

**Substance Use Prevention & Mental Health Promotion Programs Effective in Tribal  
Communities - Final Report**  
**Brittany Cooper, Amy Salazar, & Garrett Jenkins**  
**6/29/18**

## **Project Background**

The purpose of this project is to identify programs that have been shown to be effective in tribal communities for youth substance use prevention and/or mental health promotion. Our goal is to provide program recommendations based on the following four criteria: 1) strength of evaluation evidence demonstrating a reduction in behavioral health problems and/or effects on related risk and protective factors in American Indian/Alaska Native (AI/AN) youth, 2) alignment with culturally-tailored risk and protective factors shown to be related to substance use or mental health outcomes among AI/AN youth<sup>1</sup>, 3) availability of program implementation materials and support, and 4) program implementation capacity and fit with tribal communities in Washington State

## **Methodology**

There were four major phases in this project. First, we developed a preliminary list of 12 programs based primarily on strength of evaluation evidence, alignment with culturally-tailored risk and protective factors, and implementation considerations (criteria 1, 2, and 3). Second, we facilitated a simultaneous in-person and online meeting to present our preliminary list of 12 programs to tribal representatives from across the state, gather their feedback on these programs, and discuss possible implementation challenges (criteria 4). Third, based on this feedback and recommendations from members of the Evidence-based Program Workgroup and DBHR staff, we developed a list of additional programs and individuals to consult. Fourth, using the additional information gathered in phases 2 and 3, we finalized our list of recommended programs. We also used information we learned during all of these phases to inform our overall recommendations for next steps, which are summarized at the end of this report.

***Phase 1: Initial List Building.*** For the sake of the preliminary list, we focused mainly on the first three criteria: 1) strength of evaluation evidence demonstrating a reduction in behavioral health problems and/or related risk and protective factors in AI/AN youth, 2) alignment with culturally-tailored risk and protective factors shown to be related to substance use or mental health outcomes in AI/AN youth<sup>1</sup>, and 3) availability of program implementation materials and support. As a starting point, we reviewed SAMHSA's CAPT Decision Support Tool entitled *Culturally-informed Programs Designed to Reduce Substance Misuse and/or Promote Mental*

---

<sup>1</sup> Center for the Application of Prevention Technologies (2016). *Cultural Approaches to Prevention: Cultural Involvements that Protect Against Substance Misuse in American Indian/Alaska Native Populations - Draft.*

*Health among American Indian and Alaska Native Populations*<sup>2</sup>. Based on the information contained in the tool, we identified a total of 43 programs with some evaluation documentation to be included in the review process.

This SAMHSA CAPT tool provided information on programs that:

- were developed to address relevant substance use or mental health outcomes in AI/AN populations,
- incorporated cultural elements, traditions or practices, and
- were either: a) judged to be effective or promising based on standards of one or more national program registries (see Appendix A), and/or b) identified through a literature review of English-language peer-reviewed journals between January 2005 and July 2016.

Twenty-nine of these 43 programs had the most promising evidence and did not have any initial implementation concerns and therefore were the focus of this preliminary list.

- After additional review, 17 of these programs were eliminated from consideration because we determined that the program's curriculum was not available or accessible for communities wanting to replicate the program (n=14), or because they were not discernable, replicable programs (n=3). See Appendix B for details on excluded programs.
- The remaining 12 programs were included on the preliminary list because:
  - Program implementation materials were accessible,
  - There was at least some evidence from an experimental, quasi-experimental, or pre-posttest evaluation demonstrating the program reduces behavioral health problems and/or related risk and protective factors in AI/AN youth, and
  - They targeted at least one or more of the tribal-specific risk and protective factors outlined in the SAMHSA CAPT tool entitled *Cultural Approaches to Prevention: Cultural Involvements that Protect Against Substance Misuse in American Indian/Alaska Native Populations*<sup>1</sup>
    - Sense of efficacy
    - Ethnic identity
    - Traditional values
    - Traditional practices/activities
    - Cultural pride/spirituality
    - Historical trauma
    - Community support & opportunities

**Phase 2: Meeting with Tribal Representatives.** The 3-hour, simultaneous in-person and online meeting with tribal representatives was held on May 21, 2018 at the Administration Building for the Nisqually Tribe in Olympia, WA. In total, 28 people participated in the meeting.

---

<sup>2</sup> Center for the Application of Prevention Technologies (2017). *Culturally-informed Programs Designed to Reduce Substance Misuse and/or Promote Mental Health among American Indian and Alaska Native Populations - Draft*.

Twenty-two participants were tribal representatives; of those, 9 participated in-person and 13 participated online by webinar (see Tables 1 & 2).

**Table 1. Meeting Participants**

Participant Type	In-Person Participant	Webinar Participant	Total
Tribal Representative	9	13	22

Note: Two WSU staff and four DBHR staff also attended the meeting.

**Table 2. Tribes Represented**

Tribe Representation	
Chehalis	2
Colville	1
Kalispel	2
Lummi	2
Nisqually	4
Quinault	1
Sauk-Suiattle	1
Spokane	1
Swinomish	2
Tulalip	1
Yakima Nation	2
None specified	3
<b>Total</b>	<b>22</b>

The first main task of the meeting involved providing an overview of this project, including an explanation of the previous research conducted by SAMHSA and the tools they developed that informed this work. This was followed by an introduction to the preliminary list of 12 programs that we developed, an explanation of the tiers the programs were divided into, and a brief overview of each program. The brief overview of each program included an explanation of its focus, setting, target age range, targeted risk and protective factors, and implementation information. We also highlighted the specific tribes and locations where that program had been developed and/or implemented, and how tribal culture has been integrated. After each tier of programs was described, we conducted a group discussion of that subset of programs to explore how participants felt about the programs, what strengths they felt the programs had that would meet the needs of their community, and what challenges they anticipated. See Appendix C for the slides used to facilitate this meeting and discussion.

After all individual programs had been introduced and discussed, we then facilitated a group discussion activity that allowed participants to more globally explore some of the issues regarding choosing, implementing, and adapting evidence-based programs for tribal communities. Participants first gathered in smaller groups to discuss issues regarding program selection and adaptation; then, we reconvened the large group to discuss the following

questions: “In your experiences, what has worked well and what has not worked well when trying to select and/or adapt a program to implement with Native youth and families?”

Some of the most notable themes emerging from the tribal representatives included:

- The importance of and strategies for implementing school-based programs that emphasize Native American culture in public schools. Specifically, there were questions about whether the school-based programs reviewed had been implemented in schools with only Native youth or schools with both Native and non-Native youth.
- Intergenerational/historical trauma was raised as an important issue to consider in the context of prevention programming with Native communities. Participants were interested in which program addressed this, or which could be adapted to address this if they did not already do so.
- Participants were interested in how to go about integrating culturally relevant content into prevention programming that was already being implemented in the community.
- Participants raised concerns about the feasibility of implementing long-term, complex prevention programs and discussed the importance of leveraging resources and collaborating across tribes and with multiple community organizations (e.g., schools).
- In particular, participants expressed needing a better understanding of what types of resources and skills are needed in order to be able to successfully implement each program - this included things like costs of materials, training, and ongoing technical assistance and support; data collection/ record keeping needs; accessibility (including user-friendliness) of program curricula; and ability to connect with other tribal communities that have either successfully implemented programs of interest before or may be interested in working together on future implementations.
- Participants identified a variety of barriers to successful program implementation, including collaborations (particularly with schools), lack of awareness of prevention in the community, and funding limitations (including limited fundable program choice).

