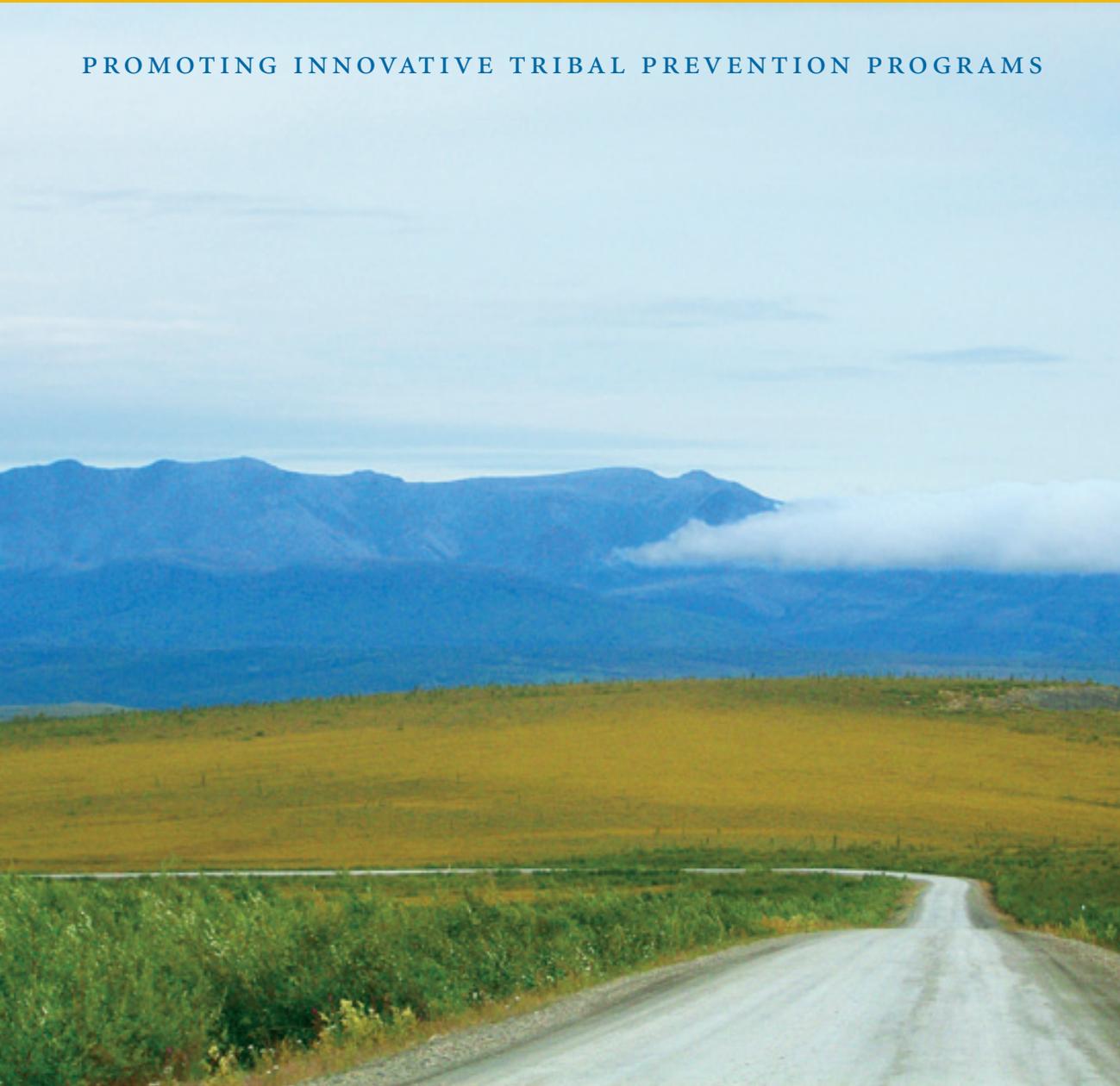


# Healthy Indian Country Initiative Promising Prevention Practices Resource Guide

PROMOTING INNOVATIVE TRIBAL PREVENTION PROGRAMS



National Indian  
Health Board





## THE HEALTHY INDIAN COUNTRY INITIATIVE

Promising Prevention Practices Resource Guide was created and printed with funding from the Department of Health and Human Services (DHHS) Office of Minority Health through a Cooperative Agreement with the Association of American Indian Physicians (AAIP).

December 2009

Cover: "The Road to Minto Village" 2008 (Audrey D. Solimon)

**NOVEMBER 2009**

Dear Friends, Colleagues, and Supporters:

On behalf of The National Indian Health Board Executive Board (NIHB) and staff, it has been our distinct honor to work with the various Tribal communities of the Healthy Indian Country Initiative (HICI). The NIHB is grateful for the opportunity to understand, support, grow and learn from Tribal communities and their prevention efforts out Indian Country. The process of building relationships to navigate the United States governmental system takes a tremendous amount of energy and leadership. The success of these relationships depends on fostering the strengths within our Tribal communities including the development of available resources to Tribal members. Utilizing the cumulative knowledge of individuals who demonstrate dedication and commitment to healthy American Indian/Alaska Native families and community members is another vital component in the success of this program.

The NIHB would like to begin by thanking the U.S. Department of Health & Human Services (HHS) Office of Minority Health (OMH) and the Association of American Indian Physicians (AAIP). This project would not have been successful without their combined staff leadership, understanding of Tribal communities in the fields of prevention, the allocation of resources, and the dissemination of information to assist in the development and replication of prevention practices.

The NIHB would also like to thank our Board of Directors for continually providing leadership, flexibility and creativity in their support of our efforts in our organizational goal of supporting Indian Country's efforts to provide quality health care and our work on this project.

The NIHB sincerely appreciates our national partner organizations, the National Council of Urban Indian Health (NCUIH) and the National Indian Council on Aging (NICOA). Each organization and their tremendous dedication to the success of the overall goals of the Healthy Indian Country Initiative (HICI) and their contributions to this project highlight their ongoing support of American Indian/Alaska Native people and provide the necessary guidance and advocacy in the building of a stronger and healthier Indian Country.

Yours in Health,



Reno Keoni Franklin  
Chairman  
National Indian Health Board



Stacy A. Bohlen  
Executive Director  
National Indian Health Board

# Healthy Indian Country Initiative Promising Prevention Practices Resource Guide

PROMOTING INNOVATIVE TRIBAL PREVENTION PROGRAMS

## ACKNOWLEDGEMENTS

The National Indian Health Board would like to thank all the Tribal communities, community members, national organizations and partners for their participation, hard work, and dedication in the creation of the Healthy Indian Country Initiative Promising Prevention Practices Resource Guide. The guidance, support, and leadership provided during the creation of this Resource Guide will continue to help shape healthy Native communities and families for years to come.

### Healthy Indian Country Initiative Tribal Grantees

Coeur d'Alene Tribe  
Confederated Tribes of the Colville  
Houlton Band of Maliseet Indians  
Hualapai Tribe  
Indian Health Board of Nevada  
Lac Courte Oreilles Band of Lake Superior Chippewa  
Lac Vieux Desert Band of Lake Superior Chippewa Indians  
Little Traverse Bay Bands of Odawa Indians  
Native Village of Minto  
Penobscot Nation Tribe  
Ponca Tribe of Nebraska  
Rosebud Sioux Tribe  
Sisseton-Wahpeton Oyate Sioux Tribe



### National Organizations/Partners

Department of Health & Human Services Office of Minority Health (DHHS OMH)  
Association of American Indian Physicians (AAIP)  
National Indian Council on Aging (NICOA)  
National Council of Urban Indian Health (NCUIH)

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# Foreword

PUBLIC HEALTH PLAYS SUCH A CRITICAL ROLE IN OUR DAILY LIVES, YET IS seldom recognized. As we face today's challenges and realities of emerging pandemics, bioterrorism, global climate change, a healthcare system in need of reform, and an increasing prevalence of high-risk behaviors, the need for a comprehensive and quality public health system has never been more critical. As we consider how to address these serious challenges to our health and wellbeing, Tribes are faced with new opportunities to define, to improve, and to grow a Tribal public health system that is unique and includes aspects of our culture. The development of "promising practices" to reduce and prevent disease is the next step toward a comprehensive public health system in Indian Country. However, the development, implementation, and evaluation of effective practices present us with new challenges to overcome and we realize that we need to closely examine what it means to be "promising prevention practice."

The National Indian Health Board is proud of the Healthy Indian County Initiative (HICI) Promising Prevention Practices Resource Guide and the opportunity to highlight promising prevention programs within Indian Country. In the era of the Evidence Based Practice (EBP) movement, the defining of success is a percentage, a dose of the greatest good for the greatest number of people. In comparison, in culture, the defining moment of success is the impact on the next seven generations; the way we as American Indians/Alaska Natives carry ourselves and relate to our Tribal community effects the next seven generations of our family and indigenous relatives.

These opposing western and indigenous world views of evidence, impact, success, and sustainability for prevention programs are far apart. As we are aware, American Indians/Alaska Natives have experienced lower health status over a wide-range of health issues. The western view of the causes include a wide range of reasons which include but are not limited to a sedentary lifestyle, predisposition to certain health problems, and lack of infrastructure. Another view,

states that the world we live in is out of balance, and through all aspects of whom we are, mind, body, spirit, and soul can provide the balance to navigate a healthy life. This dichotomy will always be there when addressing health issues in Native communities and are important to understand how to reduce health disparities among American Indian/Alaska Native communities.

As you will find in this resource guide there is no universally accepted definition of a "Promising Prevention Practice." There is not one agency or organization that provides broadly accepted guidelines of what a "promising prevention practice" looks like. Without established guidelines the identification of promising practices and the movement to manualize promising practices through written composition becomes extremely difficult. Further, written composition is not the historical method for many American Indian/Alaska Native communities in documenting their community "promising practices." In unique and diverse indigenous communities the development of a "promising practice" is taught through experience, humor, rituals, and



ceremonies and is evaluated through pain, grief, and loss. The conflict between oral tradition and written composition will be played out with indigenous communities in the era of self determination and in this movement toward defining and developing effective “promising practices.”

Today, there are approximately 5 million American Indians/Alaska Natives in the United States, or 1.6 percent of the total population. This is expected to increase to 8.6 million individuals, or 2 percent of the US population, by 2050 (US Census, 2009). These 5 million American Indian/Alaska Native people represent 564 federally recognized Indian Tribes in the United States and are spread out from the most remote areas to the largest metropolitan cities in the US (Federal Register, 2009). In 2008, the US Census stated that Alaska, Montana, North Dakota, Oklahoma, and South Dakota were the states with the largest American Indian/Alaska Native population. In addition, California, Arizona, Texas, New Mexico, New York, Washington, Florida, North Carolina, and Michigan have an American Indian/Alaska Native population of 100,000 or more (US Census, 2009).

There are incredible challenges for creating one practice that will meet the diverse health needs of Indian Country when we take into consideration the complexity of our communities and diverse indigenous health practices defined by rituals and

ceremonies. Recognizing this diversity within the mainstream public health system that does not have fully developed concepts for this type of diversity is critical to keep in mind as you review and use the HICI Promising Prevention Practices Resource Guide and contemplate the multitude of factors that contribute to our understanding of promising practices in Native communities.

The Healthy Indian Country Initiative Promising Prevention Practices Resource Guide begins the process of identifying, developing, and looking at Tribal community promising prevention practices with the intent to allow other communities to replicate these practices. Through this process, we hope our Tribal communities will begin to shift from a language of despair to a hopeful language of health and healing. As we move toward a comprehensive and quality public health system there is an enormous need for public health capacity building and workforce development so American Indian/Alaska Native professionals will be able to guide the written composition of community-based promising prevention practices that will promote a healthier Indian Country.

# Table of Contents

<b>PAGE i</b>	<b>PAGE ii</b>	<b>PAGE iii</b>	<b>PAGE iv</b>
Letter NIHB Chairman Reno Keoni Franklin and Executive Director Stacy Bohlen	Acknowledgements	Staff National Indian Health Board (NIHB) Healthy Indian Country Initiative (HICI) Staff	Foreword
<b>PAGE 2</b>	<b>PAGE 6</b>	<b>PAGE 12</b>	<b>PAGE 54</b>
Chapter 1 Introduction and Purpose of the Healthy Indian Country Initiative a) Overview of the HICI b) Background of the NIHB c) Goals and Objectives of the HICI d) Methodology of the HICI Promising Prevention Practice Resource Guide e) Purpose of the HICI Promising Prevention Practices Resource Guide f) Organization of the HICI Promising Prevention Practices Resource Guide	Chapter 2 History and Background of Promising Practices a) Need for Effective Prevention Practices b) Evidence-Based Practices c) Evidence-Based Practices Adaptations d) Introduction of Practice-Based Evidence e) Definitions f) Bridging the Gap: Promising Practices	Chapter 3 The Healthy Indian Country Initiative Promising Prevention Practices Tribal Grantee Project Profiles a) Introduction b) HICI Tribal Grantee Project Profiles • Coeur d’Alene Tribe • Confederated Tribes of the Colville Reservation • Houlton Band of Maliseet Indians • Hualapai Tribe • Indian Health Board of Nevada • Lac Courte Oreilles Band of Lake Superior Chippewa • Lac Vieux Desert Band of Lake Superior Chippewa • Little Traverse Bay Band of Odawa Indians • Native Village of Minto • Penobscot Indian Nation • Ponca Tribe of Nebraska • Rosebud Sioux Nation • Sisseton-Wahpeton Oyate Sioux Tribe	Chapter 4 Lessons Learned and Conclusion a) Lessons Learned and Recommendations b) Successful Strategies c) Closing Remarks
<b>PAGE 58</b>	<b>PAGE 59</b>		
References	Resources and Contact Information		

CHAPTER 1

# Introduction and Purpose of the Healthy Indian Country Initiative



IN 2007, DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) SECRETARY Michael Leavitt, lead a cross country tour that promoted the “A Healthier US Starts Here” initiative. The tour was aimed at promoting prevention efforts for healthier living and examined projects throughout Indian country. Over 20 project sites were visited and observed and it was noted that some Tribes had established and maintained innovative and successful programs that contribute to a healthier Tribal community. The tour gave the DHHS the opportunity to see good examples of prevention programs and as a result, the DHHS developed the Healthy Indian Country Initiative (HICI).

After additional consultation and review of the prevention needs of Indian country, a cooperative agreement between the DHHS Office of Minority Health (OMH) and the Association of American Indian Physicians (AAIP) was established in the amount of \$1.2 million for the HICI project. Based on information gathered during Secretary Leavitt’s tour and the recommendations from the OMH, 14 Tribal programs were chosen to receive the HICI grant funds and of those chosen 13 accepted the grant funds. The following are the HICI project Tribal grantees:

#### **Healthy Indian Country Initiative Tribal Grantees**

1. Coeur d’Alene Tribe (*Idaho*)
2. Confederated Tribes of the Colville Reservation (*Washington*)
3. Houlton Band of Maliseet Indians (*Maine*)
4. Indian Health Board of Nevada (*Nevada*)
5. Ponca Tribe of Nebraska (*Nebraska*)
6. Little Traverse Bay Bands of Odawa Indians (*Michigan*)
7. Hualapai Tribe (*Arizona*)
8. Native Village of Minto (*Alaska*)
9. Lac Courte Oreilles Band of Lake Superior Chippewa (*Wisconsin*)
10. Lac Vieux Desert Band of Lake Superior Chippewa (*Michigan*)
11. Penobscot Indian Nation (*Maine*)
12. Rosebud Sioux Tribe (*South Dakota*)
13. Sisseton-Wahpeton Oyate Sioux Tribe (*South Dakota*)

The funds each Tribal grantee received were used to help sustain 13 Tribal prevention programs in various capacities; however, it was determined that the Tribes would also benefit from technical assistance. The HICI allowed the AAIP to also award funds to national organizations, in part to provide technical assistance to the Tribal grantees, but also for additional deliverables, each specific to the national organization. The AAIP entered into sub-contracts with the following national organizations:

#### **National Partners/Organizations**

National Indian Health Board  
(*Washington, DC*)  
National Indian Council on Aging  
(*Albuquerque, NM*)  
National Council of Urban Indian Health  
(*Washington, DC*)

Each national organization shared the overall HICI goals and objectives however each had varying deliverables in which to make the HICI project successful.

Overall, the purpose of the involvement of the NIHB in the HICI project was to 1) Serve as the coordinator for the HICI project for the national partners and Tribal grantees, 2) Provide technical assistance for the Tribal grantee programs, 3) Maintain focus on the overall goals and objectives of the HICI project to make sure they are met and, 4) Complete the NIHB HICI deliverables specifically outlined by the AAIP and the OMH.

