

# Oregon Addictions & Mental Health Division

## Evidence-Based Programs

### Tribal Practice Approval Form, Mk V

**1. Name of Tribal Practice**

❖

**2. Brief Description**

❖

**3. Other Examples of this Tribal Practice**

❖

**4. Evidence Basis for Validity of the Tribal Practice: Historical/Cultural Connections**

Longevity of the Practice in Indian Country	❖
Teachings on which Practice is based	❖
Values incorporated in Practice	❖
Principles incorporated in Practice	❖
Elder's approval of Practice	❖
Community feedback/evaluation of Practice	❖

**5. Goal Addressed by this Tribal Practice**

❖

**6. Target Populations**

a. Institute of Medicine Strategy (check off one of the following four)

<input type="checkbox"/> "Universal"
<input type="checkbox"/> "Selective"
<input type="checkbox"/> "Indicated"
<input type="checkbox"/> Treatment

b. Socio-demographic or other characteristics

Age	❖
Sex	❖
Occupation	❖
Living Cond'ns	❖
Other	❖

## 7. Risk and Protective Factors Addressed

Domain	Risk Factors	Protective Factors
Community	❖	❖
Family	❖	❖
Peer	❖	❖
School	❖	❖
Individual	❖	❖

## 8. Tribal Practice—Personnel

❖

## 9. Tribal Practice—Key Elements

❖

## 10. Tribal Practice—Materials

❖

## 11. Tribal Practice—Optional Elements

❖

## 12. Outcomes

Decrease	Increase	Specify
Avoidable death	Longevity	❖
Disease-specific morbidity	Health	❖
Disability Handicap	Ability	❖
Pain and Suffering	Wellbeing	❖
Alienation Anomy Isolation	Social/Community/ Cultural Connectedness	❖

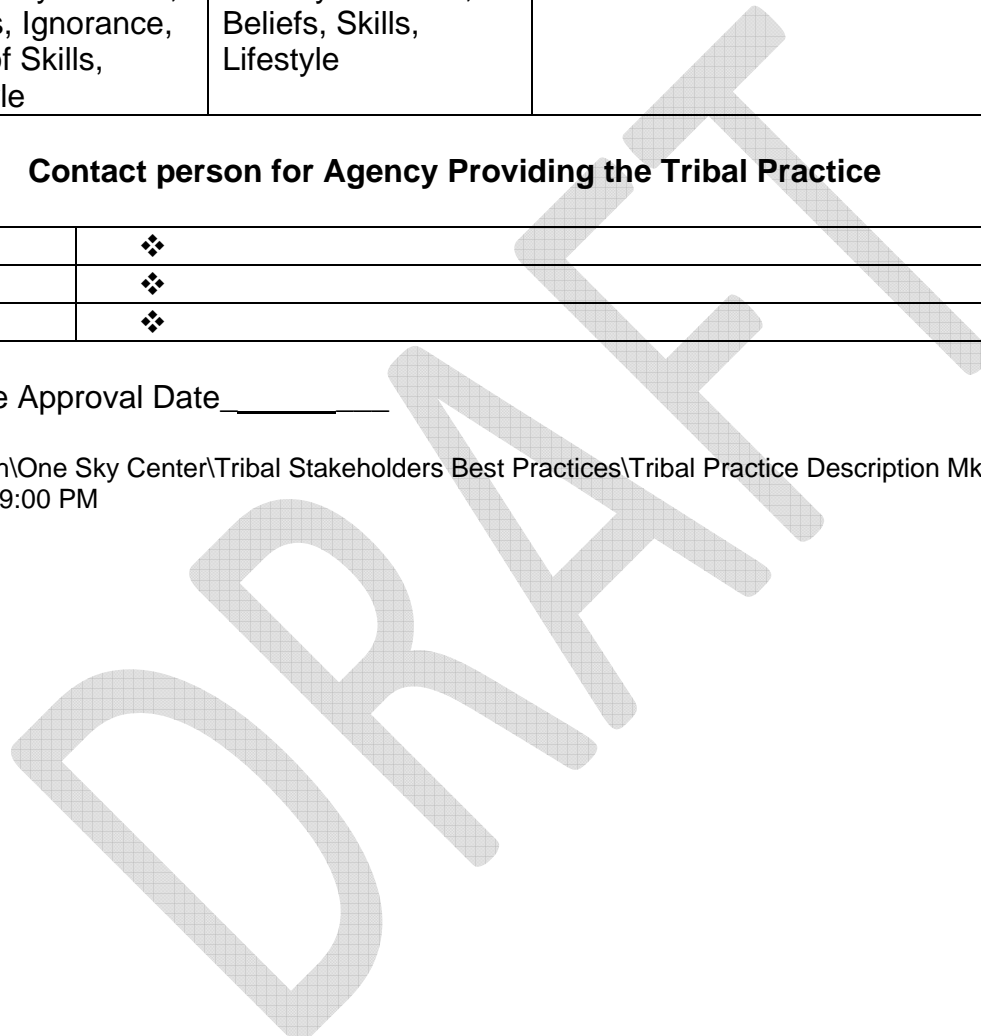
Abuse Dependency Addiction	Abstinence Non- harmful Use	❖
Unemployment	Employment	❖
Educational failure	Educational Success	❖
Dysfunctional family	Healthy Family	❖
Delinquency/crime	Good Behavior	❖
Homelessness Instability	Stable Housing	❖
Unhealthy Attitude, Beliefs, Ignorance, Lack of Skills, Lifestyle	Healthy Attitudes, Beliefs, Skills, Lifestyle	❖