Overall, this discussion gave us insight into the program implementation capacity and fit issues important to consider for tribal communities in Washington State (criteria 3 and 4), and this led us to add some additional information about each program in the descriptions and tables provided below.

***Phase 3: Follow-up with Other Recommended Tribal Partners & Programs.*** Based on feedback from the May 21<sup>st</sup> meeting and recommendations from other individuals, including members of the Evidence-based Program Workgroup and DBHR staff, we developed a list of additional programs and individuals to consult. Below is a list of individuals we consulted and the additional programs we reviewed as a part of phase 3. For each individual/program, we provide a brief summary of the information gained.

**[Monica Oxford \(University of Washington\), Promoting First Relationships](#)**: Dr. Oxford and her colleagues at University of Washington and Washington State University have an NIH grant-funded project aimed at adapting the Promoting First Relationships home-visiting program (with caregivers and children under age 3) for two tribes in rural settings - one in the Northwest region

and the other in the Rocky Mountain region, as defined by the Indian Health Service. Promoting First Relationships (PFR) is listed as a [Promising Program on the Blueprints for Health Youth Development](#) program registry and has evidence of improving caregiver sensitivity and knowledge of child development, as well as improving child competence and behavioral outcomes. In close consultation with the two tribes included in this grant-funded project, the academic research team has made adaptations to program content, training processes, and service delivery to meet the needs of rural, tribal reservation communities. Although there are no peer-reviewed publications from this project yet, Dr. Oxford shared one paper that describes the adaptation process that is currently under-review with an academic journal. She also reported that the findings from their randomized control trial study of the adapted version of PFR is currently being reviewed by tribal council before being submitted to an academic journal. It appears that this adaptation of the PFR program has been very well-received by the tribal communities involved in this project and if positive results are found in the evaluation study, it should be considered for inclusion in future DBHR tribal prevention program lists. We would consider this a “program to watch.”

**[Dennis Donovan & Lisa Rey Thomas \(University of Washington\), Healing of the Canoe:](#)**

The Healing of the Canoe program was included on our preliminary list of programs, but we were encouraged to contact the program’s developers to gain additional insight into the program’s development and implementation. Dr. Donovan provided an extensive summary of the program’s development, implementation, adaptation process, and future directions. The content of that email can be found in Appendix D. To summarize, the HOC program was developed and evaluated over 13 years using a community-based and tribal participatory research approach and as an academic-tribal partnership between the University of Washington’s Alcohol and Drug Abuse Institute and the Suquamish and Port Gamble S’Klallam tribes. The Canoe Journey/Life’s Journey curriculum, which is an 8-session life skills curriculum developed for inter-tribal urban AI/AN youth, is used as the foundation for the HOC program. When communities chose to implement the HOC, HOC trainers help facilitate a collaborative process where tribal communities and agencies adapt the curriculum’s “journey” metaphor to fit their cultural context and the specific setting/approach they plan to use for its delivery. This enhanced cultural relevance can be seen as a major strength for this program, but as Dr. Donovan describes in his email, it also makes it challenging to evaluate since HOC looks slightly different in each community. There is one peer-reviewed academic journal article that describes the results from a quasi-experimental evaluation of HOC implemented as a series of three, 2-day workshops/retreats conducted by the Suquamish and Port Gamble S’Klallam tribes showing consistent positive effects of the program on youth hope, optimism, and self-efficacy. This evaluation evidence forms the basis for our inclusion of the program in our final recommendations described below.

**[Nancy Fiander \(White Swan\), Dennis Embry, & Claire Richardson \(Paxis Institute\), Indigenous/First Nations PAX Good Behavior Game:](#)** Nancy Fiander was referred to us because of her long-standing work with evidence-based programs in the White Swan community. Specifically, she was identified because she has played an important role in the adoption, implementation, and sustainability of the PAX Good Behavior Game (PAX GBG)

curriculum in schools where a large proportion (more than 50%) are Native youth. She has worked closely with Dr. Dennis Embry and Claire Richardson from Paxis Institute to integrate PAX GBG into White Swan, being mindful of tribal culture, traditions, and values. In a discussion with Nancy, Dennis, and Claire, we learned that White Swan's implementation of PAX GBG is not a formal tribal adaptation of PAX GBG. Instead, they explained that the process by which the program was introduced to the broader community and tribal stakeholders was done in a way that respected their community's values - paying particular attention to "putting students first," encouraging community ownership of the program, having both students and teachers jointly identify the vision for their school, and describing the program as part of a collaborative "journey." Dr. Embry did provide three academic journal articles describing a Canadian Institutes of Health Research grant-funded project, which is currently in progress with 8 First Nation communities associated with the Swampy Cree Tribal Council in Manitoba, Canada. The aims of this project are to: 1) examine how the original PAX GBG is currently being implemented in Grade 1 classrooms in some of these communities and whether it is associated with improved mental health and academic outcomes for children in First Nation communities in Manitoba, 2) develop a culturally-grounded toolkit for implementation of a culturally adapted version of PAX GBG for First Nation communities, and 3) to implement and evaluate the effectiveness of the culturally adapted tribal version of PAX GBG. Because this project is still in progress, there are no published evaluation findings for the adapted tribal version of PAX GBG. However, Nancy, Dennis, and Claire explained that implementation of the original PAX GBG within tribal communities has been quite successful and therefore DBHR may want to consider adding it to their list, even though there are no tribal-specific evaluation findings. We would also recommend that the culturally adapted tribal version of PAX GBG (being referred to as Indigenous or First Nations PAX GBG) is another "program to watch."

**[Dedra Buchwald](#), (Washington State University), [Partnerships for Native Health](#): Dr. Buchwald is the Director of the Initiative for Research and Education to Advance Community Health (IREACH) and the Founding Director of the Partnerships for Native Health, whose mission is to improve the health and well-being of American Indian and Alaska Native people of all ages. She referred me to her colleague Michael McDonell, but his work focuses primarily on substance abuse treatment with Native adults and he recommended we talk with Dr. Denis Donovan, who we already had contacted.**

**[Kevin Haggerty](#) (University of Washington):** Through discussions with the EBP Workgroup, Dr. Haggerty mentioned that his colleagues with Communities that Care were in the process of reviewing tribal prevention programs with evidence of impacting youth behavioral health outcomes. He shared documentation from their review of programs with us and we were able to compare it to our preliminary list. They had identified a total of 7 programs they classified as first-tier, which had evaluations that included 1) use of an experimental or quasi-experimental design with a reasonably equivalent comparison group; 2) appropriate statistical methods for analyzing the outcome data; 3) use of an appropriate unit of analysis; and 4) impact of the program on at least one health risk behavior. Of those, 4 were already on our list (Families and Schools Together, Project Venture, Family Spirit, and Bicultural Competence Skills Program), and one was not applicable because it was health-eating focused (Healthy Foods Hawaii). The

remaining two (Native FACETS, Red Cliff Wellness) were determined to meet our criteria for inclusion and therefore were added to the final list of programs (see below for program details).