## BACKGROUND OF THE NATIONAL INDIAN HEALTH BOARD

The National Indian Health Board (NIHB) is a non-profit organization that represents 564 federally-recognized Tribal governments and their health care initiatives – both those that operate their own health care delivery systems through contracting and compacting, and those receiving health care directly from the Indian Health Service (IHS). The NIHB provides a variety of services to Tribes, Area Health Boards, Tribal organizations, federal agencies, and private foundations, including:

- Advocacy
- Policy Formation and Analysis
- Legislative and Regulatory Tracking
- Direct and Timely Communication with Tribes
- Research on Indian Health Issues
- Training and Technical Assistance Programs
- Project Management, Assessment and Evaluation

Elevating the visibility of Indian health care issues has been a struggle shared by Tribal Governments, the federal government, and private agencies. For 37 years, the NIHB has continuously played a central role in focusing national attention on Indian health care needs. These efforts continue to gain results. Since 1972, the NIHB has advised the US Congress, the IHS, other federal agencies, and private foundations about health disparities and service issues experienced in Indian Country. The future of health care for American Indians/and Alaska Natives is intertwined with policy decisions made at the federal level and changes in mainstream health care management. The NIHB provides Tribal Leaders timely information to assist tribes in making sound, effective health care policy decisions. Through effective leadership, collaboration with the IHS, the Centers for Disease Control and Prevention (CDC), the U.S. Department of Health and Human Services, the Robert Wood Johnson Foundation, as well as other organizations, the National Indian Health Board (NIHB) is increasing public health capacity, increasing awareness and health related knowledge in Indian Country.

The NIHB represents the Tribes while monitoring federal legislation and creating networking opportunities with other national health care organizations to engage support on Indian health care issues. The NIHB is committed to promoting healthy practices,

the prevention of disease and injury, providing resources and infrastructure support, as well as providing research, data on health issues, and helping to develop Tribal and national health policy.

## GOALS AND OBJECTIVES OF THE HEALTHY INDIAN COUNTRY INITIATIVE

The HICI project had two primary objectives, the first to develop a national intergenerational education/awareness campaign about prevention activities and programs and promoting and creating a healthier Indian country. The second was to create an accessible, resourceful database of successful Tribal prevention programs that could be replicated to other Tribal communities. The overall goal of the second objective was to complement existing successful tribal programs. The HICI project combined the available federal resources for a coordinated and consistent education outreach strategy that was developed in partnership with Tribal governments for urban, rural, and national Tribal organizations. In order to achieve the overall goals and objectives, the following HICI major project deliverables were established for the overall HICI project:

1. “Promising Prevention Practices” Resource Guide that is accessible and available for distribution to the 564 federally recognized Tribes, Tribal health departments, Tribal leaders, partners, and other groups/organizations in a booklet/resource guide format and web-based format via the NIHB website.
2. Identification and evaluation of a minimum of 10 Tribal specific projects for potential transfer to other Tribal communities for inclusion in the Promising Prevention Practices Resource Guide.
3. Creation of educational materials specific to Native Elders understanding Elder health and youth issues.
4. Creation of education materials specific to Urban Indians’ understanding of prevention issues.
5. Project evaluation (final project evaluation).
6. Project reporting (narrative and financial reports).

## METHODOLOGY OF THE HICI PROMISING PREVENTION PRACTICES RESOURCE GUIDE

One of the major areas of work within the HICI was the development of this Promising Prevention Practices Resource Guide (hereafter referred to as the Resource Guide) for dissemination and replication within other Tribal communities. This Resource Guide highlights the Tribal, community-developed prevention programs of the 13 HICI Tribal grantees. To develop the Resource Guide, the NIHB coordinated training on how to document promising practices, collected information from grantees, and organized the information into project profiles. Project profiles included a description of the promising practice, the project results and outcomes, a photo gallery, lessons learned, and contact information to assist other communities in their effort for replication. The NIHB provided technical assistance to the grantees to assist with the writing/production of the individual HICI project narratives for these profile pages that are posted on the current NIHB website at [www.nihb.org](http://www.nihb.org).

## PURPOSE OF THE HICI PROMISING PREVENTION PRACTICES RESOURCE GUIDE

The purpose of the Resource Guide is to highlight the work of the HICI Tribal grantees' prevention projects/programs and to provide information for other Tribal communities to examine these community-based prevention practices and learn strategies and lessons for effective implementation of prevention programs. The long-term goal of this work is to inform and improve prevention programs and services in Indian Country by providing information that other Tribal communities can use to make their Tribal programs more effective and continue the replication of these "promising prevention programs." This Resource Guide is *not* meant to be a comprehensive review of all "promising prevention practices" in Indian Country. Additionally, the prevention practices highlighted here are considered "promising" as there is not yet the level of evidence needed to be considered "evidence-based." The purpose this Resource Guide does serve is as a tool for disseminating this information and is the first step toward reaching the goal of a healthier Indian Country by documenting these Tribal, community-based practices for future research and replication.

## ORGANIZATION OF THE HICI PROMISING PREVENTION PRACTICES RESOURCE GUIDE

The Resource Guide is organized into four chapters:

### CHAPTER 1

**Introduction and Purpose:** Describes the history and background of the Healthy Indian Country Initiative and the purpose and scope of this Promising Prevention Practices Resource Guide.

### CHAPTER 2

**Background and History:** Describes the evolution, challenges, and current status of Evidence-Based Practices, Practice-Based Evidence, and Promising Practices.

### CHAPTER 3

**HICI Promising Prevention Practices:** Highlights the prevention practices of the 13 HICI Tribal grantees and includes a description of each community, a HICI project profile, project results, successes, and lessons learned.

### CHAPTER 4

**Conclusion:** Describes the lessons learned and successful strategies identified by the Tribal grantees to assist other communities in the implementation of prevention practices.

# History and Background of Promising Practices

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IN A NATIONAL EFFORT TOWARDS ACCOUNTABILITY AND EFFECTIVENESS OF health care, the use of Evidence-Based Practices (EBP) is becoming the standard for clinical care. Every health discipline has examples of “historical treatment approaches” (i.e., we’ve always done it this way) without real evidence that it works. The same trend is occurring in the area of prevention as the United States begins the shift from high cost interventions to preventative care. Unfortunately, the historical treatment and prevention approaches are not always effective and have, at times, resulted in no-improvement at best in some cases and fatalities at worst. The move toward demonstrating evidence or research-base of the effectiveness of prevention, treatment, and intervention approaches were a step toward ensuring the best possible care for patients and their community. However, as the pendulum swings toward the sole use of clinical practices with formalized research base, new challenges and limitations have emerged, especially for ethnic minority populations and the historically underserved groups of people.

American Indians/Alaska Natives suffer from some of the highest rates of disproportionality in health care of any ethnic group in the US. The life expectancy of American Indians/Alaska Natives is 4.6 years less than the general US population and they die at higher rates from tuberculosis (750% higher), alcoholism (550% higher), diabetes (190% higher), unintentional injuries (150% higher), homicide (100% higher) and suicide (70% higher; Indian Health Services, 2009). This disproportionality argues for a focus on effective prevention in Indian Country as one of the greatest priorities of Health Care reform in the 21st Century.

Health disparities are further evident in the overall lack of qualified providers in Indian Country, as well as the lack of cultural competence of the workforce. Cultural competence impacts service access, use, and outcomes for all levels of care. Policies and procedures developed without culture in mind can

result in access problems for ethnic/racially diverse communities. For example, if a health clinic set a policy that all patients must have an appointment confirmed by telephone the day before to reduce the “no-show” rate, access problems are highly likely for those living in a culture of poverty in which telephones are a luxury. Lack of cultural competence within a program can also impact a person’s willingness to use services or attend community events and has been cited as a primary reason for early drop out of programs and services for many ethnically/racially diverse communities (SAMHSA, 2001). Finally, cultural competence is critical for ensuring that American Indian/Alaska Native populations achieve significant outcomes that match the cultural values of their communities. Without a focus on achieving positive culturally relevant outcomes through an evidence-driven system, the disproportionality within American Indians/Alaska Native health will continue to plague our communities.

## EVIDENCE-BASED PRACTICES

Although Evidence-Based-Practices (EBP) have been defined in many ways, Isaacs and colleagues (2005) discuss how, although the use and expansion of EBPs appears to be a good solution for addressing ethnic disparities, it is very possible that EBPs may widen the health disparities gap if there is not significant attention given to cultural and linguistic competence of underserved cultural-based populations. EBPs were derived from the empirically supported treatment (also referred to as Evidence-Based Treatment) movement spearheaded by the American Psychological Association Division 12 Task Force on Promotion and Dissemination of Psychological Procedures (Chambless et al., 1998). Empirically supported treatments had very narrow definitions for best-practice that were largely based on highly controlled randomized clinical trials. This means that in the highly controlled research environment, clients with restrictive demographics and without co-occurring disorders, experiencing a similar symptom presentation and severity show statistically significant improvement within the criteria identified.

Evidence-Based Practices represent an attempt to move beyond the empirically supported treatment movement by including clinical judgment and patient context (American Psychological Association, 2005). In medical practice, EBP is used to make clinical decisions about individual patients and balances research, clinical expertise, and patient characteristics. Isaacs and colleagues (2005) note that without careful attention, EBPs could be as narrowly defined as empirically supported treatments, which would likely continue to widen the disparities gap for people of color. Currently, concerns about the cultural competence of EBPs include inadequate or no inclusion of cultural variables in research samples, no examination of the impact of culture(s) on outcomes, no adequate consideration for co-occurring disorders, and not taking into account context and environment (Isaacs et al., 2005). As Isaacs and colleagues (2005) elegantly state:

*Many of those involved in the development of EBPs believe that [better outcomes] is best achieved through application of scientific methodologies and that “science” trumps culture. Those who are proponents of cultural competence believe that science is important, but that culture and other social factors, such as class, race, gender, and place, cannot be ignored. In terms of ability to produce better outcomes for ethnic minority consumers and families, “culture” may, in fact, trump science.*

## EVIDENCE-BASED PRACTICES ADAPTATIONS

Attempts to attend to cultural aspects of EBPs include various adaptations to EBPs and increased attention to Practice-Based Evidence methods. Adaptations to EBPs are attempts to modify an EBP by changes in the service delivery approach, expanding or modifications of the goals of the therapeutic relationship, or any components of the treatment to better reflect the cultures values and beliefs (A Whaley, Hogg Foundation, as cited by Echo-Hawk, Hernandez, Huang, and Isaacs, 2006). The major concern with cultural adaptations of EBP is that once certain changes are made there is concern that fidelity may be compromised resulting in the practice as no longer evidence-based; thus requiring that additional support or evidence needs to be established. Further, some of the “adaptations” have been referred to as “superficial” or “stereotypical” such as changing pictures and names to be more native-like or serving native foods at a meal (Yellow Horse and Yellow Horse Brave Heart, 2005). Cultural adaptations have been done that focus on the similar core principles of Evidence-Based Practice and Practice-Based Evidence (PBE) which does not change the validity of the EBP; however that is not necessary the norm in the cultural adaptation arena (BigFoot, 2009).

## PRACTICE-BASED EVIDENCE

In an attempt to address the challenges of Evidence-Based Practices for people of color, the concept of Practice-Based Evidence (PBE) emerged from community-based practices and approaches that have existed within ethnic/racially diverse communities. PBE are practices that come from the local community, are embedded in the culture, and are accepted as effective by local communities and support healing of youth and families from a cultural framework (Isaacs et al., 2005). Many of these PBE have been in place for years and for many Tribal communities, for centuries. These practices do not have a research base as we define research today; but they do have an evidence base developed from multiple trials of experimenting with what work best. PBE are effective in supporting healing and wellbeing within the Tribal communities from which they evolved and toward whom they are intended. Many of these practices have never undergone any degree of clinical trials however they have survived the “test of time” research.

There are two major reasons that many of these Tribal PBE approaches have never been researched. First, documenting certain culturally-based interventions may be considered inappropriate, depending upon the community cultural values, spiritual teachings, and history. Unfortunately, many Tribal communities have a history of researchers “documenting” their practices from a cultural lens that did not fully appreciate what the practice was as well as the cultural context of a practice, resulting in inappropriate assumptions and misinterpretations. The consequences for these misunderstandings were very significant for Tribal communities as many were forced to hide or deny some of these practices for fear of persecution, which eventually led to the passing of the American Indian Religious Freedom Act, but not until 1978.

Second, clinical trial research has not been possible since no research infrastructure exist within Tribal communities and only in the recent past have Tribes been involved in developing medical models for inclusion in research (i.e., NARCH; Native American Research Centers for Health). Mechanisms for ensuring that Tribal communities are including in the planning, policy, ownership, and funding decisions in major research institute’s have not been historically present. It has only been recently that Tribal communities are forming research networks that are questioning what current research policies are. For example, the National Institutes of Health, the largest research funding federal agency, currently has no policy or procedure in place for Tribal consultation. Additionally, much of the scientific research is developed and implemented in a top-down approach from universities to communities, from evidence (science) to practice. In the PBE approach, practice informs evidence.

## DEFINITIONS

Determining what practices are “evidence-based” or “practice-based” can be challenging. This is primarily due to the fact that the multiple definitions and criteria for determining each have been proposed, without universally accepted consensus. To add to the confusion, the terms “best practices” and “promising practices” have been added to the discussion without good, clear, universally accepted definitions. Although there is a need for some real dialogue that engage both academia and communities to develop universally accepted definitions and criteria, this type of discussion may take years to resolve. Unfortunately, the health disparate conditions of many of our communities cannot wait as it is costing Tribal lives and increasing the risk of more disparities. In the meantime, we must create mechanisms for getting out information about what we know to be of concern and what is currently available now. The term “promising practice” allow us to accelerate this process by disseminating information as it becomes available. Much of the work in conceptualizing the

range of practices within prevention has taken place within the Substance Abuse and Mental Health Services Administration (SAMHSA). For the purposes of this Promising Prevention Practices Guide the following SAMHSA accepted definitions will be used:

**Evidence:** Refers to data resulting from scientific controlled trials and research, expert or user consensus, evaluation, or anecdotal information.

**Evidence-Based Practices:** Practices that integrate the best research evidence with clinical expertise and patient values.

**Practice-Based Evidence:** A range of treatment approaches and supports that are derived from, and supportive of, the positive cultural of the local society and traditions.

**Best Practices:** Most often is used to describe guidelines or practices driven more by clinical wisdom, guild organizations, or other consensus approaches that do not necessarily include systematic use of available research evidence.

**Promising Practices:** Clinical practices for which there is considerable evidence or expert consensus and which show promise in improving client outcomes, but which are not yet proven by the highest or strongest scientific evidence.

## **BRIDGING THE GAP: PROMISING PRACTICES**

There is much to be learned from both Evidence-Based Practices and Practice-Based Evidence approaches. While EBP allows for accountability to consumers, their families, and the communities in which they live, PBE allows for the cultural context and characteristics that represents those consumers, families, and communities. While EBP moves toward the replicability of practices so that they are more consistently implemented, PBE allows for practices that match the community context. These two approaches to clinical care are more than just two

ends of the same coin, but rather, represent two differing orientations to what is viewed as effective and helpful aspects within specific parameters, with ultimately the same goal- improving the lives of those served. Finding a way to advance both EBP and PBE simultaneously as well as understanding how each compliments the other will be critical for addressing health disparities for American Indian/Alaska Native people. Until this important dialogue and consensus building can occur we must develop mechanisms for getting information out to our communities about what we know as been evident for helpful practices and guiding teachings for better health.

The concept of “Promising Practices” can serve as such a mechanism to bridge the gap between these two competing approaches for several reasons. First, the entire concept of a promising practice allows us to accelerate the information dissemination process by releasing practices that have “promising evidence” prior to examining the outcomes more systematically. Ongoing information dissemination is critical given the current disparities within American Indian/Alaska Native communities and the real need for prevention practices now. Second, the concept of Promising Practices allows for grassroots, community, or culturally-based interventions to be recognized. As discussed in the section on Practice-Based Evidence, Tribal communities rarely have access to the appropriate research dollars to document evidence of practices that have



been used in many communities for centuries. While there may be hesitant and general concern about the application of researching culturally and spiritually based practices, the focus on assessing what is the outcome is important. For example, the content of prayers and ceremony may not be for public dissemination, but the understanding of why the prayers or ceremonies are important can be appreciated. The actual spiritual ceremony may be held in private but the frequency of participation, the supportive nature, the length of time, the number of participants, or self talk before and after the ceremony can be assessed. Finally, as defined, a Promising Practice show promise in improving client outcomes, but the “promising” part can either be research (academia) or expert consensus (community). This allows for both Evidence-Based interventions and Practice-Based interventions to be included.

As we move toward the national goal of quality, accessible healthcare for the US population, it has never been more critical for Indian Country to formulate what works best within its own communities. This is critical for Indian Country that is already significantly afflicted with health disparities and the lack of culturally competent care to guide the formulation of defining effective practices. Identifying effective practices for American Indian/Alaska Natives broadly, can be even more challenging because of Tribal diversity, differing degrees of resources, various levels of evaluation capacity, and a number of other community, state, and national factors that contribute to how effective practices are implemented, funded, and supported. Tribal communities are forced to address these challenges in the midst of ongoing disparities and a limited workforce to adequately bridge the gap between science and practice; between what is “evidence-based” and what is “practice-based.” The identification and documentation of Promising Practices is the first step toward building the evidence for community-based approaches to health and wellness for American Indian/Alaska Native people.



CHAPTER 3

# The Healthy Indian Country Initiative Promising Prevention Practices





## Tribal Grantee Project Profiles

IN CHAPTER 3, THE HICI TRIBAL GRANTEE PROFILES OF THE HEALTHY INDIAN Country Initiative are presented. These profiles are listed in alphabetical order by Tribal community. Each section has a brief community introduction, project profile, project results, and Tribal community-based lessons learned specific to that prevention project. As described in the methodology, all the HICI Tribal grantees were provided technical support and training in documenting the development of these prevention practices. In the respect of true partnership, the NIHB is proud to honor each Tribal community for their contributions to this Resource Guide and acknowledges each of the HICI Tribal Grantee Project Coordinators who are responsible for carrying out the prevention program activities and reporting requirements for completion of their HICI project or projects. The NIHB believes that these prevention practices incorporate aspects of the mind, body, spirit, and environment and have touched and impacted the youth and families in each of the Tribal communities they are intended to serve.

