

THE BLUE BAY HEALING CENTER: COMMUNITY DEVELOPMENT AND HEALING AS PREVENTION

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This paper addresses the development of the Blue Bay Healing Center and its relationship to suicide prevention efforts on the Flathead Reservation. It will summarize suicide prevention before the Blue Bay Concept was articulated and realized. The history of the Blue Bay Healing Center and results from two evaluation efforts will be presented.

The Flathead Reservation

The Flathead Reservation, located in northwestern Montana and occupying approximately 1.5 million acres of land, was established for the Confederated Salish and Kootenai Indians in 1855. In 1910, President Taft opened the Flathead Reservation to settlement by non-Indians; by the mid-1900s, Indians had become a minority on their own reservation.

The Indian people now living on the reservation are called Flathead by most whites. However, the population actually represents three tribes, although two of these — the Salish and the Pend d'Oreille (or Kalispel) — are closely related because of intermarriage during the past two centuries. The other tribe, the Kootenais, shared hunting grounds with the Pend d'Oreilles. The Salish befriended the Lewis and Clark expedition in 1805. The white explorers mistakenly believed that the Salish were Flatheads, a tribe that lived on the Pacific Coast. The name has stayed with the tribes since. The Confederated Salish and Kootenai Tribes are considered to be among the most progressive tribes in the nation.

Suicide Prevention Efforts Before the Center

In the decade prior to the development of the Blue Bay Healing Center, treatment and prevention of suicidal behavior was seen as the primary responsibility of Indian Health Service's (IHS) Mental Health Program, which originally consisted of one professional and a secretary. In the mid-1970s the Confederated Salish and Kootenai Tribal Health Department designated one of the community health representatives as a mental health paraprofessional. This step signaled the tribe's entry into mental health program development and a more visible commitment to community-based and clinic-based programming.

By 1980 the tribe's support of mental health personnel allowed for the hiring of three paraprofessionals, and the IHS was setting aside limited contract health care funds for mental health clients. Not only could the options for treatment be greater, but the program could now include prevention activities. The guiding philosophies centered on Indian self-determination both in the client-therapist relationship and in the program-community relationship. Much attention was given to the inclusion of culturally syntonik beliefs and activities in Euro-American treatment and prevention activities.

Suicidal behavior in the Flathead communities was indeed one of the major concerns that drove the expansion of the mental health program. Chronic depression, unresolved grieving, and alcohol and other drug abuse were frequent attendant concerns. The incidence of suicidal behavior in two or more generations within families suggested that the behavior should not be seen exclusively as an individual disorder but as a family disorder as well. Intervention and prevention then was focused across generations.

The establishment of a family counseling/cultural center allowed for the formation of the Mental Health Indian Studies Group, a day-long, community-based day treatment group, and was a way to move toward prevention and a new view of mental health intervention. During the summer the group established a home in the midst of a culture camp located in the mountains and led by a Salish elder. The center provided a place for cultural awareness activities (such as beading and tanning of hides), crisis counseling, family counseling, and group education for individuals who otherwise would have been resistant to involvement in mental health services.

Participants in the Mental Health Indian Studies Group were selected from the caseloads of the Mental Health Program. Particular effort was made to involve individuals who were chronic users of formal helping agencies (such as health departments, hospital emergency rooms, and welfare agencies), but who had poorly developed informal supports (such as family and friendship networks). The participation of significant others along with the clients in the group was encouraged.

The mental health issues that were addressed varied and included suicidal behaviors/thoughts, parenting, veterans' concerns, family communication, family violence, developing satisfying interests/hobbies, exploring education alternatives, developing assertiveness skills, and understanding one's cultural identity. These concerns were addressed in a variety of formats: group discussions during cultural activities such as beading, formal presentations by staff or outside speakers, movies, and outings into the community.

Through several years of intermittent consultation and in-service training, human service providers and the general community gradually assumed more responsibility for addressing suicidal and other self-

destructive behaviors. Several diverse change agents targeted at the individual, the family, and the community emerged. The most visible included local tribal elders and culture bearers; outside private consultants from the mental health field; outside private consultants from the children-of-alcoholics field; the Four Worlds Development Project from the University of Lethbridge, Alberta; the Alkali Lake Community Development Project from British Columbia; and a church-sponsored movement called Cursillo.

The Restructuring of the Alcohol Program

In early 1984, the Confederated Salish and Kootenai Tribal Council took a bold step in dissolving an existing alcohol program, which principally had provided social detoxification to a handful of chronic alcoholics who cycled frequently through the program. Outpatient services were minimal and prevention was nonexistent. A more comprehensive community-based treatment model was developed by a multidisciplinary group of human service providers, tribal and IHS administrators, and community leaders. The holistic approach they advocated can best be described by the medicine wheel, which illustrates the interrelatedness of the four human dimensions (mental, physical, emotional, and spiritual). It further demonstrates the traditional belief that healing and growth need to take place on all levels: individual, family, community, tribal, and global.

The philosophical principles on which the model was based are as follows:

1. The heart of the problem lies within the reservation communities. The solution therefore must come from within our communities. Others may assist, but we, as Native people, must be subjects of the healing process and must direct that process ourselves and in our own way.
2. The future is inseparably linked to the past. We must rediscover the life-preserving, life-enhancing values of our traditional culture. We also must come to understand the debilitating historical process we have undergone as a people. We then must unite in a common vision of what human beings can become and build a new future for our children that is based solidly on the values foundation of our own culture.
3. In order for our people to become competent directors of our own healing and development, an ongoing learning process is required. This learning process systematically will educate our children from the time they are in their mother's womb until they pass out of this world.

4. The well-being of the individual is inseparable from the well-being of the community. Individual healing and the healing of the entire community must go hand in hand.
5. The spiritual and moral dimension must be central to development and come from within our own culture.

Components of the Alcohol Program

Program components included the following:

1. A comprehensive reservationwide prevention program was implemented at seven reservation public elementary and high schools and at the tribe's alternative high school.
2. Medical detoxification was accomplished through a contract with the local hospitals.
3. A screening team was formed to refer individuals to inpatient treatment facilities located off the reservation, since none were available within the reservation boundaries.
4. Satellite offices were set up in four reservation communities to provide outpatient treatment services.
5. A transitional living center was operated to provide intermediate care.
6. A 5-day residential family treatment program was offered as part of after-care services.

The Evolution of the Blue Bay Philosophy to Community Change

The Drug Omnibus Act of 1986 gave increased attention to alcohol and other drug abuse in American Indian communities and created another vehicle through which community planning was to take place. Through a multiagency group called the Flathead Tribal Coordinating Committee, each tribe was directed to develop a Tribal Action Plan, a document coordinating the efforts of the IHS, Bureau of Indian Affairs (BIA), and all tribal programs in overcoming the devastating effects of the number-one health problem for Indians. Over the course of several months, the committee studied how the aforementioned philosophical underpinnings could be applied to bring about individual, family, and community change. The work of the committee led the Salish and Kootenai Tribal Council to approve the use of the land and resort buildings at Blue Bay — hence, the name of this approach — on the shore of Flathead Lake for an adolescent healing center.

Acknowledging that clients seen in the various health programs of the Tribal Health Department and the IHS are most likely to have multiple

needs, a chemical dependency screening team was established. The team consists of representatives from the following programs: alcohol, mental health, narcotics addiction, medical social work, family assistance, and IHS administration. A case is presented to the team if the chemical dependency assessment has indicated the need for inpatient chemical dependency treatment or for a mental health assessment because of the presence of a problem such as depression, suicidal behavior, or conduct disorder. It is this group that identifies appropriate treatment resources.