**Kayla Wells-Moses (Washington State University), [Positive Indian Parenting](#):** Kayla Wells-Moses is the Family and Consumer Sciences Education for Washington State University Colville Reservation Extension and the Interim County Director for WSU Okanogan County Extension. She is a certified Positive Indian Parenting (PIP) trainer and has trained approximately 75 PIP facilitators from WA, but she is not aware of how many facilitators have or are currently implementing the program in their communities. According to the National Indian Child Welfare Association (NICWA), who are the program developers and trainers, PIP was selected as one of the ten “Best Practices” in Indian Country by First Nations Behavioral Health Association in 2006. However, we were unable to identify any evaluation reports that empirically demonstrate the program’s impact. Kayla has done limited pre/post evaluation of parents who have attended sessions she has implemented in Okanogan County. She recommended speaking with Lauren Shapiro at NICWA for additional information on PIP’s any future plans they have for evaluating the program, but by the time we received this information, we were unable to do in time to include her response here. Kayla did report that the program is very well-received by the individuals she has trained, but she mentioned that one of the most significant challenges for PIP implementation is identifying individuals who are both strong facilitators and either members of the community where it is being implemented or, if not a member, individuals who have a good relationship with that community. She reported that the strengths of PIP are that it is designed to explicitly address historical trauma, and that it can be tailored to specific tribes. It is recommended that program facilitators bring in tribal elders in order to pass along the tribes’ history through storytelling. Each PIP lesson has two parts: 1) discussion about an aspect of traditional Indian parenting, and 2) discussion about how parents can incorporate that aspect into their parenting, given modern considerations. There are 8 sessions designed to be implemented once a week for 8 weeks. Topics include: Traditional Parenting, Lessons of the Storyteller, Lessons of the Cradleboard, Harmony in Child Rearing, Traditional Behavioral Management, Lessons of Mother Nature, Praise in Traditional Parenting, and Choices in Parenting. If evaluation evidence is identified for PIP, this program would be worth consideration for inclusion on the DBHR tribal program list.

In addition to conversations with the above individuals, we also heard back from program contacts for Our Life and Cherokee Talking Circle who provided information about how to access their curricula. These programs come from the SAMHSA CAPT tool and had the level of evidence necessary to be included on the preliminary list, but were originally excluded because we could not access the curriculum. With this added information, we were able to include them on the final list (see below for program details).

***Phase 4: List Finalization.*** As a reminder, our goal is to provide program recommendations based on the following four criteria: 1) strength of evaluation evidence demonstrating a reduction in behavioral health problems and/or related risk and protective factors in AI/AN youth, 2) availability of program implementation materials, 3) alignment with culturally-tailored risk and protective factors shown to be related to substance use or mental

health outcomes in AI/AN youth<sup>1</sup>, and 4) program implementation capacity and fit with tribal communities in Washington State. Based on the information gathered from the three phases of the project described above, we were able to collect the needed information on these criteria and finalize the program list, which is described in greater detail below. This final list reflects input received from tribal prevention providers and other key stakeholders in Washington State.

## **Final Program List**

The final program list includes 16 programs: 9 in Tier 1 and 7 in Tier 2. All of the programs included on this list:

- Were developed to address relevant substance use or mental health outcomes in AI/AN populations;
- Incorporate cultural elements, traditions or practices;
- Aim to improve one or more of the following tribal-specific risk and/or protective factors: sense of efficacy, ethnic identity, traditional values, traditional practices/activities, cultural pride/spirituality, historical trauma, and/or community support and involvement<sup>1</sup>;
- Have at least some evidence from an experimental, quasi-experimental, or pre-posttest evaluation suggesting that the program reduces behavioral health problems and/or related risk and protective factors in AI/AN youth; and
- Have implementation materials available to communities wanting to replicate it.

The primary distinction between the tier 1 and tier 2 programs is detailed below:

- For Tier 1 programs, we were able to identify at least one randomized control trial or quasi-experimental evaluation study that showed Native youth who received the program exhibited more positive outcomes (i.e., statistically significant differences in substance use/mental health outcomes or related risk/protective factors) in comparison to those Native youth who did not receive the program. Because of the stronger research designs used in these evaluation studies (i.e., random assignment to intervention and control groups or use of statistical methods to account for differences between intervention and comparison groups), we have greater confidence in their results. In other words, we feel more confident the program itself is the reason for more positive outcomes in program participants compared to non-participants. For the sake of communicating with community members, you may want to call this group “research-based programs” to more closely align with other DBHR-supported program lists.
- For Tier 2 programs, we were able to identify at least one pre-posttest evaluation study that showed Native youth (or communities) in the program exhibited statistically significant improvement on at least one of the targeted substance use/mental health outcomes or related risk/protective factors from before to after participation in the program. Because of the weaker research designs used in these evaluation studies (i.e., no comparison group), we have less confidence in their results. In other words, even though there is some indication that program participants improved from before to after the program, we are unable to definitively say these positive changes were in fact due to the program. For the sake of communicating with community members, you may want to call this group “promising programs” to more closely align with other DBHR-supported program lists.



***Tier 1: Research-based Programs - Strongest Available Evidence***

- 1) American Indian Life Skills Development/Zuni Life Skills Development
- 2) Bicultural Competence Skills Approach
- 3) Families and Schools Together (FAST) for American Indian Children
- 4) Family Spirit
- 5) Healing of the Canoe
- 6) Cherokee Talking Circle
- 7) Red Cliff Wellness School Curriculum
- 8) Native FACETS
- 9) Project Venture

***Tier 2: Promising Programs - Limited Available Evidence***

- 10) Our Life
- 11) Protecting You/Protecting Me for American Indian Children
- 12) Reward and Reminder Program
- 13) Connect Program
- 14) FACE (Family and Child Education Program)
- 15) Gathering of Native Americans
- 16) Model Adolescent Suicide Prevention Program

In the following tables, we provide a brief summary of each program. See Appendix E for more detailed information.

**Tier 1: Research-based Program - Strongest Available Evidence**

<b>Program Name</b>	<b>American Indian Life Skills Development/ Zuni Life Skills Development</b>
<b>Website</b>	<a href="http://www.ashiwi.org/">http://www.ashiwi.org/</a>
<b>Target Age Group</b>	14-19
<b>Program Description from SAMHSA's <i>Culturally Informed Programs</i> report</b>	American Indian Life Skills Development is the current version of the former Zuni Life Skills Development program. It is a school-based suicide prevention curriculum that aims to reduce suicide risk factors and increase protective factors among American Indian youth. The curriculum is comprised of approximately 60 individual sessions delivered by teachers and tribal community leaders during the school day two to three times per week over 20 to 30 weeks. The curriculum integrates general Native American beliefs and topics into a life skills program and recommends places where individual tribal beliefs, practices, culture, and language can be added for customization. Students participate in culturally relevant experiential learning exercises on: self-esteem, emotions and stress, communication and problem-solving skills, self-destructive behavior, suicide, and personal and community goals.
<b>Is historical trauma highlighted in the program?</b>	No
<b>Implementation/ adaptation strengths</b>	The original Zuni Life Skills Development program was developed to incorporate the cultural values of the Zuni Pueblo in New Mexico; the American Indian Life Skills Development program was adapted from this approach to be applicable to Native communities more broadly, with specific recommendations included for how the approach can be adapted to reflect the beliefs, practices, culture, and language of individual tribes.
<b>Potential implementation/ adaptation challenges</b>	Because the program is school-based, having buy-in from the school would be a necessary condition for successful implementation.