Please note that each of the profiles listed in this Resource Guide were written by the HICI Tribal Project Coordinators listed and technical support was provided by the NIHB HICI staff as requested throughout the duration of the project period.



# Coeur d'Alene Tribe

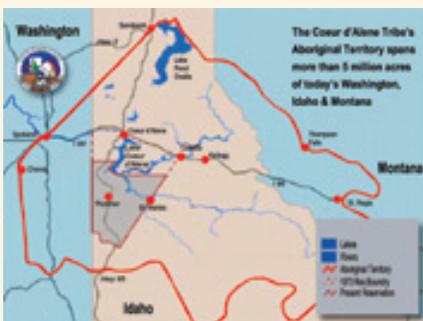
IDAHO

**Cheryl Weixel, MS Ed.**  
 HICI Project Coordinator



THE COEUR D'ALENE INDIAN TRIBE HAS a current enrollment of 1,922. The Tribe has sovereign authority on a reservation covering 345,000 acres of mountains, lakes, timber, and farmland, spanning the western edge of the northern Rocky Mountains and the abundant Palouse country.

The Coeur d'Alene Tribal Wellness Center opened in July of 1998. The center, a \$5 million facility that covers 43,000 square feet, completes an overall medical operation that is nationally award-winning and has evolved into a national model for both Indian health care and rural health care. The facility includes a five-lane 100,000 gallon lap pool, therapy pool, hot tub, and kids pool. A full-size basketball and racquetball court, indoor walking track, aerobics room, fitness and cardio equipment, community health services and health education, and conference rooms complete the Wellness Center. Programs offered include fitness classes, weight training, Hearts n' Motions, swimming lessons, water fitness classes, lifeguard training, water safety instructor training, youth sports (including football, cheerleading, basketball, wrestling, baseball, and golf), "Bigger Faster Stronger" (a sports conditioning program), Tribal Youth Council, Washington State University Youth Leadership Camp, Rock n' the Rez summer day camp, and youth employment training.



## PROJECT PROFILE

The Rock n' the Rez program is a five week day camp for youth ages 5 to 12 year olds. It runs Monday-Thursday from 9:00 am-5:00 pm. Rock n' the Rez has three camps within the program, youth can decide which camp to attend. Camps offered:

- Traditional/Cultural Camp, where youth learn the language, how to make and play stick games, tanning hides, beading, and basket weaving.
- Performing Arts Camp, where youth learn how to dance and sing. Dances include Hip Hop, Salsa, and Ballroom. This is where they share and perform live what they have learned. It is a big community celebration.
- Youth Leaders, they spend six weeks of training to be youth leaders, they are hired employees that help supervise, teach, and organized the Rock n' the Rez program, without the youth leaders we would not be able to have a program.

The impact of the program within our community is tremendous. The programs provided a chance for our youth to experience activities that they may not ever have an opportunity to experience. The youth have awesome memories that will last a lifetime. As for the Youth Leaders they are our future employees, they learn how to teach, be on time, be responsible and have a productive summer. This is not just a summer program, this is an experience and an opportunity for all the youth to grow, be healthy and active. Two hundred kids attended this year.

Youth Leaders (ages 16 to 18) and Assistant Youth Leaders (ages 13 to 15) are trained to supervise and teach various activities to youth who participate in the summer program. The Assistant Youth Leaders Employment Program was started as a recruitment and training program to provide youth ages 13 to

*“The program has been successful because of the consistency with staff and funding.”*

15 an opportunity to work during the summer and help supervise and teach activities to other youth.

In order for the youth to become Youth Leaders in the Rock n’ the Rez program they must apply for the positions. The employment training for the Youth Leadership positions consists of three classes:

- How to fill out an employment application
- Writing a resume
- Interview skills

Upon completion, the applicant proceeds through the Benewah Medical Center employment process, which consists of filling out an employment application, submitting a resume, and going through an interview. When the Youth Leaders are hired, an intensive training program begins and lasts for up to 4 weeks. The training program includes attendance at the Washington State University Leadership Camp for one week. Training also includes:

- First Aid/CPR
- Coeur d’Alene language. To help revitalize the Native language, we teach it to our youth leaders so they can be role models and teach it to the kids in the program
- Conflict resolution
- Anti-Bullying. Participants learn strategies to help intervene in childhood bullying, harassment, and conflict resolution
- Classroom management
- Hip Hop dancing
- Cheerleading
- Drama
- Positive discipline
- Team building
- Physical Activity Kit (PAK) Training (Indian Health Service Physical Activity Training)
- Water safety

The above training is designed so Youth Leaders have the resources and tools to manage a classroom situation.

### **PROJECT RESULTS**

The Rock n’ the Rez program started with 35 youth and grew to an average of 150 youth and 30 youth leaders. The program has been successful because of the consistency with staff and funding. Among the specific reasons for our success:

- Ms. LoVina Louie: She has been the heart and soul of this program and continues to make the program what it is today. Her vision and energy has always steered us in the direction we needed to go.
- Tribal funding: The Tribe continuing to fund the Rock n’ the Rez program every year has been instrumental in keeping this program going.
- Community: The community “buy in” was also important due to the emphasis on youth leadership, as well as the difference the program made in so many youth lives. The Tribal Council heard and saw the importance of the program, the community support, and in turn fully supported this summer program.
- Youth: This is our most important aspect. Our youth make difficult choices everyday to participate in healthy and safe activities.
- 90% of the Assistant Youth Leaders completed the job training requirements.
- 100% of the youth completed the job training requirement.

Feedback from the parents of participants of the Rock n’ the Rez summer camp was positive and insightful. We appreciate and listen to all the feedback from parents and ask for their assistance in the development of the youth leaders program and assist in building communication skills and the development of professionalism while in the workplace.

### **LESSONS LEARNED**

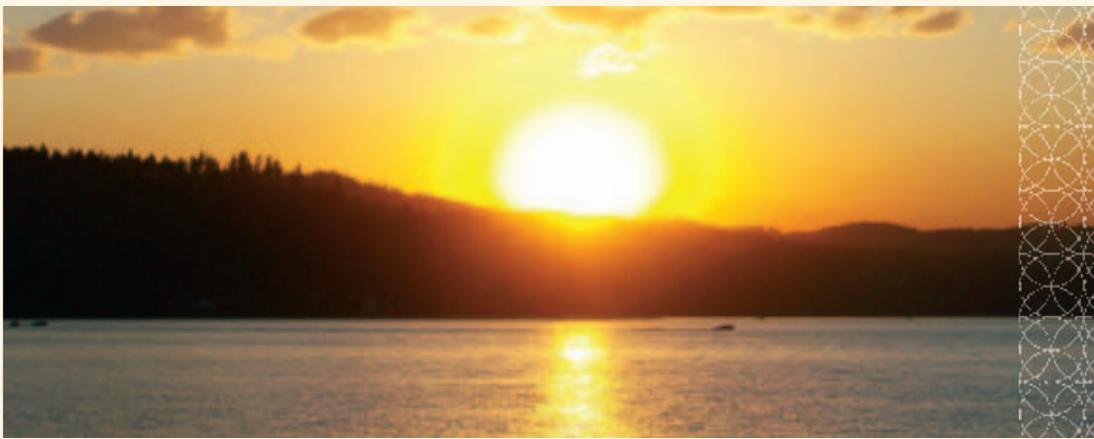
The following attributed to the success of the Rock n’ the Rez program. The Assistant Youth Leaders training took place throughout the year and allowed for weekly meetings to design and implement activities that would be conducted at the community Youth Centers. This would help the Assistant Youth Leaders by allowing them to work in a small controlled environment, give the Assistant Youth Leaders a chance to teach and see first-hand how the kids responded to their activity, and the Assistant Youth Leaders can instantly see their strength and weaknesses. The Rock n’ the Rez project is an important part of this community and we always strive to make it better by learning from the past and preparing for the future.

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# Confederated Tribes of the Colville Reservation

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HICI Project Coordinator



THE COLVILLE CONFEDERATED TRIBES (CCT) are federally recognized and was established by Executive Order of President Grant on April 9, 1872. The 1.3 million acre CCT reservation is located in the North Central section of Washington State. Current Tribal enrollment is estimated at approximately 8,700, with 58% of the membership living on the reservation. The current population residing on the reservation is estimated at approximately 5,000, which includes Tribal and non-Tribal members. The Colville Indian Reservation has four districts: Omak, Nespelem, Keller, and Inchelium.

The Colville Confederated Tribes Behavioral Health Program (BHP) provided a series of gatherings for each of the four districts on the reservation with a two-day conference focused on understanding multigenerational trauma. The conference shared knowledge of identification of historical trauma effects and knowledge to heal wounded spirits. The next step will be to invite White Bison, Inc. to each district for a vision session to further define a plan for healing. This will be followed by the Seven Trainings offered by White Bison, Inc. as part of the Wellbriety Movement.

## PROJECT PROFILE

From Legacy to Choice was a suicide prevention program that was run by the Colville Confederated Tribes (CCT) from January 2008 to December 2008. The project enrolled 105 participants and received additional funding for this prevention project from the Association of American Indian Physicians (AAIP) for the Healthy Indian Country Initiative. The HICI project built on previous lessons learned from suicide prevention initiatives that were also run by the CCT.

## PAST INITIATIVES

In 2006, the CCT experienced a dramatic increase in suicides. The cluster of suicides that affected our community was approximately 20 times the national average and five times higher than the rate for other Washington State American Indians/Alaska Natives (AI/ANs). A multidisciplinary suicide core team was established, which consisted of the Behavioral Health Program, Colville Tribal Police Services, Indian Health Services, Children and Family Services, Fire and Rescue (Emergency Medical Services), a Clinical Psychologist, a Service Department Supervisor, the Tribal Health Program, Temporary Assistance for Needy Families (TANF), and Correctional Centers.

The Core Team reviewed various promising approaches targeting suicide. One program selected for implementation in 2007 was the Native Helping Our People Endure (HOPE) project. Native HOPE

*“It was determined that addressing multigenerational trauma or historical trauma would be a necessary part of preventing suicide.”*

—TRIBAL COMMUNITY MEMBER

was selected with the goal to strengthen the capacity of AI/AN teens and young adults to help each other in leadership development and suicide prevention. The CCT trained more than 150 youth in this three-day workshop and more than 27 adults and youth to become facilitators of the trainings.

Based on the work of Native HOPE, feedback from the youth participants, and ongoing discussions among the Core Team, it was determined that addressing multigenerational trauma or historical trauma would be a necessary part of preventing suicide. The CCT began this important work by conducting two-day workshops on historical trauma in each of the four communities. These workshops served to inform community members about the role of historical trauma and its negative impact on the community (for example, suicide, substance use, and violence).

From this initial two-day workshop, a more comprehensive five-day workshop was implemented in three of the four communities. The workshop, titled “From Legacy to Choice,” was designed to:

- Help members of the community in trauma and grief work;
- Improve communications between community members;
- Increase understanding of community trauma;
- Increase support systems;
- Empower community members to work together to deal with problems as they happen in order to prevent continued community trauma passing from generation to generation.

From Legacy to Choice workshops were held in the Nespelem, Omak, and Inchelium communities with a total of 120 participants and staff in attendance.

## PROJECT RESULTS

Moving through the issues of historical trauma, and grief improved communications between community members; increased understanding of community trauma; increased support systems; and empowered the community members to work together to deal with problems in order to prevent continued community trauma passing from generation to generation.

Evaluation of the program was conducted through pre- and post-surveys as well as interviews. Significant outcomes included:

- The top two reasons participants attended the workshop were to increase personal knowledge about the historical trauma and to become a better helper with youth, family, and the community.
- In addition to suicide, drug and alcohol abuse, dropping out of school, and violence, 10% of participants voiced these additional problems in the community: hopelessness; and miscommunication or lack of communication.
- When asked, “What would help you continue to heal?” a majority of participants requested additional information about the community trauma, access to support groups, opportunities to release and express emotions, a place to practice and gain confidence with coping skills, working on this with friends and family, and allowing for more time.
- In addition to feelings of fear and shame around historical trauma, participants added a lack of trust as a reason this topic could not be discussed.

Through the program evaluation, participants also conveyed a process in which they engage in **self-help**, through developing personal coping mechanisms to deal with feeling of fear, shame, and/or guilt, **in order to help others** (family, friends, community) and through helping others, find affirmation and accept that they themselves can reach out and **accept help from others**.



*“The ‘From Legacy to Choice’ workshops are an exceptional promising practice for other Tribes to consider for their people.”*

—TRIBAL COMMUNITY MEMBER

## SUCCESES

Although there was not a specific staff member assigned to this project, the ability of various community members/leaders to come together and make the project a reality was remarkable. Various members of the suicide Core Team provided staff, financing, and equipment to make this project a success.

Another important success was the positive feedback we received from the people who attended the workshops. Many attendees learned valuable skills to help them cope with the negative impacts of historical trauma.

The community feedback we received will guide future suicide prevention activities. For instance, members of the suicide core team are actively involved in starting natural healing systems within each of the communities. These natural healers are meant to address issues surrounding loss and historical trauma and how they relate to suicide. This approach will involve youth, young adults, and elders working collaboratively to address the complex challenges surrounding suicide prevention.

## LESSONS LEARNED

One primary obstacle to this project was the scarcity of resources (staff, financial, and time). There was not one specific staff member assigned to oversee this project; therefore, members of the suicide core team dedicated themselves to the project's completion. This presented a serious challenge given that the team members were employed full time, but the project became a reality due to the commitment of key stakeholders.

Another obstacle encountered early in the project was that some members of the community did not understand the relevance and importance of historical trauma. As a result, there was some initial hesitation to proceed with some of these community workshops. In light of these obstacles, it is important for other communities to consider assigning staff to oversee the project.

Another consideration is the importance of providing background information to the community and key stakeholders before the project begins, especially highlighting the relevance of historical trauma to the needs of the local community.

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# Houlton Band of Maliseet Indians

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IN THE EARLY 1970'S, SOME MALISEET and members of other Tribes not living on recognized reservations banded together to form the Association of Aroostook Indians, which eventually allowed them access to federal and state programs. The Houlton Band of Maliseet Indians (HBMI) has been federally recognized as a government by the United States of America since October of 1980. This federal recognition gives HBMI a unique government to government trust relationship with the United States. In turn, recognition entitles the Houlton Band to many services provided to Indians by the United States of America, including health care through Indian Health Services (IHS), housing through the United States Department of Housing and Urban Development (HUD), and the ability to govern our own Tribal Affairs.

The Houlton Band of Maliseet Indians is comprised of some 800 members and is lead by a Tribal Chief. A smaller band of the larger Maliseet Nation of New Brunswick, Canada, the Houlton Band calls the Meduxnekeag River home. The Maliseets are river people who have traditionally been hunters and gatherers in the St. John River basin, of which the Meduxnekeag is a tributary.

The Maliseet Health Department has established a comprehensive prevention program for Tribal and community members of all ages. The program included health education and health promotion events focused on youth, elders, and fitness and clinic based activities.

## PROJECT PROFILE

The goal of the HICI Project within the Maliseet Community was to promote a healthier lifestyle through prevention programs and activities. These activities were designed and implemented to increase awareness of making healthy choices and provide the opportunity for learning and participation.

The project primarily focused on tobacco cessation/prevention, increased physical activity, and diabetes management; and indirectly addressed weight loss/management, stress relief, and diabetes prevention/management. The activities for each of the Project areas ranged from hands-on involvement to classroom-type education sessions. The project aspired to reach the greatest number of community members to share the message of healthy living.

Activities specifically geared toward the youth included:

- *“Knock Out Smoking” Bowling Tournament*: a six-week tobacco prevention activity with the goal of reaching and educating 20 youth through program participation. It is a bowling tournament where each pin represents a cigarette.
- *“GPSing Tobacco Road”*: a community walking event in which youth found educational tobacco prevention messages along the trail during the activity. The curriculum was provided by the Boys and Girls Club and the path used GPS units to create the trail and the prevention messages were placed along the trail path by the staff.

Activities specifically geared toward the family and community members included:

- “*Healthy through the Holidays Challenge*”: a six-week challenge encouraging HBMI staff and community members to make healthy choices throughout the busy holiday time from Thanksgiving to New Years. The focus of the program was adequate intake of water, fruit, and vegetables, as well as participating in some form of physical activity each day.
- “*Diabetes Self-Management*”: a program to educate the local medical community on how to promote behavioral change in patients with diabetes. The program provided a guest educational speaker and follow up session for those pre-diabetic and their support individuals.
- “*Returning to Our Traditions*”: a smoking cessation informational program for Tribal Elders with a goal of reaching 25 elders and family members encouraging them to stop smoking and/or support their loved ones in the endeavor to stop smoking
- “*Trek to Katahdin*”: a 12-week Training Challenge to reach the grand total of 65 Trek Training Miles and the Final Relay.
- Fitness Classes: including Bike Rodeos and Water Aerobics

## PROJECT RESULTS

Overall the Maliseet Community found positive results from all of their programs. Through the Youth activities the project found the “Knock Out Smoking” Tournament improved the knowledge of tobacco prevention from a score of 34% on the pre-test to 73% on the post-test. Twenty-eight youth participated in “Knock Out Smoking” knocking down a total of 1,148 cigarettes over the six-week tournament.