In May 1987 several representatives of the Flathead Tribal Coordinating Committee prepared a proposal in answer to the Office for Substance Abuse Prevention (OSAP) initiative establishing grants for high-risk-youth demonstration projects. The proposal, which called for establishment of the Blue Bay Healing Center, was 1 of 18 projects ultimately funded.

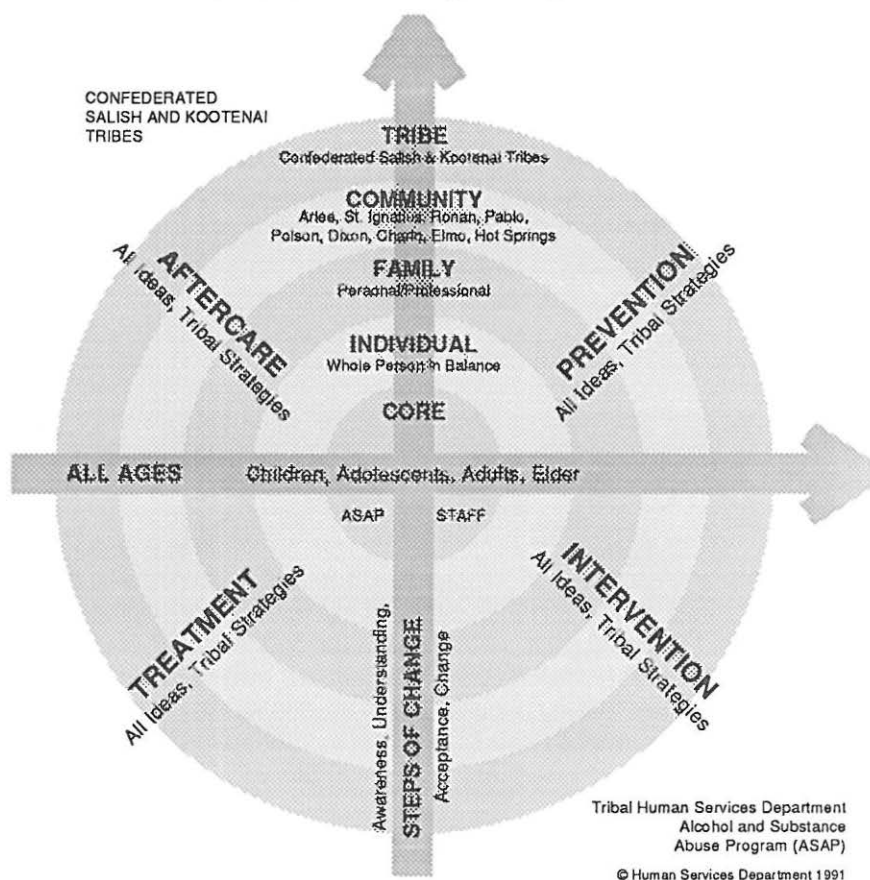
The Blue Bay Healing Center's primary goal is to prevent substance abuse among youth on the reservation by breaking the generational cycle associated with this problem. This is done by developing a culturally relevant treatment modality that engages the entire reservation population in the healing process. The healing radiates from the Blue Bay Healing Center through two distinct components (see diagram in Figure 7-1.).

The first component is client progression through a continuum of care specifically developed for the center. The second is a training component with three levels: (a) center staff receive intensive training in order to provide the best quality of care for clients; (b) human service providers receive training that will assist them in developing a responsive, knowledgeable network of committed individuals working with high-risk youth in the area of substance abuse; and (c) community members receive training that facilitates the development of support networks for high-risk youth in the communities. The generational cycle will be broken when youth from dysfunctional homes can identify healthy community members and begin modeling their behavior after them, rather than on the dysfunctional behavior within their own homes.

It is the belief of the center that healers can bring clients only to the level of health they themselves have achieved. Therefore, the healing of pain within all of the workers is a necessary step. It is only after the recovery journey begins that others (clients and the general community) can be brought into the healing process.

The Blue Bay model is further based on the belief that the greatest positive impact on the children of the reservation will be seen by engaging the entire community. Research shows that only 10% of what children learn is received in an academic setting. The other 90% is learning through parents, church, mass media, peers, elders, and other life experiences. A comprehensive prevention process must, therefore, influence these areas if there will be any success with young people.

Table 7-1
Diagram of the Blue Bay Healing Process.



Prevention Activities as Implemented at the Center

The Blue Bay Healing Center has the following five components:

1. A residential intervention program targets both age-specific groups and intergenerational groups from the community at large. The intervention has an educational focus within which information on chemical abuse/dependency is presented to residents. Other issues, including suicide, also are addressed. Some residential sessions have a therapeutic component, such as youth retreats, during which trained counselors are available as supports for intra- and interpersonal counseling.

2. An outpatient intervention program targets high-risk youth groups in the community. Training about a variety of topics is provided in a group setting.
3. An outpatient training program targets caregivers (known as the core group), both those in the formal human services system and those who informally function as caregivers.
4. An outpatient treatment program provides community and program caregivers with support for the healing of personal distresses, problems from either childhood or adulthood.
5. Community events include diversion activities for youth and adults and celebrations of sober and healthy life-styles.

Evaluation of the Center

The Blue Bay Healing Center's leaders value evaluation as a tool for refining program activities and goals. Their funding source, OSAP, requests evaluation for demonstration projects. During the summer of 1989, a process evaluation based upon a series of key informant interviews was conducted by the National Center for American Indian and Alaska Native Mental Health Research. Community leaders and project staff were interviewed. Other information came from the 1987 proposal for the Blue Bay Healing Center, which was submitted to OSAP, and a 1988 evaluation of the Flathead Alcohol Program conducted by an external source. The earlier evaluation efforts will be summarized in this report next and will be followed by a summary of the more recent process evaluation.

Summary of Independent Evaluation Conducted in 1988

After site renovations were completed near the end of the first year of funding, the Flathead Alcohol Program contracted with the Evaluation Research Associates from Missoula, Montana, to conduct an evaluation of the entire alcohol program, with some emphasis on the Blue Bay Healing Center (Walsh & Dana, 1988).

Program Audit

The first evaluation component was an audit of program utilization and functioning. The data were generated primarily through an audit of case files and internal records of the alcohol program. The program director and staff also were interviewed.

Of note are the data relating to "problems associated with chemical dependency." The life difficulties clients reported as most frequently associated with chemical dependency were legal problems and family

relations. The most commonly associated clinical problems among both clients and their family members were depression and suicide attempts (and some successful suicides in the case of family members). Table 7-1 summarizes the 84 out of 116 client responses for which this information was available.

Table 7-1
Client Response Summary

Additional Clinical Problem	Number
Depression	40
Suicide attempt	17
High blood pressure	12
Ulcers	9
Hepatitis/liver damage	9
Mental illness	8
Migraines	5
Venereal disease	5
Heart problems or stroke	3
Diabetes	2

Budget Analysis

The second component was an interpretive analysis of the program's budget. Its foci were (a) the program's emphasis as reflected in the budget and (b) the possibility that reallocation of funds might lead to improved treatment capabilities.

The usual indicator of the degree to which a human service organization is in fact service oriented is the overall percentage of total direct costs for professional personnel, including fringes. The overall percentage of total direct costs, including Tribal Health Department supplemental funds, going to personnel at the Blue Bay Healing Center is about 44%. (The upper limit usually seen in the literature is about 65%.) In a facility under development, and especially where nonpersonnel costs are for such basic items and are so clearly itemized, the decisions regarding resource allocation denoted by this figure would be hard to challenge. The one item that might merit discussion is the consultant category. The present allocation may be somewhat high as a percentage of direct costs.