**Tier 1: Research-based Program - Strongest Available Evidence**

<b>Program</b>	<b>Bicultural Competence Skills Approach</b>
<b>Website</b>	<a href="https://www.socio.com/products/state-wide-indian-drug-prevention-program">https://www.socio.com/products/state-wide-indian-drug-prevention-program</a>
<b>Target Age Group</b>	9-11
<b>Program Description from SAMHSA's <i>Culturally Informed Programs</i> report</b>	Bicultural Competence Skills Approach is an educational substance abuse prevention intervention that aims to prevent abuse of tobacco, alcohol, and other drugs among Native American adolescents. The intervention employs bicultural competence and social learning theories. It is comprised of 10 to 15 sessions on problem-solving, communication, coping, and discrimination skills. The program also teaches skills related to resisting temptation and identifying healthy alternatives to substance misuse through culturally relevant examples that help participants predict and avoid situations where substance misuse is likely.
<b>Is historical trauma highlighted in the program?</b>	No
<b>Implementation/ adaptation strengths</b>	Program manual is relatively inexpensive
<b>Potential implementation/ adaptation challenges</b>	It is unclear how amenable the program is to adaptation for different communities. Information on technical assistance was not available.

**Tier 1: Research-based Program - Strongest Available Evidence**

<b>Program</b>	<b>Families and Schools Together (FAST) for American Indian Children</b>
<b>Website</b>	<a href="http://www.familiesandschools.org/">http://www.familiesandschools.org/</a>
<b>Target Age Group</b>	Elementary school-age kids and their parents and teachers
<b>Program Description from SAMHSA's <i>Culturally Informed Programs</i> report</b>	The tribally-controlled College of Menominee Nation worked with program developers to adapt the Families and Schools Together (FAST) program for American Indian children. The FAST program is designed to fortify family bonds and increase positive parent-child communication, thereby improving children's academic performance and emotional functioning. FAST for elementary school-age children includes eight weekly sessions (and subsequent booster sessions over two years). Each session is organized such that: first, the family unit meets together to establish cohesiveness; second, parents and children participate in separate activities designed to foster connections to peers; third, parents and FAST children reconvene in one-to-one play time; and finally, each session ends with activities that illuminate and celebrate the interdependencies of family members. Adaptations for American Indian children include: (1) making interventions for at-risk youth and families more accessible; (2) using role modeling, behavioral rehearsal, action-oriented, and present-focused intervention approaches; (3) integrating traditional healing methods; and (4) having a culturally represented team of tribal community members facilitate program implementation.
<b>Is historical trauma highlighted in the program?</b>	No
<b>Implementation/ adaptation strengths</b>	60% of the program is adaptable to new communities.
<b>Potential implementation/ adaptation challenges</b>	Because the program is school-based, having buy-in from the school would be a necessary condition for successful implementation.

**Tier 1: Research-based Program - Strongest Available Evidence**

<b>Program</b>	<b>Family Spirit</b>
<b>Website</b>	<a href="http://caih.jhu.edu/programs/family-spirit">http://caih.jhu.edu/programs/family-spirit</a>
<b>Target Age Group</b>	Teen moms and their children
<b>Program Description from SAMHSA's <i>Culturally Informed Programs</i> report</b>	Family Spirit is a home-visiting mental health promotion and substance abuse prevention intervention for American Indian teenage mothers that aims to increase parenting competence, reduce risk factors that could inhibit effective parenting, and promote healthy infant and toddler behaviors. The intervention comprises 63 lessons on prenatal care, infant care, child development, family planning, and healthy living; and is based on the American Academy of Pediatrics' guide <i>Caring for Your Baby and Young Child: Birth to Age 5</i> . Cultural adaptations to program style, graphics, delivery, and content were made with input from community-based participants. Moreover, the intervention employs Native paraprofessionals as home visitors, building local human capital and reflecting American Indian stakeholder provider preferences.
<b>Is historical trauma highlighted in the program?</b>	No
<b>Implementation/ adaptation strengths</b>	Has been implemented in over 100 tribal communities across 16 states.
<b>Potential implementation/ adaptation challenges</b>	While stating that the model is designed to be flexible, the website notes that changes to the model need to be approved by an Affiliate Liaison with the program office. Fidelity requires that there is 1 trained supervisor for every 10 trained paraprofessionals who deliver the in-home sessions.

**Tier 1: Research-based Program - Strongest Available Evidence**

<b>Program</b>	<b>Healing of the Canoe</b>
<b>Website</b>	<a href="http://www.healingofthecanoe.org">www.healingofthecanoe.org</a>
<b>Target Age Group</b>	High school students
<b>Program Description from SAMHSA's <i>Culturally Informed Programs</i> report</b>	A number of programs have been modeled on the cultural experience of the Canoe Family. Youth who belong to the Canoe Family participate in activities that prepare them for annual canoe journeys to visit other tribes. These activities include: (1) participation in "talking circles" with elders and respected community members; (2) the construction of large ocean-going canoes that can carry groups of paddlers from one community to another; (3) learning how to navigate the waters; and (4) celebrations with cultural protocols that include feasting on local specialties, singing, dancing, and participation in potlatches (gift giving ceremonies). Youth who participate in the Canoe Family must make a commitment to be clean and sober throughout all activities. Martlett and colleagues (2003) developed an 8-session, skills-based course that used aspects of the canoe journey as well as other Native symbols to teach life skills such as decision-making, communication, and goal-setting, as well as provide information about alcohol and drug use and its consequences. This curriculum was further adapted for and evaluated with the Suquamish Tribe.
<b>Is historical trauma highlighted in the program?</b>	No
<b>Implementation/ adaptation strengths</b>	Curriculum was intentionally designed to accommodate adaptation.
<b>Potential implementation/ adaptation challenges</b>	Since this curriculum/program uses a canoe journey as the guiding metaphor, it may require significant up-front work to adapt if Tribe is not located near a navigable body of water.

