Population Evaluation Guidelines

For **Native American** populations

California Reducing Disparities Project, Phase 2

Population Evaluation Guidelines for Native Americans

California Reducing Disparities Project, Phase 2

PIRE Native American Technical Assistance Team:

Roland S. Moore, PhD, Anna Pagano, PhD, Juliet P. Lee, PhD, Elizabeth Waiters, PhD, Janet L. King, MSW, Claradina Soto, PhD (USC), Cathleen Willging, PhD, Narinder Dhaliwal, MA (ETR), Jennifer Silver-Herman (ETR), Carlos Recarte, MCP

Prepared for:
Office of Health Equity
California Department of Public Health
Under CRDP contract #16-10574,
funds made possible by the Mental Health Services Act

Prepared by:
HBSA/PIRE
(Pacific Institute for Research and Evaluation)
180 Grand Avenue, Suite 1200
Oakland, CA 94612
http://natap.prev.org

April 18, 2017

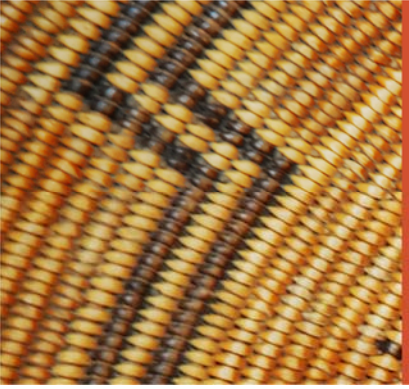
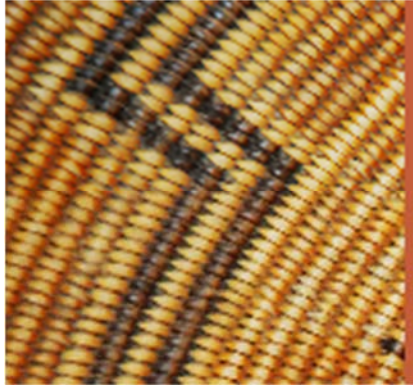


Table of Contents

Table of Contents



Acknowledgements

For their insights, we are grateful to the California Reducing Disparities Project (CRDP) team (Office of Health Equity staff, especially Edward Soto, Rafael Colonna, and leadership, fellow TAPs, SWE, and above all the Native American Grantees and *Native Vision* authors from CRDP Phase 1). We also acknowledge the insights and contributions of consultants serving this Native American Technical Assistance Provider contract: Michael E. Bird, MPH, MSW, Roxane Spruce Bly, Nicole R. Bowman-Farrell, PhD, Raymond Daw, MSW, Bonnie Duran, PhD, and Nadine Tafoya, MSW. With gratitude, we acknowledge Dr. Kaye Herth, Dr. James Allen and the People Awakening Team, Dr. Paul Masotti, Dr. Angela Snowshoe, Dr. Les Whitbeck and colleagues for their survey instruments offered as potential tools in the appendix. We also thank PIRE librarian Julie Murphy for her assistance with the literature review.

We dedicate this work to the future generations,
and in honor of those who came before us

Introduction

Commissioned by the California Department of Public Health Office of Health Equity, this booklet presents evaluation guidelines that are specific to the populations served by the California Reducing Disparities Project (CRDP) Phase 2 Native American Implementation Pilot Project (IPP) Grantees. In the spirit of community partnership, we offer the contents of this booklet to the Grantees in support of the Grantees' efforts to document, evaluate, document, and disseminate the results of their groundbreaking work. We aim for the booklet to reflect and respond to the vision and goals of the Grantees' proposed projects and evaluation plans, and we hope Grantees, their evaluators, and the communities they serve will find the booklet useful. The booklet is written as a narrative technical report. Details and examples of research tools (for example, survey measures) are included in the Appendix.

Defining "Guidelines"

The assignment from the Office of Health Equity is as follows: "Guidelines shall be focused on three critical factors: 1) Fulfilling the requirement for effectively incorporating community stakeholders in the full evaluation process; 2) Ensuring the evaluation is culturally and linguistically appropriate for the individuals that will be served by the population, including addressing any cross-population issues; and 3) Ensuring the timeline is compatible with the Contractor's need to coordinate technical assistance across seven IPPs."