Through the Community activities the Maliseet Community found positive feedback from the “Healthy through the Holidays Challenge” as participants enjoyed receiving incentives and found the physical activity goals to be attainable. There were 17 participants with nine completing all six weeks of the challenge. The “Trek to Katahdin” proved also to be a success with 18 “trekkers” ranging in age from 7 to 65. Each participant contributed to the 65 mile route by walking, running, or biking.

## LESSONS LEARNED

Although each setting was different, the Maliseet community does provide the following general recommendations:

- For youth programs, the community would recommend a similar program to “*Knocking Out Smoking*” for those looking for a fun, educational activity for youth of all ages.
- For outdoor activities such as the “*GPSing Tobacco Road*,” it is suggested that an alternative date be coordinated in the case of bad weather.
- For all community-wide programs advertisement is important. The Maliseet Community suggest flyers to the community, emails to staff members, and a “Welcome to the Challenge Brunch” was held to go over the details of the programs.
- For the Elder community, it is suggested to use high quality video with large images and suitable audio for their sight and hearing needs.

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# Hualapai Tribe

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THE HUALAPAI TRIBE HAS A 992,463 acre reservation, located in northwest Arizona along the south rim of the Grand Canyon. According to the 2000 Tribal census reports, there were 1,928 residents living on the reservation, with 56% under the age of 16 years. The local 2006 Indian Health Service (IHS) and 2007 Hualapai Diabetes Program records indicate that among adults, 43% have been diagnosed with Type 2 Diabetes Mellitus (DM); and 30% of DM patients have cardiovascular disease or significant risk factors, such as high blood pressure. In recent years, the age of DM diagnosis has declined, which leaves great concern about this debilitating condition as it begins to affect the Hualapai youth at more significant rates.

## PROJECT PROFILE

The Hualapai Tribe's Healthy Indian Country Initiative (HICI) project encompassed four prevention activities to address the impact of diabetes in our community:

### Diabetes Support Group

The aim of the Diabetes Support Group is to provide a forum for participants in the Hualapai Cardiovascular Disease (CVD) Risk Reduction Program, locally known as the *Hualapai Healthy Heart Program*. This forum allows participants the opportunity to share experiences, maintain the bonds created in the program's health education classes, learn new health behaviors, and to have fun together. The program focuses on the topic areas of diabetes and healthy eating.

The support group meets once a month from 5:30 pm-7:30 pm. The meetings provide time for visiting with other members and a sharing activity and food is provided "potluck" style. Activities have included:

- Healthy cooking – led by a Healthy Heart staff member.
- Exercising with dyno-bands and videos – led by a Healthy Heart staff member.
- Introduction to the equipment available through the local Fitness Center – led by a Healthy Heart staff member.
- Beading – led by a Diabetes Support group member.
- Scrapbooking – led by a Diabetes Support group member.

- Healthy lifestyle presentations – offered by local and outside health educators.
- The group, together with the Healthy Heart staff, has also coordinated field trips such as a trip to Phoenix to attend the Diabetes Expo and an overnight camping trip in a forested area of the reservation.

### Family Gathering Project

The Hualapai Tribe's *Family Gathering Project* is aimed at addressing historical and multigenerational trauma within the community by providing activities that give families an opportunity to enjoy healthy foods and honor themselves and other families as the true strength of the community. Planning for the event is a two-three month period where the planning committee meets once a week. Tribal departments and programs are consistently represented throughout the planning process.

In 2005, the Hualapai Tribal Council sponsored the coordination and implementation of a Father-Son Gathering and Mother-Daughter Gathering. The intent of these events was to re-enforce bonds within families. Coordination of two large events required significant time and personnel. In 2008, the decision was made to combine the events into a single Family Gathering.

The annual, one-day events have consistently offered opportunities for participants to:

- Try novel activities, e.g. archery, climbing wall, and jumping castle.
- Compete with other families in horseshoes, volleyball, and softball.
- Participate in traditional Hualapai cooking.
- Play traditional Hualapai games.
- Hear local (Hualapai or other Native) inspiration speakers.
- Honor those who have strengthened the community.

### Sobriety Festival

The goal of the *Sobriety Festival* is to provide substance abuse education and alternatives to alcohol for the Tribal community. The Sobriety Festival is an annual event held in June by the Hualapai Tribe since 1998. The goal of the festival is to provide substance abuse education and alternatives to alcohol for the Tribal community. The project focuses on the topic area of alcohol/drug prevention and has an intergenerational target group. The Sobriety Festival of 2008 was held from June 19 to June 21. There were 82 participants on the first day and 104 the second day.

The 2008 festival included the following activities:

- Participant's pictures were taken and displayed on a large piece of paper. The participants wrote positive affirmations on each other's papers.
- The participants made diagrams of their River of Life, which is a representation of their life from birth to the present time. They drew, cut out magazines or used craft materials. The River of Life drawings/collage was inspiring and sparked discussion during the sharing period.
- The Salt River Pima-Maricopa Indian community members gave a presentation describing their crisis team and response process, an unmet need in our community. The presentation was intended to provide community members with information that would allow them to see the prevention possibilities for our community.
- Educational presentations were done on HIV/AIDS/STD Awareness.
- A local Tribal member talked about his life in sobriety.
- A presentation was made on Protecting You/Protecting Me.
- Healthy family games were played, including horseshoes and cultural games.
- A Matrix Honoring Ceremony was held. Eleven Matrix graduates were invited, eight attended. The graduates were given the Red Road book, a certificate and a steak dinner. The Hualapai Cultural Singers/dancers provided entertainment. A Mini Alcolthon was held after the dinner. The participants were from various Alcoholics Anonymous (AA) groups within Northern Arizona.

- A six-mile walk in memory of those that passed away from substance abuse or and its complications was held on old Route 66. A breakfast was provided for the runners and walkers after the run/walk which ended the 2008 Sobriety Festival.
- The local programs that assisted with the event included: Behavioral Health, Medical Transportation, Community Health Representatives (CHR), Tobacco, Multi-Systemic Therapy, Women, Infants, and Children (WIC) program, Recreation, Emergency Medical Services (EMS), Law Enforcement, Cultural resources in the communities, Indian Health Service (IHS), Community Workers, Head Start, Hualapai Lodge, community members, Hualapai Singers and Dancers.

### Youth Camp

The Hualapai Youth Camp is a week-long experience held at a Tribally-owned facility located in the forest, 40 miles from Peach Springs. Youth Camp activities are designed for youth 8 to 13 years and involve interactive health education activities, healthy food preparation, regular physical activity and field trips with elders and/or cultural experts to culturally relevant sites (e.g. petroglyphs and plant gathering areas).

The aims of the Youth Camp are to:

- Increase youth’s knowledge of healthy food choices.
- Increase youth’s knowledge of health behaviors associated with the prevention of Type 2 Diabetes.



## PROJECT RESULTS

Events are well attended by individuals of all ages. High attendance is linked to adequate notice/advertising and Tribal council’s willingness to grant administrative leave for Tribal employees to attend events that are held during a weekday, and during working hours.

### Attendance averages:

- The Diabetes Support group has an average monthly attendance of five participants. This number represents about 8% of the total number of Healthy Heart enrollees.
- The Youth Wellness Camps have an average attendance of 15 youth, between the ages of 8 and 13 years.
- The Healthy Family Gatherings have an average of 200 participants ranging in age from newborn to 90 years of age.
- The Sobriety Festival has an annual average of 100 participants ranging in age from 10 to 75 years.

### Factors that Increase Success:

- Small residential proximity: All Hualapai community members live within a 15 mile radius around the Peach Springs town center. Event participants can walk, catch a ride, or drive themselves to the events. Transportation and gas costs are *not* a deterrent for the community.
- Social cohesion: Participants anticipate that they will see friends and family and the events will give them a chance to “visit.”
- Food: All events provide healthy meals and snacks.
- Pre-printed and posted agenda: Participants can review the agenda and make a decision to attend all or part of the event.
- Door prizes and incentives: All events offer t-shirt/sweatshirts and/or other health promotion incentives, e.g. pedometers, lunch bags, etc. Incentives are publicized throughout the marketing of the events.
- Presence of leadership: When the Tribal Council members are scheduled to speak, participation in events generally increases during that time period.

- **Planning committee:** The majority of the planning committees are community members who have a sense of what events, incentives and time would be preferred by their peers.
- **Family Friendly:** General acceptance to allow entire families, members of all ages to attend.

### Factors that Create Barriers

- **Event timing:** No one time works for all community members. Although administrative leave is granted to Tribal employees to attend, leave is not granted for federal employees (i.e. Bureau of Indian Affairs, Indian Health Service, Law Enforcement) and therefore creates a barrier for those individuals.
- **Unanticipated events:** The most notable event would be the death of a community member who is linked by family or community role to a large numbers of people. Such occurrences have caused poor attendance at scheduled events. In such a small community, unanticipated events are even more disruptive.
- **Participation of Leadership:** The inability of the Tribal Council members to participate due to their work schedules impacts their ability to attend the events.

The events have led to community awareness of serious chronic health problems that affect many community members. The community awareness and involvement in events has made the Tribal leadership aware of these chronic health programs and they are willing to address these concerns when the resources are available in the community.

The Tribal Council has been encouraging and open to the Health Department's requests for Tribal resolutions in support of proposals for external funding to develop sustainable interventions. Further, the HICI project has created new opportunities for the community, including some recently funded interventions/programs which were formed due to the enhanced awareness created by the HICI projects. Some of these newly funded programs are:

- **Each One, Reach One:** A Native American Research Center for Health (NARCH) research project funded by the IHS and National Institutes of Health (NIH). The project proposal included a physical activity promotion intervention used data on community-based strategies from the Youth Wellness Camps, Healthy Family Gathering and the Sobriety Festival in the grant application.

- **Drug Free Community Mentoring Grant:** This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The state of Arizona used data on community interest and perception of substance abuse problem from the Sobriety Festival in proposal development.
- **State Funding:** Arizona Governor's Office on Children, Youth and Families, Division of Substance Abuse Policy funded a Hualapai Underage Drinking Prevention Program that used data on community interest and perception of substance abuse problem in the proposal from the Sobriety Festival.

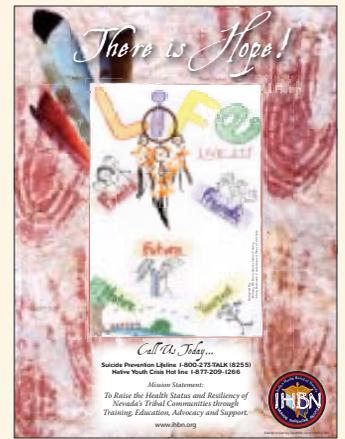
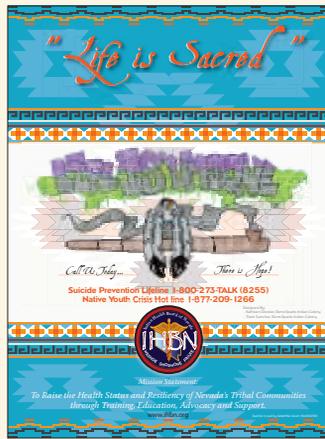
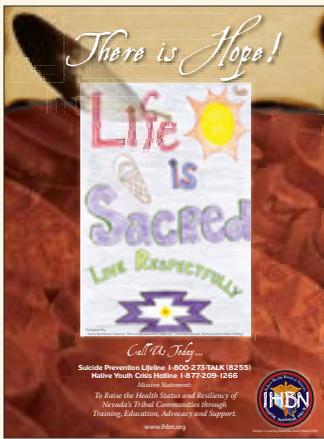
### LESSONS LEARNED

An on-line, easily accessible, handbook on program design would have greatly benefited this project. The planning committee needed some guidance on how to design, publicize, coordinate and evaluate community-wide events and programs. Further, the community needed training on how to create an idea map or logic model to guide their work. The training needed in a program design handbook would include:

- How to develop and implement simple evaluation.
- How to conduct various evaluation methods such as reflective post experience questionnaires, exit interviews, key informant interviews, etc.
- How to record and enter data from the evaluation results.
- How to analyze and summarize evaluation results.
- How to design presentations/documents to disseminate results.
- How to use program outcomes to modify existing programs and to design new programs.

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# Indian Health Board of Nevada

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**HICI Project Coordinator**



THE MISSION OF THE INDIAN HEALTH Board of Nevada (IHBN) is to raise the health care status of Indians living in the state of Nevada. The IHBN provides Nevada Tribal Leaders with the information they need to make decisions in support of advocacy for full funding for Indian health programs in their area. Examples include support for budget formulation with the Indian Health Service, the US Congress and the current Administration; and support for consultation with federal agencies concerned with health care-especially the Indian Health Service.

The IHBN initiative, Methamphetamine Education and Prevention Project began due to data from provided by the Substance Abuse & Mental Health Services Administration (SAMHSA) that indicated that methamphetamine addiction grew by 58% between 1995 and 2005. Nevada now ranks first in the country in the number of people who have used methamphetamine (“Meth”) in their lifetime; first in the number of people who used Meth in the past year; and first in the number of people who used Meth in the past thirty days. These data also indicated that one Tribal health clinic showed Meth abuse cases represented 9% of the population. As a result of the prevalence of Meth abuse cases in the State of Nevada, Governor Jim Gibbons established a Governor’s Working Group on Methamphetamine Use immediately after his inauguration in January 2007. The IHBN conducted a Methamphetamine Education and Prevention Tribal Project to emphasize education and prevention as part of a long term strategy of addressing the Meth problem. This was important to ensure that future generations of Indian youth have the opportunity to maximize their opportunities unimpeded by the debilitating effects of Meth use, directly and indirectly.

## PROJECT PROFILE

With this HICI project, the IHBN on behalf of Nevada’s Tribes gathered existing data sources to ascertain the prevalence and incidence of Meth abuse in Indian communities. This effort underscored the commitment on the part of Nevada Tribes to support Nevada Governor Gibbon’s Working Group on Methamphetamine Use as well as educate the Working Group on the needs of Tribes as it developed its recommendations to the Governor submitted in 2007. The IHBN also financed the participation of Nevada’s 22 Tribes at a one-day Methamphetamine educational seminar in Nevada that was conducted by the Centers for Disease Control and Prevention (CDC) Agency for Toxic Substance and Disease Registry (ATSDR). This was built upon the ongoing collaborations between Region IX and the CDC/ATSDR for the development of a Meth prevention seminar designed for a broad audience including public health professionals, environmental health professionals, social services providers, law enforcement and hazardous materials professionals and public policy professionals.

### Statewide Native American Coalition (SNAC)

This is a statewide Native coalition that was formed to address substance abuse issues in Indian Country. Meetings have been held with the SNAC staff to identify education and prevention efforts implemented by the SNAC to reduce duplication and increase the effectiveness of the IHBN’s Meth prevention program. These meetings have identified the SNAC efforts, strengths, and areas requiring additional responses. Based on these meetings, the IHBN has identified areas that will be addressed and types of programs to be developed in the future. Moreover, the IHBN has, as a result of these meetings with

the SNAC, concluded that meetings with various organizations and groups are required to ensure that stakeholders are involved in the conceptualization and implementation of the approach to be taken by the IHBN's Meth prevention program efforts. As a part of this coalition, the IHBN worked with partners to identify a process for the development and implementation of the Statewide Methamphetamine Summit. The Summit occurred in the Spring 2009 and brought together various Tribal organizations such as Social Services, the Health Department, Environmental Health Department, Law Enforcement, Judicial, and elected Tribal officials together with workshops designed to educate, inform, and identify comprehensive solutions to the Meth problem.

#### **Nevada Tribal Police Chief Coalition (NTPCC)**

The IHBN met with the Nevada Tribal Police Chief Coalition (NTPCC) spokesperson to discuss the IHBN's Meth prevention efforts and requested their involvement in the conceptualization and development of the IHBN's prevention program. The IHBN's efforts were enthusiastically received and welcomed and in mid-August 2008, the IHBN met with the NTPCC to begin planning and developing Meth prevention modalities which supports Tribal law enforcement efforts to reduce the incidence of Meth abuse in Indian Country. This meeting was held on August 29, 2008 in Fallon, NV. The Tribal Chiefs of Police from five Police Departments were in attendance as was staff from the SNAC. The IHBN presented the Goals and Objectives of the HICI award and requested input regarding training needs as perceived from the law enforcement perspective. All agreed that Training was needed in the area of:

- Tribal Councils and elected Tribal officials;
- Tribal judges and the judiciary system; and
- Advocacy at the State level to increase cross-jurisdictional cooperation.

The NTPCC expressed concern over the lack of Homeland Security Funds available to Tribal governments – especially since a majority of the Methamphetamine was being transported through the Mexican border to Nevada. A strategy to bring attention to the Meth problem was conceptually developed: Have Tribes identified the Meth problem on Tribal lands as an “Emergency” and as a “national security” issue. Follow-up meetings will be developed and scheduled to plan the Meth Summit. Moreover, plans were developed to have presenters

during the Region IX Federal Inter-Agency Tribal Consultation on September 9-10, 2008, in Sparks, Nevada. The IHBN believes with NTPCC's involvement and participation in the planning process, a program can be developed with is responsive to their needs.