**13. Contact person for Agency Providing the Tribal Practice**

Person	❖
Phone	❖
e-mail	❖

Practice Approval Date \_\_\_\_\_

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# Oregon Addictions & Mental Health Division

## Evidence-Based Programs

### Tribal Practice Approval Form

#### Definitions and Suggestions

- ❖ (Note: Within any box, you may add additional points using your “enter” key; a four-diamond bullet appears to indicate your next point.)

#### 1. Name of the Tribal Practice

This is the name of a (proposed or already) approved Tribal Practice—which makes it cost-reimbursable under an EBP mandate.

The name of the practice is important. It is very convenient to have the same name reflecting a tribal practice which is implemented similarly in many tribes: e.g., Sweat Lodge Ceremony. Among other conveniences, a name that gains credibility lends credibility: e.g., *Project Venture*<sup>1</sup> (a Service Learning program) has “NREPP Best Practice” credibility<sup>2</sup>; *Canoe Journey*<sup>3 4</sup> is supported by scientific evidence; as is *American Indian Life Skills*<sup>5</sup>. Horse programs or equine therapy<sup>6</sup> are well researched. Other published Native American evidence-based Practices can be found on published lists.<sup>7 8 9 10 11</sup>

However, every implementation is somewhat different—one *Canoe Journey* is not exactly the same as another, even in the same Tribe. Some names have proprietary issues; some have sacredness issues. Without copyright, FDA, or other protections, there is vulnerability to inappropriate use and exploitation of creditable Tribal Practice names. And some names are applied to some practices which are so different in fundamental ways that they should not use

<sup>1</sup> Project Venture website.

[http://www.npaihb.org/images/epicenter\\_docs/suicide\\_prevention/2008/Promising%20Strategies%20-%20ProVenture.pdf](http://www.npaihb.org/images/epicenter_docs/suicide_prevention/2008/Promising%20Strategies%20-%20ProVenture.pdf)

<sup>2</sup> Project Venture listed as a model program.

[http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM\\_ID=146](http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=146)

<sup>3</sup> Journeys of the Circle, a ppt presentation on the Canoe Journey. [http://www.aap.org/NACH/Marlatt\\_plenary.pdf](http://www.aap.org/NACH/Marlatt_plenary.pdf)

<sup>4</sup> La Marr J, Marlatt GA. (2007). *Canoe Journey Life's Journey: A Life Skills Manual for Native Adolescents*. Facilitators Guide with CD-ROM. Hazelden.

[http://www.hazelden.org/OA\\_HTML/ibeCCtpltmDspRte.jsp?item=7580&prddb\\_prod=vGCMsek5Mw-dESkuf5eyUenw:S&prddb\\_prod\\_pses=prddb\\_prod%3DvGCMsek5Mw-dESkuf5eyUenw%253AS~](http://www.hazelden.org/OA_HTML/ibeCCtpltmDspRte.jsp?item=7580&prddb_prod=vGCMsek5Mw-dESkuf5eyUenw:S&prddb_prod_pses=prddb_prod%3DvGCMsek5Mw-dESkuf5eyUenw%253AS~)

<sup>5</sup> LaFamboise TD. (1995). *American Indian Life Skills Development Curriculum*. University of Wisconsin Press.

