ethnicity-, and other diversity-based discriminatory behavior such as systematic exclusion, ridicule, and rumor mongering. Bullying is often verbal, sometimes involving menacing, and painful-but-not-injurious assault and battery (e.g., "binging"). Consequences for the victims may be severe and lasting,[4] depending upon the severity of the bullying and the vulnerability of the victim. Among the serious consequences are extreme avoidance, internalization, or, alternatively, offensive defense and retaliatory tactics adopted by victims. Bullying does not have to involve injurious assault and battery to be deadly: suicides have been attributed to e-mail cyber-bullying.[5]

**Violence: Assault and Battery.** Youth violence also includes aggressive behaviors such as hitting, slapping, or fist fighting. School and gang violence are of particular concern. In addition to causing injury, youth violence undermines communities by reducing safety, interfering with normal peaceful activity, and burdening community institutions.

**Violence: Homicide**. More extreme levels of violence include homicide, such as young people beating their peers to death, knife attack and fights, and shootings. Although extremely rare, random, wanton, multiple-victim, hateful violence, and violence that invades school and family home sanctuaries are especially distressing to the community, motivating policy development, programmatic innovation, and public expenditure.

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[3] Chandler MJ, LaLonde C. (in press). Cultural continuity as a moderator of suicide risk among Canada's First Nations. In LJ Kirmayer, G Valaskakis. (Eds.). *Healing Traditions: the mental health of Canadian aboriginal peoples.* Vancouver, British Columbia, Canada: University of British Columbia Press.

[4] Jared's story. Available at: http://www.jaredstory.com/

[5] Center for Safe and Responsible Use of the Internet. Available at: http://www.cyberbully.org/

**Substance Abuse.** There are two reasons for bundling youth substance abuse together with suicide and violence. Substance abuse, itself, causes disability and death. Substance abuse also facilitates suicide and violence by reducing self-control (disinhibiting) and by stimulating aggressiveness. Furthermore, substances of abuse are important commodities in the commerce of crime. Finally, substance abuse is implicated in the majority of suicides and violence.

Youth substance misuse becomes abuse when amounts and patterns of consumption cause serious negative consequences. The harmfulness of substances of abuse includes acute toxicity, toxicity from chronic use, and dangerous method of administration. Societal harm includes consequences of intoxication (vehicle accidents, aggression, and sexual misadventures); detrimental effect on families (neglect of children, theft); and costs to social institutions (health care, enforcement, justice, and corrections).

Abuse can become a life-style which destroys normal youth development and, therefore, the *future of the people*.

## THE CULTURE-BASED VERSUS EVIDENCE-BASED ISSUE

Cultures have unique ideas about modes of knowing, validity of knowledge, and limitations of knowledge (epistemology). Western, evidence-based epistemology questions the validity of a traditional world view, the opportunity to live by that world view, and the right of self-determination while participating in the larger social enterprise (specifically, provision of health services).

Traditional culture-based interventions (CBI) are primarily based on “tradition, convention, belief, and anecdotal evidence”. Within the traditional society, these CBI are known and found compelling. Outside the traditional society, the cultural knowledge base is neither known nor appreciated. In addition, some traditional knowledge is considered to be sacred or to have special powers, per se, and may not be shared. Western research methods, per se, may be considered invalid, inappropriate, or even harmful to the interventions and the knowledge upon which they are based. The perspective and concerns of the world outside the traditional culture may be considered irrelevant.

The practical issue is funding and regulation of those culture-based health services: government and private funding sources are increasingly insisting upon EBI. Developers of behavioral health interventions must present evidence meeting certain criteria, in order to be recognized as a promising or model

program—and, therefore, able to generate revenue.[6] The evidence is reviewed by committees of scientifically-oriented professionals.

Federal grant agencies, state program funding agencies, and some private funding sources then require recognition as "promising" or "model" programs as a precondition for funding. In effect, the scientific perspective maintains control of interventions through the purse strings, whether or not a community agrees with the epistemology.

To help resolve this problem for traditional AI/AN communities, this document puts the description of CBI on the path toward NREPP recognition of promising and model programs. Translation of CBI for western audiences has been done before.[7] This document facilitates recognition and acceptance by the science-based service and government community with a "scientific framework" for describing CBI.

## EVIDENCE FOR INTERVENTIONS

Logical descriptions of CBI go a long way toward achieving recognition, understanding and approval of western, science-based audiences, including funding sources. While such description is, per se, a major advance toward understanding and approval, we also need to find evidence that the CBI is safe and that it works. This is an interesting and challenging task. AI/AN culture-based interventions involve the spiritual, which is not admissible in scientific frameworks or research. While the spiritual is not admissible, belief is manipulable, measurable, and the empirical relationship of belief to outcome variables like youth suicide, violence, and substance abuse is testable. So, CBI are amenable to scientific study and evaluable.

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[6] National Registry of Evidence-based Programs and Practices (NREPP). Available at: http://www.nrepp.samhsa.gov/about-evidence.htm

[7] White Bison. (2001). *Developing culturally-based promising practices for Native American communities.* Colorado Springs, Colorado: White Bison, Inc.

## THE "EVIDENCE" IN EVIDENCE-BASED INTERVENTIONS

Scientific research evidence is information obtained by research design, measures, and data analyses. There is a great deal of merit in looking to evidence-based services. However, a good understanding of evidence in the context of behavioral research and behavioral health treatment and prevention practice is also important.

A key concept in the recent western tradition of "evidence-based medicine," "model and promising programs," "best practices," etc., is that an *active ingredient* exists in each intervention/practice/program which may be discovered by *internally valid*, randomized controlled trials employing dependable measures of the intervention and the outcome (or end-point). Important, useful evidence is also found by methods other than controlled research, e.g. various qualitative designs; case study (story telling; community story telling); case control for rare incident studies; follow-back analyses of secular trends; and natural experiment (program evaluation, policy research).

The names of Best Practices (cf., NREPP list) sometimes seem to suggest that the active ingredient is somewhere in the words chosen for the name. However, the behavioral health interventions/practices/programs found in Best Practices lists are, in fact, frequently combinations of the same, often imprecisely described core components. Furthermore, the core components, themselves, consist of a multitude of "active ingredients" including "warmth," "expertise," "directiveness," "intensity," and other well known, fundamental aspects of most efficacious behavioral health interventions.

The characteristics of effective interventions are often *confounded* with the characteristics of effective research methods and measurement. For example, in the study of effective treatments, behavioral interventions tend to look good. But behavioral interventions, and behavioral outcome variables, and behavioral measures are correlated in ways other than the efficacy of the intervention (i.e., are *confounded*).

Surrogate measures (e.g., measuring attitude change as a surrogate for changes in rates of suicide because the former is more convenient to measure) are also a technical source of misunderstanding of effective intervention. Many interventions cause changes in the surrogate with no effect on the ultimate outcome/end-point, while some interventions have caused positive changes in the surrogate while causing unexpected negative changes in the ultimate outcome/end-point.

One source of misunderstanding about evidence supporting the effectiveness of interventions is statistical issues like sample and effect sizes. Another source of misunderstanding is "external validity" or "generalization." It is simply impossible to test a protocol for every set of conditions found in practice, so one cannot maintain a strict "evidence-based" criterion for acceptable interventions. One must fall back on the same reasoning used for Practice-Based and Culture-Based Interventions.

Altogether, the concept of "replication with fidelity" of an intervention consisting of an identified active ingredient (cause) with a measured outcome/endpoint (result) is a simply misunderstanding of the reality of science and of behavioral health intervention.

Several common components of behavioral health interventions, especially CBI, make research challenging:

- Choice is a powerful factor in making an intervention work, which rules out randomization in research design.
- Self-healing belief is guided by expert healers, which rules out "blinding" and "double-blinding" in research design.
- Guided development of unique interpersonal relationships is a crucial determinant of health and thriving, which rules out "control (of treatment conditions)" in research design.
- Complex webs of inter-related and reciprocal factors are not reducible to simple, linear causal models.

Understanding evidence-based interventions/practices/programs requires understanding the role of "adaption" in the dissemination, adoption, and implementation of "best practices." In addition to finding that EBI can be implemented among diverse groups, Miranda et al., note that interventions must be adapted to both subcultures and individuals. Adaptation for the local context (individual, community, and culture) includes engaging the interests (economic, social status, and other interests) of the stakeholders as well as their beliefs and conventions. In the end, every replication is and must be an adaptation.

The Surgeon General's Report[8] attributes at least 50 percent of a program's success, not to the protocol, but to aspects of implementation. Aspects of

[8] US Department of Human Services. (2001). Youth Violence: A Report of the Surgeon General. Rockville, MD: US Dept of Human Services. Pp. 123-124.

implementation include nature of the local problem, needs of the target population, receptiveness of the setting, leadership commitment, practical implementation tactics, and local ownership. The protocol is extensively reshaped by these local considerations.

## A SCIENTIFIC FRAMEWORK FOR COMMUNITY-BASED INTERVENTIONS

The Western scientific perspective emphasizes theory, deductive reasoning, mechanistic models, verifiable prediction, experimental testing, objective observation, and mathematical analysis of quantitative information. This perspective is referred to as the "scientific framework." The enormous material success of the scientific framework has led to its widespread acceptance and dominance in most sectors of life, including the regulation and funding of health services. Within this scientific framework, we have identified several models to help describe CBI: the ecological model, prevention models, a logic model, and operational manuals.

### AN ECOLOGICAL MODEL FOR UNDERSTANDING YOUTH SUICIDE, VIOLENCE, AND SUBSTANCE ABUSE

Ecology refers to the web of relationships among humans, animals, plants, natural forces, and land forms. To conceptualize the many forces driving youth suicide, violence, and substance abuse (especially the relationships among those drivers) public health professions use an ecological model. The basic ideas are that individual behavior is the result of interactions among the individual (throughout his/her life course) and sectors of his/her social environment. The social sectors are separated into those earliest/closest and those further away from the individual.