Training Needs

The third component dealt with staff training needs, both long- and short-term, and the ways they might be integrated into overall

program planning. The analysis emphasized the relationship of training needs to a larger complex of issues that illuminated organizational strengths and weaknesses.

Of necessity, many staff members are hired for their experience with alcohol and other drug abuse rather than on the basis of professional training. While the program has an extensive training program that provides excellent exposure to current thinking in the field and to high-level practitioners, it cannot produce an immediate professional style in newly hired counselors who are largely without a formal educational background. In such an environment, there will always be a few counselors who project an image to other agencies and to the community at large that raises questions of ethics and propriety. Within the agency, there are likely to be instances when gossip and an informal friendship network replace responsible communication and professional-level consultation.

Client Surveys

The goals of this survey were to contact by mail every individual who had used the services of the program during the previous 2 years and to assess the satisfaction of these 359 clients and former clients with the services they received. Twenty of these individuals also were contacted by a telephone interviewer who used open-ended questions to investigate attitudes, judgments, and viewpoints whose importance or existence might not have been targeted by the mail survey.

Survey recipients were asked to

1. Provide information about gender, age, marital status, when they entered treatment with the program, and whether they had been in treatment other than with the program
2. Give the reason they entered treatment and say whether or not the program had helped them
3. Say whether they still drank or used drugs and whether they considered themselves alcoholics or drug addicts
4. State whether they would refer a friend who had alcohol or drug problems to the program
5. Provide information about the ways in which they had benefited from treatment and counseling
6. Offer opinions about the best and worst aspects of the program
7. Describe the characteristics of a good drug and alcohol counselor, the single most important quality he or she should have, and the best kind of educational background and/or training for a counselor to have

8. Suggest ways in which the program might be changed to better serve clients

Of the 339 questionnaires that were presumably delivered, 72 were completed and returned, for an overall response rate of 21%. The demographic material provides us the following portrait of clients who responded. A majority of them, 57%, were men. Nearly half were between 26 and 35 years of age. Only a quarter were married, and beginning with 1986, they were fairly evenly distributed as to year of entry into the program. Slightly more than one fifth had been in treatment before, most of them at locations in-state or in the Northwest.

The dominant reasons for entering treatment were court orders and the individual client's feeling that he or she needed help. Treatment received a generally positive rating; one quarter of the clients felt they had definitely been helped and another half felt that they had received at least some benefit from counseling.

It appears from the responses that the program is especially strong in helping clients achieve a better understanding of what it means to be an alcoholic or drug addict, in providing a better understanding of the effects of drug and alcohol abuse on physical health, in putting clients in better touch with their feelings and emotions, and in improving clients' relationships with their families. The program appears to help about a third of its clients achieve an understanding of how drug and alcohol abuse runs counter to traditional culture and provides a bit more than a fourth with healthier approaches to alcohol- and drug-free recreation. The program is relatively ineffective in helping clients find a spiritual path to recovery. Table 7-2 summarizes this information.

Finally, clients wanted counselors who are recovering alcoholics or addicts. They preferred that they have strong ties to the community and reservation regardless of their professional training or qualifications. They felt that in personal terms the counselors should be experienced, competent, sincere, compassionate, empathetic, understanding, and nonjudgmental. Overall, the clients viewed the program favorably but felt a moderate need for more highly trained counselors and some improvement in intake and follow-up procedures.

General Survey

The recipients of this mail survey were a general sample of 1,200 IHS-eligible residents of the Flathead Reservation who were selected without regard to whether they had been clients of the Flathead Alcohol Program. The purpose of the survey was to discover how knowledgeable these residents were about the alcohol program and how they rated its services.

Table 7-2
Specific Help Percentage Summary

Specific Help	Percent (%)
I have a better understanding of what it means to be an alcoholic or drug addict.	64
My relationship with my family is better.	4
I am more able to understand my feelings and emotions.	48
I was helped to find a spiritual path to recovery.	16
I have a better understanding of the effects of alcohol or drug abuse on my physical health.	61
I have a better understanding of the way alcohol or drug abuse goes against my own culture.	34
I am more able to use my free time for recreation that keeps me away from alcohol or drug abuse.	28
I was not helped in any of these ways.	9
I was helped in another way: _____	4

The total survey was divided into three sets that covered different areas: awareness and use of the alcohol program, knowledge of the satellite offices and the Blue Bay Healing Center, and factors contributing to alcohol abuse and recovery. The demographic questions were asked of everyone. Survey recipients were asked to do the following:

1. Provide information about their gender, age, marital status, and community of residence
2. Indicate their awareness of changes in the alcohol program since 1984 and their use of program services
3. Make a personal evaluation of the quality of the present alcohol program and its services and provide suggestions about how the program could be improved
4. Rate the effectiveness of the alcohol program's satellite offices in the reservation's major communities, describe desirable qualities of counselors in these offices, and address issues associated with use of the community offices
5. Describe their knowledge of the Blue Bay Healing Center, its services, the activities planned for it, and factors that would influence their use of it

6. Make choices among possible alternatives for future development of the alcohol program
7. Provide their opinions about discrimination against alcoholics, factors contributing to drug and alcohol abuse, the effectiveness of Alcoholics Anonymous as a path toward sobriety, and desirable qualities for counselors in the drug and alcohol program

Each of the three sets was mailed to 400 members of the total sample. A cover letter from the director described the need for information from community members with which to evaluate the program and its services. To encourage completion of the surveys, each respondent received a ticket for a \$250 prize to be awarded at a drawing to be held August 27, 1988, at the ceremonies marking the grand opening of the Blue Bay Healing Center. Stamped, pre-addressed envelopes were provided for recipients to return their completed questionnaires and ticket stubs.

Nearly equal numbers of the three sets were received (92, 95, and 100), for a total of 287 completed and returned. Out of the 929 questionnaires that were presumably delivered, the response rate was 31%.

Demographic characteristics. Sixty percent of the individuals who responded to this survey were females and 40% were males. The respondents tended to be younger rather than older, averaging just over 36 years of age, and their age distribution spans that of the reservation population in a fairly representative way. Slightly more than half of the respondents were married, another quarter were single, and the remaining 23% were separated, divorced, or widowed. Finally, the respondents were drawn from the reservation's communities in a proportional fashion.

Awareness and use of the alcohol program. Several findings stand out with respect to awareness and use of the alcohol program. More than two thirds of those surveyed had some awareness of changes in the program in 1984. Nearly a quarter of the sample had requested its help either for themselves or for a friend or relative, and more than a quarter had attended an event such as the Sobriety Campout, sponsored by the program.

Of the services provided by the alcohol program, counseling was the single most useful component, recognized by half of the people who evaluated the services. Alcoholics Anonymous was viewed as a useful support group, and informational, recreational, and social components were frequently cited as well. Cultural and spiritual components were seen as less useful.

All parts of the education and prevention program were viewed as having considerable utility. Community recreation events and school curricula were seen as somewhat more valuable than community training meetings or the youth centers in two of the towns.

Education/prevention programs increased understanding of the effects of alcohol and drug abuse in all of the five areas reviewed (emotions

and feelings, cultural and spiritual, physical health, the family of the alcoholic, being an alcoholic or drug addict), but cultural and spiritual effects were seen as much less strong than the others.

Knowledge of the Blue Bay Healing Center. The first question about the Blue Bay Healing Center focused on respondents' awareness of the center's purpose. They were asked whether they were aware that Blue Bay is intended to support recovery and education and prevention activities rather than detoxification. Fifty-six percent knew that Blue Bay was not a detoxification center, but 44% had not been correctly informed.