<sup>6</sup> Native American and Native Horse Human-Animal Healing Center.

[http://www.ispmb.org/index.php?option=com\\_content&id=49](http://www.ispmb.org/index.php?option=com_content&id=49)

<sup>7</sup> Suicide Prevention Resource Center. <http://library.sprc.org/browse.php?catid=31>

<sup>8</sup> National Registry of Evidence-based Programs and Practices.

<http://www.nrepp.samhsa.gov/listofprograms.asp?textsearch=Search+specific+word+or+phrase&ShowHide=1&Sort=1&T1=1&T2=2&T3=3&T4=4&T5=5&R1=1&R1OPT=3>

<sup>9</sup> Center for the study and prevention of violence.

<http://www.colorado.edu/cspv/infohouse/publications.html#blueprintspubs>

<sup>10</sup> Office of Juvenile Justice and Delinquency Prevention. [http://www2.dsgonline.com/mpg/mpg\\_search.aspx](http://www2.dsgonline.com/mpg/mpg_search.aspx)

<sup>11</sup> One Sky Center Native Programs Directory.

<http://www.oneskycenter.org/oscservices/programs/dspAdvanceSearch.cfm>

the same name. As names gain credibility, the problem of using names that don't apply gets worse.

In short, established names should be used, but used carefully. Each of the AMH named Tribal Practices—whether imported or home-grown-- is backed up by a detailed, *strategy* and *operational* description (items 5-12) which details their uniqueness and their relation to such practices described elsewhere

## 2. Brief Description of the Tribal Practice

The brief description is the content that most people will see. For example, many of the programs listed on the sites footnoted above have brief descriptions. A brief description covers the critical elements of the Practice; it is a summary of the specifics in items 5 – 12: goal; target population; key elements; providers; and outcomes.

## 3. Other Examples of the Tribal Practice

A powerful proof of effectiveness is simply the fact that a Tribal Practice has been implemented in other locations (“replication”), especially if those implementations have been written up (“transparency”), have how-to manuals (basis of “fidelity”), or have been evaluated (“research”) and their outcomes demonstrated (“outcomes associated with the practice”). It is good to cite articles, books, and web pages for the replications. For example, Horse Program (equine therapy), Canoe Journey, Sweat Lodge, and many other Tribal Practices have been replicated and written up. Such replications can be found by searching the internet.

## 4. Evidence Basis for the Tribal Practice: Historical/Cultural Connections

Evidence for the validity of a Tribal Practice does not come solely from research. Other “streams of evidence”<sup>12 13</sup> increase our knowledge of the effectiveness and validity of practices in local and cultural contexts. In the Native American framework, there are several specific criteria for valid Tribal Practices.

- **Longevity** of a tribal practice is a criterion for a practice rooted in tradition. For example, Canoe Journey and Sweat Lodge have centuries-old traditions.
- A tribal practice based on specific **teachings** is considered valid in the framework. For example, teachings of the *Medicine Wheel* are evidence of validity for some Native American practices.
- The incorporation of traditional Native American **values** is considered evidence in the framework. For example, basing a Tribal treatment Practice on the values of *harmony*

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<sup>12</sup> Center for Substance Abuse Treatment. *Understanding Evidence-Based Practices for Co-Occurring Disorders*. COCE Overview Paper 5. DHHS Publication No. (SMA) 07-4278. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007

<sup>13</sup> Mareasa R. Isaacs, Larke Nahme Huang, Mario Hernandez, Holly Echo-Hawk. (December 2005). *The Road to Evidence: The Intersection of Evidence-Based Practices and Cultural Competence in Children's Mental Health*. National Alliance of Behavioral Health Associations.

and *acceptance*, or a Tribal prevention Practice on the basis of *holism*, is evidence of validity.

- Similarly, incorporation of traditional **principles** is evidence. For example, the Mehl-Medrona's principles of treatment of chronic illness<sup>14 15</sup> such as "*healing takes time and time is healing*" lend credibility to Tribal Practices explicitly based on those principles.
- Review-and-approval of a Tribal Practice by **elders** constitutes evidence of validity within the Native American framework.
- Finally, feedback from the **community** is evidence within the framework (and is "client satisfaction" generally).