The contributing causes of youth suicide, violence, and substance abuse into four domains: individual; interpersonal (family, peer and other close relationships); community (including school, work, and local culture and social institutions); and the broader society (especially, the tribal and American Indian and Alaska Native cultures) (

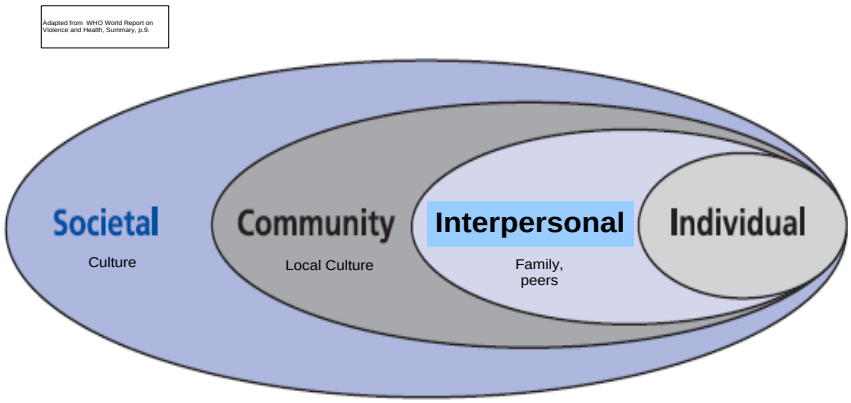


Figure 1). This is merely one way of picturing an ecological model; other configurations would do as well.

FIGURE 1. AN ECOLOGICAL MODEL FOR UNDERSTANDING YOUTH SUICIDE, VIOLENCE, AND SUBSTANCE ABUSE

## PREVENTION MODEL

Prevention is distinguished from treatment and rehabilitation in terms of *timing* of the intervention relative to the course of illness, injury or disorder. **Prevention** occurs before an illness emerges; **treatment** occurs when the illness emerges; and **rehabilitation** occurs after illness. Prevention is also a forward-looking *attitude* and *perspective*. That is, prevention involves looking forward to the next negative consequence to avoid and the next healthy option to pursue. **Primary** prevention is to prevent an illness from ever occurring (or to reduce the number that occur). **Secondary** prevention is to prevent an illness from becoming more severe or long-lasting. **Tertiary** prevention is to prevent long-term or severe disability from setting in after an illness. Even in the case of death, there are adverse consequences for the family, community, and culture to be avoided and healthy options to be pursued, if one is thinking preventatively.

In the last 10 years another prevention model has been adopted by the Institute of Medicine and federal agencies. This one focuses on the *target population* for a preventive intervention. **Universal** prevention is directed to an entire population or subpopulation before an illness occurs. **Selective** prevention is directed to a target population of people currently at significantly high risk of the illness. And **Indicated** prevention is directed to a target population of persons who currently have the illness, injury or disorder.

It is very helpful to identify which type of prevention one is using for youth suicide, violence, or substance abuse. The logic of universal (or primary) prevention strategy is very different from the logic of indicated (or rehabilitation or tertiary) prevention. The preferred universal prevention strategies are public education, school curricula, family strengthening, and environmental changes, while the preferred strategy for indicated prevention will often be intensive treatment. Similarly, the logistics are very different. Universal prevention involves a very large target population and the cost of the intervention per person must be very low.

## A LOGIC MODEL FOR CULTURE-BASED INTERVENTIONS

In the scientific framework, a program or intervention is diagrammed using a “logic model.” Logic models are vitally important for grant writing, as well as planning, project management, and program evaluation.

Most people have plausible but inexplicit theories about youth suicide, violence, and substance abuse and how to fix them. The purpose of a logic model is to make those ideas explicit, focused, and logically related.

The project theory can be represented in a general logic model as follows (Figure 2).

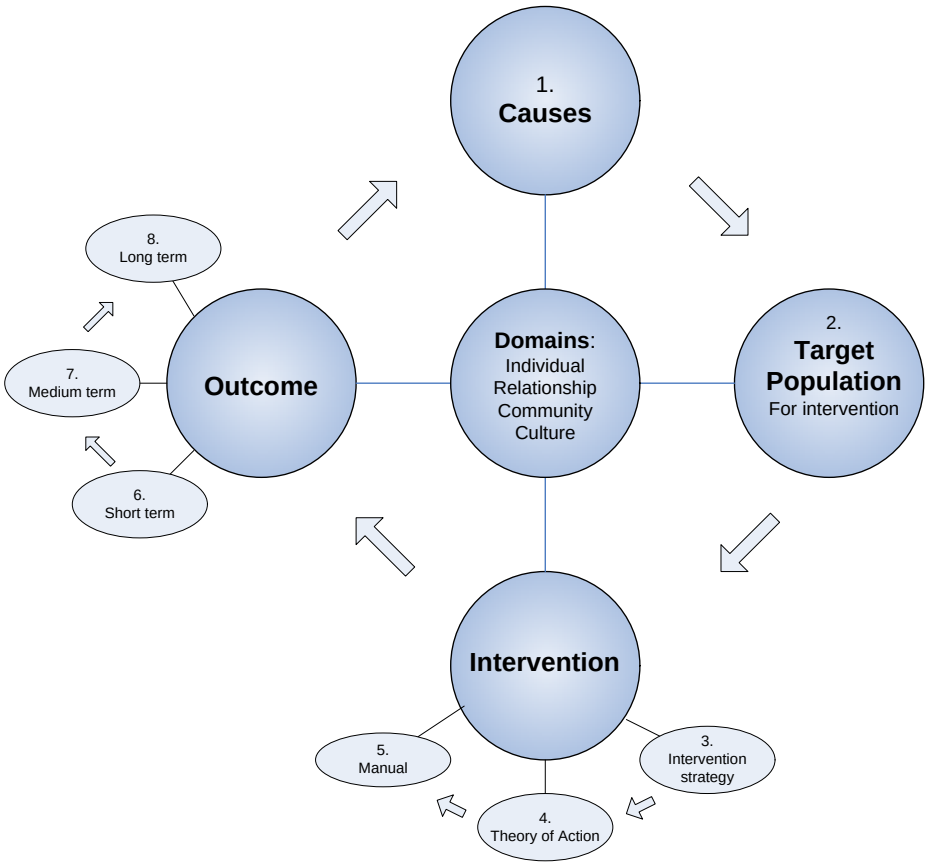


FIGURE 2. LOGICAL MODEL FOR YOUTH SUICIDE, VIOLENCE, AND SUBSTANCE ABUSE PREVENTION AND TREATMENT INTERVENTIONS

Logical description is an important mode of reasoning in a science-oriented community. Just by being phrased in the terms of this logic model, the CBI is justified (i.e., has face validity) to a funding and regulating community. Indeed, the majority of currently accepted, funded, Practice-Based western psycho-social Interventions (PBI) can claim little more than face validity, testimony, and anecdotal support—but they are described in a logically acceptable way.

How do we actually use the logic model (Figure 2) to help translate a CBI? The logic model can be expressed as a set of eight questions. Good answers to these questions yield grant proposals in the language of the science-oriented service and government community.

## CAUSES OF YOUTH SUICIDE, VIOLENCE AND SUBSTANCE ABUSE

*Introduction: There may be many causes of youth suicide, violence, and substance abuse. These causes may fall into individual, family, community and/or cultural domains.*

*For example: personality or character; mental illnesses like depression or soul sickness; substance abuse; isolation; unemployment; family conflict and disintegration; negative or negligent community attitudes; loss of culture with which to inspire and guide youth; institutional and official incapacity or corruption; infiltration and exploitation by criminal elements; etc.*

***"What causes of youth suicide, violence, or substance abuse is your CBI focused on?"***

## TARGET POPULATION

*Introduction: Many kinds of people, families, components of communities, and/or components of the culture, may be affected by—and affect—youth suicide, violence, and substance abuse.*

*For example: isolated persons; school-aged children; youth (16-24); school drop-outs; single parents; care-takers who have themselves been traumatized; urban migrants; the 10% of the people that have 90% of the problems; etc.*

***"Who/what target population is your CBI focused on?"***

# INTERVENTION STRATEGY

*Introduction (strategy): There are three ways of describing your intervention. First, your CBI uses a general strategy.*

*For example: Mentoring of youth by Elders; Talking Circles; Sweat Lodge ceremonies; Youth development; Community Healing ceremonies and rituals; Community assessment, mobilization and planning; Cultural restoration and renewal.*

***"Which kind of strategy does your CBI use?"***

## INTERVENTION THEORY OF ACTION

*Introduction (theory of action): This is the second way to describe your intervention. You understand that your CBI works by some mechanism; you have a theory about how or why it works ("theory of action").*

*For example, Wiping of Tears allows people to release their grief, emotionally let go of a dead person, and get on with life. Mentoring by Elders gives youth guidance in successfully navigating life's challenges and passages. Close monitoring and supervision mitigates violent peer norms.*

***"How does your CBI work? What is your "theory of action" about how the CBI addresses the causes of youth suicide, violence, or substance abuse for your CBI's target population?"***

## PROGRAM MANUAL

*Introduction (program manual or any how-to-do-it documentation): The third way to describe your intervention is by saying exactly what you do, step-by-step. Your CBI strategy consists of a number of separate steps, actions, or "how-to-do-it" instructions. These steps may be written down in an implementation plan or program manual.*

***"What are the steps in implementing your CBI? Do you have a manual?"***

# INTERVENTION STRATEGIES FOCUSED ON POTENTIALLY OR ACTUALLY SUICIDAL, VIOLENT, OR SUBSTANCE ABUSING INDIVIDUALS

Pursuing our logic model, we now discuss major intervention strategies (#3, Figure 2). Culture- and Practice-Based, as well as Evidence-Based Interventions fall into these strategies. Here they are grouped into domains of the socio-ecological model described above (

Figure 1), i.e., Individual; Interpersonal; Community; and Culture. We start with the Individual domain.

Some causes of youth suicide, violence, and substance abuse lie within individuals. Some people have something wrong inside them that drives them toward youth suicide, violence, and substance abuse. That something is a medical, developmental, or spiritual type of problem. Interventions in the individual domain identify individuals at risk and intervene to reduce their immanent or longer-term youth suicide, violence, and substance abuse potential.

## SCREENING AND GATEKEEPERS

An often recommended youth suicide, violence, and substance abuse prevention strategy is improved detection of suicidal potential among persons at immanent risk of youth suicide, violence, or substance abuse, usually with mental illness co-morbidity, followed by a supportive, guiding intervention, and referral to appropriate (i.e., sufficiently intensive and expert) care and treatment. Some strategies train and support “peer helpers” and some focus on breaking through the “code of silence.”

Youth suicide, violence, and substance abuse prevention plans pursue this strategy by systematic screening programs and by education and brief training for non-expert, lay persons in contact with an immanently suicidal person, especially when that person is isolated or masking suicidal motivation. Detection, supportive guidance, and referral are provided by friends, family and such other key observers as schools, law enforcement officers, etc.

Gatekeeper training programs are provided by, for example, **Question, Persuade, and Refer (QPR)**.[9] Mentoring programs, such as **Native Helping Our People Endure (HOPE)** [10] elaborate the on-going, supportive component.