Respondents were then asked about their awareness of a set of activities listed on Table 7-3 that have been or may be considered for development as part of the recovery program at Blue Bay.

Table 7-3
List of Activities

Would Organize (%)	Would Participate (%)	Activity
15	39	Swimming, fishing, and boating
4	16	Retreats
7	28	Crafts (beading, hide tanning, decorating tepees)
4	23	Artistic activities such as drawing, painting, wood carving, sculpture
5	15	Card playing tournaments
9	34	Softball, volleyball, basketball tournaments
2	12	Singing
4	4	Talent shows

Only 17 (18%) of the 95 members of the sample said they knew about these activities, but there is some question about the meaningfulness of this figure, since some respondents interpreted the question as being about awareness of the entire set of activities. That is, some respondents said they were not aware of the activities unless they were aware of all of them.

Individuals were next asked about their interest in participating in these activities and if they would be willing to help organize them. The numbers in the two columns in Table 7-3 show the percentages of the 95 respondents who were interested in participating in and organizing specific activities, respectively. Fishing and water sports, crafts, artistic activities, and softball/volleyball/basketball were most popular among prospective participants, and singing and talent shows least so. Relatively

few individuals were interested in organizing activities; only fishing and water sports drew replies from more than 10% of respondents.

Given its newness, respondents were asked if they would be more willing to use the recovery facilities at Blue Bay if someone who knew more about it was willing to go along and act as a support person. Forty-seven (51%) of 92 respondents indicated that a support person would increase their willingness to use Blue Bay, and 45 (49%) said a support person would not make them more willing to use the recovery facilities.

The sample members were asked about their awareness of Blue Bay's codependency program. Of 94 people who responded to this item, 31 (33%) were aware of the program and 63 (67%) were not.

When asked whether the provision of transportation would make them more likely to use the facilities at Blue Bay, 38 (40%) of 94 people responding to the question said it would increase the likelihood and 56 (60%) said it would not.

The final question in this segment of the survey asked respondents whether they planned to use Blue Bay during the year. Ten (11%) people out of the 94 who answered the item said they did plan to use Blue Bay, 41 (44%) did not intend to use the facilities, and 43 (45%) were not sure which choice they would make.

In summary, awareness of the Blue Bay Healing Center appear to be good after 1 year of operation. Despite its relative newness, over half of the respondents were aware of it and its purpose. Half of the group responding said that having a support person accompany them to the facility would enhance their likelihood of use. Another large section of the group believed that the provision of transportation would likewise increase their likelihood of use. Nevertheless, only a small percentage had definite plans to use the Blue Bay facilities in the current year. More publicity aimed at the 45% who were not sure if they would use it would seem likely to increase its utilization.

Evaluations, Conclusions, and Recommendations

The major conclusion is that the total alcohol program, of which the Blue Bay Healing Center is a part, is well known and well regarded on the Flathead Reservation. "Given the limitations of its resources and the fact that it serves a population that is in many respects greatly afflicted and underprivileged, the alcohol program provides effective treatment to its clients and an influential program of education and prevention to the residents of the reservation" (Walsh & Dana, 1988, p. 81).

Two of the 15 recommendations are particularly interesting. The one salient to suicidal behavior states that given the relatively high incidence of eating disorders, depression, and suicide among clients, the program should institute more formal screening procedures in these

areas and offer more training to its counselors in dealing with these problems.

The other recommendation is based on the lack of concern among clients and the general public with matters of traditional culture and religion. In addition, treatment efforts focused on these areas seem to have had little effect and to have been largely unappreciated. The program was encouraged to re-examine its commitment and its efforts in these areas. This would seem to challenge the presumption that a culturally based treatment program is more comfortable and efficacious for Indian clientele.

Summary of Process Evaluation

In the summer of 1989, the alcohol program consented to a process evaluation to be completed by the National Center for American Indian and Alaska Native Mental Health Research. The evaluation was based upon a series of key informant interviews conducted with community leaders and project staff. (The reader is encouraged to read the summaries of all interviews, which are found in the Appendix.)

In summary, there is a strong consensus that the Blue Bay Healing Center and its philosophy is addressing suicidal behavior and thinking among selected high-risk youth groups, some community members, and formal and informal human service providers. Alcohol and other drug use is considered to be "slow suicide" and is acknowledged to greatly potentiate risk taking and other types of self-destructive behavior. It is commonly believed that the Blue Bay Healing Center, with its structure and concepts, can powerfully raise community awareness about suicidal ideation and behavior, as well as about healing from the hurts associated with suicidal behavior in families and communities. It is seen as a focal point, perhaps one of the few visible ones, for a blend of prevention and treatment activities and a combination of community-based, school-based, and clinic-based services.

Given the large support for what was often referred to as the "Blue Bay philosophy," the 12 interviewees brought up a number of excellent issues that can have an impact on the actualization of the center's goals and objectives. The following points were raised:

1. The Blue Bay Healing Center and alcohol program staff members deserve support for personal and professional growth. Continued training and clinical supervision is one very important avenue. Advocacy with the tribal personnel system and the tribal council is highly desirable for developing a workable plan for ongoing professional development.

2. The promotion of a positive working relationship between the Blue Bay Healing Center and strategic programs, agencies, and grass-roots groups is a top priority. Dialogue among these entities should be ongoing and frequent. Long-term planning to develop multiple strategies that can be implemented by many sectors of the communities is extremely important.
3. Systematic community involvement with the articulation of the vision, the development and implementation of program elements, and the evaluation of program efficacy is essential. The involvement of youth, elders, non-Indians, nonmember Indians, and school personnel should continue to yield positive results.

Finally, a provocative and recurrent theme within the interviews is the belief that recovery and promotion of mental health in Indian communities has to include the acquisition of cultural knowledge and skills and has to address "community identity" issues as well as individual and family identity.

One person interviewed captured this theme very well: He does not believe that the "Indian community" exists. What exists are enclaves of Indian individuals and families, but true community does not exist. Another example is the fragility of Indian identity at the individual and tribal levels. There has not been a natural progression of Indian identity at either level because of sudden acculturation changes that adversely affected development in various dimensions (economic, social, cultural, and spiritual). He believes that non-Indian structures have been used to build the reservation's macrostructure and that this has also diminished the positive contributions of Indian culture to individual and group identity. What Blue Bay does is to highlight the question "What does it mean to be a Salish or Kootenai Indian in the 1980s?" and this is a laudable accomplishment.

He has observed that Blue Bay Healing Center has had positive short-term outcomes but that the healing effort needs reinforcement so that careful long-term planning can take place. "Blue Bay is community development without a vision of the future." He believes that Blue Bay activities represent the first attempt at communitywide development, and one outcome has been the healthy challenging of the existence of "Indian community." This challenge has raised anxieties within community members, but the ensuing confusion and unmet expectations are a necessary and healthy part of re-establishing new, viable community structures that support healthy community values.

The Blue Bay model focuses on the individual and also on the "collective." The goal is to help people identify the many sources of pain that lie within and without a person; e.g., poverty, sexism, racism, and ageism. It is important to address pain but also to address the positive

side of the emotional gamut. Role models are powerful teachers in this regard.

The "collective" includes attention to families and communities. In the past no attention was given to Indian families, but a critical mass of individuals has formed and a vision of healthy Indian families has arisen. Non-Indian entities within the reservation system are now being informed by tribal government, IHS, and the BIA. This amassing of individuals who ask, "When is enough, enough?" has been a very lonely enterprise, but Blue Bay now provides them with a place for the strong articulation of the family vision. The "Indian individual vision" is clear, as is the "Indian family vision," but the "Indian collective vision" is not clear.