**Tier 1: Research-based Program - Strongest Available Evidence**

<b>Program</b>	<b>Cherokee Talking Circle</b>
<b>Website</b>	<a href="https://www.crimesolutions.gov/ProgramDetails.aspx?ID=363">https://www.crimesolutions.gov/ProgramDetails.aspx?ID=363</a>
<b>Target Age Group</b>	13-18
<b>Program Description from crimesolutions.gov</b>	<p>The Cherokee Talking Circle (CTC) is a culturally based intervention targeting substance abuse among Native American adolescents. The program was designed for students who were part of the United Keetoowah Band of Cherokee Indians, the eighth largest tribe in Oklahoma. The goal of the CTC is to reduce substance abuse, with abstinence as the ideal outcome for students.</p> <p>CTC is a school-based, manualized intervention that consists of 10 sessions. Keetoowah–Cherokee students meet weekly for 45-minute sessions over 10 weeks. They are led by a counselor and a cultural expert in the format of a talking circle. Students who participate in CTC pledge to the group that they will maintain confidentiality of what is shared during the sessions. The manual uses both English and Cherokee languages.</p>
<b>Is historical trauma highlighted in the program?</b>	No
<b>Implementation/ adaptation strengths</b>	The implementation manual is written in both English and Cherokee languages.
<b>Potential implementation/ adaptation challenges</b>	<p>No cost information is published.</p> <p><b><u>With regards to training requirements/provider certification, the group leader must identify as Keetoowah–Cherokee, be trained in the Cherokee Talking Circle, and be culturally engaged and involved in the Cherokee community.</u></b> The leader needs to understand Keetoowah–Cherokee history and traditions and how these can be applied to the treatment of youths with substance use/abuse.</p> <p>This information implies that adaptation may not be immediately possible.</p>

**Tier 1: Research-based Program - Strongest Available Evidence**

<b>Program</b>	<b>Red Cliff Wellness School Curriculum</b>
<b>Website</b>	<a href="https://lion.militaryfamilies.psu.edu/programs/red-cliff-wellness-school-curriculum">https://lion.militaryfamilies.psu.edu/programs/red-cliff-wellness-school-curriculum</a>
<b>Target Age Group</b>	Kindergarten - 12 <sup>th</sup> grade
<b>Program Description from SAMHSA's National Registry of Evidence-Based Programs and Practices</b>	<p>The Red Cliff Wellness School Curriculum is a substance abuse prevention intervention based in Native American tradition and culture. Designed for grades K-12, the curriculum aims to reduce risk factors and enhance protective factors related to substance use, including school bonding, success in school, increased perception of risk from substances, and identification and internalization of culturally based values and norms. The Red Cliff program is taught by teachers who have been trained in interactive, cooperative learning techniques and facilitation. The manualized curriculum has separate components for grades K-3, 4-6, and 7-12. Each component includes 20-30 developmentally appropriate lessons and activities designed to enhance the values of sharing, respect, honesty, and kindness and to assist students in understanding their emotions. Small-group discussions (described as "talking circles" in Native American terms) are extensively used, along with small-group process activities, independent workbook activities, and collaborative projects for older students.</p> <p>The school curriculum was created by the First American Prevention Center, an arm of the Red Cliff Band of Lake Superior Chippewa. The curriculum is part of a broader wellness initiative that includes a community curriculum and home wellness kit. Since its initial development for Native American youth, the tribally based curriculum has been used in schools with a wide range of populations, including some with only a small percentage of non-Native students.</p>
<b>Is historical trauma highlighted in the program?</b>	No
<b>Implementation/ adaptation strengths</b>	Appears at least somewhat able to incorporate adaptation, as there is a component of the school-based curriculum that relies on local tribal legends.
<b>Potential implementation/ adaptation challenges</b>	Would require school administrative buy-in and collaboration. Would also require recruitment of numerous respected community members to function in a coalition-leadership type function.



### Tier 1: Research-based Program - Strongest Available Evidence

<b>Program</b>	<b>Native FACETS</b>
<b>Website</b>	<a href="https://rtips.cancer.gov/rtips/productDownloads.do?programId=118095">https://rtips.cancer.gov/rtips/productDownloads.do?programId=118095</a>
<b>Target Age Group</b>	8-13 years
<b>Program Description from National Cancer Institute's Research-Tested Intervention Programs</b>	<p>The program name, Native FACETS, stands for Family/Friends, Active healthy choices, Cancer prevention, Eating wisely, Thankfulness, and Survival as a Native American. The program was designed to lower cancer risk among American Indians through youth tobacco prevention and dietary modification. The diet curriculum was based on federally recommended dietary guidelines and culturally specific food practices of the indigenous peoples of the Northeast, as described in interviews with American Indians. The tobacco use prevention curriculum was based on reviews of the relevant literature and tailored to the study sites by collaborative community representatives. To further increase the intervention's cultural sensitivity, American Indians were recruited and trained to deliver the intervention.</p> <p>The intervention teaches facts about tobacco and nutrition using films, storytelling, lectures, activities, and demonstrations, as well as media literacy exercises and problem-solving role plays. Group leaders build subjects' knowledge of ancestral tobacco use and its modern-day abuse, and the meaning and significance of ancestral food and traditional respect for the body. Leaders also stress the importance of family and the survival of American Indian culture as a way of combating negative peer pressures and other social influences. Throughout the curriculum, youth learn and practice resistance skills, decision making, problem-solving, and self-reward skills.</p>
<b>Is historical trauma highlighted in the program?</b>	No
<b>Implementation/ adaptation strengths</b>	Downloadable materials include an implementation and evaluation guide, which are free.
<b>Potential implementation/ adaptation challenges</b>	Part of the curriculum focuses on the ceremonial history of tobacco use by Native Americans, highlighting how smoking is an abuse of this practice. For Tribes not having traditional/ceremonial tobacco practices, this program may not be applicable.

### Tier 1: Research-based Program - Strongest Available Evidence

Program	Project Venture
<b>Website</b>	<a href="http://www.niylp.org/contact-us-2/">http://www.niylp.org/contact-us-2/</a>
<b>Target Age Group</b>	5 <sup>th</sup> – 8 <sup>th</sup> grade
<b>Program Description from SAMHSA's <i>Culturally Informed Programs</i> report</b>	<p>Project Venture aims to help youth—primarily American Indian youth— resist substance use by building their social and emotional competence. Project staff lead games and activities in classrooms; experiential activities (e.g., hiking, camping) after school, on weekends, and during summers; extended adventure camps and wilderness treks during summers; and community-focused service learning and service leadership activities throughout the year. The program promotes the development of a positive self-concept, a community service ethic, and an internal locus of control; and builds decision-making, problem-solving, and social skills. All activities are strengths-based and centered on American Indian values about the role of family, learning from the natural world, spiritual awareness, service to others, and respect.</p>
<b>Is historical trauma highlighted in the program?</b>	No
<b>Implementation/ adaptation strengths</b>	<p>There is a well-maintained program website with multiple contacts options: <a href="http://www.niylp.org/contact-us-2/">http://www.niylp.org/contact-us-2/</a></p> <p>The program has been implemented across 20 states (including by Port Gamble and Kalispell in WA) and 5 Canadian provinces.</p>
<b>Potential implementation/ adaptation challenges</b>	<p>Project Venture is a complex, multi-component intervention with class-room, afterschool, community-based, and experiential outdoor components. Therefore, it would require good program coordination and partnerships with school and community agencies.</p> <p>It appears multiple adaptations have been created by the National Youth Leadership Project for various behavioral challenges, but it is unclear how effective the adaptations have been.</p> <p>Training costs are expensive (minimum of \$6000 plus travel to New Mexico for training).</p>