Project HOPE trains youth in making commitments, strategic planning, and knowledge of traditional humor, spirituality, culture, risk and protective factors, hostility, violence, assertive life skills, communication with peers, developing and maintaining healthy relationships, and breaking the code of silence. Local facilitators are trained to lead the youth trainings. The facilitator's and learner's manuals are downloadable at the One Sky Center site.[11]

However, a meta analysis by the US Preventative Services Task Force found little evidence supporting use of screening instruments in primary care settings.[12] The base rate of suicide is extremely low, even in communities with suicides so frequent that community-wide trauma is experienced.

While the evidence on actual prevention of suicide and violence by screening and gate keeping may be weak and mixed, there is still potential for amelioration of the immediate cognitive, emotional, and behavioral problems of referred individuals. In addition, reducing the immediate youth suicide, violence, and substance abuse rate is not the only outcome. Persons trained and designated as gatekeepers experience increased health and thriving as a result of the attention they receive, secondary benefits of training, and the sense of responsibility and control inherent in the gatekeeper role. The community also benefits by the creation of opportunities for constructive roles aimed at securing a public benefit, as well as by creation of a means of processing community concern and grief. These outcomes, too, reduce youth suicide, violence, and substance abuse risk in the long run.

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[9] QPR Institute. Site with printed materials and other resources at: http://www.qprinstitute.com/.

[10] Small C, Big Foot E. *Native H.O.P.E.* Available at: http://www.oneskycenter.org/education/publications.cfm

[11] Small C, Bighorn E. (no date). *Training of facilitators manual. Native youth training manual.* Portland, OR: One Sky Center. Available as downloads: http://www.oneskycenter.org/education/publications.cfm

[12] U.S. Preventive Services Task Force. (May 2004). *Screening for Suicide Risk, Topic Page.* Rockville, MD: Agency for Healthcare Research and Quality, http://www.ahrq.gov/clinic/uspstf/uspssuic.htm

## TREATMENT OF MENTALLY ILL, SUBSTANCE ABUSING, AND VIOLENT OR SUICIDAL INDIVIDUALS

Screening programs and gatekeepers refer suicidal, violent, or substance abusing persons to expert care and treatment, as do school counselors, law enforcement personnel, courts, family, friends, and individuals themselves. The clearest of youth suicide, violence, and substance abuse prevention strategies is improving treatment of individual cases of mental illnesses, crises, and emergent suicidal process.

An international team of suicide experts did an extensive review and evaluation of the literature on suicide prevention (reviews, meta-analyses, quantitative studies, randomized controlled trials, cohort studies, ecological studies, and population-based studies).[13] The evidence indicated that education of treatment personnel in depression recognition and treatment and the tertiary/indicated prevention strategy of restricting access by a suicidal person to lethal means prevented suicide. This appears to be the most strongly evidence-based approach to suicide prevention.

While a suicidal event surprises as well as shocks, death is often just the end point in a longitudinal process. The sub-acute phase leading to suicide may extend over many years. As the acute phase leading to suicide emerges, there are often signals, preparations, multiple attempts, and signs of escalating distress. This suicidal process may be detected among persons already identified as mentally ill, especially those with depression. Somewhere along this pathway, an intervention may be made: treatment to reduce the immanent risk of youth suicide, violence, or substance abuse.

Care may include hospitalization or other intensive monitoring and supervision; separation from lethal means; crisis intervention; etc. Treatment may include medication; listening, supporting and understanding; cognitive behavioral therapy; group therapy; etc. It takes extraordinary skill and dedication to provide this intervention and “compassion burn-out” is a serious problem. Even well-trained therapists sometimes shy away from indications of suicidality.

The US Air Force suicide prevention program includes a treatment strategy (together with an organizational climate change similar to “healthy schools”).

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[13] Mann JJ, et al, an international team of 22 national suicide researchers and experts, plus a senior WHO representative. (2005).Suicide prevention strategies: a systematic review, *Journal of the American Medical Association, 294(16),* 2064-2074

Strong evidence supports its preventive impact on suicide, moderate-to-severe family violence, and homicide outcomes.

The "Matrix" program[14] incorporates a number of interventions into a comprehensive, intensive outpatient treatment program which has been successfully used for drug and alcohol problems in Indian Country. Such treatment is appropriate for individuals at risk of youth suicide and violence, but not actively suicidal. It is an example of secondary prevention.

Motivational Interviewing is a cultural adaptation of the established protocol[15] itself a further development of the stages of change model. [16] Manual downloads are available at the One Sky Center site. [17]

AI/AN healing includes beliefs, practices, botanical medicines, religion, spirituality, and rituals of several hundred AI tribes and AN villages. AI/AN traditional healing and medicine means "practices… shaped by long-standing cultural world-views and values."[18] It is concerned at least as much with prevention as curing. Where curing illness and repairing injury have done all they can, traditional healing provides reconciliation to the natural course of life including morbidity and mortality. Religion and spiritual matters are completely intertwined with health. Principal goals are balance in the four realms of spiritual, emotional, mental and physical health; following a cultural path; and sharing in the cycle of life.[19] Purification, cleansing, and cognitive change are central themes.

Spirituality of AI/AN people is crucial to their CBI, as to everything in the traditional AI/AN way of life. Traditional belief is that everything has a spirit—

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[14]Matrix Institute on Addictions. Site and materials available at: http://www.matrixinstitute.org/

[15] Miller WR, Rollnick S. (2002). *Motivational interviewing: preparing people for change (2nd ed.).* New York, NY: Guilford Press.

[16] Prochaska JO, Norcross J, DiClemente CC. (1994). *Changing for good*. New York, NY: Avon.

[17] Tomlin K, Walker RD, Grover J, Arquette W, Stewart P. (no date). *Motivational interviewing: enhancing motivation for change—a learner's manual for the American Indian/Alaska Native counselor. American Indian trainer's guide to motivational interviewing.* Portland, OR: One Sky Center. Available as downloads: http://www.oneskycenter.org/education/publications.cfm

[18] Johnston SL. (2002). Native American traditional and alternative medicine. *Annals of the American Academy PSS, 583*: 195-213.

[19] Hunter LM, Logan J, Goulet JG, Barton S. (2006). Aboriginal healing: regaining balance and culture. *Journal of Transcultural Nursing, 17(1).* 12-22.

celestial bodies, flora, fauna, inanimate objects (like rocks), and people. These spirits exist both in a spirit world and in the observable, material world. Knowledge is received from the spiritual world, as are healing influences. A state of harmony with the spirits is sought—good health and thriving depend upon it. Connection to the spirit world is a sophisticated religious practice of healers.

Healers' recommendations to patients include life-style changes; offerings to spirits; diet; improved knowledge of language and culture, meditation, and engaging in certain treatments. The outcome of the diagnostic process is focus, expectations, commitment, and mobilization of effort (which is also the goal of western Motivational Enhancement Therapy).

Goals of AI/AN traditional medicine and healing are wholeness, balance, harmony, beauty, and meaning,[20] spiritual well-being, restoration of emotional and physical health and well-being. Traditional healing and medicine confront imbalances, negative thinking, and unhealthy lifestyle. The outcome is restoration of well-being and harmony, and change of thought, feeling, and behavior. In particular, indigenous medicine has the task of healing emotional pain. If anything, AI/AN healing is more concerned with behavioral health than physical, although that distinction is not made. Healing also aims to alleviate the alienation of illness and to achieve reintegration. It focuses on healing the person (or community) even more than curing a disease.

Exposed to many traumas and much pain, and with little access to western medicine, even for the illnesses, disorders, and injuries with which western medicine does best, AI/AN peoples have had to rely on traditional healing and medicine by default. In dealing with disease, the goal may not be a cure. A good transition into the next world is important, even when mortality cannot be prevented. (In western medicine, this is the goal of palliative care.)

Health means a person has a sense of purpose, follows inner guidance (inscribed by the Creator); walks on a path of beauty; balance; harmony; has good thoughts; is grateful, respectful and generous.[21] One concept of illness is fragmentation of the soul with some parts lost to another dimension or reality or world. This soul illness is very much a part of substance abuse, youth suicide, violence, and substance abuse. The goal of soul healing is to attract back those fragments. Because illness is a matter of morality, balance, and spiritual forces,

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[20] Cohen K. (November, 1998). Native American medicine. *Alternative Therapies in Health & Medicine, 4(6),* 1-23.

[21] Cohen K. (November, 1998). Native American medicine. *Alternative Therapies in Health & Medicine, 4(6),* 1-23.

not all presenting problems are treatable. Some are nature's retribution (for disrespect or violation of taboos). Some are an expression of self-centeredness, imbalanced living, or feeble constitution. Some illnesses are imposed by sorcerers or non-human evil entities. Some illnesses involve the intrusion of supernatural objects. Other illnesses initiate passage to a higher level of being or a new role.

Diagnosis rests on experience and acute observation, while the more overt adjuncts to diagnostic procedures include communication with spirits, sacred bundles, pipes, masks, etc. Intuition, sensitivity, and spiritual awareness are key assets of traditional diagnosticians. The healer engages the patient by explaining his/her philosophy, plausible causes of illness, and acceptance of offerings and gifts. Among the causes a diagnosis may reveal are discord in prominent social relationships, e.g., male/female.[22] Other causes are cruel words, abusive behavior, and violence. Failure to love and care for one's spouse and children, and desertion of them, are taboo violations causing illness in the person, community, and tribe.

Treatment includes teaching, mentoring, counseling; ritual, ceremony, prayer, songs; energy work; lying on of hands; smudging; community ceremonies (e.g., chanting, singing, dancing, and sweat lodge); and botanicals. Traditional practitioners use the most powerful intervention known to any healing practice: skillful and effective use of the well-known but sometimes misunderstood, powerful "placebo" effect.

Prayer helps to focus the mind on harmony and balance among all things, free of anger, fear, and strife. Music invokes ideas and its rhythm entrains the mind. Smudging affects consciousness, feeling, and sensitivity through the ritual, possibly potentiated by the aerosols. Oral and topical application of botanicals also involves rituals, and active ingredient in addition to the activity of the substance per se. Massage is used in a fashion more like acupuncture than sports medicine—it helps to visualize the disorder and the healing process.

Counseling may be potentiated by sacred venues like ceremonial lodges and associated sacred rituals. Ceremony affirms cultural values and identity, and involves communication with spirits, placating them, and gaining release from their perceived controlling influence. A sweat lodge ceremony can overcome avoidance, denial, and get the patient back in touch with primal wisdom.