As the term "guidelines" has multiple definitions, we discussed it with the directors and evaluators of the Native American IPP Grantees before and during the CRDP Kickoff Meeting in March of 2017. It was determined that "guidelines" should refer to suggestions and considerations (rather than requirements) for the Grantees to use as they finalize their evaluation plans for their community-defined evidence practices. These population-specific guidelines complement the overarching evaluation guidelines offered by the Statewide Evaluator. The guidelines in this booklet may help the Grantees

and their evaluators to account for the unique historical, political and cultural contexts that have shaped the lives and health of American Indians and Alaska Natives.

In this document, we provide evaluation tools, measures, and concepts that Grantees may adopt if they find them useful. These guidelines consist of suggestions or options based on the wisdom of those who have conducted evaluations in Tribal communities in the recent past. However, the collection of evaluation tools placed in our metaphorical basket of shared offerings may change and grow as we return to the basket over the course of the next five years. As Technical Assistance Provider, we will continue collecting and reviewing instruments, including ones specified at the request of Grantees.

As the CRDP Phase 2 participants (Grantees, Technical Assistance Providers, Statewide Evaluator, as well as the Office of Health Equity) collaborate over the next five years, we will gain important new understandings. Therefore, we view these initial guidelines as "version 1.0," certain to be revised extensively throughout the evaluations of the seven funded Native American community-defined evidence practices.

Terminology

We recognize that some Grantees or their community members may prefer the term "Native American," some may prefer the term "American Indian/Alaskan Native," some may prefer "Indigenous," and some may prefer to be referred to by the name/s of their specific tribe/s. Grantees have noted that these different preferences reflect community members' different experiences, thoughts, and feelings about their sense of individual and collective identity, as well as terms they use in interactions with government agencies, researchers, and funders. The people we serve in the CRDP project include California Natives and other American Indians and Alaska Native tribes (whether or not they are Federally or State recognized), within sovereign rural Tribal settings as well as in urban locations. For the purposes of these Population Evaluation Guidelines we use these terms interchangeably, acknowledging that we often refer to "Native Americans" in keeping with the phrase used in Native Vision, the Native American population report produced in CRDP Phase 1.

Native Vision: A Source of Inspiration

The *Native Vision* report produced by the Native American Stakeholder Population Workgroup in CRDP Phase I (California Reducing Disparities Project, 2012, pp. 30-31) was the product of intensive deep thinking, visioning, research, and conversation by a distinguished panel of consultants, refined through many meetings with community members throughout California. In shaping this booklet, we follow the recommendations which are summarized at the conclusion of the *Native Vision* report produced by the Native American Stakeholder Population Workgroup in CRDP Phase I (California Reducing Disparities Project, 2012, pp. 30-31). We include thumbnail summaries of those recommendations within the relevant sections of this report.

A Summary of Best Practices

There is a large and growing body of literature on evaluation of health promotion programs for Native American populations. In this document, we discuss examples of best practices that recur in the literature. Table 1, adapted from Kawakami et al. (2007), provides recommendations for conducting culturally appropriate program evaluations in Native American communities. While Kawakami and colleagues' work is informed specifically by a Native Hawaiian cultural background, their recommendations align with those of evaluation scholars from other American Indian and Alaska Native communities, whose work we review throughout this document. We have included Table 1 because it summarizes several main points explored below:

Having a community-generated research agenda. To be useful for the communities involved, an evaluation should begin with a needs assessment. Questions might include:

- How do community members define and understand mental health?
- What are their views of mental health services offered in the community?
- How could these services be improved?

Community input can be solicited during the evaluation process through a variety of methods, such as town halls and community advisory boards, which we will discuss below.

Using mixed-methods evaluation approaches. There are many ways to conduct a needs assessment and gather information for evaluation purposes. Surveys are the most popular method, but may not always be the best method, especially on their own. It is often beneficial to use qualitative methods of data collection, such as open-ended interviews or focus groups, for program evaluation if they seem appropriate for the team's research questions and acceptable to participating community members.