## Tier 2: Promising Program - Limited Available Evidence

<b>Program</b>	<b>Our Life</b>
<b>Website</b>	None
<b>Target Age Group</b>	7-17 years old
<b>Program Description from SAMHSA's <i>Culturally Informed Programs</i> report</b>	Our Life is a psycho-educational group-structured program focused on violence, trauma, and substance abuse among American Indian youth (7-17 yrs old) and families with four components: (1) healing historical trauma through experiential methods and cultural practices, (2) reconnecting to traditional cultural language by learning from elders and practitioners, (3) parenting/social skill building, (4) building relationships between parents and youth through equine-assisted activities.
<b>Is historical trauma highlighted in the program?</b>	Yes
<b>Implementation/ adaptation strengths</b>	Implementation materials appear to be free (but may be difficult to access - see below).
<b>Potential implementation/ adaptation challenges</b>	<p>There is currently no program website to access program materials. However, Jessica Goodkind (jgoodkin@unm.edu), an Assistant Professor at University of New Mexico has shared these materials with us in a DropBox, and appears be offering them at no cost. At this time there does not appear to be any available training or technical assistance available and therefore adaptation may be difficult.</p> <p>One component of the intervention is equine-assisted activities and therefore would require access to horses and trained providers.</p>

## Tier 2: Promising Program - Limited Available Evidence

<b>Program</b>	<b>Protecting You/Protecting Me for American Indian Children</b>
<b>Website</b>	<a href="http://www.hazelden.org/pypm">http://www.hazelden.org/pypm</a>
<b>Target Age Group</b>	Elementary-school children and high school peer helpers
<b>Program Description from SAMHSA's <i>Culturally Informed Programs</i> report</b>	Protecting You/Protecting Me (PY/PM) is a five-year long elementary school curriculum that consists of 40 lessons taught to students in grades one through five with eight lessons per grade. Lessons focus on vehicle-related safety, risky behaviors, and the dangers of alcohol and its effect on brain development. The program also trains high school students to serve as peer helpers who may teach PY/PM lessons to elementary school students. Tribal representatives worked with curriculum developers to tailor the curriculum to American Indian children. Adaptations included: (1) altering specific words and concepts to ensure that they conveyed appropriate meaning to students; (2) emphasizing tribal language throughout the curriculum; (3) changing Anglo names to names more familiar to Indian children; (4) removing images that likely would either convey the wrong meaning or no meaning; (5) replacing generic "positive values" with tribal values; (6) adding stories likely to resonate with particular tribes; and (7) expanding the scope of the curriculum to emphasize wellness, honoring one's body, recognizing that one's behavior affects others, and assuming responsibility for oneself, one's family, and one's community.
<b>Is historical trauma highlighted in the program?</b>	No
<b>Implementation/ adaptation strengths</b>	This program has already been adapted for broad American Indian use. Web-based training and in-person training is available.
<b>Potential implementation/ adaptation challenges</b>	We were unable to access any information on its suitability for further tribal adaptations.

## Tier 2: Promising Program - Limited Available Evidence

<b>Program</b>	<b>Reward and Reminder Program</b>
<b>Website</b>	<a href="http://paxis.org/products/view/reward-reminder">http://paxis.org/products/view/reward-reminder</a>
<b>Target Age Group</b>	Underage youth
<b>Program Description from SAMHSA's <i>Culturally Informed Programs</i> report</b>	The culturally-tailored Reward and Reminder Program aims to reduce convenience store alcohol sales to youth living on or near nine American Indian reservations. Decoys are used to assess alcohol sales to youth. The buyer also records additional descriptive information about the interiors of the outlet. Adaptations have included feather imagery in the reward and reminder letter graphics and model tribal council resolutions in support of the program.
<b>Is historical trauma highlighted in the program?</b>	No
<b>Implementation/ adaptation strengths</b>	<p>Training for this program is readily available and offered through the PAXIS Institute, which has a well-developed and maintained website. Only minor, superficial adaptations (e.g., to program logos and letters) may be needed.</p> <p>Training and two years of technical assistance is included with purchase.</p>
<b>Potential implementation/ adaptation challenges</b>	Start-up costs are quite expensive (minimum of \$9000).

## Tier 2: Promising Program - Limited Available Evidence

<b>Program</b>	<b>Connect Program</b>
<b>Website</b>	<a href="http://www.theconnectprogram.org/training/suicide-prevention-intervention">http://www.theconnectprogram.org/training/suicide-prevention-intervention</a>
<b>Target Age Group</b>	Tribal community members
<b>Program Description from SAMHSA's <i>Culturally Informed Programs</i> report</b>	Typically implemented by community coalitions, the Connect Program trains community members, including high school students, on appropriate procedures for responding to youth suicide risk. Connect includes: (1) a 3-hour gatekeeper training for adults and high school students; (2) discipline-specific training for professions in 13 different disciplines (e.g., law enforcement, education, religion); and (3) clear evidence-supported protocols that provide an integrated approach to guide individuals' responses when recognizing warning signs. Connect has partnered with American Indians and Alaska Natives to conduct suicide response training. These trainings are strengths-based and include adaptations such as: customizing evidence-supported protocols that recognize tribal customs and culture, offering substitute terms for suicide, and recognizing tribal healing for individuals at risk or who have suffered loss due to suicide.
<b>Is historical trauma highlighted in the program?</b>	No
<b>Implementation/ adaptation strengths</b>	<p>This program has a well-developed and maintained website: <a href="http://www.theconnectprogram.org/training/suicide-prevention-intervention">http://www.theconnectprogram.org/training/suicide-prevention-intervention</a></p> <p>Training and technical assistance is available, but the cost is unknown. The program has been implemented broadly and is adapted in collaboration with Connect Program trainers prior to initial program implementation.</p>
<b>Potential implementation/ adaptation challenges</b>	<p>Pricing information is not published and trainers are not willing to disclose the prices, except when they are in negotiation with a specific community.</p> <p>This program requires a collaborative effort between schools, youth, family, and other community agencies.</p>

## Tier 2: Promising Program - Limited Available Evidence

<b>Program</b>	<b>FACE (Family and Child Education) Program</b>
<b>Website</b>	<a href="http://face.familieslearning.org/index/about/">http://face.familieslearning.org/index/about/</a>
<b>Target Age Group</b>	Birth – 5 year-old children and their families
<b>Program Description from SAMHSA's <i>Culturally Informed Programs</i> report</b>	FACE (Family and Child Education) Program is a family-based program that seeks to provide American Indian children with a culturally relevant early childhood education. The program is based on <i>Parents As Teachers (PAT)</i> , <i>Parents And Child Education (PACE)</i> , and the <i>High/Scope Curriculum</i> for early childhood and K-3. FACE consists of weekly or biweekly home visits to each family in which parent educators assess the child's developmental level and provide parent-child learning experiences, refer the child/family to additional services based on assessment, and encourage parents to attend a planned monthly group meeting. Center-based services are offered to families once the child reaches age 3. These services consist of adult education, early childhood education, parent time, and parent and child together time.
<b>Is historical trauma highlighted in the program?</b>	No
<b>Implementation/ adaptation strengths</b>	<p>Much if not all of the program materials appear to be freely available for download on their website. Training and technical assistance is also available: <a href="http://face.familieslearning.org/index/about/">http://face.familieslearning.org/index/about/</a></p> <p>The program has been implemented with at least 31 BIA (Bureau of Indian Affairs)-funded school catchment areas, and is designed to incorporate tribe-specific language and culture.</p>
<b>Potential implementation/ adaptation challenges</b>	<p>Pricing information for training and technical assistance is not publically available.</p> <p>Program appears to be only available to students of BIA-funded schools.</p>