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[22] Quintero GA. (1995). Gender, discord, and illness: Navajo philosophy and healing in the Native American Church. *Journal of Anthropological Research, 51,* 69-89.

Mehl-Madronna[23] identified eight principles of traditional healing: healing takes time and time is healing; healing takes place within the context of a relationship; achieving an energy of activation is necessary; systems are isomorphic (biological, psychological, cosmic); self-discovering in peace and quiet (avoidance of distraction); awareness of emotions; bed rest; and ceremony.

AI/AN culture is also used as a partner in western medicine and healing. It is used to create expectancy and engagement of patient and healer and family and community. Controlled research showed that spiritual healing sessions are effective in creating high expectations in both healer and patient (versus controls) and, subsequently, greater improvement in objectively evaluated medical outcomes.[24]

Culture-specific elements of youth suicide, violence, and substance abuse prevention interventions aim to make members of the indigenous culture feel valued, included, empowered and responsible—these are an off-set to historic marginalization and oppression. Culture-specific elements tailor interventions by means of culturally appropriate language (e.g., passages of text, speech in indigenous words); terminology (e.g., “all my relations”); traditional graphic elements (e.g., use of circles more often than lines; use of symbolic feathers); significant items of traditional dress (e.g., ornamentation); concept-laden symbols (e.g., medicine wheel); ceremonial music (e.g., drumming); culturally-specific forms of common social process (e.g., diplomatic protocols for expressing honoring and respectfulness); social institutions (e.g., powwow); references to social structure (e.g., importance of lineage, clan); ideas of spirituality and universal relatedness, etc.

Culture-specific elements of youth suicide, violence, and substance abuse prevention respond to the culturally unique meanings of youth suicide, violence, and substance abuse, identify and address the culturally unique risk and protective factors, and identify and utilize/accommodate the culturally unique interventions (and opportunities to create such interventions).

Adaptation of treatment interventions include dealing with causes of youth suicide, violence, and substance abuse unique to the circumstances of many AI/AN communities, and taking advantage of treatment modes that are believed in by members of those communities. Healing from loss, recovering from trauma,

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[23] Mehl-Madrona LE. *Traditional [Native American] Indian medicine.* Available at: www.healing-arts.org.

[24] Wirth DP. (1995). The significance of belief and expectancy within the spiritual healing encounter. *Social Science & Medicine, 41(2),* 249-260.

healing from sexual abuse, and transforming normalized “co-dependent” thinking processes are required for many suicidal members of AI/AN communities. The 12-step process of Alcoholics Anonymous is a well-known protocol which underlies a number of interventions for the target population of suicidal persons. Discovering and rebuilding individuals’ cultural identity through flute playing, working with horses, traditional meditation, and mentorship are unique opportunities that AI/AN cultures provide for individual treatment of at risk persons. Others include: Story Telling, Sweat Lodge; and Talking circle.

**Telling stories** is powerfully healing and instructive. Many are now posted on the internet. They need little or no interpretation, ritual, musical or other adjuncts to have their impact. However, the telling of stories (as opposed to simply reading them) carries additional impact related to the story-teller (e.g., grandmother, medicine person) and the setting (e.g., family living room, community lodge).

A **sweat lodge** ceremony is a widely used and flexible ceremony that involves steam generated by hot rocks in a dark enclosure. Water, sometimes including herbs, is applied to the hot rock by a medicine person who also leads the ceremony. The ceremony includes the medicine person, subject, relations, and guardians. The sweat lodge has spatial orientation (four directions, spirit world), is constructed to hold in heat and be dark. There is an important etiquette. The ceremony is a tangible and decisive commitment to accomplishing something, and requires fortitude. The outcome is physical and mental experiences (purification, renewal, and fresh start), affirmation of an individual’s sense of personal, and cultural identity.

The **talking circle** is a group activity which enables orderly expression, unburdening, and consolation. The circle is a symbol of connectivity and completeness. The outcome is emotional and social healing. (Western group therapy and support groups operate in a similar way for similar purposes.)

The **vision quest** begins with a premise that individuals are put on the earth for a reason, but the reason is often unclear. The vision quest is a very serious, arduous journey into the spirit world to learn what that purpose is. It involves extensive preparation and guidance from a medicine man. Symbolic objects are made or gathered, prayers are said and a mind-set created, a ceremony is held, and the supplicant is taken to a certain spot where he remains for a given period of time during which he prays and has visions. Then he is brought back to share the vision with the medicine man and to integrate the experience into his life.

## CAPACITY FOR TREATMENT AND PREVENTION FOR AT-RISK INDIVIDUALS

Of course, **capacity** is the elephant in the room. There is far less capacity (i.e., sufficient numbers of sufficiently expert personnel) than needed in most AI/AN locales. In some locales, especially small, rural, AI/AN communities, expert treatment and care are almost non-existent. It is obvious that greatly increased capacity (i.e., funded positions) is required to meet the need for behavioral health services dealing with depression, substance abuse, and behavioral problems. For example, May described ramping up the capacity in the Navajo Nation over a 10 year period.[25]

This cultural intervention consisted of comprehensive health services developed and delivered over a 10 year time period, begun as an Adolescent Suicide Prevention Project. Upon community input, it broadened to address the complete array of underlying issues. It obtained active involvement of the community in assessment and planning, ultimately being institutionalized as a tribal behavioral health department. Interventions included education and awareness raising; identifying and monitoring risks; identifying high-risk persons and families; outreach/screening/intervention in service institutions and social venues; school-based life skills and other interventions; natural helpers for advocacy, referral and non-professional counseling; and professional mental health delivered in community settings. The capacity was increased over the period from 1.2 full time equivalents (FTE) to 57 FTE. Outcomes were reduced suicide gestures and attempts.

Increased numbers of funded personnel positions is not an easy solution. Another solution is to increase the productivity of existing personnel. The capacity gap is so huge and so crucial, that increased youth suicide, violence, and substance abuse prevention training for existing personnel can be considered a system-wide strategic imperative, per se.

In-service training increases productive capacity of existing personnel. The state of Alaska is implementing a promising approach to increasing capacity through its **village behavioral aide** program. Persons employed by the health corporation are provided with comprehensive manuals and trained by the

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[25] May PA, Serna P, Hurt L, DeBruyn LM. (2005). Outcome evaluation of a public health approach to suicide prevention in an American Indian tribal nation. *American Journal of Public Health, 95(7),*1238-1244.

University of Alaska.[26] The manualization, training program, certification, and employment components of this program are highly promising.

Technical assistance also increases the productive capacity of existing personnel. **Public-academic liaison** (PAL) programs, originally sponsored by the PEW Memorial Fund, have successfully infused expertise into local treatment services. Direct consultation assists with individual cases, while behavioral health providers in training at the universities also learn to appreciate the local communities and some later choose to work there. The University of British Columbia, with support from the Ministry of Health, has run a highly successful PAL for many years. Many manuals on behavioral health and youth suicide, violence, and substance abuse prevention for Aboriginal peoples are posted on the UBC website.[27]

**Telemedicine** is also being used at Fort Belknap reservation, Montana, and in rural California. Telemedicine brings tertiary level expertise to sites having only primary care services. Diagnosis and care planning are a major contribution to local capacity to manage and treat youth suicide, violence, and substance abuse cases.

Bottom line: Identification, mentorship, referral of persons at risk of youth suicide, violence, and substance abuse are established youth suicide, violence, and substance abuse prevention interventions. Treatment by the specialty service sector is the most strongly evidence-based tertiary/indicated preventative intervention for youth suicide, violence, and substance abuse. However, the strongest evidence is for a beneficial impact on short-to-medium term outcomes: cognitive, emotional, and behavioral outcomes.

## INTERVENTION STRATEGIES FOCUSED ON THE INTERPERSONAL DOMAIN

Some causes of youth suicide, violence, and substance abuse lie within the interpersonal domain—peers and families. Families are also the victims of youth suicide, violence, and substance abuse. Countering, or positively transforming

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[26] Alaska Native Tribal Health Consortium behavioral aide program. Available at: http://www.anthc.org/cs/chs/behavioral/behavioralhealthaidematerial.cfm

[27] University of British Columbia, Division of Aboriginal People's Health. http://www.familymed.ubc.ca/aph/resources.html

peer group norms, is typically the focus of innovative social activists, Boys and Girls Clubs, youth development, service-learning and similar programs. Some families need support and strengthening, especially, in delivering adequate child care, but also in spouses caring for each other. That support and strengthening is typically a focus of social work, whether as a public or religious service. Supplementation of parental nurturance and guidance is typically a focus of school counseling and behavioral psychologists.

## PARENTING AND FAMILY SKILLS

Parenting is extremely important to the healthy functioning and development of a child. Culture provides guidance and parents provide a model together with close monitoring and discipline. When either are lacking or distorted, unhealthy behavior patterns may be transmitted and unhealthy behavior may be instigated. For example, parental neglect and abuse is a risk factor for a child's youth suicide, violence, and substance abuse. Even average parenting skill may be insufficient to protect the child against toxic environments outside the family, for example, bullying at school, or peer norms of risky behavior. Challenging child behavior can also overwhelm a parent's capacity to respond in a positive, constructive manner. Parent skill training can put the parents back in charge and help reduce the child's risk for youth suicide, violence, and substance abuse and to improve health and thriving.[28] [29] Parent skill training is prominent among model programs for youth suicide and violence.

The model program, **Multi-Systemic Family Therapy**, is one of the best known parental skills interventions. The original goal of Multi-systemic family therapy was to improve behavior of offending youth. However, the intervention deals with the broad spectrum of unhealthy behavior, including those increasing the risk of youth suicide, violence, and substance abuse. Interventions typically aim to improve caregiver discipline practices, enhance family affective relations, decrease youth association with deviant peers, increase youth association with

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[28]Kumpfer KL, Tait CM. (April 2002). *Family skills training for parents and children.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention. Available at: http://www.ncjrs.gov/pdffiles1/ojjdp/180140.pdf

[29]Besaw A, Kalt JP, Lee A, Sethi J, Wilson JB, Zemler M. (August 2004). *The context and meaning of family strengthening in Indian America.* Cambridge, MA: The Harvard Project on American Indian Economic Development, John F. Kennedy School of Government, Harvard University.

pro-social peers, improve youth school or vocational performance, engage youth in pro-social recreational outlets, and develop an indigenous support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes. Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including cognitive behavioral, behavioral, and the pragmatic family therapies.[30] **Functional Family Therapy**, another model program, also changes and strengthens family behavior patterns, while the **Early Childhood Home Visitation** program mitigates maltreatment, abuse, and neglect in order to prevent the development of youth violence later on.