## 5. Program Goal

The goal is the one, broadly stated purpose—the intended outcome—for the Tribal Practice. A goal may be stated as reducing a specific behavioral health problem or as improving health and thriving in some particular way. Specific areas of improvement—the intended outcome—are found among the list of "Outcomes" (item 12). They include:

- Longevity (vs. avoidable death)
- Health (vs. disease-specific morbidity)
- Wellbeing (vs. pain and suffering)
- Social/community/cultural connectedness (vs. alienation/anomy/isolation)
- Abstinence/non-harmful use of ATOD (vs. abuse/ dependency/addiction)
- Employment (vs. unemployment)
- Education (vs. school failure)
- Healthy family (vs. dysfunctional family)
- Good behavior/non-criminality (vs. delinquency/criminality)
- Stable housing (vs. homelessness/instability)
- Positive attitude, beliefs, knowledge, skills, lifestyle (vs. unhealthy attitude, beliefs, ignorance, lack of skills, or lifestyle)

The goal can be stated even more specifically, for example:

- Reduction of specific alcohol abuse like public inebriation, or underage drinking, or driving under the influence
- Reduction of specific drug abuse like prescription medications, or methamphetamine
- Reduction of specific violence like domestic violence, violence against women, or school bullying
- Reduction of youth suicide specifically
- Reduction of specific mental illness like PTSD, or depression, or childhood maladjustment, or ADHD, or co-occurring (substance and mental) disorders

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<sup>14</sup> Mehl-Madrona L. Traditional (Native American) Indian Medicine. Treatment of Chronic Illness: Development of an Integrated Program with Conventional American Medicine and Evaluation of Effectiveness. <http://www.healing-arts.org/mehl-madrona/mmtraditionalpaper.htm>

<sup>15</sup> Mehl-Madrona L. (1998). Coyote Medicine: Lessons from Native American Healing. Touchstone.

Other more specific goals/outcomes are focused on the positive side, especially the strengthening of protective factors, developmental assets, and resilience:

- Youth development programs such a *Project Venture* (service learning) are focused on such goals as increased caring about the community, although its measured outcomes include reductions in the full range of substance abuse, mental health, and criminal justice problems
- *Leadership Development* programs are focused on goals of community competence (ability of the community to deliver services and cope with challenges), rather than the problem of youth suicide which community competence ultimately impacts

## 6. Target Population

- a. Funding agencies (e.g., SAMHSA's *block grant*) are currently using the Institute of Medicine's (IOM) "*Universal*," "*Selective*," and "*Indicated*" categories to classify prevention programs in terms of their target population (and, therefore, their programming strategy).
- "*Universal*" means that the target population for a program (e.g., "youth") is not limited to persons who are at risk of having the problem (e.g., alcoholism) which the program is intended to prevent
  - "*Selective*" means that the target population for a program is known, as a class, to be at risk for developing the behavioral health problem (e.g., youths who are children of alcoholics)
  - "*Indicated*" means that the target population consists of individuals who each have subclinical levels of the behavioral health problem (e.g., youths who have experimented with alcohol, but are not otherwise abusing, dependent, or addicted)

The above categories of "prevention" are distinct from "treatment" for individuals with clinical levels of behavioral health problems. (Treatment can be subdivided into case identification/early diagnosis and brief intervention; standard treatment; long-term treatment (also known as "maintenance"); and aftercare/rehabilitation. But this subdivision is not required by funding and administrative agencies.)

- b. Beyond the IOM classification, it is helpful to describe the target population in terms of socio-demographics or other characteristics if such a focus exists. While many groups may benefit, a Tribal Practice is often more narrowly focused on one or two primary target populations. Thus, a behavioral health prevention or treatment program might be directed primarily toward "youth," or "mothers," or "fishermen," or "prisoners," or some other group defined by:

- Age
- Sex
- Occupation,
- Living circumstances

The programmatic activity may, itself, create a socio-demographic focus, e.g., basketball is likely to be focused on youth; child rearing education on mothers; occupational stress

management on occupational groups like fishermen; and cultural connection on groups with specific living conditions like prisoners.

## 7. Risk and Protective Factors

The ultimate goal (intended outcome) of a Tribal Practice is reached by addressing some mediating or moderating conditions that increase or decrease the likelihood of a behavioral health problem (vs. behavioral health and thriving). “Risk Factors” increase the likelihood of behavioral health problems; “Protective Factors,” “Developmental Assets,” and “Resiliency” increase the likelihood of behavioral health and thriving. On a day-to-day basis, the Tribal Practice is operationally focused on one or more of these risk or protective factors.