The following were recommended: First, fully develop the collective vision. Communicate that vision to the human services community. Emphasize that the human services staff "walk their talk," and demonstrate that healing and stability to the community. Reduce high staff turnover. In response to the possibility that the Blue Bay Healing Center become an institution with a guru or gurus, it is important for the Blue Bay leadership to demonstrate that they want to "facilitate" the philosophy and work of Blue Bay, not to "control" it. A "giving away" of the ownership of the Blue Bay Concept needs to occur; ownership needs to rest in the community.

The challenge of the community development approach rests in the articulation of a community vision and the creation of strategies for the giving away of the vision to the Indian community. The community development approach has much support in Indian communities today, and it is important for the mental health disciplines to identify a leadership role in this movement and to assist in its evaluation.

Reference

- Walsh, J.A., & Dana, D.A. (1988). An Evaluation of the Alcohol Program of the Confederated Salish and Kootenai Tribal Health Department. *Evaluation Research Associates*, Missoula, MT: author.

Appendix

1989 Process Evaluation Summary of Interview Data

Informant No. 1

This individual was very conversant with the five components that make up the Blue Bay Healing Center and explained how suicidal thinking and behavior are addressed within these components. Her observation was that most of the Blue Bay clients experience suicidal ideation. Suicidal issues are highlighted in the Blue Bay training activities, which address knowledge, attitudes, emotions, and skills vis-à-vis suicidal

thinking and behavior. She believes that effective education around these issues needs to involve intervention that seeks to change both cognitive and emotional behavior.

This respondent described the usual pathways to standard inpatient alcoholism treatment followed by outpatient after-care. It is her opinion that youth returning to their homes and communities after completion of inpatient substance abuse treatment are at high risk for suicide because they have a new awareness of the ways in which their host environments are nonnurturing and nonchanging. One aspect of the Blue Bay philosophy addresses this observation; in order to really positively influence the child's environment, the youth in recovery from substance abuse needs healthy adults who will be a constant in his/her life, not just a part of intensive residential treatment. The philosophy behind the Blue Bay Healing Center was presented as "not a new idea"; the philosophy is an old idea that needed a new structure to be revitalized.

Informant No. 2

This individual felt that the entire reservation community is in denial about suicide, but he observed that youth involved with Blue Bay activities have been bringing up the issue of suicide. He felt that a major activity that would reduce suicidal behavior is the education of parents and children specifically about suicidal behavior.

He also supported the notion that in the process of effecting community change, it is important to identify and connect key persons from the sectors of the community who are concerned about social and personal health. One of the more obvious sectors rests within the human services system (schools, courts, outpatient community alcoholism program, mental health program, and family counseling program). The Blue Bay Healing Center has very good linkages with this sector according to this individual. One demonstration of this working relationship across programs are weekly staffings of clients. Another central group consists of the culture bearers, principally the elders.

This respondent felt that the Blue Bay Healing Center needed more staff and a more secure funding base in order to accomplish its goals in the best possible fashion.

Informant No. 3

This person believed that suicide is a problem in the reservation communities and it is linked to the concepts of helplessness and hopelessness. There is a need to document the phenomenon by gathering statistics from key agencies. It was observed that local suicidal behavior increased during the time in which another reservation had experienced a

suicide epidemic, thereby suggesting a contagion effect across tribal groups.

The respondent believes that Blue Bay activities have raised community awareness about suicide and the conditions that foster suicidal behavior. Blue Bay's philosophy challenges the "Don't ask for help" message that is prevalent in the communities. Blue Bay is available as a safe place that can promote healing and growth. In addition to attention to attitude change, Blue Bay programming teaches skills such as decision making and coping. Program activities also promote values such as order and respect, which are viewed as life and health supporting. Youth get to know people who are able to show that they care what happens to them. This individual articulated the following cultural beliefs about suicide: Suicide is wrong; it goes against the purpose of why each of us has been placed on earth. The Indian who knows about Indian culture further believes that either suicidal thinking represents a true cry for help or it represents the loss of childhood.

Pursuing cultural beliefs and practices is very valuable in teaching Indians about help that can come from other people and the physical world, but it is important to remember that cultural learning takes time. Cultural learning does not bring about instant and complete positive change. Recovery of a culture is an ongoing and often gradual process.

Informant No. 4

This person believes that the entire reservation reverberates with grief when an Indian individual completes suicide, although many parts of the reservation "family" do not promote any overt activities that address suicidal behavior. It is the generation of parents in their 30s and 40s who are demonstrating the strongest "push for life." Ironically, it is this generation (and not the generation of elders) that is most active in attending to the life-supporting aspects of Indian culture. The task of integrating Indian culture and Euro-American culture involves taking risks and facing complex issues.

This respondent believes that contemporary Indian youth are more at risk for suicide than other generations because they do not perceive themselves holistically; i.e., as having physical, cognitive, emotional, and spiritual dimensions. It was his personal belief that spiritual healing and growth is the most neglected of these dimensions.

This individual also shared his concern that the rapid turnover of staff that Blue Bay had been experiencing was not desirable. He felt that increased community involvement and team building would help reduce this turnover.

Informant No. 5

This informant observed that suicidal behavior has been more frequent than suicide completions in the Indian communities. He views suicidal behavior "acting-out behavior" and believes that most people do not make the connection between suicidal behavior and abstract issues. Most of the attention is focused on the concrete stressors in the suicidal person's life, such as unemployment or chronic illness. An example of an abstract issue that is related to Indian suicidal behavior is "the absence of community." This person does not believe that the "Indian community" exists. What exists are enclaves of Indian individuals and families, but true community does not exist.

Another example is the fragility of Indian identity at the individual and tribal levels. There has not been a natural progression of Indian identity at either level because of sudden acculturation changes that adversely affected development in various dimensions (economic, social, cultural, and spiritual). This individual believes that non-Indian structures have been used to build the reservation's macrostructure and that this has also diminished the positive contributions of Indian culture to individual and group identity. What the Blue Bay Healing Center does is to highlight one aspect of Indian identity: "What does it mean to be a Salish or Kootenai Indian in the 1980s?" This is a laudable accomplishment.

He observed that the Blue Bay Healing Center has had positive short-term outcomes but that the long-term healing effort needs reinforcement through careful long-term planning. "Blue Bay is community development without a detailed vision of the future." The informant believes that Blue Bay activities represent the first attempt at communitywide development; one outcome has been the healthy challenge of the idea that an "Indian community" exists. This challenge has raised anxieties within community members, but the ensuing confusion and unmet expectations are seen as a necessary and healthy part of re-establishing new, viable community structures that support healthy community values.

What do community members think of Blue Bay? The first perception is that it represents a fad, the influence of which will diminish in time. It is grossly underutilized. Also, the vision of Blue Bay is not clearly perceived by the community. There is a strong emphasis on the physical location and not enough emphasis on the philosophy.

The previously used model for change within the human services programs primarily had focused on the individual; helping the individual deal with pain and live with pain. The Blue Bay model focuses on the individual and also on the "collective." A goal of the center is to help people identify the many sources of pain that lie within and without a person; e.g., poverty, sexism, racism, and aging. It is important to address pain but also to address the positive side of the emotional gamut. Role models are powerful teachers in this regard.

The "collective" includes attention to families and communities. In the past no attention was given to Indian families, but a critical mass of individuals has formed and a vision of healthy Indian families has arisen. Non-Indian entities within the reservation system are now being informed by tribal government, Indian Health Service, and the Bureau of Indian Affairs. This amassing of individuals who ask, "When is enough, enough?" has been a very lonely enterprise, but Blue Bay now provides them with a place for a strong articulation of that vision of healthy families. The "Indian individual vision" is clear, as is the "Indian family vision," but the "Indian collective vision" is not clear.