#### **Nevada March of Dimes (NMOD)**

The IHBN met with the Nevada March of Dimes (NMOD) to discuss the Meth program among Nevada's Indian community. The IHBN's reason for meeting with the NMOD is discuss their involvement in the development of a prevention program designed to prevent the problems associated with the use of Meth during pregnancy. Plans include the implementation of an education program that is culturally and socially relevant to the Indian community. These efforts will target potential mothers and pregnant mothers and educate them on the health-related issues resulting from meth usage. In addition to these efforts, the NMOD is planning to implement a Training and Education program which targets Tribal healthcare providers to work with and prevent the future use of meth in their communities. The NMOD plans to provide classes to nurses who will then be able to:

- Perform a comprehensive psychosocial assessment of a pregnant woman.
- Provide accurate information to parents and others about the impact of prenatal substance use on later child development.
- Conduct a brief intervention with a pregnant substance user to aid the woman in moving toward positive change.
- Effectively refer a pregnant substance user to an appropriate treatment program.
- Provide appropriate monitoring and supportive care to a chemically dependent woman in labor.

#### **Region IX Federal Inter-Agency Tribal Consultation**

On September 9-10, 2008, the Department of Health & Human Services (DHHS) Region IX in collaboration with the IHBN sponsored a Federal Inter-Agency Tribal Consultation meeting in Sparks, Nevada. In addition to the federal agencies, State of Nevada officials heard the NTPCC present their concerns regarding the epidemic nature of Meth abuse in Indian country and the cross-jurisdictional non-cooperation between Tribal and

local law enforcement. The Nevada Attorney General's office will investigate the matter and ensure that cooperation does exist. During this meeting, discussions were held with the DHHS Region IX Environmental Protection Agency during which the agency agreed to provide training program on the dangers and impact of Meth on investigating law enforcement officers. In September 2009, a follow up Region IX Tribal Consultation was held in Sparks, Nevada. This meeting was held in an effort to determine progress made since the last meeting in 2008. The Attorney General's office is currently developing a Memorandum of Agreement (MOA) between the Nevada Highway Patrol and the Tribal Police Chiefs Association. This draft will be disseminated in early 2010 for review and finalization later in the year.

### **Media Campaign**

In early 2009, the IHBN met with an advertising firm to develop plans to implement a media campaign in two targeted areas of the state. First, a radio spot with a one-minute anti-meth message was developed. A script was developed and two Tribal members were hired to present the message: one in Paiute and the other in Shoshone. These ads are currently being aired in the Churchill County area and will be ongoing for a period of six months. In addition to these messages, a billboard is currently being designed by the ad agency that will be placed on Interstate 80 in northern Nevada and the message will be in the Shoshone language. The purpose of this is two-fold: 1) to express the anti-meth message and 2) reinforce the language and culture of the peoples of Nevada.

### **The Methamphetamine Prevention Summit**

In April 2009, the sponsored Meth summit was held in Fallon, Nevada. The meeting brought together approximately 125 individuals including judges, Tribal attorneys, Tribal substance abuse counselors, Tribal police officers, and social workers, the Nevada Attorney General and Nevada's First Lady, Dawn Gibbons. Issues related to jurisdiction, barriers to collaboration between law enforcement agencies, treatment methodologies, and effects on family and communities. The Meth Summit accomplished the plans originally developed to ensure a statewide meeting to discuss the meth problem among Nevada's Tribal community.

## **PROJECT RESULTS**

The original stated goals of the IHBN, to gather existing data sources to ascertain the prevalence and incidence of Meth abuse in Indian communities did not change through the duration of the IHBN HICI project. The commitment on the part of Nevada Tribes to support Nevada Governor Gibbon's Working Group on Methamphetamine Use as well as educate the Working Group on the needs of Tribes as it develops its recommendations to the Governor was completed by the stated plan, agency meetings, staff interaction, and cross trainings. The comprehensive outreach plan to educate the community on the prevalence and incidence of Meth abuse in the state of Nevada allowed the current staff for this HICI project to be efficient and innovative.

The project focused on systemic change and therefore, a process evaluation method was used to determine the impact of the project on the local Tribal community and the statewide efforts for Meth prevention. In addition to the training provided to the 124 professionals at the 2009 Health Summit there were a number of system level outcomes that resulted in capacity building, policy changes, and sustainable partnership that will move Nevada toward their goal of preventing Methamphetamine use in Tribal communities in Nevada and throughout Indian country.

The major project outcomes are as follows:

- Leadership and involvement in Statewide Meth Prevention Efforts through the SNAC.
- 2009 Statewide Meth Summit, training of 124 professionals from diverse disciplines.
- 2007 Governor's Strategic Approach to Methamphetamine Use in Nevada. This document outlines the following plans for Tribal communities in Nevada:
  - a) Addressing law enforcement problems involving various restraints across Tribal, county, and municipal jurisdictions.
  - b) Development of a comprehensive law enforcement plan between Tribal, state, and local offices with completion of a MOA between agencies.
  - c) Continue and broaden information sharing between state, local, and Tribal agencies and allow appropriate access to information to those agencies that are affected by a drug crime.

- Beginning work with the Nevada Tribal Police Chief Coalition for a comprehensive strategy for Tribal Law Enforcement with the goal of reducing Meth use in Indian Country.
- Partnership with Nevada March of Dimes to develop a program focused on reducing Meth use during pregnancy. Additionally, the March of Dimes is preparing for Training and Education of Tribal Health Nurses to address Meth prevention.
- In the process of developing a MOA between the Nevada Highway Patrol and the Tribal Police Chiefs Association. The draft is scheduled to be released in early 2010.
- Development of a radio spot with 1-minute anti-meth message in two languages: Paiute and Shoshone. This radio spot is currently being aired.
- Development on an anti-meth billboard in Shoshone language.

## LESSONS LEARNED

The development of the HICI project provided some lessons learned with the coordination and collaboration effort of the IHBN and the collaborating agencies. A project when originally planned is not the same once it “hits the ground.” The flexibility to adapt the project to the actual environment is critical and the strength of this project effort was its flexibility. Outreach efforts cannot just be a “one time” effort, it has to be constant otherwise interest wanes and the momentum is lost.

When working with the Tribal Police Chiefs Association, their interest was mostly in hardware, i.e. tazer guns, communication issues, etc. Meetings and telephone conversations to keep the Meth issue on the table took extraordinary efforts. When the need to link Meth abuse with the need for hardware, i.e. “you need tazer guns due the difficulty in taking down a meth user who has become violent and if meth abuse is decreased, the need for this hardware is reduced.” This worked. In meetings held with the Tribal Police Chiefs Association, their previous efforts to work with local law enforcement agencies had met with resistance and through IHBN’s efforts, this issue was reframed in a “national emergency” policy issue and the Association passed a resolution declaring it a “national emergency” issue. This caught the attention of Tribal leaders, state leaders, and the media.

Creativity in linking these issues together resulted in the Meth Summit. Moreover, Meth brought to light the need for a MOA to be developed due the jurisdiction issues – not only intrastate, but internationally. The Tribal Police Association met with US Border Patrol to continue their discussions. Discussions will continue and it is the hope of the project that this will result in a formal agreement in the coming months. In collaborating with other substance abuse organizations and agencies, there were initially concerns with territoriality, but this was alleviated through discussions and collaboratively planning the summit and subsequent follow through on issues brought to the table during the summit.

The use of Tribal elders in translating the anti-meth message was a challenge due the limited number of elders who still spoke their traditional language. In areas where traditional practices are still available these resources were plentiful, but more time was needed to identify the elders and complete the translation. It was the underlying intent of the project to infuse efforts that would strengthen and reaffirm Tribal traditions and language. The anti-meth was designed to accomplish this.

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# Lac Courte Oreilles Band of Lake Superior Chippewa

**LCDR Kelli Stamper**  
HICI Project Coordinator

WISCONSIN



THE LAC COURTE OREILLES (LCO) BAND of Lake Superior Chippewa Indian reservation is located within Sawyer County in northwestern Wisconsin. Tribal enrollment is nearly 6,000 members, of which 60% live on the Reservation in 23 different community villages.

The Intimate Partner Violence Data Profile Pilot Project is a Healthy Indian Country Initiative project performed in 2008 by the Lac Courte Oreilles (LCO) Band of Lake Superior Chippewa. Injury prevention efforts at LCO have been led by a Community Injury Prevention Coalition that has sustained participation for more than 17 years. During the strategic planning process, the coalition identified intimate partner violence (IPV) as a priority for the LCO Tribal community.

## PROJECT PROFILE

The HICI Injury Prevention Project focused on developing a data profile of Intimate Partner Violence (IPV) within the LCO community. In 2006, the LCO/Sawyer County Joint Injury Prevention Coalition determined that more data were needed to determine the prevalence of IPV as an injury prevention problem within the tribal community.

The team developed a “Spectrum of Prevention Model” for IPV. In this model, multiple activities, each associated with a level of the Spectrum, are incorporated simultaneously to create a comprehensive approach (community partnerships – partnership with local Coordinated Community Response Committee) – going beyond an individual-focus, to a systems approach. The expectation is that this will set the stage for further collaboration on this and other community projects.

The Violence Prevention Project was focused on identifying and reducing intimate partner violence through systems change while utilizing the Spectrum of Change Model.

*“The development of a protocol for fully implementing IPV screening in the health care system will be a step towards ensuring better identification and care for victims of IPV.”*

Activities as part of this effort included:

- Providing domestic violence (DV) screening training for health care providers and implementing a DV standard of care protocol in health care;
- Developing a data collection protocol and forms for collecting victim and perpetrator data;
- Providing injury coding training to data clerks to improve the coding/identification of IPV cases;
- Conducting ongoing data collection and analysis of screening and referrals via chart reviews and perpetrator data via police records;
- Providing mandated reporter training for all staff;
- Developing culturally appropriate and relevant information for outreach and education by recruiting elders and spiritual leaders within the community to participate in an advisory and advocacy role;
- Coordinating with the Coordinated Community Response Committee (CCRC) to identify systems change issues, ensure standardized case response by law enforcement, and identify primary prevention strategies.

The initial project vision was to develop a baseline data profile of IPV by collecting and analyzing victim, perpetrator, and community data. As the project progressed, we realized we needed to re-evaluate the goals and methods based on barriers we encountered to developing the IPV data profile and to identifying and implementing prevention strategies. The data would help develop a better informed picture of victims, perpetrators, and community related data, such as cultural attitudes and perspectives about IPV. The local Coordinated Community Response Committee (CCRC) was intended to be our primary partner in this process, as all of the agencies and entities serving victims and perpetrators of IPV are members and ultimately, intimate partner violence efforts would be led by this group.

## PROJECT IMPLEMENTATION STEPS

### Creation of the Epidemiology (EPI) Workgroup

The Workgroup’s goal was to identify existing public health related data, potential sources of data, partnerships needed for data sharing, and methods of collecting, analyzing, and managing data. The Workgroup created an umbrella “prevention programs coalition,” which brought together all the core prevention programs and committees in the community for one monthly meeting where they could work together, share information and coordinate planning. This broad partnership identified previously unknown sources of data and information, provided a basis and network for sharing data, and allowed us to develop a long-term plan for building data sources. Workgroup members included staff from the LCO Health Services, LCO Behavioral Health, Sawyer County Health Department, LCO Schools, LCO Family Services, and the Northern Native American Health Alliance.

### Development of a Data Collection Protocol and Appropriate Forms

The development of the data collection protocol and additional forms allowed for the ongoing collection of IPV data from health care facilities and law enforcement. As part of this, an IPV workgroup in health care was formed to provide input on a screening protocol and a DV Standard of Care. Members included individuals from the medical field, including medical records, coding, nursing, behavioral health, and safety.

### Training Health Care Providers and Support Staff

The health care IPV workgroup and the Injury Prevention Coalition collaborated with the Family Violence Prevention Fund, Mending the Sacred Hoop, and the Wisconsin Domestic Violence Coalition to identify tools and training specifically targeting health care and health care providers. Two health care specific trainings were provided, as well as a variety of tools, information, and resources focused on IPV screening and Standards of Care to raise awareness of IPV as a health care issue and better informed staff of their role as partners in community violence prevention.

*“Broadening our ideas about who our partners were, could be, and should be was key.”*

The development of a protocol for fully implementing IPV screening in the health care system was a step towards ensuring better identification and care for victims of IPV. Addressing coding issues further improved the process by allowing not only numbers of cases and case identification, but allows for evaluation of health care response to IPV victims. Based on a barrier to reporting possible IPV and DV cases identified by providers, and to comply with applicable law, additional mandated reporter training was provided to all health care and support staff, and is required for all new health care employees.

### **Gathering Data on Children**

We worked to build a stronger relationship with the LCO Indian Child Welfare (ICW) Program in order to improve the flow of information, and the rate of reporting IPV cases where children were involved or at risk. Health care providers had reported the lack of any standardized reporting form, such as that used by the non-Tribal child welfare program, as a barrier to reporting, as it led to the appearance that cases were not investigated. As ICW provides the local mandated reporter training, this collaboration serves both purposes and builds a stronger, more collaborative relationship between health care and social services.

### **Launching Marketing and Media Campaigns**

Marketing and media campaigns were developed using the data collected in 2008 and the input of the Injury Prevention Coalition, the CCRC, and the health care IPV workgroup. Local media, including the Tribal radio station, WOJB, was central in planning for media campaigns and public service announcements. The campaign included the following:

- A “Peace at Home” theme, which involved presentations in the community on local IPV issues and the distribution of tote bags with the Peace at Home logo and message. More than 400 tote bags were distributed.
- A “Myths about IPV” campaign, which included print articles and PSA’s, radio interviews and PSA’s, and brochures and other printed materials.

## **PROJECT RESULTS**

Although the evaluation was not complete for this project at the time of publication, initial implications are that development of the umbrella meeting structure for prevention programs has resulted in increase collaboration between programs and greater sharing of resources. Also, screening training for providers and efforts to raise awareness seem to have resulting in better documentation of IPV cases and thus, improved coding. Key informant interview data (although still being collected and not fully analyzed) seem to indicate key attitudes and beliefs about IPV that will be crucial in developing prevention strategies and will require more training for providers, advocates, and social services.

During the course of this project the lack of data, the lack of adequate and up to date training on DV and standards of care for many providers, the organizational changes in health care, the jurisdictional and political issues related to law enforcement and courts, the racial and communication barriers in social services, and the lack of existing policies, laws, protocols inhibited the implementation of the intervention. These barriers need to be considered and addressed for future replication.

A plan outlining short and long term prevention goals and objectives based on the Spectrum of Change injury prevention model will be the framework for ongoing efforts. Key components of the plan include skills training, policy implementation, and performance monitoring in health care; partnership and collaboration with law enforcement to standardize protocols and ensure ongoing training specific to domestic violence; enhancing data related to IPV to inform prevention efforts, and community targeting efforts to reduce instances of IPV and empower victims to seek help.

The team was largely successful in completing the action steps defined in our project plan. A data collection protocol was developed and used for medical record chart reviews and police record reviews. The process also provided collaborations and provided the CCRC the first confirmation of some of the systems related concerns that had been discussed and questioned within that committee.

## Successes

Combining prevention-based committees and coalitions into a broader coalition allowed the staff to enlist help, and build partnerships and information sharing that had not existed before. We were able to collaborate with other programs on violence prevention efforts rather than developing new ones. Broadening our ideas about who our partners were, could be, and should be was critical. Also crucial was making this expansion something that reduced the meeting burden of individuals rather than increasing it. Our “umbrella approach” meant that people went to one longer monthly prevention meeting a month instead of 5 to 10 meetings.

Gaining the support of leadership was the most important step in the project. Systems change is complex and difficult, often requiring individuals to learn new skills and adopt new techniques and protocols, as well as requiring agencies and programs to change practices and adopt new policies. Key support for this project included that of the LCO Health Director, who made training mandatory for all providers and support staff. The LCO Health Director also supported linking DV screening and standards of care to performance measures. The hiring of additional medical staff, to include a women’s clinic lead was also significant. Police Chiefs from the various law enforcement jurisdictions were also instrumental in the success of this project. They gave us access to data, and opportunities to provide training and input. They also allowed law enforcement staff to participate in DV-related coalition activities.

By getting out into the community, talking with individuals about IPV and using community events as a forum for raising awareness, our team was able to develop relationships with community leaders and identify resources which would, in turn, provide community profile information that would help better inform our prevention strategies. Community leaders were also recruited for key informant interviews and as advocates for project efforts.

## Barriers

The initial idea was that our challenge would be *access* to data. What we learned was that much of the data we needed didn’t exist in a usable format or was not being collected. This led to the modification of the project to focus on systems change related to identifying data sources, developing methods to collect that data, building partnerships to ensure access to data, and identifying where gaps continued to exist. Through the efforts of this project, more data related to violence is now available and accessible to the agencies and programs working with DV issues than has ever been available locally before.

The project had trouble identifying usable health care data. The legibility of provider’s notes was a significant issue. A further complication was the lack of a provider summary or the lack of adequate descriptive information to allow the team to determine if the injury was related to IPV. Mortality data related to IPV was also not available. This lack of information precluded developing the victim component of the data profile and shifted the project focus to a systems change approach aimed at addressing the issues identified as barriers to health care data.

Working with the local CCRC to address identified systems change issues and develop prevention strategies proved to be a barrier as the committee was weakened by the chronic lack of participation by key players, the lack of strong leadership, and unclear goals and objectives. In an effort to continue progress, project team members maintained contact with individual CCRC members to seek input, provide updated and ongoing data, and to request assistance. Partnership with the CCRC for long-term implementation of prevention strategies remains a goal of this project.