The concept of risk and protective factors<sup>16</sup> is very strong in behavioral health and public health programs, especially prevention and public health. The idea is that a program/practice can indirectly achieve an ultimate behavioral health outcome by changing the factors which modify or mediate it—the risk factors which induce or exacerbate problems and the protective factors which prevent or counteract behavioral health problems.<sup>17</sup>

Further, these risk and protective factors exist in each of the: (a) community, (b) family, (c) peer group, (d) school/workplace, as well as (c) the individual domains.<sup>18</sup> In each domain, risk and protective factors can be seen as mirror images, which means that preventive and treatment interventions are aimed at shifting any factor from the risk end to the protective end of a continuum. For example, shifting from:

<b>Socio-Ecological Domain</b>	<b>(From) Risk Factor</b>		<b>(To) Protective Factor</b>
Community	Economic deprivation	⇒	Local control, community competence, thriving
Community	Favorable attitudes toward drug use	⇒	Intolerance and rejection of drug use, with clear standards, monitoring & enforcement
Family	Conflict-ridden, inconsistent supervision, delinquency-modeling	⇒	Well-managed family, with bonding, constructive modeling, clear standards, monitoring, skill teaching, and recognition
School	Delinquency tolerant (including absence, substance use, acting out, bullying)	⇒	Healthy school policy, with school commitment, clear standards, monitoring, skill teaching, and recognition
Peer	Bonding with models of problem behaviors and	⇒	Bonding with models of healthy behaviors and thriving

<sup>16</sup> Hawkings JD, Catalano RF et al., as cited in Hogan JA, Gabrielsen KR, Luna N, Grothaus D. (2003). Substance Abuse Prevention. Boston, MA: Allyn & Bacon. P15-25.

<sup>17</sup> An example of programs addressing specific risk and protective factors (and a lists of risk and protective factors) organized into a searchable database can be found at: <http://www.findyouthinfo.gov/ProgramSearch.aspx>

<sup>18</sup> Known as the “social-ecology” model. For example, the Center for Disease Control: [http://www.cdc.gov/ncipc/dvp/social-ecological-model\\_DVP.htm](http://www.cdc.gov/ncipc/dvp/social-ecological-model_DVP.htm)

	failure		
Individual	Alienation	⇒	Balance and harmony

Many Tribal Practices focus operationally on just one, or a few, such factors:

- Gathering of Native Americans (GONA)<sup>19</sup> and the Community Readiness Model<sup>20</sup> focus on mobilizing communities to confront behavioral health problems and to improve health and thriving in their communities
- The Native American Family Strengthening<sup>21</sup> program focuses on family management
- A Healthy Schools Program focuses on creating a safe environment for learning and childhood wellness
- Native Helping Our People Endure (HOPE) and Question, Persuade, Refer (QPR) focus on a reducing a suicide risk in the peer domain, i.e., the “conspiracy of silence”
- Sweat Lodges usually focus on restoring a troubled individual’s state of harmony

## 8. Tribal Practice Personnel

Some Tribal Practices require personnel with special knowledge, skill, community status or certifications, e.g., elders, medicine people, teachers, registered nurses, physicians, certified counselors. Some Practices require volunteers, some require peer volunteers. For example, the Canoe Journey requires many volunteers for many different roles.

## 9. Tribal Practice—Key Elements

A concrete and specific description of the elements which constitute a Tribal Practice can be called a “staff/operations/instruction manual,” “guidebook,” “blueprint,” “pattern board,” etc. It can be a work plan, action plan, powerpoint presentation, or any other reasonably concrete and specific description of what the Tribal Practice does. Such a document is very helpful in reviewing the evidence, establishing credibility with third parties, managing the Practice, measuring its outcomes, and providing technical assistance to other Tribes who may wish to learn from it. It is very helpful for the program personnel to have a written listing of the things they should do. It can be helpful to Tribal leaders who are planning and managing the Practice to describe the activities it consists of.

It is not necessary to include details that are particularly sacred such as the use of specific symbols in sacred sand painting. However, a number of written and video-taped/DVD descriptions exist for Sweat Lodge, Vision Quest, herbal therapy, and other Tribal Practices involving some degree of spirituality.