The following were recommended: First, fully develop the collective vision. Communicate that vision to the human services community. Emphasize that the human services staff "walk their talk," and demonstrate healing and stability for the community. Reduce high staff turnover. In response to the possibility that Blue Bay could become an institution with a guru or gurus, it is important for the Blue Bay leadership to demonstrate that they want to "facilitate" the philosophy and work of Blue Bay, not to "control" it. This individual advocates a "giving away" of the ownership of the Blue Bay concept. Ownership needs to rest in the community. His last issue addresses a level of rigidity within the structure of Blue Bay; he believes that the program fails to respond to naturally occurring needs within the community.

Informant No. 6

This person has observed considerable suicidal ideation within the mental health treatment (clinical) population. There are high numbers of attempts within the adolescent population. The clients of the alcohol program are considered to be at high risk for demonstrating suicidal behavior. The reservation has experienced few suicide completions over the years, but each completion has had a huge ripple effect in the large extended families and friendship circles. The completed suicide is devastating for those who survive.

It is believed that the mental health staff intervenes as early as possible and the general theoretical approach is to consider suicidal behavior as a symptom of distress of the individual and his or her family. The mental health program keeps a register of suicidal behavior and this register documents that this phenomenon is continuing to occur at a steady rate. The general community is understandably very fearful about suicidal behavior, and therefore, immediate hospitalization is considered to be the only recourse for suicidal ideation and attempts.

When suicidal ideation and/or behavior is evident in a client receiving treatment for alcohol and other drug abuse, the chemical dependency staff tends to expect the mental health staff to take the case over rather than using the mental health staff as consultants around the

suicide issues. The reverse is often the case as well. To address this, an in-service on suicide was provided for the entire Tribal Health Department staff. This was helpful, but education about suicide needs to be ongoing; the department staff needs a way to process the natural anxieties (and, for many, actual family and friendship losses to suicide) associated with the issue. Other programs like the tribal college, schools, and law and order are very much in need of education about suicide. There is no focused effort to organize funding and human resources so that this goal might be reached.

This informant believes that the activities of the Blue Bay Healing Center prevent many disorders (suicide, alcohol and other drug abuse, depression, child abuse, etc.). High-risk youth who are involved are given the opportunity to see healthy principles of living at work. The Blue Bay approach is an extraordinary one in that it is an effort to educate at the community level and there is an excitement to do so.

However, it is believed that the Blue Bay philosophy is not clearly understood by the Tribal Health Department staff, including those from the Flathead Alcohol Program and the Blue Bay Healing Center. There is no clarity about how the Blue Bay approach operates vis-à-vis grassroots change phenomenon. Does the Blue Bay approach supplant, encompass, support, or merely coexist with nonagency-based movements? There is an observed naive expectation that the Blue Bay Healing Center will "cure" the communities' ills and that big changes will take place in a short time.

Fruitful directions include a continued sharing of the Blue Bay message with a set of expectations that are tempered by the realization that time will allow the message to filter into the many sectors of the reservation communities. The community and interagency meetings that were held initially to support dialogue about the Blue Bay approach should be held on a regular basis. The frequent turnover of Blue Bay Healing Center staff needs to be addressed because it is "bad press" for the Blue Bay philosophy; some staff members left the program with unresolved negative feelings. Continued training and clinical supervision of the alcohol program staff would promote continued clinical competence and staff cohesion. It also would assist in the maintenance of the balance of community-based and clinic-based services. The bottom line seems to be that the Blue Bay Healing Center is not viewed as a fad by the community at large and the human service providers; it is expected to have a tremendous impact in the area of suicide prevention.

Informant No. 7

The persons at highest risk for suicide are believed to be alcohol and other drug abusers. With the increase in cocaine and crack use on the reservation among youth as young as 13 years old, that subgroup of

drug abusers is at highest risk because of the increased vulnerability during withdrawal. The vulnerability does not necessarily decrease when an adolescent and his/her family begin recovery. Alcohol and other drug use is still an organizing theme for these families and continues to be a compelling factor in meeting many needs. Intergenerational conflict arises when parents of adolescents realize that they have no healthy model for parenting and they experience natural jealousy because their children are having the healthy childhood they could not have.

Adult survivors of child sexual abuse also are at risk for suicide because they struggle with the aforementioned issues as well as the healing of their abuse and fears that they will not be able to protect their own children.

This respondent does not believe that suicide prevention is a significant part of the mental health program, as it was in the past. Other programs within the tribal and nontribal system have activities that are targeted at suicidal behavior; most notably, two of the schools. However, the community of service providers has not taken responsibility to develop a comprehensive plan to address this very critical issue.

There now exists a group of several adolescents who are in recovery; i.e., they have received inpatient and/or outpatient chemical dependency treatment. These youth are experiencing increased expectations about the maintenance of their recovery and development of their leadership. With the recent loss of several tribal elders, there may even be a magnification of the anxiety that comes with being perceived as the "future" of the tribe. Blue Bay provides a special and nurturing place for these youth. In the early stages of development, any program may place too much emphasis on intense psychological and social work. A balance between play and work needs to be kept so that therapy and growth can be achieved in both play and work spheres.

The recommendations coming from this interview had several themes. More systematic community involvement, including the adolescent consumer, is needed to combat the community perception that Blue Bay is an exclusive club. Perhaps an advisory board with one or two adolescent members could be created to fill this void. It is believed that the "family of service providers" is still very dysfunctional and not yet fully involved with the healing that needs to take place within that "family." The idea of giving up control over programs and giving it to the communities is frightening and overwhelming. To really make the Blue Bay vision more widely known in the communities, the leadership needs to be open to criticism, to allow creativity within the staff, and take the programming into the community.

This respondent recommended a greater mixture of high-risk and low-risk youth in Blue Bay Healing Center activities. Many activities are family oriented, and an expansion of the clinical work into classical family intervention would make a more powerful impact. More communication

with other agencies about Blue Bay's schedule of events would increase the utilization, as would greater integration of Salish and Kootenai culture into the programming.

Informant No. 8

This individual began the interview by stating that suicidal behavior in adolescents was a definite problem. The Indian community is aware but doesn't know how to address the issues associated with suicidal behavior. There is minimal planning at the community level. Some human service provider meetings mention the issue, but that is as far as it goes.

This person believes that the mental health program is addressing suicidal behavior through crisis intervention and early case finding. Mental health interventions that target adolescents need to include the teaching of tools to cope with life stresses. She does not believe that Blue Bay Healing Center is capable of intervening with suicidal clients, because the center has no clinical supervisor or way of managing suicidal cases.

Specific recommendations for Blue Bay Healing Center follow: (a) send out regular notices of events and activities, (b) more clearly delineate the role of the center's director so that the director can concentrate on leadership, (c) include the director of Blue Bay Healing Center on the chemical dependency and mental health staffing team, (d) encourage more cooperation between Blue Bay and other programs, (e) extend invitations to Blue Bay to a larger group of persons instead of to a "chosen few," and (f) add more clinical supervision to the programming.

Informant No. 9

Adolescent suicidal behavior is a great concern to this individual, who believes that suicidal behavior is related to high prevalence of adolescent depression, which in turn is related to inadequate parenting. Situations involving suicidal behavior are referred to the mental health program.

What is standing in the way of a more comprehensive approach to suicidal behavior in the youth is the unwillingness of the community as a whole to work together. This person believes that programming that is offered to Indians and non-Indians in the schools would have a great impact.