These challenges and barriers identified by the team are clear opportunities for systems change in the health care, law enforcement, and social services arenas, especially in training and policy development and implementation. Such change would be expected to make significant improvements in the identification and handling of IPV cases.

## LESSONS LEARNED

The most specific and important recommendation would be to require that some prevention efforts have additional time (more than 1 year or perhaps less in the case of this project) to implement and identify outcomes. This project is targeting systems change and thus developing a project plan of perhaps a 3 year time period would be more beneficial. Addressing injury issues such as those related to domestic violence cannot be accomplished in such a short time period.

For future projects considering utilizing agencies with strong skills sets and experience related to prevention efforts with American Indian/Alaska Natives, for example, the IHS Injury Prevention Program and CDC's Injury Prevention Branch is a recommendation that would be beneficial to the project.

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# Lac Vieux Desert Band of Lake Superior Chippewa Indians

MICHIGAN



**Mary Spalding-Antilla**  
HICI Project Coordinator

THE LAC VIEUX DESERT BAND OF LAKE Superior Chippewa has a Tribal membership of approximately 600 individual with nearly 80% of those members living on the Tribal reservation. The tribe is located in a rural area of the Northwoods where distance restricts any instant responses. Communication is extremely difficult with limited cell phone reception and the nearest hospital or ambulance response is 30 miles away, a drive of at least 30 minutes. The climate is harsh and can create a home-bound, powerless situation within moments.

## PROJECT PROFILE

The purpose of the project, “Care Giving in the Absence of an Adult” was to develop and implement an educational camp and events for the youth ages 9 to 15 to teach skills needed to care for themselves and others in the event of an unforeseen emergency with the ultimate goal of reducing injury and harm experienced by such events.

One quarter of the Lac Vieux Desert Band of Lake Superior Chippewa households are supported by a single parent. Many of these single parents are forced to resort to leaving younger children in the care of older sibling due to lack of finances, lack of family assistance, and or day-care. Many of these “younger sisters/brothers” have responsibility thrust upon them, without the maturity, emergency training, basic first aid training, real life experience, and knowledge of best practices for various home-life situations.

A community partnership was developed to encourage preparedness and teach care giving skills through the “*Care Giving in the Absence of an Adult*” project. The collaboration between the Lac Vieux Desert Health & Human Services Department/Clinic, Lac Vieux Desert Behavioral Health Department, Lac Vieux Desert Police, Watersmeet Fire Department, and the Lac Vieux Desert Elders (in conjunction with the Michigan State University Extension Programs) have created an educational program aimed at skill building for young people on how to respond to various unforeseen emergencies.

The “*Care Giving in the Absence of an Adult*” project focuses on youth ages 9 to 15 years with inter-generational participation. The seven day camp trip covers life skills, youth leadership and prevention. The goals of the project are to teach the necessary life skills to enable a youth to take care of another child or elderly. As a part of the curriculum, youth take a test to examine their knowledge and have the opportunity to practice solving real problems by role playing with actual actors. Topics covered include:

- Emergency response: fire escapes, weather emergencies and disasters.
- Rule setting for children, 911 calls, age-appropriate activities and “what if’s.”
- Nutrition, safe food handling, traditional recipes and healthy cooking
- Safety, including outdoor, water, CPR/first aid (including discussion about the body), poisonous plants/look-a-likes, animals, inspecting the environment of the house, car seats and bathroom.
- Creative play, making up games, songs and storytelling.
- Interviewing for a job, respecting the homeowner’s house, phone calls, and dealing with strangers and people under the influence of alcohol.

### PROJECT RESULTS

The HICI project shared resources for a total of 69 youth and 41 Tribal volunteers for the “*Care Giving in the Absence of an Adult*” for 2008:

#### Number of Tribal Participants:

Tribal Youth	45
Non-Tribal Youth	16
Unsuccessful Youth	8
<b>Total Youth</b>	<b>69</b>
<b>Total Intergenerational Volunteers</b>	<b>41</b>
<b>Total Number of Participants</b>	<b>110</b>

Since the inception of the Care Giving in the Absence of Adults program there have been a total of 123 graduates from the training program and 157 people who chose to attend the various trainings but did not graduate.

Feedback was shared by the community that provided structural ideas for future camps, situational needs for families due to environmental emergencies, and a community avenue of support that the clinic could not provide. Some of the comments from Tribal members included:

- “My child seems more mature!”
- “I tried to trick them up, but they really know their stuff!”
- “Thank You! Thank You! I didn’t know how to teach them.”
- “I think I’d like to go into healthcare!”

Since program inception the Tribe has seen increases in the number of youth attending college, the number of youth volunteers and increases in overall youth self-confidence. The youth inspire our staff, assist in the ability to think out of the box, and provide overall faith that the community prevention programs are working. These suggestions below are summarized themes that the youth have shared to create a strong youth program that keeps youth connected and motivated for a positive experience.

- Be creative in teaching a life skill. Each activity should be hands-on, like putting out real fires, because that’s part of real life.
- Tell the truth. The youth are very smart. Tell youth the truth about the body and truthfully answer questions that they have about the different parts of the body.
- Make sure words, feelings, and respect are part of the criteria.
- Include the elders, spouses, and graduated youth and community volunteers.
- Get as many community groups, departments, Inter-Tribal, State and governmental departments as possible to contribute their specialties to the camp.
- Pre-plan as much as possible.
- Create a trusted core team.

## LESSONS LEARNED

The need for an understanding of youth culture, staff that connects with youth, patience to understand youth train of thought, and the creativity of staff to stay ahead of youth for interesting workshops are all critical components for successfully working with young people on the Lac Vieux Desert reservation.

The ability to have family buy-in and involvement was key to the success of our prevention programs. In the beginning, some parents required their youth to attend the trainings, which created anger and frustration from some of the youth. The anger was disruptive and non-productive to the spirit of the camp. In order to alleviate this situation we had the parents and the youth sign a contract stating that they knew that the seven-day camp would be educational as well as fun, which helped establish a better attitude towards the camp experience. The camp staff members were familiar, positive community role models that the youth knew and trusted.

The parents were asked to allow their children to participate without their interference so the youth could participate actively and without any inhibitions. We learned that the youth were different in front of their parents and didn't take on as much responsibility, which made it difficult to teach them the leadership skills needed to respond in an emergency. No electronic devices were allowed throughout the camp and the only phone was through the camp staff. This encouraged the youth to rely on creativity and the other participants for fun and entertainment. A "team approach" was used and the teams did most things together. For example, one team would be responsible for meal preparation and then everyone ate together. The teams had to finish in one task/activity before moving on to the next so no one was left behind.

The partnership between Health & Human Services, Behavioral Health, Police, Fire Department, Elders, MI Extension office, and Indian Child Welfare have formed an excellent project that resulted in a curriculum for the week-long training sessions that included real "hands-on" scenarios for young people to practice taking leadership roles, especially in the event of an emergency. Additionally, the partnerships formed created the infrastructure needed for ongoing injury prevention and harm reduction through education and training within the Lac Vieux Desert community.

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# Little Traverse Bay Band of Odawa Indians

MICHIGAN

**Regina Brubacker-Carver, RN**  
HICI Project Coordinator



THE WAGANAKISING ODAWAK, OR LITTLE Traverse Bay Bands of Odawa Indians, have lived on Michigan's Lower Peninsula's northwest shores for hundreds of years. It is an area surrounded by water and forests, with abundant wildlife. The Odawa supported themselves by hunting, fishing, gathering, and tending crops; and the people were healthy. In the late 1800s, a journalist from the Detroit area took the railroad north and subsequently wrote an article describing "the million dollar sunset" that this area is famous for, and Michigan's tourism industry was born. As more and more settlers came to the area, the Tribes lost important hunting and fishing sites and travel throughways.

Over the decades, much of the traditional way of life was lost, and like much of America, this included the ability to feed ourselves. We eat much of the same over processed, nutritionally poor foods available to everyone, and are dealing with obesity, diabetes and heart disease in ever-increasing numbers. As we looked around for an effective means of fighting this epidemic, one thing became clear – the answer did not lie in another diabetes education class, or more screening. These options already exist, and while useful, they are clearly not halting the advance of these health issues. The thought occurred to us that maybe the answer to the future laid in our past; more specifically in re-establishing a healthy connection with our food and Mother Earth, its source.

One hundred years ago, if an Odawa did not hunt, fish or gather, they often didn't eat. This resulted in a very respectful attitude towards the earth and the spirit of our food sources. Now, there are fast

food and junk food options everywhere, and we are consuming empty calories that don't nourish us. Many children today have no idea berries and beans grow on bushes, or potatoes grow in the ground. We realize that it's not possible to turn the clock back, but we hoped that by bringing the people closer to the source of their food, we could get back some of that respect for the earth and maybe begin to heal.

## PROJECT PROFILE

In order to accomplish our plan of getting our community closer to a more traditional food source and a new way of consuming food, we developed a 3-phase plan. Phase I established a Community Supported Agriculture (CSA) program which we hoped would encourage a taste for cooking with fresh, locally grown produce. Phase II included assembled food gathers and took the group to a local U-Pick farm and which would allow them to be involved in actively gathering their own food. During Phase III, people then were encouraged to start growing their own food, and begin planning for a community garden or orchard.

The original goal of the Home Grown Project was to improve the health of our Tribe by beginning a reawakening our spiritual connection with our food which was to be achieved by increasing the amount of fresh locally grown foods consumed. We have accomplished the Phase I of our project, which was to increase awareness of and access to those foods through our Community Supported Agriculture program. On average, we have had around 1000

*“The thought occurred to us that maybe the answer to the future lies in our past; more specifically in re-establishing a healthy connection with our food and its source.”*

contacts (twice a week on vegetable days we set up tables with the produce set out and as the elders come through they select what they want and then everyone else gets to select from what is left). We have accomplished some of our second phase objective (increasing participation in gathering their own food) by taking groups to local U-pick farms and to the Berg Farms when conditions were right. The final phase, which is still ongoing, involved hiring a temporary worker to travel to homes and set up raised beds for personal gardens and providing those people with heirloom seeds for the 2009 season, as well as literature about raised bed gardening.

The largest activity was the CSA program; thousands of pounds of produce was brought to the Tribal government site and distributed to elders, employees, and Tribal families. In addition, any Tribal member who came to a farm market where Berg Farms had a booth was able to access free produce there as well. We also arranged four gathers at the farm itself – two for corn, one for tomatoes, and one for what was available at the time (potatoes, corn, tomatoes, and green beans) where over 50 people participated.

We also had two fruit gathers; in June we went to the U-pick strawberry farm and gathered over 1,000 pounds of berries and in September we went to a local apple orchard and gathered over 1,700 pounds of apples. In all we had about 100 attendees at the U-pick events. We had planned to try a cherry gather as well, but due to weather and timing we were not able to fulfill that one.

Food preservation classes developed as a result of a workgroup started by the Michigan State University (MSU) extension program with interested LTBB shareholders. Forty-four people took part in the programs, which included learning to can tomatoes, applesauce, venison, and fish and to make traditional style Indian corn for soup, throughout the fall and winter months. Each participant was given a copy of a food preservation book and a food dehydrator. Since most of our Tribal population is considered at risk for diabetes, pre-diabetic or metabolic syndrome we did not limit participation. The events or classes were announced and whoever responded was signed up.

## PROJECT RESULTS

During the course of this HICI project, Phases I and portions of Phase II were accomplished. Other results include the development of an evaluation tool that could be adapted for all of our gathers. The evaluation included questions such as how the participant heard of the event, if they had participated in any Home Grown events before, how they planned to use the produce, what impact the gather had on them and asked for suggestions to improve future events. Evaluations will be sent out at the end of the summer to those people or families who received the raised beds through the Home Grown project. The project had approximately 132 people of all ages attend the gathers, however not all the participants completed an evaluation.

Many people are very open to the Home Grown Project, and very interested in learning more about food preservation. Many people were using the produce for a variety of purposes including fresh eating, cooking, and preserving. There were a lot of multi-generational sharing of produce and also sharing the workload of gathering and preparing food. The age ranges of those involved varied widely, from families with young children to elders. The elders were the least interested in food preservation, most citing limited space and single households as reasons to not get involved.



In the future, we plan to initiate a workgroup for food preservation, where anyone interested shows up for a day of preparing and preserving food, with all who participate receiving a share of the product. The project staff are also working to establish a pantry where participants with limited space will be allowed to store their preserved goods until they are ready to use them.

Before the program began, an informal relationship with an area farmer was already established and the individual was willing to enter into a Community Supported Agriculture (CSA) program with the Tribe. In 2005, our first year, 350 bushels of miscellaneous produce, 75 quarts of fruit, 1,100 dozen ears of corn and 30 pints of maple syrup were provided to the community and the CSA remains a popular program to-date. We have also taken people to the farm to gather their own sweet corn, tomatoes, green beans, and potatoes. We live in an area with a lot of smaller family farms, and we have arranged strawberry and blackberry gathers and several apple gathers. The project worked with the MSU Extension office to develop a series of preserving classes and a “Master Garden” class is being planned for the Spring with a lecture and demonstration on pruning and care of apple trees. Also, in the Fall arrangements were made to place two dozen raised beds on Tribal members’ property and the project staff will be working with those individuals during the Fall/Winter months to provide the Tribal members with seeds and educate them on raised bed gardening.

Although the future of this great program is unclear due to financial circumstances, the project staff are hopeful that enough interest and awareness was raised that some of the people who were reached will continue to garden and seek out fresh foods. The project staff will continue to work with other Tribal departments such as the Natural Resources Department and the Planning Department to develop joint programs such as a garden for the youth services to grow corn for a popcorn fundraiser and to turn the current apple trees on Tribal property into an orchard. We will continue to seek help and support from outside agencies such as the MSU Extension office to keep us informed of local opportunities to expand our programs.

## LESSONS LEARNED

Establishing good working relationships with other departments and the local farmers is critical. Developing a delivery system that works for both collaborators is also important, as the more demands placed on the workers the less likely they will continue to work with you to accomplish the project goals. Putting together a project plan in advance would also help the project to gather data on the effectiveness of the program (evaluation data) so the project can continue to keep current funding and acquire additional funding.

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# Native Village of Minto

ALASKA

**Sheryle Charlie**

HICI Project Coordinator

THE NATIVE VILLAGE OF MINTO, A FED-erally-recognized Tribe, is a community that consists of 92.2% Alaska Native or part Native. Minto Village residents are mainly Tanana Athabascans. Several families have seasonal fishing/hunting camps and trapping areas on the Tanana River and Goldstream Creek. Most of the year-round employment is with the school, lodge, and clinic or village council. Many residents work during summer's fire fighting for the BLM. Some residents trap or work in the arts and crafts center, making birch-bark baskets and beaded skin and fur items. Subsistence is an important part of the local economy. Most families travel to fish camp each summer. Minto Flats is one of the most popular duck hunting spots in Alaska. Salmon, whitefish, moose, bear, small game, waterfowl, and berries are utilized.

The Native Village of Minto Healthy Indian Country Initiative (HICI) project goals were to engage the community in prevention activities with the ultimate goal of promoting and educating the community about cultural and traditional activities and increasing awareness on various health issues. With funding from the HICI, Minto Village was able to host activities that provided critical health information and increased knowledge and awareness of

the community about healthy living and traditional lifestyles. The following prevention activities were conducted throughout the project:

- Sponsoring alcohol and drug free community wide events that encourage and supporting healthy activities.
- Supporting cultural activities like the Minto Youth Dance Group.
- Increasing knowledge and awareness of the detrimental effects of alcohol/substance abuse on families and children at community wide events.
- Acknowledging and recognizing community members for their community service accomplishments.
- Sponsoring "Talking Circles" which identify and communicate alcohol/substance abuse issues and support prevention activities.
- Enhancing community support for a Village Public Safety Officer.
- Identifying and completing activities focused on preventing bootlegging.
- Beginning discussions focused on identifying strategies to prevent sales of alcohol/drugs to minors.
- Increasing knowledge and awareness of prevention and healthy activities with a focus on "Native Pride" messages and cultural living.

Although the target population for the project was 50 participants, the community events were open to all community members living in Minto Village and outside of Minto Village. Minto Village is located in a remote area of central Alaska and according to the 2000 US Census, Minto Village had a population of 258, ninety-two percent (92%) of whom were Alaska Native, primarily Athabascan. By targeting 50 participants, this project provided outreach and education to 20% of the residents of Minto Village.

Understanding the demographics of the community is critical to fully appreciate the strengths and challenges of administering the Healthy Indian Country Initiative. Based on the 2000 US Census data, of the Alaska Natives residing in Minto Village age 18 or older, 38% have obtained a high school diploma and small percentage of individuals have completed a bachelor's degree or higher and many live at or below the federal poverty level. Although the community struggles with the challenges of isolation, remote geography, and lack of economic resources, they work to maintain cultural ways of life and nearly 20% of the Alaska Native people in Minto Village speak their traditional Native language.

### **PROJECT PROFILE**

The overall goal of the Minto Village HICI project was to promote and educate community members through cultural and traditional activities and provide information on concerning community issues such as alcohol/drug prevention, tobacco cessation, domestic violence, suicide prevention and restoring family values. The strategy for accomplishing this goal was to re-establish the Minto Village Cultural Heritage Camp. The Old Minto Village, located down the river from the current Minto Village, was the original site of the Native Alaskan village. Many of the elders were born and raised there until the Village was relocated in 1969-1970 to the present site. The Cultural Heritage Camp is housed within the area of the Tanana Chiefs Conference (TCC) recovery center, a 30-day treatment facility for those who are trying to stop using drugs and alcohol. The TCC is located within the Old Minto Village. The counselors and staff of the TCC provided critical interventions through counseling and provided ongoing support for the prevention activities of the project when they were available to help.