## Tier 2: Promising Program - Limited Available Evidence

<b>Program</b>	<b>Gathering of Native Americans</b>
<b>Website</b>	<a href="https://www.samhsa.gov/tribal-ttac">https://www.samhsa.gov/tribal-ttac</a>
<b>Target Age Group</b>	10-18 years old
<b>Program Description from SAMHSA's <i>Culturally Informed Programs</i> report</b>	Gathering of Native Americans (GONA) is a community prevention and strategic planning curriculum that aims to promote and guide community discussions, help communities heal from historical trauma, and address planning and prevention issues by focusing on the four themes of Belonging, Mastery, Interdependence, and Generosity. GONA provides culturally specific substance abuse prevention training in tribal communities; and emphasizes the importance of Native American values, traditions, and spirituality in helping heal from historical trauma. Four main developmental themes reflect key life teachings: belonging and learning who one is during infancy and childhood; mastery of one's talents during adolescence and young adulthood; interdependence with and responsibility to others, and connectedness to all things during adulthood; and generosity or giving back to one's community through teachings, rituals, stories, and song during the later years.
<b>Is historical trauma highlighted in the program?</b>	Yes
<b>Implementation/ adaptation strengths</b>	<p>The facilitator guide for this program is freely available for download on SAMHSA's website:  <a href="https://www.samhsa.gov/sites/default/files/gona-goan-curriculum-facilitator-guide.pdf">https://www.samhsa.gov/sites/default/files/gona-goan-curriculum-facilitator-guide.pdf</a>.</p> <p>The curriculum is designed to capture broad traditional AI/AN values, so may require less adaptation. However, it is designed to be adapted for specific community challenges.</p> <p>Program is envisioned as a four-day event, but has been delivered as one, two, or three-day events as well.</p>
<b>Potential implementation/ adaptation challenges</b>	Training and technical assistance is available through SAMHSA's Tribal Technical Assistance Center, but cost is unknown.



**Tier 2: Promising Program - Limited Available Evidence**

<b>Program</b>	<b>Model Adolescent Suicide Prevention Program</b>
<b>Website</b>	<a href="https://www.sprc.org/resources-programs/model-adolescent-suicide-prevention-program-maspp">https://www.sprc.org/resources-programs/model-adolescent-suicide-prevention-program-maspp</a>
<b>Target Age Group</b>	Children, adolescents, young adults
<b>Program Description from SAMHSA's <i>Culturally Informed Programs</i> report</b>	The Model Adolescent Suicide Prevention Program (MASPP) is a community-wide suicidal behavior prevention intervention for American Indian adolescents and young adults that aims to reduce the occurrence of adolescent suicides and suicide attempts through education about suicide and related behavioral issues (e.g., child abuse and neglect, family violence, trauma, and substance abuse). Central culturally-framed features of MASPP include: (1) surveillance of suicide-related behaviors, (2) a school-based suicide prevention curriculum, (3) community education, (4) enhanced screening and clinical services, and (5) extensive outreach. Trained neighborhood volunteers also serve as natural helpers providing service navigation of, advocacy for, and counseling with youth who may feel more comfortable seeking help from a familiar lay person.
<b>Is historical trauma highlighted in the program?</b>	No
<b>Implementation/ adaptation strengths</b>	This program's manual appears to be freely available for download at: <a href="https://www.sprc.org/sites/default/files/migrate/library/AdolescentSP_ProgramManuaPH_ModelINA_Communities.pdf">https://www.sprc.org/sites/default/files/migrate/library/AdolescentSP_ProgramManuaPH_ModelINA_Communities.pdf</a>  Two-day trainings are available for a fee, and ongoing phone and email support are available free of charge.
<b>Potential implementation/ adaptation challenges</b>	It is unclear how amenable this program is to adaptation. The program requires trained clinical mental health staff, which may make it prohibitive for some communities.

## Recommendations for Next Steps

A variety of recommendations for next steps to consider have emerged from this work. They include:

- Creating opportunities to build capacity, readiness, and additional prevention professionals and partnerships needed in tribal communities to most effectively implement effective tribal prevention programs.
- Developing and building a lending library of the curricula needed for implementing the programs included in this report, as purchasing them may be cost prohibitive for communities. In addition, this provides an opportunity for communities to do a closer review of the possible programs to help them choose those that best fit their needs.
- Collecting information on what programs other tribes in WA State are implementing and providing a list of this information to tribes so they can connect with other tribes that are interested in similar programs. Relatedly, possibly coordinating a learning community where tribes can connect about this work in person (e.g., at the Tribal Gathering).
- Developing a dissemination and communication plan for sharing the programs included in this report with tribes and brainstorming next steps.
- Considering the small number of programs that meet rigorous evidence criteria, it is also recommended that DBHR consider additional resources and guidance tribes may need to adapt the programs on this list to fit with the needs of their communities. Additionally, considerations of what supports communities may need to implement with and monitor fidelity may also be beneficial.
- Supporting more rigorous, innovative evaluation of tribal programs implemented in Washington in an effort to continue expanding the evidence base for these programs and to grow the number of programs that meet criteria for being considered “evidence-based.”
- Having the EBP Workgroup and Caroline Cruz review the final list developed in this project for any additional feedback.
- Paying special attention to new research coming out on the two “programs to watch” we identified: the tribal adaptation of Promoting First Relationships and the tribal adaptation of PAX Good Behavior Game. We recommend reaching out directly to the program developers/purveyors and requesting that they inform you of when new evaluation results will be available.

We would like to acknowledge a challenge related to compiling a list of evidence-based prevention practices for tribal communities. Many prevention programs have been developed for use in tribal communities, and many offer a great deal of promise for meeting the needs of communities; however, until they have been evaluated it is uncertain whether these programs will have positive or negative impacts on communities. While the list provided in this report includes programs with the highest level of available evidence, there are many other existing programs that have been developed and/or used in tribal communities with less evidence of effectiveness that we did not include on this list. While it is important to provide tribal communities with as many options as possible for prevention programming, supporting options

with limited, unconvincing, and/or no evidence is not advisable, even if these programs were designed with a focus on tribal communities, as it is not yet clear whether these programs are in fact effective at helping communities reach their prevention-related goals. While it is possible that programs that have not yet been rigorously evaluated could be found to be quite effective at helping communities meet their goals, it is also possible that those programs could be ineffective or could even have negative impacts on community outcomes. A balance must be found between (a) maximizing program choice for tribal communities, (b) ensuring that program options have the capability of bringing about meaningful, positive change in community outcomes, and (c) acknowledging the crucial need for more research and evaluation to build the evidence base for prevention programs appropriate for use in tribal communities.