Two important program elements of Blue Bay were identified: training for all tribal health employees and the summer recreation program for the youth. This respondent wants Blue Bay to continue and recommended that more public relations work be done with other programs so that others are oriented to Blue Bay's goals and objectives and that a

schedule of events is well dispersed. He recommended expansion of collaboration with schools.

Informant No. 10

This individual participated in successful "New Directions" training at Blue Bay and saw this as an opportunity to establish a bond with Blue Bay staff. This goal was not realized because the Blue Bay staff did not attend from beginning to end. This respondent was concerned that the Blue Bay staff is not able to balance work, training, and vacation times. The tribal council does not understand the unique pressures that service providers experience, and therefore, personnel policies do not support balance between professional and personal growth. Better public relations activities would address this issue.

Successful aspects of Blue Bay Healing Center mentioned in this interview were (a) the elders believe Blue Bay area is a healing place and, therefore, are supportive of the principle, and (b) youth who participate in programs at Blue Bay "love it."

Informant No. 11

Suicide is a huge problem according to this health professional whose clients participate in Blue Bay programming. The community doesn't talk about suicide directly, but many families have lost members through suicide over two to three generations. The mental health program is one entity that directly confronts the issue, in that referral questions routinely include the question "Is this person suicidal?" This individual makes more referrals to the mental health program than the alcohol program, because clients tend to deny alcohol and drug abuse but will identify personal and family problems as a focus of intervention by a counseling program.

This individual believes that tension between Indians and non-Indians is a huge factor in suicidal thinking of individuals. There are stereotypes and expectations attached to the Indian identity that raise the levels of stress and confusion in Indian youth. Blue Bay is not directly addressing race relations yet, but programming has focused on increasing pride in Indian heritage and in oneself.

Who utilizes the Blue Bay Healing Center? Sectors of the Indian communities are participating in activities sponsored by Blue Bay. This is especially true for those activities that do not preach about alcohol and drugs. The message that draws community members is, "Come to Blue Bay and you will have a good time, a good getaway." Persons who have been referred to Blue Bay see it in a positive light; it is a nurturing place.

Elders who know of the Blue Bay Healing Center really like it because they are included as consultants as well as participants. This

interviewee saw the family focus as a definite strength of Blue Bay and the summer youth program, SORNAP, which is sponsored by Blue Bay, was judged as "great." Blue Bay is one of a few developing programs for Indian and non-Indian youth on the reservation. Others include a Lake County prevention program called "Parents and Teens Can Talk" and youth centers in major towns.

This informant recommended greater communication about Blue Bay events, because she often became aware of the events after the fact. She also recommended more follow-up with individuals who have participated in Blue Bay events.

Informant No. 12

This person views suicidal ideation and gestures as related to a greater sense of hopelessness and helplessness felt by individuals. Prevention interventions are currently offered through two avenues: (a) the alcohol and drug curriculum in the schools and (b) Blue Bay Healing Center, because its location can be conducive to a lifting of depression; i.e., a time-out from depression.

The informant views Blue Bay Healing Center as family oriented and believes that its major target population is the youth. He believes that the grant that supports Blue Bay came from Indian Health Service. He doesn't know how people are referred to Blue Bay. Community members have said that they want to go to Blue Bay; they think it is a residential treatment center for alcohol and drug abuse. This individual finds out about Blue Bay activities from the alcohol program and mental health program staff. It is his understanding that the support groups that are offered at Blue Bay are all based on the Twelve-Step model.

This person has not seen advertisements about Blue Bay activities but knows about training and in-service that has been offered by Blue Bay to tribal health staff. He doesn't think other agencies are targeted and he doesn't see that Blue Bay training is pertinent to his job situation. He is concerned about the frequent staff changes at Blue Bay and recommends the following: (a) stabilization of the Blue Bay staff with a serious look at the unique job pressures that contribute to attrition, (b) dissemination of written material about Blue Bay, and (c) the offering of more models to healing and growth than the Twelve-Step model.

Discussion

Dr. Schoettle: The best focus to review are the common themes among programs in the field that actually not only work but present itself for future research. I think one of the things in research is to look at what is actually going well. Suicide, I think, is a statement to our society that we have somehow failed, both as individual, as parents, and as a community. We,

thus, should look at what prevents the high risk Indian child from becoming a suicide or substance abuser. What are the positive aspects of that person's well-being that maintains their mental health?

A particular research question that has not been delved into that extensively, at least as far as I'm aware of, is what happens to those survivors who were acutely suicidal and subsequently became successful in their own lives as well as their community. I would not only like to look at it from an illness model, but also from a wellness model.

What are the common themes? The issues of trust, sanctioned healing, and mutually satisfying relationship all come into play. Theresa, your comments interested me about how the actual curriculum was changed and augmented. I know when I've done research it's been very frustrating because I try to keep variables, as one knows, independent and dependent. The fact that people try to change the curriculum is positive, not necessarily negative. It's difficult for the teachers and the administrator, but nevertheless I think it allows for individual differences. We can allow for diversity and differences rather than deviance. But if you allow for diversity and individual ownership then, in fact, we do exactly what we try to do as parents of children. We initially provide the children with a structure of our cultural views or societal views and the educational views.

I think in the overall programs, one of the things that impressed me was that there was a very good core structure. Each of the programs was very comprehensive and focused on relevant issues. Yet they also allowed for divergence and for individual needs as the individual programs progressed.

When keeping in mind funding and resource allocation, we need to answer what is minimally necessary to make change, and also what is maximally possible? We often talk about the "Cadillac" programs as exemplary model programs. I guess I'm still thinking of my little red Volkswagen bug. It was a car that was minimally necessary but allowed my wife and me, after graduation, maximal appreciation of everything from the Ozarks to Boston, back to home base, then to UCLA. We don't all need Cadillacs.

In essence, how do you bring those minimally necessary programs together to talk to each other, to not feel like they're just on the fringe but effective programs? I tend to think that people who have minimally necessary types of programs often feel embarrassed about making national presentations. The programs presented today seemed to me relevant and actually working. They were focused not only on adolescence, but over the whole range of development from preschool all the way up to the elderly. That's a key issue. We need to focus on individual programs not just for adolescents but adolescents as part of a developmental continuum. Another point to make is the programs work with the children, the community, and the family, not on the community, children, and the family.

Another point I wish to make is moving from the data base, the epidemiological studies, the research findings, actually to training programs. I think a lot more research hopefully can be done at that particular interface between what we know and how we use what we know. I think the four or five programs that we heard about this morning are actually exemplary in that particular process. They were ongoing and used training materials. I was thinking of the Zuni experience. You were using training materials from all walks of life and all disciplines, tailoring it for a particular population. You get the feedback and allow for local ownership and regional ownership. I appreciate those processes. Whenever I hear that, I think we're actually doing something with what we have learned.

Dr. Bromet: On some level what's really missing from our group are some teenagers. In my experience, teenagers really have all the answers anyway, so they could probably guide us in some major ways to sort out what we're talking about. I would love to hear some kids react to all of the different discussions we've had today. I think it would be a very interesting perspective.

When programs get delivered they present some obvious opportunities for learning things that we need to know. The whole general attitude is that program evaluation is not research. I think one of the things you heard this morning is that none of us here really feels that way. There are different levels at which we can learn from intervention programs. It depends on the nature of the program and how much involvement there is from researchers from the time the program is conceived throughout the time that it's delivered.