## POSTVENTION

”Postvention” (aka, Crisis Response Plan) is the most likely first step at the local level, because youth suicide and violence tend to be the alarm that gets people’s attention and motivates them to act. The community responds spontaneously to a tragic loss—someone comforts and assists the victims and survivors. Postvention builds upon that naturally occurring protocol by planning in advance of an incident, planning a systematic and systemic response, and applying evidence to the design of the response plan.

Postvention is influenced by evidence on averting common, maladaptive responses to youth suicide and violence (for example, isolation of the survivors, and unrelenting demands upon affected care-givers). The immediate outcomes of postvention are relieving the distress of those affected by youth suicide and violence including family, friends, and care providers who may all be traumatized, especially in the case of multiple or cluster youth suicide, bullying, and violence. Postvention provides immediate relief, enables people to carry on and prevents the trauma from turning into handicaps typical of youth suicide and violence survivors. AI/AN communities often have resources and traditions for postvention including, customary help and support of extended families, cleansing ceremonies for discharging grief, and ways of interpreting loss. Youth suicide, violence, and substance abuse prevention in AI/AN communities includes rediscovering and facilitating the employment of these traditions.

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[30] *Multisystemic Therapy: Treatment Model.* Available at: http://www.mstservices.com/text/treatment.html

One such protocol is **Wiping the Tears** for grieving and emotionally letting go of the dead. The Wiping of the Tears ceremony is a ritual meant to release the spirits of the dead and heal the grief of survivors.

Postvention also prevents contagion by finding and treating high risk cases associated with the youth suicide and violence, and by redirecting survivors' grief into community mobilization. The risk of contagion may also be reduced by putting motivations and consequences into perspective by means of debriefing sessions.

Bottom line: Teaching parents to effectively raise children, to deal with challenging child-rearing issues like peer pressure, substance abuse, school failure, and risky behavior, and to maintain nurturing environments for the child are effective preventative interventions. Reducing family dysfunction and preventing family break-down by family therapy is an effective youth suicide, bullying, and violence preventative intervention. Postvention for families (and other caretakers) in the wake of a youth suicide and violence is an effective prevention of further youth suicide, violence, and substance abuse.

## PUBLIC HEALTH INTERVENTION STRATEGIES

Public health strategies bridge between strategies focused on the individual/interpersonal domains, on the one hand, and strategies focused on the community/cultural domains, on the other. Public health strategies are more influenced by the disease model of western medicine than are the community/cultural domains which we return to in the next section. The public health strategies focus on changing the immediate external causes and moderators of youth suicide, violence, and substance abuse.

### RISK FACTOR REDUCTION

A central public health approach is reducing exposure to risks. We refer here to a strategy aimed at broad subpopulations such as school children, new parents, and new retirees. SAMHSA offers a manual for building resilience and reducing

exposure to risks among young children, *Building Blocks for Healthy Futures*.[31] Similar strategies may be targeted on subpopulations at higher risk: persons in contact with family services or law enforcement or justice.

Reducing exposure to risks can be achieved by **removing** the risk (e.g., closing down drug houses); by **shielding** the people at risk from the source of risk (e.g., establishing, monitoring, and enforcing rules); and by **warning** the people at risk about the risk (e.g., public education).

Many risk-reduction interventions for behavioral health problems are based on the theory that individuals make **decisions** based on **information**. Prevention of unhealthy diet and lifestyle, substance abuse, risky sexual behavior, dangerous driving, suicidal impulse, bullying, violence, etc., includes providing information on consequences of risky behavior and methods of dealing with that risk.

One means of reducing exposure to risks is **public education** (aka, **social marketing**). Such campaigns use media, posters, lectures, and promotional events to raise awareness of risk; encourage risk avoidance in the general public; and mobilize the community's front-line institutions (schools, churches, workplaces, law enforcement, justice, and corrections) to eliminate risks. This public education approach is well known in its use to promote better diet and exercise and to discourage tobacco and excessive alcohol use.

Professional social marketers employ the technologies of commercial advertising to achieve the objective in national campaigns. However, local campaigns take advantage of local communication methods about how to get out a message tailored to the local gestalt.

Public education is favored in national and local strategic prevention plans because it is a well-understood protocol; it is relatively easy and economical; and because it gives the youth suicide, violence, and substance abuse prevention agency a high public profile.

Evidence on the efficacy of public education and social marketing is mixed. It is known for some spectacular failures (e.g., "reefer madness" and many sex scare materials for classrooms) but also some successes (e.g., awareness of HIV/AIDS risk management).

It is now thought that peer pressures are a very important driver of unhealthy diet and lifestyle, substance abuse, risky sexual behavior, dangerous driving,

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[31] *Building blocks for a healthy future: trainer's manual.* Available at: http://www.bblocks.samhsa.gov/media/bblocks/FacilitatorsManual.pdf

suicidality, and violence. The normal developmental process involves a transition from the controlling influence of parents/family through a period of predominantly peer influence, followed by the larger influence of the family which the individual forms him/herself. The period of predominant peer influence is risky, involving support for exploration of opportunities and reduced awareness of and regard for hazards and moral obligation. This is exacerbated by parent influences which have been weakened by family dysfunction or break-up. Risk-reduction includes shortening exposure to unsupervised peer influence. Related interventions include teaching resistance and refusal skills (e.g., the **Iowa Strengthening Families** and **Preparing for Drug-Free Years** programs). Finally, peer norms are changed to be less risky by means of adult-led youth groups (e.g., Cubs, Scouts, and Guides).

## PROTECTIVE/RESILIENCY FACTOR ENHANCEMENT

Another central public health approach is strengthening resiliency and establishing protective factors in the community. The enhancement of protective/resiliency factors is one of the most frequently used approaches to youth suicide, violence, and substance abuse prevention. The theory of action is that people are subject to many and continuous reasons to choose not to live, or not to live well—losses, failures, disappointments, hardship, etc. It takes resilience to carry on living despite these adversities. Resilience comes from personal attitudes, social bonds, obligations, support, coping skills, continuity of identity, engagement in ongoing activity, etc. The protective/resiliency strategy builds up these elements.

**Mentoring** (elder to youth): Elders pass on culture via stories, advice, values, rules/guidelines for living, and a personal connection with the past. Raudenbush and Hall developed a protocol for this intervention called "Wisdom Teachings: Lessons Learned from Gathering of Elders."[32] The National Football League Players Association and Johns Hopkins Center for American Indian Health holds an annual **Native Vision Sports and Life Skills Camp**. AI/AN youth are taught sports by the professionals and engage in festivities. The messages to youth are stories of personal hardship, courage, and victory. Native leaders participate to encourage citizenship, respect of elders, and Indian pride. The **Career and Life Skills Curriculum** of the Native American Achievement Program at Arizona State University encourages achievement of academic goals, determination of

[32]Raudenbush S, Hall M. (2005). *Wisdom Teachings: Lessons Learned from Gathering of Elders.* 1667 Snelling Avenue North, Suite D300, Saint Paul, MN 550108: National Leadership Council.

career goals, attainment of leadership skills, and development of personal life skills. The outcome is persistence and graduation.[33]

Techniques for resisting peer influence and asserting healthy self-interest are taught by the NREPP model program, Zuni/American Life Skills Curriculum.[34] It teaches and instills coping and life skills which, the theory of action explains, displace and counter the negative forces driving substance abuse, risky sexual behavior, dangerous driving, suicidality, and violence. Others include **Promoting Alternative Thinking Strategies**; **I Can Problem Solve**; **Al's Pals**; **Improving Social Awareness-Social Problem Solving**; **Peer Coping Skills Training**; Social-Moral Reasoning Development Program; and **Viewpoints**.

The **Zuni/American Indian Life Skills Development curriculum** is a school-based, culturally tailored, suicide-prevention curriculum.[35] It teaches communication, problem solving, management of stress and depression, anger regulation, and goal setting skills. It also increases knowledge of suicide. Methods are informing, demonstrating skill, and feedback on student performance. Outcomes are reduced suicide probability and hopelessness, increased problem-solving and suicide intervention skills. A manual is available.[36]

The **Canoe Journey**[37] is based on a tradition of making and operating large coastal canoes. It uses a combination of life skills, activity, and community

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[33] Hammond R. (2003). *The career and life skills curriculum of the Native American Achievement Program at Arizona State University.* Bethlehem, PA. National Association of Colleges and Employers.

[34]Zuni Life Skills is available at the Suicide Prevention Resource Center website: http://www.sprc.org/

[35] LaFromboise TD. (1995). The Zuni Life Skills Development Curriculum: description and evaluation of a suicide prevention program. *Journal of Counseling Psychology, 42(4)*, 479-486.

[36] LaFromboise TD. (1996). *American Indian Life Skills Development Curriculum.* University of Wisconsin Press.

[37]Marlatt GA, Larimer ME, Mail PD, Hawkins EH, Cummins LH, Blueme AW, Lonczak HS, Burns KM, Chan KK, Cronce JM, La Marr J, Radin S, Forquera R, Gonzales R, Tetrick C, Gallon S. (2003). Journeys of the Circle: a culturally congruent life skills intervention for adolescent Indian drinking. *Alcoholism: Clinical & Experimental Research, 27(8)*, 1327-1329.

involvement. The eight week skills course teaches communication, decision-making, goals-setting, and other skills. A manual is available.[38]

Natural experiment and case study methods have provided scientific evidence to prove the safety and effectiveness of a number of CBI, resulting in NREPP recognition for some, including Project Venture, a service learning program. **Service Learning** is a primary/universal preventative intervention for individual youth who do not have elevated risk factors for youth suicide, violence, substance abuse, or mental illness. Examples include the NREPP model program, Project Venture,[39] Tribal Service Learning Manual,[40] and various Boys & Girls programs.

The Service Learning theory of action is that giving to the community (i.e., service) develops moral character, constructive habits, and a lasting emotional attachment to the community. In addition to the bonding aspects of service learning, these projects provide activity, challenge, and skill development.

**Project Venture**[41] [42] is a cultural adaptation of the youth development movement's "service-learning" intervention by the National Indian Leadership Development Program[43] which achieved SAMHSA "model program" status.[44] It consists of an experiential, learning-based program which challenges youth to deliver community service. Outcomes include a developed sense of community

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[38] La Marr J, Marlatt A. (2007). *Canoe Journey Life's Journey. A Life Skills Manual for Native Adolescents.* Facilitators Guide with CD ROM. Hazelden.