<sup>19</sup> This SAMHSA web page contains a detailed manual with step-by-step instructions for conducting a GONA: <http://preventiontraining.samhsa.gov/CTI05/Cti05ttl.htm>

<sup>20</sup> The Tri-ethnic Center webpage gives access to the Community Readiness Model: <http://www.triethniccenter.colostate.edu/communityreadiness.shtml>

<sup>21</sup> <http://www.strengtheningfamiliesprogram.org/sp-amind.html>

Gathering of Native Americans (GONA),<sup>22</sup> Native Helping Our People Endure (HOPE),<sup>23</sup> Project Venture,<sup>24</sup> American Indian Life Skills Curriculum,<sup>25</sup> Choctaw Challenge Course,<sup>26</sup> Canoe Journey,<sup>27</sup> and other Native American model prevention and treatment behavioral health programs have detailed manuals. Manuals are also available for Social Marketing against drug abuse which is being used throughout Indian Country, notably in the Indian Country Methamphetamine Initiative (e.g., Winnebago Tribe of Nebraska),<sup>28</sup> the Center for Disease Control and Prevention, and the Office of National Drug Control Policy.<sup>29</sup>

Such a document can be quite lengthy. For the purposes of this application, it is only necessary to list the key elements. GONA has an example of a very thorough, specific and concrete manual. GONA is a four-day training program for community members who want to become change agents. Key Elements listed in the manual are: a goals presentation; philosophy presentation; values presentation; registration procedures; and 10 training modules, each with two or three descriptive bullets. This level of detail would suffice for Key Elements. However, further detail is extremely useful, if available. Helpfully, the GONA manual goes on to describe the steps/activities within each module.<sup>30</sup> Accompanying hand-outs, newsprint, resources, and transparencies are provided for each module.

## 10. Tribal Practice—Materials

Significant material items are needed for some Tribal Practices, e.g., a canoe, bill boards, brochures, horses, lodge (sweat), drums, auditorium, or camp grounds. In some cases, these materials may be very special, e.g., eagle feathers, cultural artifacts. GONA provides written stories and slides and the National Congress of American Indians (NCAI) provides some downloadable social marketing materials.<sup>31</sup>

## 11. Tribal Practice—Optional

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<sup>22</sup> This SAMHSA web page contains a detailed manual with step-by-step instructions for conducting a GONA: <http://preventiontraining.samhsa.gov/CTI05/Cti05ttl.htm>

<sup>23</sup> An overview of HOPE is provided at this page: [http://www.nmassembly.org/pages/pyd\\_nativehope.html](http://www.nmassembly.org/pages/pyd_nativehope.html)

<sup>24</sup> A description of Project Venture is provided at this SAMHSA page:

[http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM\\_ID=146](http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=146)

<sup>25</sup> A description of American Indian Life Skills Curriculum is provided at this SAMHSA page:

[http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM\\_ID=118](http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=118)

<sup>26</sup> Examples of key elements for several Tribal Practices are provided in this slide presentation, including the Choctaw Nation Challenge Course: <http://indianeducation.org/userfiles/file/ICMI%20feb%202009.pdf>

<sup>27</sup> An example of a Canoe Journey protocol is given in the Appendix adapted from the webpage:

<http://tribaljournays.wordpress.com/basic-tribal-journays-info/>

<sup>28</sup> Examples of key elements for several Tribal Practices are provided in this slide presentation, including the Winnebago social marketing campaign: <http://indianeducation.org/userfiles/file/ICMI%20feb%202009.pdf>

<sup>29</sup> Many examples of Social Marketing key elements exist. One description of the key elements of social marketing involves identifying the target population; developing messages; cost-benefit analysis (of target population's potential responses to messages); disseminate messages through specified media (flyers, inserts, brochures, info for interested readers, news releases, fact sheets, cover letters to groups), and location for disseminations (retail outlets, churches, health care providers, talk shows, work places, highway billboards). See *The Basics of Social Marketing; How to Use Social Marketing to Change Behavior*. Seattle, WA: Turning Point, downloadable at:

<http://www.turningpointprogram.org/> A software CD is offered as technical assistance for developing a health-related social messaging program: <http://tangibledata.com/CDCynergy-SOC/Drive-thru/index.cfm>

<sup>30</sup> The GONA Key Elements, and an example of one detailed module, are copied in the Appendix from the SAMHSA webpages: <http://preventiontraining.samhsa.gov/CTI05/Cti05ttl.htm>

<sup>31</sup> Anti-meth social marketing materials downloadable at: <http://www.ncai.org/meth/>

Other items are not necessary to implement the program, but do facilitate the Tribal Practice (e.g., food, attendance prizes).