I want to distinguish between two different ways as researchers we can collaborate with people who implement these programs. The first couple of presentations really exemplified one way. These were programs already implemented, which after awhile needed some mechanism for determining whether or not what they were doing was successful. Is the content being delivered the way we want it to be delivered? Do people feel it's satisfactory? Whether some of the behaviors that, in fact, perhaps are risk behaviors for suicide are changing? The kind of data that those programs and those questions lend themselves could be conceived as surveillance data where essentially you collect information over time from cross sections of your target. It's limited. You're only learning it from the people involved in the program. There are only limited inferences you can make from it. However, we can still learn something, and it's an opportunity that shouldn't be missed.

Then, you heard about a program that was really designed as an experimental intervention. The research and the program people were involved from the beginning so that the data gathering efforts could be designed into the program. Of course, that's the essence of experimental research. The program could be put on in such a way that there were people who received it, and people who didn't. It also has limitations, as I

think Theresa described very nicely. The contamination that occurs when you do that within a single school is probably most important.

What do these two different approaches have in common, and where do they differ? I think it's important to think of both of them as opportunities for learning and for research. One thing that Candace mentioned is terribly important. In both cases, issues of confidentiality are critical. Whether you decide to collect surveillance data or you decide to do a research program, there has to be confidentially built in which everybody involved believes. So it's not enough to tell people that your answers are confidential, and that only a number is assigned. You have to make people believe that what you're telling them is true. You have to prove it.

The second commonality is that whoever is collecting the data should be independent of who is implementing the program. If you're offering the program, designing and collecting the data, you have a stake in what you're going to obtain. You need to plan in such a way that there's independence between providing the program and designing, collecting, and analyzing the data that you get from the program.

The third thing that they have in common is that you should be collecting information over time, maybe annually, semi-annually or quarterly. If you've designed an intervention, then you have the luxury of looking at follow-ups of the same people, knowing how to identify them so that you can actually look at change in individuals over time.

The other thing you should try to do, whether it's an experimental study or you're going to monitor, is try and get some data before you start. Now, without a control group, it's still hard to make inferences because things change over time anyway. They change over time because you have media influences on behaviors. Without a control group it's almost impossible to say, my program had this effect.

There are some obvious differences between an experimental design and what you can get from a medical surveillance. The basic difference is what questions you can hope to answer are going to differ depending on whether you have the luxury and the funding to do an experimental study. However, you still have to think through in experimental study such things: as what kind of sample size do you need to get enough power, what kinds of outcomes are realistic to look at in relation to change? We have a real gap in understanding Indian adolescent suicide. We know a lot about the descriptive epidemiology, but we don't know much about the analytic epidemiology. We can only hope that what we've learned from non-Indian studies is going to apply.

think the collaboration between grass roots people, teachers, investigators, is obviously critical to designing and implementing these programs. However, I still think you need objective evaluations, both for the sake of the credibility of the design, as well as being able to convince other people that you've done it objectively in the first place.

Dr. Guilmet: Culture is a general concept. If you had to bring it down to its fundamental aspects, it's a set of shared and learned attributes. Archaeologists plug in projectile points, the frequency of different kinds of types. Symbolic anthropologists would put in key symbols and language and the meaning of these. One can use it and operationalize it in any given context. Behaviorists would operationalize the culture concept in terms of the kind of social behavior that a group displays. Culture is then about shared acts and the collective significance of those acts.

We've discussed the various kinds of scientific techniques to be utilized, and the various kinds of intervention programs that are to be studied through evaluation techniques. Of course, statistics is the only thing we ever use as a form of evaluation. If there's no numerical difference, there's no difference. This is strange.

Ethnoscience is another kind of science based on the concept of culture which has a lot of value. When we listen to other colleagues, when we listen to the community in particular, and when we listen to adolescents, we may engage in ethnoscience. That is one of the main things that anthropology can offer — good listeners. I think all of these projects have been good. They've all started out with a premise, either from a deliverer's point of view or from community's point of view. We have seen that if you don't work with the community, that you have real problems. You're questioned and the effectiveness of your program is questioned.

Wolfgang Jilek, a psychiatrist, has done some work where he's operationalized the idea of anomic depression. It hasn't been tested using the validity of science, but he did show that participation in traditional spiritual healing cut down on alcoholism because drinking was negatively sanctioned by being a member of that group. It also kept people busy with an alternative. We have seen a similar process with the PRIDE school program. They've tried to establish alternatives to the kinds of behavior and activities that the community offers the teenager.

But what is the role of the media? Is there cognitive dissonance going on here? Is television bringing us to that? Is it the American Indian Movement with heightened expectations? Do we have Indian people beginning to have a feeling that yes, we can re-empower ourselves? That's what happened in this particular community's experience. There was a whole revitalization movement around fishing and around health care, in which people really began to acquire renewed expectations for re-empowering their lives. What about this generation? Do they feel the same way? I know the college students that I teach on an ongoing basis are just beginning to get that sense after 10 years. They're so overshadowed by prior social movements that they, irregardless of ethnicity, have been feeling powerless, and are again, beginning to get this resurgence of hope.

I don't want to seem negative because I'm not. I think that there are a lot of real possibilities in terms of future research. I think that we

need the epidemiological approach. It's absolutely essential that we get that kind of hard numerical data on group trends. That's the only way we can find out what kind of social conditions are causing this individual manifestation that we're worried about. I think that we also need to experiment with these developing intervention programs. However, we need much better assessment. I think in all the cases we've seen, we need more assessment tools. This means researchers and more money for evaluation.

But, I'm not hearing as much as I would like about the cultural orientations of the Indian people with whom we are supposed to be primarily concerned. I think there's a lot more listening we need. One of the value orientations that come from most of the Indian communities that are being tapped by these successful programs is that no individual exists by himself or herself. Indian people historically have not ever believed that. So when we're talking about value structures, we're talking about the relationship of that individual to the group. Programs based on this premise work.

One of the issues that, in the PRIDE experience that maybe offensive is this idea of forced control: random checks of lockers, police dog, and patrolling in a structured way to make an environment drug free. One of my responses is that no community, especially a face-to-face one where everybody knows everyone, is without a form of social control. There are definite definitions of what is acceptable behavior and there are known kinds of consequences to rule violations. But, in the context of schools and other environments, the development of stereotypes of social control should come from the Indian communities themselves. In my opinion, certain kinds of rule definitions exist and actual consequences are explicitly carried out in terms of rule violations. That's a traditional concept.

Spiritual and moral discussions in this context excite me because Indianness has always emanated from the basis of spirituality. Indian people tell us every time: start from the spiritual basis and work forward. I think that means a lot in terms of the healing paradigms. We have to have an integrated, holistic, face-to-face community where there's communication between care givers, individuals under stress, and family members. It has to be that way. If you can't start a rumor in the Indian community, you don't exist. If you try to do something without starting a rumor, it won't work. Information goes through the community on the moccasin telegraph extremely fast. It is hard for outsiders to believe this. We must tap this characteristic as a strength and not a weakness.

This means that many people in the community will know when there is social or individual dysfunction. One purpose of the traditional healing system, shamanism, is to interpret behavior that does not follow the rule structure of the community and give it meaning. Informal dispute resolution, rapid social communication, and the tendency to integrate

marginal individuals into the community are strengths in contemporary Indian communities. These are consistent with traditional value orientations. Indian culture still is continuous.

However, there is a great challenge here for any social scientist who has come into possession of such knowledge. Not primarily by "being an objective scientist," but first and foremost, by being a patient, sympathetic, and virtually "silent" listener. The other role such an individual must play, of course, is quite different in its expectation that the researcher "translate" such findings to a much wider, and therefore not necessarily so sympathetic audience. Furthermore, the people "studied" in this case — the Indian community — have up to now had few positive experiences being the subject of study by outside experts. The challenge, therefore, is to be true to the legitimate demands of both roles — listener and publicizer — without damaging the integrity of either role relationship.