[39]Project Venture. Available at: http://niylp.org/programs/project_venture

[40]Corporation for National Community Service. *Tribal director's manual.* Available at: http://www.servicelearning.org/nslc/tribal_dir_manual/index.php

[41] Carter S, Straits KJE, Hall M. (2007). *Project Venture: evaluation of an experiential, culturally based approach to substance abuse prevention with American Indian youth. Journal of Experiential Education (no volume, issue),* 1-4.

[42]Native Indian Youth Leadership Program. http://niylp.org/programs/project_venture

[43]Native Indian Youth Leadership Program http://niylp.org/about

[44]Project Venture NREPP Description: http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=146 . http://casat.unr.edu/bestpractices/view.php?program=135

responsibility and ownership. Instructions for obtaining the program replication guide are available at the Project Venture site.[45]

## THE MEDIA

The media have an impact on public health, for example, the recent increase in public attention to diet is attributed in part to the media. On the negative side, however, the media are also thought to increase or decrease suicidal risk, depending on how they publicize youth suicide and violence.[46] Suggested justifications, glamour, common cause, and just the attention, per se, make youth suicide, violence, and substance abuse contagious and subject to copycat repetition. [47] [48] Case studies of school violence have found some instances in which mimicry played a part. Evidence exists that fictional material can also materially affect youth suicide, and violence rates (and, currently, episodes of multiple murder/youth suicide and violence).

The Centers for Disease Control (CDC) have suggested guidelines for reporting youth suicide and violence, as has The Suicide Prevention Resource Center,[49] the WHO, the UK, Canada Health,[50] and some other Commonwealth countries.[51] Suggestions to the media include avoid detailed descriptions, avoid romanticizing or glamorizing, avoid simplistic explanations of motivation and other causes, provide referral information, indicate that the problem is avoidable/treatable, report existing counter-measures, and get expert opinion.

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[45]Project Venture site with instructions for obtaining training and program replication manuals. http://niylp.org/files/Project%20Venture%20Model%20Program%20Info.pdf

[46] Hawton K, Williams K. (2002).The influence of media on suicide. *British Medical Journal, 325,* 1374-5.

[47]Gould M. *Suicide contagion (clusters).* Suicide and Mental Health Association International. Available at: http://suicideandmentalhealthassociationinternational.org/suiconclust.html

[48]*At-a-glance: safe reporting on suicide.* Available at: http://www.sprc.org

[49]*At-a-glance: safe reporting on suicide.* Available at: http://www.sprc.org

[50]Media Guidelines. http://casp-acps.ca/Publications/MEDIA%20GUIDELINES.doc

[51] WHO. (2000). Preventing Suicide: *A Resource for Media Professionals. (WHO/MNH/MBD/00.6).* Geneva, Switzerland: WHO.

Bottom line: Developing local community leadership and mobilizing community agencies and members is effective in identifying and mitigating risk factors, and in enhancing protective factors. Risk factor reduction is accomplished by interdiction, suppression, changing community environments (e.g., healthy schools policy, and media campaigns. Media campaigns, in particular, are a popular intervention for youth suicide, violence, and substance abuse prevention (and other risky or destructive behaviors). Enhancing protective factors include training interventions for entire groups (e.g., school children) and experiential and service learning). School-based coping and life-skills training is an evidence-based, primary and secondary prevention intervention. Engaging individuals by means of service learning programs is an evidence-based primary prevention intervention.

## INTERVENTION STRATEGIES FOCUSED ON COMMUNITY COMPETENCY

Community structure and functioning is a source of health and thriving of individuals (and families); structural defects and dysfunction in communities contributes powerfully to youth suicide, violence, and substance abuse. Communities have, to varying degrees, the leadership, organization, and capacity, i.e., the community competence, to improve the quality of life for members, to provide opportunities, and to rise to challenges. Part of community competence is social capital, the fund of trust and reciprocity that exists among members of the community. Improving the structure and functioning of communities is typically the focus of advocates and coalitions.

### COMMUNITY ASSESSMENT

The **American Indian Community Suicide Prevention Assessment Tool** is a protocol (built on a manual) that brings AI/AN community members together to assess a youth suicide or violence or substance abuse) problem, survey resources which can be applied to a community solution for the problem, and initiate organized activity in multiple community sectors toward that end. The survey of resources is comprehensive—more comprehensive than a problem-oriented committee might initially suppose. Barriers and opportunities otherwise overlooked are systematically included: identity, history, lifestyle, population characteristics, government, land, environment, water, economy, recreation, medical and social services and facilities, housing, education, community self-

helping processes, community cohesion, and family integration. The assessment protocol culminates in a plan. The tool is downloadable.[52]

## COMMUNITY LEADERSHIP

Initiatives like Native Aspirations, WellBriety, Drug Free Communities, Weed and Seed, Community Anti-Drug Coalitions of American (CADCA), and the Indian Country Methamphetamine Initiative require local leadership for initiation, implementation, maintenance, and sustained institutionalization at the local site. Community leaders must rely on volunteers and contributions of time and effort from thinly-funded agencies. There are many other community needs competing for time and attention. At the same time, local leadership faces vested interests with effective veto power. It takes outstanding motivation, knowledge and skill to be an effective community leader for youth suicide, violence, and substance abuse prevention.

A systematic development of community leadership among AI/AN communities is required to operate in a challenging environment of scarce resources and normalized denial, resistance, and unhealthy lifestyle. Leadership development includes creating role models, facilitators, strategic leadership, and assertive healing.

The Four Worlds Institute has a **College of Human and Community Development** which systematically trains community leaders within a cultural framework, learning system, and value orientation.[53] [54] [55] White Bison provides

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[52] *American Indian Suicide Prevention Assessment Tool.* http://www.oneskycenter.org/education/documents/AmericanIndianCommunitySuicidePreventionAssessmentTool.doc

[53] Four Worlds Institute for Human and Community Development. Lethbridge, Alberta. Available at: http://www.4worlds.org/4w/exesum/execsum.html

[54] The Four Worlds Centre for Development Learning. (2000). *The community story framework.* http://www.fourworlds.ca/pdfs/Com_Story_Framework.pdf

[55] The Four Worlds Centre for Development Learning. (2002). *Mapping the healing journey.* http://www.fourworlds.ca/pdfs/Mapping.pdf

a formal training program for "**fire-starters**," creating local leaders with community organizing, small group leadership, and medicine wheel skills.[56]

Community-to-community leadership has proven effective in stimulating, supporting, and guiding local leadership. Community-to-community advocacy for reform and technology transfer, and evidence for its effectiveness, has been documented by case study methodology, e.g., Alkali Lake, British Columbia to Hollow Water, Manitoba.[57] Local players often say they **prefer to receive leadership, training, and technical assistance from their peers in other communities**, rather than from a national or other expert source.

The Kennedy School of Government at Harvard University, government agencies, and various foundations have programs to recognize, honor, and publicize the methods and achievements of local leadership.

## COMMUNITY MOBILIZATION

Community mobilization marshals public interest and involvement; brings local resource managers and actors together to plan and commit and to acquire the knowledge and expertise they need to proceed with actual youth suicide, violence, and substance abuse prevention work. Advanced community mobilization interventions have been developed for drug abuse prevention. SAMHSA has funded a number of such projects as has the Robert Wood Johnson Foundation and others. Community Anti-Drug Coalitions of America (CADCA) provides instructional materials for community coalition building and operations.[58] These evidence-based techniques apply to community mobilization for youth suicide, violence, and substance abuse prevention as well.

Unique opportunities also exist in indigenous communities for community mobilization. Pervasive unhealthy living and a high degree of family relatedness to victims are pressures to do something. Resources for this mobilization include traditional values and principles supportive of healthy living and cultural content that can be applied to community mobilization.

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[56]White Bison, Inc. *Firestarter training.* Available at: http://www.whitebison.org/firestarter/index.htm

[57] Four Worlds Institute. (no date) Community Healing and Social Security Reform. *Part IV, Case Studies,* pp 135-149 http://www.4worlds.org/4w/ssr/TABLE333.html

[58]Community Anti-Drug Coalitions of America. Available at: http://cadca.org/

Prochaska and DiClemente's[59] individual change model is the basis for quite a few community mobilization protocols, including the Tri-ethnic Center for Prevention at Colorado State University.[60] The "**Community Readiness Model**" is theory- and evidence-based, manualized, and supported with an extensive training program, together with quantified, normed community assessment.

The Community Readiness model applies the DiClemente & Prochaska model of personal readiness for change[61] to the community. The model not only assesses readiness for prevention interventions, it participates in mobilizing and moving an AI/AN community forward along the readiness path, instituting prevention as it progresses. The manual is downloadable.[62]

**Gathering of Native Americans (GONA)** is a 4-day gathering for Native Americans who want to become change agents, community developers, and leaders. The GONA is based on several ideas: community healing is necessary for prevention; healthy traditions in the Native American community are key to effective prevention; the holistic approach to wellness is a traditional part of Native American belief systems; every community member is of value in empowering the community; and the GONA is a safe place for communities to share, heal, and plan for action.[63]

GONA takes participants through four stages of development—belonging; mastery; interdependence; and generosity. The cultural ideas communicated are healthy traditions and community healing, holistic approach, historical trauma, people's contribution to leadership and healing within a community, support and empowerment for people, rituals and teachings, feelings and healings into action, and use of a safe place. The outcomes are enhanced motivation for community

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[59] DiClemente CC, Prochaska JO. (1982). Self change and therapy change of smoking behavior: A comparison of processes of change in cessation and maintenance. *Addictive Behavior*. 133-142.

[60] *Community readiness model.* Tri-ethnic Center for Research, Colorado State University, Fort Collins, Colorado. Available at: http://www.triethniccenter.colostate.edu/

[61] Prochaska JO, DiClemente CC, Norcross JC. (1992). In search of how people change: applications to addictive behaviors. *American Psychologist, 47(9),* 1102-1114.

[62] Edwards RW, Jumper-Thurman P, Plested BA, Oetting ER, Swanson L. (2000). Community readiness: Research to practice. *Journal of Community Psychology, 28(3),* 291-307. Available at: http://www.triethniccenter.colostate.edu/index.html

[63] *Gathering of Native Americans.* Washington, DC: SAMHSA. Available at: http://preventiontraining.samhsa.gov/CTI05/Cti05ttl.htm

action and understanding of the opportunities. The manual is downloadable at the SAMHSA site.[64]

White Bison has published a seven-step approach to community development[65] and provides training for coalition-building (**Using Clan Knowledge**)[66] specific to AI/AN communities. The method includes community readiness assessment, GONA training, and an adapted CADCA approach to coalition-building and operations. White Bison, Inc. is an organizational base for the Wellbriety movement which includes a number of culturally-based programs, projects, teachings, and materials aimed at improving AI/AN health.[67] These include the **Sacred Hoop Journey; Coalition Building through Clan Knowledge; Families, Mothers, Fathers, Sons, and Daughters of Tradition; Fire-starters; Warrior Down; The Healing Forest; and The Medicine Wheel and the Twelve Steps**. Printed, video, and in-person training are available for these interventions.