## 12. Outcomes

A list of possible areas in which a Tribal Practice might have outcomes is listed in the Form. Information within these categories is very powerful evidence for the effectiveness of a Tribal Practice. The outcomes are both those important to tribes and those recognized in the National Outcome Measures System (NOMS)<sup>32</sup> in which AMH is required to participate in order to receive federal funding.

For any applicable outcome category, describe what changes the Tribal Practice will achieve, e.g., Social/Community/Cultural Connectedness might include, specifically, increased knowledge of cultural songs and prayers; identification of participants with their culture; involvement in cultural events (e.g., Powwows).

Identify any available measures of the outcomes.

Following are some invented examples of outcomes and outcome measures that might apply to some Tribal Practices.

<b>Decrease</b>	<b>Increase</b>	<b>Specify</b>
Avoidable death	Longevity	<i>Reduce deaths due to alcohol-related traffic crashes (Measure: coroner's reports)</i>
Disease-specific morbidity	Health	<i>Increase Quality of Life for persons with Serious and Persistent mental illnesses (Measure: annual Quality of Life interviews)</i>
Disability Handicap	Ability	<i>Eliminate disabling hallucinations (via medication clinic) among persons with Serious and Persistent mental illnesses (Measure: quarterly clinical rating of clinical condition of patients)</i>
Pain and Suffering	Wellbeing	<i>Reduce pain and suffering of suicide survivors (Measure: Post-vention closing interview)</i>
Alienation Anomy Isolation	Social/Community/Cultural Connectedness	<i>Re-establish tribal-cultural involvement of previously homeless urban Indians (Measure: participation of clients in cultural events)</i>
Abuse Dependency Addiction	Abstinence Non-harmful Use	<i>Convert social activities for youth into ATOD-free events (Measure: number of ATOD-events and participants per year)</i>
Unemployment	Employment	<i>Foster tribal business/ industry opportunities and tribal recruitment (Measure: year-over-year employment rate for tribe)</i>
Educational failure	Educational	<i>Implement Healthy Schools policy (standards,</i>

<sup>32</sup> National Outcome Measures (NOMs).

[http://www.nationaloutcomemeasures.samhsa.gov/PDF/NOMS/revised\\_grid\\_4\\_1\\_08.pdf](http://www.nationaloutcomemeasures.samhsa.gov/PDF/NOMS/revised_grid_4_1_08.pdf)

	Success	<i>monitoring, training, recognition) (Measure: year-over-year number of policies in place and operational) (Measure: year-over-year drop-out rate; grade-point-average)</i>
Dysfunctional family	Healthy Family	<i>Parent knowledge of family management practices (Measure: post-training knowledge test)</i>
Delinquency/crime	Good Behavior	<i>Increase degree of rehabilitation achieved with DOJJ clients (Measure: opinion of rehabilitation officer re: clients out-sourced to Horse Program and re-entering DOJJ program)</i>
Homelessness Instability	Stable Housing	<i>Reduce loss of housing among residents of Tribal Housing due to violation of housing rules and policy (Measure: annual eviction rate)</i>
Unhealthy Attitude, Beliefs, Ignorance, Lack of Skills, Lifestyle	Healthy Attitudes, Beliefs, Skills, Lifestyle	<i>Reduce favorable attitudes toward drug abuse among at-risk youth groups (Measure: attitude questionnaire at end of session)</i>

### 13. Contact

Contact information for the individual responsible for and knowledgeable about the Tribal Practice whom AMH for information.

#### Questions: E-mail Oregon Tribal Best Practice Panel at:

Co-Chair Caroline M. Cruz [caroline.cruz@wstribes.org](mailto:caroline.cruz@wstribes.org)

Co-Chair John Spence [jdougspence@msn.com](mailto:jdougspence@msn.com)

Doug Bigelow [bigelowd@ohsu.edu](mailto:bigelowd@ohsu.edu)

AMH State Tribal Liaison Jason Yarmer [jason.yarmer@state.or.us](mailto:jason.yarmer@state.or.us)