The facility and its resources assisted in reaching the goals of the project through collaboration and integration of community knowledge and resources and the guidance of cultural knowledge and traditions. The week long Cultural Heritage Camp held at the Old Minto Village involved presentations by HICI staff, workshops with local teachers, storytelling by elders, and sharing of cultural traditions to assist in building strong family support and healthy lifestyles free of alcohol and drug abuse.

Community celebrations, potlatches, talking circles, and youth fun nights created momentum and keep the community engaged throughout the year on the knowledge shared within the cultural camp and prevention resources. These efforts built internal community support for working relationships with the community infrastructure to understand the negative effects of bootlegging and narcotics sales in the Village.

### **PROJECT RESULTS**

The project hosted 6 community events within the HICI project year that reached an estimated 120 people and created partnerships and collaborations that helped sustain many of the HICI project activities. The original goals and objectives of the Minto Village Cultural Heritage Camp helped inform the cultural and traditional activities and provide information on health issues such as alcohol/drug prevention, tobacco cessation, domestic violence, suicide prevention and restoring traditional family values.

#### **Community-Level Outcomes**

Although the target was to reach a total of 50 individuals, the project by far exceeded this number and ultimately reached 46% of the entire Minto Village of the 190 residents of the village.

#### **System-Level Outcomes**

The Minto Village HICI project has worked to integrate the community and the systems that operate within the Tribal community. As a result of this project and collaboration with the Minto Village Public School System, the TCC cultural community center, YMCA/Big Brothers/Big Sisters Program, the Episcopal Church and the Center for Non-Violent Living, the project staff were able to complete the project activities and create sustainability within

much of the services and support. For example, the Public School is continuing to offer the Breakfast Club, the Afterschool Program, and the Fitness Program. Additionally, we are in the planning stages for the Minto Village Cultural Camp in the summer of 2010 and current staff support, including the Tribal Family & Youth Services (TFYS) worker, community health aides and the behavioral health counselor will assist in the planning efforts as well as other community organizations such as the TCC, the Center for Non-Violent living and the YMCA/Big Brother Big Sister programs. These agencies offer their guidance and expertise in social and health issues and they provide intervention and prevention services to support Native people on the road to recovery.

Further, the Minto Village Council has offered the site of the Old Minto Village to any organization that is hosting an alcohol/drug free event that is open to the local tribal community free of charge. Tribal community members have been available to help in promoting cultural and traditional ways of life for events like this, as they volunteer their time and equipment (boats, chainsaws, and camping supplies) when it is needed. The funding from the HICI was critical to increase system-level partnerships, increase capacity for prevention programs, and sustain many of these programs beyond the funding period.



## LESSONS LEARNED

The Minto Village did experience difficulties of integrating prevention services throughout the HICI project. Staffing was an issue during the project period. The individual that was chosen for the HICI coordinator position was hired, but because of health issues could not take the position and a search for a project coordinator continued until the position was filled, although this took additional time. Second, the technology and capabilities of services in Minto Village proved to be a problem when we set up the office and purchased a computer and printer. Continued problems occurred throughout the duration of the HICI project period with internet connectivity and the HICI project staff found no way to alleviate this problem with the outside internet service provider.

The limited amount of trained staff that could offer specific prevention services and health related knowledge was a challenge due to difficulty recruiting individuals to Alaska. The HICI Project Coordinator hired also had other job responsibilities that allowed the individual to connect with other Tribal community organizations as well as have regular contact with the children in the Village. This created consistent involvement of youth in the project and created easily access to knowledgeable staff to learn about critical issues of the project. Unfortunately, the additional commitments of the HICI project coordinator did not allow for the individual to consistently work on the HICI project; however a schedule was developed that worked for all parties involved.

The unpredictable weather also provided a barrier and made it difficult to make long-term plans throughout the duration of the HICI project. During the project period, rain and flooding during most of the summer caused the Cultural Camp area to be postponed for over a week. With the cooler weather many of the elders invited canceled due to health concerns.

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# Penobscot Indian Nation

MAINE

**Dale Lolar**

HICI Project Coordinator



THE PENOBSCOT INDIAN NATION IS A federally-recognized Tribe located in the east central portion of Maine. It is the largest of the Abenaki Tribes that occupied the Central and Southern portion of Maine prior to the European invasion. The Penobscot Indian reservation is located approximately 12 miles north of Bangor, the nearest urban area, and immediately adjacent to the city of Old Town. The primary community settlement within the land owned by the Penobscot Nation is Indian Island, which is comprised of 315 acres. The estimated 2008 population of Indian Island is 539, of which 402 are Penobscot Tribal members, 96 are non-Indians and 47 are from other Tribes. The total population of the Penobscot Nation is approximately 2,270.

Over the past three decades the Penobscot Indian Nation has established various programs for the provision of health and social services to the members of the Penobscot Tribal community. These programs are funded through a Public Law (P.L. 93-638) contract with the Bureau of Indian Affairs (BIA) and a Self Governance Compact with the Indian Health Service (IHS). The Penobscot Indian Nation also receives funding from various state and local agencies.

## PROJECT PROFILE

Through the HICI funding the Penobscot Nation Health Department (PNHD) worked with other Tribal departments and programs such as the Summer Youth Employment Program, the Indian Island School, local high schools and the Penobscot Nation Boys and Girls Club to develop activities for the adolescent population that will provide skills and education in the areas of substance abuse prevention, leadership, self esteem building and other chronic disease prevention. The activities included the following:

- Inter-Tribal Sacred Fire Relay Run
- Graduating Seniors Recognition Night
- Monthly Community Fun Runs
- Summer Youth Workers Prevention Education Series
- Community Health Summit
- Community Walk for a Safe and Healthy Community
- Fit Club
- After School Snowshoe Club
- Community Fun Walk/Runs
- Indian Island School Classroom Prevention Education
- Suicide Awareness and Prevention Education
- Kids In the Kitchen

Prevention is one of the priorities established by the IHS. The primary mission of the Prevention Committee is to develop and implement various prevention activities targeting youth in the community. The development of the logic models was

*“Project activities focused on providing adolescents skills and education in the areas of substance abuse prevention, leadership, self esteem building and other chronic disease prevention.”*

a Tribal wide activity mandated by the Tribal Chief and Council. The purpose of the logic models was to provide the Tribal Council with priorities for each department and to assist the Tribal Council in determining funding priorities. All the logic models for the HICI projects were approved by the Tribal Chief and Council and helped with community “buy-in,” approval and implementation.

## PROJECT RESULTS

The Penobscot activities were closely linked to the goals and objectives of the project to reinforce the existing prevention program, increase the capacity of prevention services provided, and increase the number of prevention services by increasing the number of “new” activities. The project hosted an array of “staple” (i.e., “old” but useful) prevention activities and integrated some “new” activities to add to prevention knowledge, keep youth engaged, and expand spectrum of prevention services. These activities were directly linked to accomplishing the goals set by the HICI project, which were: substance abuse prevention, leadership skills building, self esteem building, and other chronic disease prevention.



## Community Level Outcomes

Community level outcomes are defined by real changes that are seen at the individual or family level. An estimated 670 community members participated in a number of HICI programs activities and events that took place throughout the duration of the project. This number does not include those that participated in broad community training activities, such as community “fun runs” and school presentations. Therefore, it is expected that the number of people reached by this project was much higher than estimated. Given the documented community problems with health related conditions, it was critical to increase community education regarding physical health and wellness. This accomplishment was evidenced by the combined group weight loss of 200 pounds that the youth lost throughout the course of the project. Weight loss today is prevention for weight-related health diseases tomorrow and was a very positive outcome for this project.

The project utilized survey monkey (an online survey tool free to the public) to disseminate evaluation surveys that allowed participants to provide feedback on events and the overall impression of the prevention programs. This information was used to provide direction for the project and make mid-course corrections as needed. One example of the use of data involved the results from a survey examining the low participation rate of the Fun Run events. Project staff conducted a 6 question survey with youth to determine why the middle school students had stopped attending the Fun Run events during the project period. The questions were aimed at identifying what they liked about the event, why they stopped attending, and what they want to see in future runs. The goal of the survey was to find a way to increase the number of students who were attending this healthy event. The results of the survey indicated that a high percentage of the students (68%) had a commitment that conflicted with the time the Fun Runs were being held. Further, incentive prizes were identified on the survey that assisted in drawing in youth that were available for the event. As a result of these data, the approach was changed for this particular event and additional youth were able to participate in a future program.

### System Level Outcomes

The PNHD was fortunate to have most of the key partners within the same community. Solid, ongoing working relationships were built throughout the project with many of the critical agencies and organizations such as the Indian Island School, Law Enforcement, Education and Career Services, Tribal Government/Administration, and the Boys and Girls Club. The prevention activities were supported by these agencies, departments and organizations and many of the activities, events and programs will be sustained as a result of these partnerships and collaborations. For example, the YMCA donates space and the pool, the community center donates the kitchen to teach healthy cooking, and the school donates space and staff to sustain the afterschool program. Further, the project has impacted community policy. For example, the Tribal Government passed a resolution to enforce a no-tolerance policy at the local level for methamphetamine use following the Methamphetamine Prevention Training, a training that was funded through the HICI project.

### LESSONS LEARNED

It has been a challenge to bring the communities' adolescent population in to the PNHD due to several factors. First, the community high school and middle school adolescent attends high school off the reservation and are spread out between four high schools in different cities. Often extra-curricular activities prevent adolescents from attending community activities as there are often time conflicts.

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## Ponca Tribe of Nebraska

**Lora Lee Langley, RN**  
HICI Project Coordinator



THE PONCA TRIBE OF NEBRASKA IS ONE of four Tribes considered indigenous to Nebraska with the other three – the Omaha, Santee Sioux, and Winnebago – possessing reservations. Historically, the Ponca are believed to have been part of the Omaha Tribe, having separated by the time Lewis and Clark came upon them in 1804. At that time, they were situated along Ponca Creek, in Knox County, near present-day Verdel. They lived in earth lodges, were primarily horticulturists, but also made seasonal hunting trips. They were on such a trip when Lewis and Clark came upon their village. Although the Tribe’s exact origin is unknown, some scholars believed the Ponca migrated from an area along the Red River near Lake Winnipeg. However, by the early 1700s, the warring Sioux had forced them to relocate to the west bank of the Missouri River.

The Ponca were never a large Tribe. In 1780 the estimated population size was approximately 800. By 1804, largely because of smallpox, their numbers dwindled to around 200. By 1829, their population had increased to 600 and by 1842, to about 800. In 1906, the Ponca in Oklahoma numbered 570 and those in Nebraska, 263. The census of 1910 listed 875 Poncas, including 619 in Oklahoma and 193 in Kansas. By 1937, the Ponca population reached 1,222 with 825 in Oklahoma and 397 in Nebraska. Today, the Ponca Tribe of Nebraska alone numbers slightly over 2,500.

The Intergenerational Indian Women’s Health Education Program, “Women Educating Women throughout the Lifespan” program was established at the Fred LeRoy Health and Wellness Center under the auspice of the Ponca Tribe of Nebraska. The purpose of this program is to improve the health status of Native American Women by establishing a comprehensive health promotion/disease prevention education program. The Fred LeRoy Health and Wellness Center used traditional teaching by Tribal Elders and aimed to enhance women’s knowledge of impacting health issues by providing them with the tools necessary to make informed health care decisions.



## PROJECT PROFILE

The Intergenerational Indian Women's Health Education program is built upon strong partnerships, developed collaboration and the integration of community knowledge to support strong women and families. Bi-monthly education classes and interactive sessions as selected by community members through an internal health education needs assessment, were developed and facilitated by female healthcare providers and educators; and Elder Tribal women collectively.

Educational topics and interactive sessions included the following:

- *Cradleboards: Using Traditional Practices to Promote Baby Safe Sleep and Reducing the Risk of Sudden Infant Death Syndrome (SIDS)*. Classroom instruction focused on SIDS prevention and interactive session included creating cradleboards.
- *Catching the Dream to Perfect Oral Health*. Classroom instruction focused on dentition and oral cancer prevention and interactive session focused on creating dream catchers.
- *Our Body, Our Health: Beading Our Way through the Future*. Classroom instruction focused on Women's Health Visits and interactive session included beading key chains.
- *Healing The Spirit: The Dance against Violence*. Classroom instruction focused on Domestic Violence and interacted session included creating shawls.
- *Returning To Tradition: Health through Nutrition*. Classroom instruction focused on nutrition and portion sizes; and interactive session included preparing and cooking traditional foods such as corn soup, fry bread and wojapi.
- *Traditional Women Sew To Fight Breast Cancer*. Classroom instruction focused on breast cancer prevention and interactive session included creating pink shawls.
- *Protecting Our Nation: Health through Immunization*. Classroom instruction focused on adult and child immunizations and interactive session included creating quilts.
- *Red Women Bingo to Prevent Diabetes and Heart Disease*. Classroom instruction focused on diabetes, hypertension and heart disease; and interactive session included playing bingo.
- *Gestational Diabetes: Native American Women and Nutrition*. Classroom instruction focused on gestational diabetes and nutrition and interactive session included creating totes for glucose monitors.
- *Alcohol and Pregnancy: Protecting the Future of Our Nations*. Classroom instruction focused on fetal alcohol syndrome and prevention and interactive session included creating diaper bags.
- *Pregnancy and Postpartum*. Classroom instruction focused on the three trimesters of pregnancy, labor, postpartum and well baby visits; and interactive session included creating cradleboards.
- *Tobacco and Diabetes Are Not Native Traditions*. Classroom instruction focused diabetes and tobacco use. Interactive session included beading necklaces for diabetes identification emblem.
- *Reproductive Health: The Trail from Menses to Menopause*. Classroom instruction focused on menstruation, contraception, sexually transmitted infections and menopause. Interactive session included creating a tote for personal items.
- *Babies, Blankets, Bathing and Bonding*. Classroom instruction focused on bathing, umbilical cord care, circumcision and uncircumcised care, bathing and breastfeeding. Interactive session included creating baby blankets.
- *Daughters of Tradition: Our Journey through Pregnancy to Cradleboards*. Classroom instruction focused on pregnancy and postpartum health and interactive session included creating cradleboards.
- *Coping With Pregnancy: From Conception to Cradleboards*. Classroom instruction focused on stress during pregnancy and interactive session included creating cradleboards.
- *The Tale of the Moons*. Classroom instruction focused on menses. Interactive session included conversation of traditions that surround menstruation and hands on experience with anatomic teaching models.

These classes and workshops were developed and facilitated only by the constant focus on fostering positive relationships and meaningful collaboration to maximize the resources that could positively affect our community. A list of the internal collaborations and the external relationships that assisted the Ponca Nation in meeting the goals of the HICI project are as follows:

### Internal Partners

Ponca Tribe of Nebraska Tribal Council  
Tribal Elders  
Community Members  
Administrative Officer  
Social Services  
Public information Specialist  
Domestic Violence Program  
Dental Program  
Licensed Medical Nutrition Therapist  
Registered Dietician  
Providers and Staff  
Certified Nurse Midwives  
Psychiatry  
Substance Abuse Counselors  
Youth Specialist  
Patient Benefits Coordinator  
Diabetes Program Certified Diabetes Educator Clinic

### External Partners

Women, Infants and Children (WIC) Program  
National Indian Health Board Association of  
American Indian Physicians  
Clarkson College School of Nursing  
Nebraska Health and Human Services  
Douglas County Health Department  
University of Nebraska Medical Center  
American Diabetes Association  
Aberdeen Area Indian Health Services  
March of Dimes  
Douglas County Baby Blossoms  
Nebraska Regional Poison Center  
Every Woman Matters Program  
Center for Disease Control and Prevention (CDC)  
Department of Health and Human Services,  
Office of Minority Health – Nebraska  
Pregnancy Risk Assessment Monitoring Program  
(PRAMS)  
Nebraska Reproductive Health Program  
Nebraska Maternal and Child Health Program

### PROJECT RESULTS

The “Intergenerational Indian Women’s Health Education Program Women Educating Women throughout the Lifespan” program found positive results through their analysis. The review of statistical data that included subjective and objective information indicated the following significant outcomes provided by the 232 program participants, 7 years old to 87 years old.

- Broader community support
- Committed Community engagement
- Increased knowledge of the health issues impacting Native American Women
- Enhanced capability to discuss health issues with Health Care Providers
- Increased insight into Traditional ways that includes customs, values and morals
- Expanded capacity to establish camaraderie
- Increased ability to initiate and sustain support systems

In addition, a Clarkson Masters of Science in Nursing Student completed her Capstone Project using a component of the program. The program was also a recipient of the 2008 Community Wellness Champion by the Aberdeen Area Tribal Chairmen’s Health Board.

### LESSONS LEARNED

As with many projects, time constraints were the principal barrier. However, once the education curriculum that included sign in sheets, pre- and post-tests, PowerPoint presentations, and participant satisfaction surveys were completed and classroom materials, equipment and supplies were obtained, time was no longer an issue. In addition, while the classroom was quite sizeable, the capacity to accommodate the number of program participants at times was restricted.