Other evidence-based methodologies for community mobilization include the "**Community Story Telling**" methodology of the Four Worlds Institute.[68]

Tested community collaboration manuals have been developed by a number of health care organizations.[69]

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[64]Gathering of Native Americans (GONA) manual available at: http://preventiontraining.samhsa.gov/CTI05/Cti05ttl.htm

[65]White Bison. *Seven steps for systematic community development.* Colorado Springs, Colorado: White Bison, Inc. Available at: http://www.whitebison.org/trainings/2004pdf/SystemicChangeflyer.pdf

[66]White Bison. *Coalition building using clan knowledge.* Colorado Springs, Colorado: White Bison, Inc. Available at: http://www.whitebison.org/trainings/2004pdf/CoalitionFlyer.pdf

[67]White Bison, Inc. http://www.whitebison.org/

[68] Four Worlds Institute. (no date) Community Healing and Social Security Reform. Appendix A, 197-206. http://www.4worlds.org/4w/ssr/TABLE333.html

[69] GW Torres and FS Margolin. (2003).*The collaboration primer.* Health Research & Education Trust (HRET). www.hret.org Chicago, ILL.

## COMMUNITY CHANGE STRATEGIES

Community competency involves leadership, mobilization, and change toward preventing youth suicide, violence, and substance abuse. Three strategies for community change can be distinguished.

One approach is a **grass-roots, reform movement** strategy. In some of its efforts, White Bison seems to have perfected that strategy using elements such as “fire-starters” and “sacred hoop journeys”.

A second approach is **collaboration** among established stake-holders, including citizens and agency personnel, in a strategic planning and implementation oversight capacity. SAMHSA’s *Strategic Prevention Platform* and its predecessor, RAND’s *Getting to Outcomes*, are principal methods. CADCA can be seen as exemplifying that strategy. Challenges are persuading stakeholders to participate, the technology of assessment and planning, and the leap from plans to implementation by agencies.

A third approach consists of initiatives **mandated** by government and implemented by agencies. Such an initiative consists of multi-sector planning, policy harmonization, procedure alignment, and resource allocation among multiple agencies. Such initiatives are common in federal, state, and local mainstream government. In AI/AN communities, one example of this approach is the use of Task Forces in the Indian Country Methamphetamine Initiative. Challenges here are the tendency for agencies and personnel to want to be seen as on-board with important causes, the usual duplication of effort, and attempts by all to leverage the resources of others.

Suicide, violence, and substance abuse prevention in Indian Country is necessarily a community-wide, multi-sector effort. Circumstances are different from the mainstream in many AI/AN communities. For example, agencies may have more committed personnel, but fewer resources. The dynamics of governance may be different and, indeed, tribal governance seems to have been a moderating factor in some attempted interventions. The empirical question is how well each of these approaches works and why.

# INTERVENTION STRATEGIES FOCUSED ON CULTURE

Cultures, like communities can be made less risky, healthier, and more able to cope with threats to health and thriving. As an *object of an intervention*, culture is rediscovered and reinvigorated. Traditional strengths are preserved while

evolving toward meeting current conditions. Rediscovery and reinvigoration of AI/AN culture is central to many AI/AN agenda, including nation-rebuilding.[70] [71] This is frequently a primary objective of AI/AN communities and the people who lead and serve them, so it must be a major principle of a CBI strategy for Indian Country.

Re-discovering and re-establishing language, arts, ceremonies and identity is part of preserving the strengths of cultures that have been damaged by conquest and other adversities. Re-establishment of institutions and self-government (sovereignty) are among the strategies designed to strengthen such cultures.

At the same time, envisioning the future, identifying current opportunities for improving health, social and economic status are essential to the health and thriving of Indian Country. One very well developed strategy for revitalizing an indigenous culture is the **Access to Determinants of Health** developed by Four Worlds.[72] This protocol is logically stated, methodologically thorough, and well documented.

The health and thriving of individuals (and families and communities) is supported and directed by a culture; but culture, itself, requires participation and nurturance from its people, as well as contributions to its constructive evolution. Badly damaged cultures are a major contributor to youth suicide, violence, substance abuse, and pathologies of all kinds. Maintenance of healthy culture, treatment of sick culture, and rehabilitation of badly damaged culture requires civic leadership as well as popular participation. Important aspects of civic leadership include both “how to do it” (methods) and the “vision”. Such civic leadership is typically the focus of very unique people who emerge, and dedicated non-governmental organizations. Encouragement and support for their efforts is typically the focus of enlightened government.

There are three major ways CBI emerge. (1) Culture, per se, *is* the prevention or treatment. (2) Interventions are developed originally and directly *from* beliefs, practices, and other elements of the culture. (3) Imported EBI and Practice-

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[70] Honoring Nations Board of Governors. (2005).*Honoring Nations: celebrating excellence in tribal government.* Cambridge, MA: John F. Kennedy School of Government, Harvard University.

[71] Harvard Project on American Indian Economic Development. (in press). *The state of native nations: conditions under U.S. polices of self-determination*. New York, NY: Oxford University Press.

[72] Four Worlds Institute. (no date) Community Healing and Social Security Reform. Appendix A, 197-206. http://www.4worlds.org/4w/ssr/TABLE333.html

Based Interventions (PBI) are adapted using beliefs, practices, and other elements of the culture.

## CULTURE *IS* TREATMENT AND PREVENTION

The belief that "culture is treatment" has been advanced by professionals, government leaders, and AI/AN activists.[73] [74] [75] [76] [77] Cultural teachings, practices, and social conventions yield balance of mind, body, spirit and emotions. Living in a *good way*, as guided by cultural leaders and *written in the heart*, will bring behavioral health. Traditional cultural beliefs and practices constitute a principal form of treatment and prevention, per se. "Culture *is* prevention" means an awareness of (and participation in) the values, traditions, ceremonies, and sense of community, per se, that improves health and thriving, while preventing suicide, violence, and substance abuse.[78]

Culture as an intervention shares the stage with western-style risk-reduction and protective interventions for suicide, violence, and substance abuse. As an intervention, culture (consisting of stories, ceremonies, knowledge, skills, values etc.) is used to strengthen individuals, families, and communities. As an intervention, culture provides constructive, time-filling activity as well as social services and productivity. As an intervention, cultural activities provide social

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[73] Christian WM. (1990). Culture is treatment. Paper delivered at the *35th International Institute on the Prevention and Treatment of Alcoholism*. Berlin. Cited in Brady M. (1995). Culture in treatment, culture as treatment. A critical appraisal of developments in addictions programs for indigenous North Americans and Australians. *Social Science and Medicine, 41(11),* 1487-1498.

[74] SAMHSA. *Gathering of Native Americans (GONA) Training Guide. Philosophical Overview.* Available at: http://preventiontraining.samhsa.gov/CTI05/Cti05ttl.htm

[75] SAMHSA Administrator, Charles G Currie cited by Pond MH. (September/October 2005).Tribes weave visions for healthy future. *SAMHSA News, 13(5)*.

[76] White Bison, Inc. *Our Culture is Prevention–Preventing underage drinking on the White Earth Reservation.* DVD available from White Bison, Inc., http://www.whitebison.org/giveawayDVD.html

[77] "Culture is treatment and prevention" is not just about treatment and prevention. It is also about politics—the assertion of cultural autonomy, the persistence and renewal of cultural identity, distinction from the dominant North American society, and pursuit of legal and legislative objectives. This document does not deal with the political aspects of culture as treatment and prevention.

[78] White Bison. http://www.whitebison.org/home.html

contact and a vehicle for the communication of caring. A common CBI is re-instituting a traditional mentoring relationship between elders and youth.

There are many culture-based interventions, each to be found in different forms at different times and cultural locations. These are described in a great many documents; many not part of any professional literature. Documentation and artifacts are being collected in university and government archives. Following is mention of several interventions which have some application in the prevention and treatment of youth suicide, violence, and substance abuse as part of the global goals of culture-based interventions. Generalized descriptions are provided, recognizing that there are tribal and community variations within each intervention.

Flute playing is used, like meditation, in self-discovery and self-healing. Dancing, fasting, drumming, making of relations, medicine wheel, naming, pipe, powwow, potlatch, give-aways, honoring, rites-of-passage, ritual art, masks, sand painting, shaking tent, singing, and smudging ceremonies are culture-based interventions to promote health and thriving, bring good fortune, and heal. These interventions produce trances and visions, focus and entrain the mind, and connect to the spirit world. They establish and strengthen interpersonal relationships; create or transform identity; provide instruction on values, morals, principles, behavioral protocols; and relieve feelings of loss, guilt, and fear. They apply to youth suicide, violence, and substance abuse in individual, interpersonal, and community domains.

## OUTCOMES OF INTERVENTIONS FOR YOUTH SUICIDE, VIOLENCE, AND SUBSTANCE ABUSE

The fourth box in our scientific framework or logic model contains the outcomes expected for the CBI and measures or indicators (see Figure 2).

***"What will change when your efforts (CBI) are successful?***

i. *In the long run, the outcome may be a drop in the youth suicide, violence or substance abuse rates, or a restored and vital culture.*

ii. *In the medium term the outcome may be family re-integration, employment opportunities, or community control of services.*

iii. *In the short term the outcomes might be acquired knowledge, skills, attitudes, community plans, or agency agreements.*

***"What will be the outcomes of your CBI? What measures or indicators of these outcomes will there be?"***

Categories of outcomes for SAMHSA-supported behavioral health programs are morbidity, employment/education, housing (stability), crime, and social connectedness, (*National Outcome Measures*).[79] The outcomes and their measures/indicators are listed by SAMHSA:[80] Good health, thriving (high); Identity, future vision, future commitment (high); Depression (low); Substance abuse (low); Suicidality (low); and Violence (low).

There is an art to evaluating outcomes. It starts with knowing what is achievable, as distinct from what is called for.

Programs with long-term goals (such as reduction of suicide and homicide rates) are usually measured in terms of short- and medium-terms outcomes (such as increased awareness, participation in activities, skill in the expression of emotion, and changed interaction patterns). Focusing on achievable, measurable short- and medium-term outcomes is very wise, as is stating the expected long-term outcome.