## Appendix A

### National Sources Used in SAMHSA's CAPT Decision Tool: Culturally-informed Programs Designed to Reduce Substance Misuse and/or Promote Mental Health among American Indian and Alaska Native Populations

The below sources were used by SAMHSA CAPT to identify programs that were developed to prevent or reduce substance misuse or abuse and/or promote mental health among American Indian/Alaska Native populations and incorporated cultural elements, traditions, or practices.

The [Athena Forum's Excellence in Prevention Strategies List](#): Provides a list of substance abuse prevention programs and strategies that have at least two research studies demonstrating evidence of intended results.

[Child Trends' What Works](#): Searchable database of over 700 programs that have been evaluated to assess child or youth outcomes related to education; life skills; and social/emotional, mental, physical, behavioral, or reproductive health.

[First Nations Behavioral Health Association's Catalogue of Effective Behavioral Health Practices for Tribal Communities](#): Describes evidence-based and practice-based tribal behavioral health practices identified by Board and Staff of First National Behavioral Health Association.

[Indian Health Service's Methamphetamine and Suicide Prevention Initiative Best Practices in Use](#): Lists evidence-based and practice-based methamphetamine and suicide prevention interventions for Indian Country.

[Johns Hopkins' Center for American Indian Health](#): Provides descriptions of tribal programs on a variety of topics, such as alcohol and drug abuse prevention, mental health, and adolescent health.

[National Indian Health Board's Healthy Indian Country Initiative Promising Prevention Practices Resource Guide](#): Highlights 13 tribal, community-developed prevention programs that are considered promising practices for reducing and preventing disease in Indian Country.

[Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide](#): Details information about evidence-based juvenile justice and youth prevention, intervention, and reentry programs by highlighting what works, what is promising, and what does not work according to expert reviews of evaluation research.

[One Sky Center's Evidence-Based Practices and Best Practices](#): Provides a list of best practices that have been found to be effective in the prevention and treatment of substance abuse and mental health issues among Native populations.

[Public Health Agency of Canada's Canadian Best Practices Portal](#): Describes successful public health interventions in First Nations, Inuit, and Métis urban and rural communities.

[Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices](#) (NREPP): Evidence-based review system that provides reliable information on mental health and substance abuse interventions.

[U.S. Department of Health & Human Services' Home Visiting Evidence of Effectiveness](#): Provides a list of evidence-based home visiting program models implemented in tribal communities or evaluated with AI/AN families.

Note: Source descriptions were taken from SAMHSA's CAPT Decision Support Tool entitled *Culturally-informed Programs Designed to Reduce Substance Misuse and/or Promote Mental Health among American Indian and Alaska Native Populations*.

## **Appendix B**

List of Excluded Tribal Prevention Programs - See Attached Excel File

## **Appendix C**

Tribal Partners Meeting Slides - See Attached PowerPoint File

## Appendix D

### Email Response from Dennis Donovan Regarding Healing of the Canoe

I am pleased to learn that DBHR is interested in learning more about the Healing of the Canoe (HOC) prevention curriculum. I have attached the peer-reviewed article that provides an evaluation of the curriculum as implemented in a series of 3, 2-day workshops/retreats conducted by the Suquamish and Port Gamble S'Klallam tribes. Other articles in peer-reviewed journal articles found on the project web page provide information about the project, the community engagement process, and the curriculum development. I have also attached an article from the National American Indian/Alaskan Native Addiction Technology Transfer Center that provides an overview of the Healing of the Canoe project, which was funded over the course of 13 years by the National Institute on Minority Health and Health Disparities (NIMHD).

A major issue in evaluating the curriculum beyond this stage is that the training we provide is to facilitate tribal communities and agencies to adapt the curriculum's "journey" metaphor to fit their cultural context and to also adapt the curriculum itself to fit the venue into which it will be implemented and the method of its delivery. It has been implemented in summer school settings, as after school sessions with middle school youth, as a full year-long class for high school students, in culture camps, and as a series of workshops. In addition to youth, the curriculum has also been adapted for use with families and with adults in tribal wellness programs focusing on both mental health and substance use/abuse. A number of tribal communities and agencies have been successful in sustaining the curriculum's use through grants, embedding it into tribal wellness, youth, recreation and wellness programs, and integrating it into their education systems (both in tribal schools and public schools). As such, given the lack of standardization, we have not been able to provide a systematic evaluation of the curriculum's implementation across such a varied landscape.

Some additional information relevant to your inquiry:

- The Northwest Portland Area Indian Health Board's (NPAIHB) THRIVE suicide prevention program contracted with our HOC team to develop and integrate two modules focused on suicide risk and protective factors into the HOC curriculum. They also provided funding to support training on this expanded curriculum to a number of tribal communities. The THRIVE program has a contract with NPC Research to conduct an evaluation of the implementation of the expanded curriculum. Attached is a brief article in the Northwest Portland Area Indian Health Board's newsletter about the HOC project and curriculum. Also attached is a brief description of the evaluation in progress conducted by NPC Research in its newsletter.
- All of the materials, including a generic curriculum template, the training/adaptation/implementation manual, handouts, and supporting materials are made available at no cost through the Northwest Portland Area Indian Health Board's *Healthy Native Youth* website (<https://www.healthynativeyouth.org/curricula/The-Healing-of-the-Canoe>) where it is listed as a Tribal Best Practice, Promising Practice.



- The Northwest Addiction Technology Transfer Center (NWATTC, <http://attcnetwork.org/regional-centers/?rc=northwest>) has incorporated training and technical assistance on the adaptation and implementation of the HOC curriculum as one of its primary offerings. The NWATTC provides training and technical assistance on evidence-based practices for workforce development across HHS Region 10 (Alaska, Washington, Oregon, Idaho). Training on the HOC curriculum was the first training offered under by the NWATTC in October 2017 after its relocation to the UW Alcohol & Drug Abuse Institute from Oregon Health and Science University. This first NWATTC-sponsored training was held in Spokane; the second is scheduled two weeks from now in Southeast Alaska.
- As of that October 2017 NWATTC-sponsored training, our HOC team had provided trainings on the HOC curriculum content and its adaptation/implementation to 350 individuals from a variety of professional backgrounds, representing 46 Tribes and 14 Tribal organizations. There is actually a training currently being conducted with the Coeur D'Alene Tribe in Idaho this week. These trainings have been funded via a number of sources, including our original National Institute on Minority Health and Health Disparities (NIMHD) grant, the NPAIHB THRIVE program, the NWATTC, and tribes who have contracted for training.

Please let me know if this information is sufficient for your review and evaluation of the Healing of the Canoe curriculum. I would also be happy to speak with you if you would like or if you feel it would help you better assess the value of the HOC program

Thanks,

Dennis

Dennis M. Donovan, Ph.D.  
Director, Alcohol & Drug Abuse Institute  
Professor, Psychiatry & Behavioral Sciences  
Adjunct Professor, Psychology, Health Services, and Global Health  
University of Washington Schools of Medicine and Public Health  
1107 NE 45th Street, Suite 120  
Seattle, WA 98105-4631  
Phone: 206-543-0937  
Fax: 206-543-5473  
ddonovan@u.washington.edu  
<http://adai.uw.edu>

## **Appendix E**

Final List of Tribal Prevention Programs - See Attached Excel File