Historically American Indians/Alaska Natives have faced health disparities in virtually every category of disease, many of which can be traced to a lack of culturally appropriate healthcare education. Through meaningful programs like this that elevate the health of American Indian/Alaska Native Women, it is imperative that there be a direct parallel between accurate and uniform health information and the healthcare decision making process that incorporates Traditional teaching.

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# Rosebud Sioux Tribe

SOUTH DAKOTA

**Ed Parsells**

**Mike Burbank**

HICI Project Coordinators



THE ROSEBUD SIOUX TRIBE IS LOCATED in south central South Dakota, eight miles West of Mission, South Dakota. The Tribe is primarily located in Todd county and is also located in the counties of Gregory, Tripp, Mellette and Lyman.

The HICI project headed by the Rosebud Sioux Tribe was titled the Piya Mani Otipi (PMO) program Tokala Inajio (PMOTI) project. The project location is a 4,500 acre ranch purchased by the Tribe for the purpose of youth program development and activities to provide services to all twenty of the reservation communities. The PMOTI project was designed to directly impact twenty-five youth by training them to become peer mentors. In turn, these twenty-five mentors would directly impact their friends, classmates, and family. The PMOTI Project hoped to indirectly impact all 20,000 Tribal residents on the Rosebud Sioux reservation through its efforts to educate the public about suicide prevention.

## PROJECT PROFILE

“Tokala Inajio” is a Lakota term that describes a young person taking the initiative to stand up for what is right. The PMOTI project selected the candidates for the program through the Rosebud Sioux Tribe and the three school systems on the Rosebud: Todd County School District, St. Francis Indian School, and the White River School District. These youth were provided training in leadership development, drug and alcohol prevention, Lakota Culture/Spirituality and suicide prevention. Over 1,100 youth and adults on the Rosebud participated in PMOTI sponsored and co-sponsored events. Three incentive trips were sponsored through this grant, including a trip to Washington, DC for select Tokala Inajio mentors to meet and educate National elected leaders about issues surrounding suicide on the Rosebud Sioux reservation.

The goal of the project was to reduce the incidence of drug and alcohol abuse, gang activity, suicide, and juvenile delinquency. To reach this goal, collaborative efforts focused on community partnerships and integration into the school system. Within the tribe, the HICI resources supported the connections with the Alcohol Treatment Program Youth Component, the PMO Program, the Diabetes Prevention Program, the Law Enforcement Agency, the Budget and Finance Committee, the Rosebud Sioux Tribal Council, the Tribal Education system, the Lakota Tiwahe Program, the Tribal Chairman’s Office and Tribal Vice-Chairman’s Office. Resources also built connections with Todd County Schools, St. Francis Indian School, and White River Schools.



## PROJECT RESULTS

The PMOTI project found a reduction in suicide rates during the time frame of their project that could be correlated to the program. Data provided by the Rosebud Indian Health Service (IHS) indicated that between January 1, 2005 and December 31, 2008 the completed suicide rate was an average of 7 per year. The IHS reported that this number only reflected data from the IHS Rosebud Hospital. Data from additional sources indicated the rate of completed suicides on the Rosebud for the same time period was 10 per year. The PMOTI project took place from January 1, 2009 to July 31, 2009 and data provided by the IHS for the period of January 1, 2009 to June 1, 2009 indicated that there were no completed suicides. Combined data from all sources indicate one completed suicide during this period *(please note that the information/data above is provided directly from the HICI Project Coordinators).*

## LESSONS LEARNED

The keys to success of the PMOTI project were the partnerships with established programs and institutions. These partnerships were strengthened through this project by leveraging resources, mutual support and producing positive results. The youth were enthusiastic about the project and grateful for the experience.

The PMOTI project encountered minor obstacles of local political interference but resolved these issues with assertive, positive and professional communication.

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# Sisseton-Wahpeton Oyate Sioux Tribe

SOUTH DAKOTA



**Shannon White**  
HICI Project Coordinator

THE SISSETON-WAHPETON OYATE RESERVATION is located in South Dakota on approximately 106,153 acres. Approximately 5,000 Tribal members live on the reservation with more than 12,000 enrolled members, which represent two bands: Sisseton (People of the Marsh) and Wahpeton (People on Lake Traverse).



## PROJECT PROFILE

Between 1996 and 2003, the Sisseton-Wahpeton Oyate reservation experienced a tragic number of motor vehicle crashes. Fifty percent of all the individuals involved in the accidents were between the ages of 14 and 29. In 2003 the Tribal Health Programs established the Sisseton-Wahpeton Oyate Injury Prevention Program (SWIPP) and it is currently administered by the Division of Tribal Health Program's Office of the Tribal Secretary.

Using initial funding from the Indian Health Service (IHS) Tribal Injury Prevention Cooperative Agreements Program (TIPCAP), the SWIPP has been able to:

- Hire a full-time Injury Prevention Specialist
- Reactivate the Community Injury Prevention Team
- Compile and analyze injury data
- Replicate the Gallup Seatbelt Model at two reservation school sites
- Promote injury prevention awareness through program and mass media outreach
- Train new program staff on injury prevention
- Develop a Five-Year Injury Prevention Plan for 2005 - 2010

The Five-Year goal of the SWIPP is to prevent motor vehicle crash related fatalities and injuries among young people between the ages of 14 and 29 by implementing strategies that target the following: driving under the influence, speed and improper/non-use of occupant restraints.

The first year goals included collaborating with law enforcement, Tribal courts, schools and other agencies to design, implement and evaluate motor vehicle safety and injury prevention activities. In year two, the SWIPP has continued to build upon its foundation to coordinate efforts that continue to work to support and promote injury prevention through events such as:

- Monthly traffic safety checkpoints that is coordinated with Tribal Police.
- “Seat Belt Wearer of the Month” with a prize package and the recipient is highlighted in the Tribal newsletter.
- Monthly Victim Impact Panel presentations held for driving under the influence (DUI) offenders.
- Traffic safety videos presented monthly at the Victim Impact Panel Meetings, “Gone Too Soon, Stories of Drinking and Driving from the Lake Traverse Reservation.”
- Promoting traffic safety awareness at local Tribal schools through annual mock motor vehicle crash sites.

## PROJECT RESULTS

We were able to identify some keys to the success of the HICI project, one of which was the great collaboration that was established with the Tribal Police. They understood the goals of the project and have been quick to assist. The Injury Prevention Specialist (IPS) and HICI Project Coordinator, Shannon White, has worked hard to find funding to support the SWIPP events and activities. Each year a Police Appreciation Dinner is held for officers and their families. Tribal officers are presented a Certificates of Appreciation and are recognized for the most drunken driver arrests and most seat belt citations. Another key to success was gaining Tribal Council support. The Tribal Council was quick to support

SWIPP projects – even for potentially controversial projects such as coordinating checkpoints outside Tribal land with non-Tribal enforcement agencies. Overall, the hallmark of the Injury Prevention Program is in its partnerships and collaborations. This program came at a time in which the community was willing to work together for the greater good of the Tribe. Also during this time Mothers Against Drunk Driving (MADD) was a new presence the reservation, providing outstanding evidence-based strategies trainings. The IHS has also been extremely supportive in sponsoring training opportunities throughout the duration of this HICI project.

## LESSONS LEARNED

Initially, it was difficult to convince Tribal Police that issuing seat belt violations would help reduce motor vehicle fatalities. The Captain of the Tribal Police agreed to conduct checkpoints on Tribal roads. At these checkpoints the Injury Prevention Specialist (IPS) was able to communicate the goals of the SWIPP to the officers and gain support.

The IPS also promoted the importance of enforcing seat belt, child seat safety and drunken driving laws. The IPS conveyed to the police officers that their efforts would be publicized, which would help have a deterrent effect. Over time, there were fewer incidences (crashes) and arrest for drinking and driving arrests decreased. The Tribal officers also noticed, first-hand, an increase in the use of designated drivers through check points. Checkpoint also became a way for police officers to positively interact with the community members and in turn, the community members began to perceive that the police were working hard to keep the roads safe.

Next, the SWIPP wanted to expand with checkpoints on non-Tribal roads with help from the three police jurisdictions. The town of Sisseton has the Sisseton Police Department, the Roberts County Sheriff's Department, and the South Dakota Highway Patrol. There have been some rivalries between these three groups in the past, but the core of each department understands the need for public safety. This enduring compassion helped move these barriers.

The Highway Patrol was approached about conducting joint checkpoints with the Tribal Police on Highway 10, a major road running through the center of Sisseton. The Injury Prevention Specialist worked to submit a letter of request to the Tribal Chairman, who asked several questions and then approved the checkpoint and instill the Tribal approval for the safety checkpoint. The first checkpoint on Highway 10 took place on July 4th weekend and as been in place for the annual holiday since.

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# 4

## CHAPTER 4

# Lessons Learned and Conclusion





THE CROSS COUNTRY TOUR, “A HEALTHIER U.S. STARTS HERE,” THAT BEGAN WITH DHHS Secretary Leavitt in 2007, set the path for the Healthy Indian Country Initiative and the incredible work of the Tribal communities toward developing, implementing and evaluating promising prevention practices in Indian Country. The work of the Tribal communities who participated in the Healthy Indian Country Initiative included a wide range of prevention practices that were focused on addressing a multitude of concerns and challenges that were unique to each of these communities.

In Chapter 4, the NIHB presents an overview of the lessons learned from the NIHB organizational perspective on lessons learned through the HICI project, recommendations, and successful strategies of these promising prevention practices broadly in hopes of impacting future projects and programs focused on identifying and developing effective practices in Indian Country. This Resource Guide serves as the first step toward building the evidence and bridging the gap between evidence-based-practice and practices-based-evidence models of prevention through a culturally-relevant pathway to health.

#### **LESSONS LEARNED AND RECOMMENDATIONS**

The Healthy Indian Country Initiative provided new opportunities and challenges for the NIHB and our efforts in providing support for Tribal communities throughout Indian Country. The wide range of issues experienced by the Tribal communities, the diversity of the Tribal infrastructure for carrying out projects, and diverse communication styles allowed the NIHB staff to examine the support needs, individualize support, and look toward a future of assisting Tribal communities in the development of prevention programs in a productive and culturally appropriate manner. The following represent the lessons learned and recommendations for future projects and programs focused on establishing promising prevention practices in Indian Country.

#### **Communication**

Developing a clear communication plan for both Tribal and national involvement is critical for implementing any project and, within Tribal communities, may be even more necessary given the cultural, social and contextual factors that drive our communities. Throughout the HICI project, there were multiple challenges in communication due to these factors which included rurality of the HICI project sites, changes in staffing throughout the course of the HICI project for both the Tribes and the national organizational partners, the lack of a common language to guide discussions for completing project tasks, and a feedback loop that can support ongoing dialogue between technical assistance providers (national organizations) and Tribal communities. In overcoming these challenges, it is important to develop a comprehensive communication plan from the beginning to build trust with grantees. The HICI project brought forth areas in which the NIHB could also improve communication and provide support to Tribal communities. The spectrum of lessons learned and the NIHB staff rising to the occasion to address the support and needs of the community shed light on the possible changes that can enhance the guidance and support of the mission of the NIHB.

**RECOMMENDATION: Implement a clear, comprehensive communication plan, and provide in writing, for future projects to maximize the overall goals, objectives, and outcomes.**

## A Common Language

Another challenge presented by the HICI project was the language used to support the growth of the Tribal community promising prevention practices. The work pace, time constraints, level of collaboration and political and legal ramifications create a culture of professional development that is unique to the nation's capital. Defining a common language when it comes to technical assistance and support needs to be understood by all individuals working on the initiative, both on a national level, consultant level, and tribal community level. It is important that this occur so when this information is disseminated to project partners and grantees a clear understanding of the required tasks is maintained and accepted by each organization and Tribal community. Even the term "Promising Practices" comes with assumptions and beliefs that are not shared by all. The identification of a common language was critical for the HICI grantees' understanding the various aspects of evaluation, deduction of results and the utilization of the findings during HICI trainings, national conferences, one-on-one support, and participation in conference calls.

**RECOMMENDATION:** Create opportunities to establish common understanding up-front so all project facets are understood universally; be open to suggestions in improvement throughout the project duration.

## The Need for Resources for Training and Evaluation

During the HICI project, many communities reported their overall lack of understanding of the evaluation process and how to document project outcomes. This is primarily due to a lack of training and support that wasn't able to be provided during the course of the HICI project in conducting program evaluation and documenting and utilizing the results. The Tribal communities were responsible for some type of evaluation; however, the Tribal grantees did not have access to specific evaluation training and one-on-one time with the national evaluators for the HICI project throughout the HICI project. Additionally, the spectrum of knowledge and skills of evaluation varied considerably from community to community and the training initially provided by the HICI project did not account for this spectrum of community diversity in knowledge and skill.

Future initiatives should emphasize evaluation training for the Tribal grantees, taking into consideration different aspects of the evaluation process, with the essentials or an introduction to evaluation and building upon those skills to provide specific evaluation components for each of the projects with an overall concentration on building the capacity for evaluation at the local level. Each Tribal grantee should also be asked to submit a preliminary but detailed evaluation plan as a part of the proposal for participation, with feedback from the evaluator (assuming an evaluator has already been chosen) to improve the quality and/or feasibility of each of the evaluation plans. Given the Tribal communities varying levels of evaluation methodology and data utilization, future projects should have substantial, individualized, technical assistance support on how to develop, implement, and use an evaluation to understand the impact of their project. Again, the focus should be on building evaluation capacity at the local level so that the ability of the community to evaluate their programs is sustained over time and can be used in future projects.

**RECOMMENDATION:** Future work should include comprehensive training on evaluation; ongoing technical assistance support on completing the evaluation; and training and support in disseminating and utilizing evaluation results. If possible, identifying and hiring of the evaluator(s) should take place at the beginning of the project..

## SUCCESSFUL STRATEGIES

Each of the HICI projects were built by partnerships and collaborations that cast the widespread "prevention net" within each of the HICI Tribal communities. The saying that "two heads are better than one" really is true when it comes to strengthening children and families through prevention. Through planning and working together, the HICI grantees, both national and Tribal, maximized the limited resources and accomplished goals that neither could achieve alone. Diverse stakeholders shape their holistic efforts through collaborative partnerships. These partnerships gave the Tribal communities a structure for organizing, planning, and implementing their ideas. Although the effort takes time and requires careful attention, it's essential to creating strong, viable partnerships that produce lasting change and create a healthier Indian Country.

Other successful strategies were noted throughout the duration of the HICI project, specifically, the use of humor when discussing the realities of the impact of negative behaviors within our Tribal communities also served as a successful strategy for many of the grantees. Humor transcends across age lines and provides the opportunity to learn from situations that could and would be detrimental if not processed at all. Many of the HICI projects used of humor within their projects and shared the mindset of how to have fun together while educating, interacting and providing support around various important health issues effecting each of their Tribal communities. Indirectly, programs that engaged youth with the concept of fun prevention practices cultivated positive emotions, in which counteracted negative emotions, but also broaden individuals' habitual modes of thinking and build their personal resources for coping.

The HICI project also defined the need for successful programs to encapsulate the whole community in the “buy in” for prevention. In order for this to happen, the HICI projects were successful with the integration across generational lines to capture community wide prevention. The possibility of offering an array of services is one thing, but getting participant through the door and involved is another. The HICI projects were successful at engagement within their communities by offering programs that youth, elders and families were interested in attending. Prevention programs need to have a finger on the pulse of change to address the complexity of the ever changing negative behavior that exist within our societies and the creative ways youth use the negative behaviors for their personal experiences. The need to understand youth culture; the support and knowledge of the local staff to digest and translate the communities changing behaviors; and the patience to understand how to engage elders are the defining characteristics of a successful community prevention program were key to making the HICI projects successful.

## CLOSING REMARKS

The information presented in the Healthy Indian Country Initiative Promising Prevention Practices Resource Guide, demonstrates the need for establishing effective prevention practices. Evidence of the effectiveness of the prevention activities and interventions is needed throughout Indian Country. It is clear that the community-based prevention practices listed in this Resource Guide, although not deemed evidence-based practices, are effective in the tribal communities where they are being implemented. Through the engagement of Tribal communities shared aspects of cultural knowledge, integration of generational culture, and the experiences of the project staff, these promising prevention practices are poised to serve as guides for other Tribal communities looking to establish a prevention program in their community. Sharing knowledge with each other and creating a strong communication network for Tribal communities helps to build a healthier Indian Country by allowing Tribes to stop “re-inventing the wheel” by providing the information and tools with documents like this Resource Guide.

The National Indian Health Board believes that the information shared in this Resource Guide will be beneficial to many Tribal communities, health department staff, prevention program staff, community health representatives, and Tribal Leaders when looking to create or build upon current prevention programs in their communities. The NIHB encourages the Tribes to establish one-on-one contact with each other and communicate their successes, barriers, strategies, and outcomes with each other to help improve prevention programs throughout Indian Country. The NIHB believes that this Resource Guide is an excellent first step in that direction. The NIHB will continue to serve as a bridge for support and communication for the Tribes in documenting promising prevention practices that will help improve the health and wellness of American Indians/Alaska Natives throughout the US.

**For additional information about the Health Indian Country Initiative or to request additional copies of the resource guide please contact the NIHB at 202-507-4070. You may also visit the NIHB website at [www.nihb.org](http://www.nihb.org) to download an electronic copy of HICI Promising Prevention Practices Resource Guide.**

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## **National Council of Urban Indian Health (NCUIH)**

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