While research evidence for the safety and effectiveness of interventions remains important, only very modest levels of certainty are currently achievable. Furthermore, self-report is often used as the measure. Self-report is useful and many studies have tested its reliability and validity. However, self-report has some serious, inherent weaknesses, especially when questions pertain to what is clearly fashionable, unfashionable, censured, prognostic, heavily dependent on memory and judgment, etc.

An evaluation of the intervention would include measuring improvements in outcome due to the intervention. Outcomes are sometimes divided into short-, intermediate- and long-term. This is particularly appropriate for youth suicide, violence, and substance abuse prevention interventions where the nominal outcome, measurable changes in youth suicide, bullying, and violence rates, is a

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[79] Four of the "outcomes," *access/capacity, perception of care, retention*, and *cost-effectiveness* are actually process variables.

[80] Available at: http://nationaloutcomemeasures.samhsa.gov/outcome/index_2007.asp

long-term outcome that may not occur until after major social changes (intermediate-term) have been accomplished.

Short-term outcomes are evident at the end of an intervention, or within a few months thereafter. Outcomes in FDA RCTs are usually measured within a six week to six month time frame. Examples of a short-term outcomes for youth suicide, violence, and substance abuse prevention interventions would be “short-term survival rates for patients admitted to hospital on suicide-watch,” “creation of a community crisis response plan,” and “knowledge of and skill in coping with conflict and crises.”

## SUMMARY

The purpose of this document is to describe Culture-Based Interventions using a scientific framework with supporting evidence in order to secure their acceptance and support of regulating and funding entities.

Youth range in age from 15/16 to 24/25 years according to some international definitions. For some purposes, we consider the range from 10 to 25 years. During those years they transition from childhood into adult family, civic, and productive roles. Although the rates per 100,000 population vary, suicide, violence, and substance abuse are tragic failures in that transition in all societies and all socio-economic groups. These rates are high, on average, in AI/AN country. In some locations, at some times, these problems are of epidemic proportions. On the other hand, some AI/AN communities are doing very well indeed on these indicators.

While “suicide” seems straightforward, an identified, completed suicide is generally part of a larger, longer process of self-destruction which includes suicidal ideation, distress, disconnection from attachments, and attempts. Opportunity plays a role in timing of suicide. “Violence” ranges from teasing, bullying and harassment to fist fighting to multiple homicide. Violence is an aspect of unsafe, low morale, low control, and disorderly school, neighborhood, or community climate. Suicide and violence are very frequently exacerbated by substance abuse, especially, alcohol.

Suicide and homicide are low frequency events, even where perceived to be overwhelming. Instances are extremely difficult to predict and prevent in individual cases. Statistical prediction from risk and protective variables is also very problematic due to confounds, measurement error, and false

positives/negatives. However, doing something about risk and protective factors remains important because of more immediate outcomes.

AI/AN communities innovating solutions for these problems are faced with a dilemma. On the one hand, it makes sense to them to use their culture and traditions to develop such interventions as elder-mentoring, sweat lodges, talking circles, and community ceremonies. Indeed, SAMHSA, IHS, OMH and other federal agencies, together with RWJ and other non-governmental organizations (NGO) endorse the “develop their own solutions” and “self-determination” approach. On the other hand, regulatory and funding agencies insist upon “evidence-based interventions” chosen from lists.

To ease this dilemma, this document does several things. It identifies a scientific framework for describing CBI, including several key conceptual models which are persuasive, per se, in the western scientific epistemology.

We have used the universal/selective/indicated prevention model in which “prevention” and “treatment” blend as they do in Indian Country. We used the ecology model because of the logistical need to distinguish among interventions aimed at individuals and interventions aimed at the public health, community environment, and culture. We used a logic model to organize CBI information into the classic western paradigm. Our logic model consists of causes, target populations, interventions, and outcomes. One part of “intervention” is a manual which describes the intervention in terms of its steps which is highly regarded in western epistemology. We have distinguished short, medium, and long-term outcomes in the logical model.

We reviewed intervention strategies. Some of these strategies are interventions with at-risk and indicated individuals. These include screening, gate keeping, treatment for disordered individuals, behavioral health services capacity, tertiary consultation to support primary behavioral health services, training for primary care providers, training of parents, and postvention. Sources of indigenous knowledge and practice, dissemination and teaching, practitioners, safety, holism, goals, outcomes, etiological ideas, diagnosis, and treatment topics are reviewed. Fundamental concepts of spirituality, harmony, balance, relationship of healer to patient, and the psychology of healing are discussed. We discuss AI/AN healing and medicine. A number of traditional, cultural health interventions are also reviewed. These are a resource of practices, symbols, materials, and ideas for CBI for youth suicide, violence, and substance abuse prevention.

Some strategies are focused on public health which bridges between the individual and community. Public health strategies include risk reduction, establishment of protective factors, and moderating the effects of media

coverage. Protective factors include positive youth development. Some strategies are focused on community competency—the capacity of communities to facilitate the quality of life of members and to organize themselves to effectively meet challenges to the wellbeing of the community and its members. Community strategies include leadership development, community mobilization, and several approaches to implementing community initiatives. We identify strategies" which involve raising the level of community functioning by means of some specific protocols: GONA; Community Readiness; Community Assessment; and Community Healing. Finally, we identify strategies focused on revitalizing the culture itself. We discuss the "culture *is* prevention" assertion which has wide currency in Indian Country today.

Of central importance to this document is AI/AN CBI. We review a number of well-described, manualized, researched, and evaluated CBI which are either greatly adapted EBI, applications of the wider behavioral health knowledge base, or de novo developments from AI/AN culture. These include a treatment protocol (MI/MET), a couple of life skills approaches (Zuni Life Skills, Canoe Journey), a service-learning approach (Project Venture), three community development approaches (Assessment, Readiness, and GONA), a couple of bicultural programs (Traffic Safety and Mathematics), and an example of the development of a culture-based public health system (Navajo).

Finally, we looked at the measured outcomes of interventions aimed at treating and preventing youth suicide, violence, and substance abuse. We identified the federally designated outcomes for such interventions (National Outcome Measures). These tend to be concerned with actual changes in indices of public health such as morbidity (suicide and homicide), employment, housing stability, crime. A few programs, such as the USAF suicide prevention program have actually measured changes in the intended long-term outcome, suicide incidence, moderate-to-severe family violence, fatal accident, homicide. Some (e.g., Zuni Life Skills) measure demonstrated skills and competencies. Some interventions aimed at suicide prevention actually measure a surrogate, referrals for treatment. Most, however, measure satisfaction, ideation, attitude, mood, problem solving practices. Self-report is often used to measure behavior such as substance abuse. Again, the expectation for CBI outcome assessment cannot be set unreasonably high.

## CONCLUSIONS AND RECOMMENDATIONS

Youth suicide, violence, and substance abuse are regrettable but routine failures in normal maturation from childhood to adulthood. The rates of these failures vary greatly throughout the world. On average, AI/AN communities experience elevated levels of pathology by comparison with other Americans. In some communities, the problem is epidemic proportions and in some communities the problem is a “disaster”, i.e., overwhelms capacity of the community.

Most importantly, it is the underlying issues which should attract our attention. One of the underlying issues is the sheer lack of a well-trained behavioral health infrastructure of sufficient capacity to address routine problems in normal youth development. Insufficient capacity is a problem for most communities, but in rural and remote AI/AN communities, the lack of capacity is equivalent to a failed public health system. Another underlying issue is the limited ability of the community (community competence) to facilitate the quality of life of members and to organize itself to effectively meet challenges to the wellbeing of the community and its members.

We have seen a hunger for community mobilization among those touched by the AI/AN troubles. Community members want to be motivated and to develop hope and vision for a better life (including relief of youth suicide, violence, and substance abuse burdens). We believe a program of AI/AN community development through protocols like GONA, Community Mobilization/Readiness, Strategic Prevention Planning, etc. are necessary precursors to sufficient hope, vision, and commitment to result in action. The process of community change takes time and focused investment. Long-term commitment to a few AI/AN communities with intensive developmental consultation and support would make a substantial, long-term difference in youth suicide, violence, and substance abuse as well as the fundamental issues underlying those indices.

Tribes need to get control of basic quality of life matters for their communities, families, and individual members, rather than attending to symptoms. Gaining control requires a significant commitment of leadership. Community leadership needs training and support to carry out its strategic mission, over and above day-to-day management duties. Economic development is a central, long-term task.

Youth are clearly the major asset the tribe has for its long-term health and thriving. Youth development is the most important investment strategy tribes can made in their future. Youth need clear vision and driving motivation to become the pillars of tomorrow’s tribe—the parents, workers, stable and committed tribal members, and leaders. To clear vision and driving motivation must be added knowledge and skill—education and training. Through development of the vision,

motivation and capabilities of the next generation, AI/AN communities could achieve improvements in quality of life which would also moderate much of the behavioral health pathology that currently exists and currently attracts attention.

We believe this investment in the next generation begins now with mobilizing the community.

## RESOURCES

A number of exhaustive inventories and reviews of youth suicide, violence and substance abuse programs and interventions exist, including some which are evidence-based, some which are adapted for use with AI/AN target populations, and some which are developed specifically by and for AI/AN people In addition, the knowledge base on youth suicide, violence, and substance abuse has been systematically incorporated into advocacy organization/foundation, agency, professional association, state, and international, prevention policy, recommendations, and strategy plans, including some focused on indigenous peoples. These sources can be tapped for programmatic ideas and descriptions as well as supporting evidence.

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*Best Practices Registry (BPR) for Suicide Prevention*. Suicide Resource Center/American Foundation for Suicide Prevention. Available at: http://www.sprc.org/featured_resources/bpr//index.asp. Reviews available at: http://www.sprc.org/featured_resources/bpr//ebpp.asp

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Department of Health and Human Services. *National suicide prevention strategy.* Available at: http://mentalhealth.samhsa.gov/suicideprevention/

Good Character.com. Contains materials for children K-5. Available at: http://www.goodcharacter.com/GROARK/Bullying.html

Government of Canada, Safe Canada. Links to several dozen provincial and program sites. Available at: http://www.safecanada.ca/link_e.asp?category=28&topic=166

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*Model Programs Guide*. Office of Juvenile Justice and Delinquency Prevention. Available at: http://www.dsgonline.com/mpg2.5/mpg_index.htm

*Model Programs*. School Violence Resource Center, Criminal Justice Institute. University of Arkansas. Available at: http://www.svrc.net/ModelPrograms.htm

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