Disseminating evaluation findings to community participants as well as academic/funding agencies. Many community members appreciate being appraised of evaluation results, especially if they participated in the evaluation. Dissemination can take place in a variety of venues and formats, such as a debriefing with the local community to validate and further discuss results, highlighting findings on a local radio station or in a newsletter, and providing a report with all results/findings to those who participated.

Using visual, oral and other culturally specific formats for sharing results. This recommendation can apply to results being shared both with community members and with funding agencies. For instance, in some communities, storytelling or other narrative practices may be a customary way to express thoughts about the community's historical trauma and ways to heal. Another example is using PhotoVoice or VideoVoice, in which community members record images from their daily lives that show something about community mental health or the impact of an intervention.

Linking the data to specific community contexts. There are over 560 federally recognized Tribes, with many people living not only on their respective reservations but in urban settings. American Indian and Alaska Native evaluation scholars stress that research findings cannot be separated from the community in which they were generated. This concept goes against the grain of "generalizable" data by acknowledging that interventions will unfold in different ways depending on community characteristics. Culturally responsive evaluation makes the case that effective interventions must be adapted to fit the needs and reality of each community in which they are implemented.

Applying evaluation findings to empower communities in resolving challenges and celebrating community strengths. This is perhaps the most important general guideline offered by the American Indian and Alaska Native evaluation

specialists whose work we discuss throughout this document. If community members are involved from the beginning of the evaluation process and are aware of the results, there is a greater chance that they can use the information to make changes and sustain effective programs.

In this document, we provide evaluation tools and concepts that Grantees may adopt if they find them useful. The collection of tools placed in our metaphorical basket of shared offerings may change and grow as we return to the basket over the course of the next five years. In pulling together these resources we were guided by the Grantees' proposals, requests, and recommendations, and thus this report does not constitute a systematic review of the literature. We apologize for any oversights, and welcome comments and suggestions.

Native American Technical Assistance Provider contact:

Roland S. Moore, PhD roland@prev.org (510) 883-5770 http://natap.prev.org

Prevention Research Center
Pacific Institute for Research and Evaluation

Table 1. A conceptual framework for Indigenous evaluation practice, adapted from Kawakami et al. (2007).

	Methodology	
Function	**Primarily Indigenous (includes some mainstream and adds dimensions)**	**Primarily widely practiced mainstream**
Purpose and goals	Set by community agenda.	Externally generated.
Driving question	Has the community been affected in a positive way as a result of the program/ project/initiative?	Have proposal goals/objectives been met?
Methodology	Quantitative, qualitative, and more.	Primarily quantitative.
Data	Spiritual, cultural, historical, social, emotional, cognitive, theoretical, situated information. Graphics, narratives, culturally created manifestations valid to that place.	Objective decontextualized data. Objective validity and reliability.
Analysis	Cultural and environmental significance.	Statistical and practical significance and effect size.
Format for findings	Narratives, stories, relationships, photos, DVDs, CDs, videos.	Written reports, charts, tables, graphs, databases.
Conclusions and recommendations	Shared among project, community, evaluator, and funder. Revised community agenda.	Submitted to funder. Fulfillment of contract.
Impact	Value added, lessons learned, clarity, empowerment.	Revised funding priorities.

A. Community driven evaluation

Native Vision Recommendation 3A.
Ensure a community driven evaluation process. Require the use of community-based participatory research methods within each community. It is essential to move beyond "cookie cutter" paper surveys to community members and standardized forms to project staff as methods to evaluate the success of program implementation. … with a strong grassroots evaluation strategy that is driven, literally, from the ground up.

Community-based participatory research (CBPR) approaches are recommended by many American Indian and Alaska Native and allied researchers, evaluators, service providers, and community members as the most ethical, equitable, and effective for conducting evaluation in American Indian and Alaska Native communities (Baydala, Ruttan, & Starkes, 2015; Jernigan et al., 2015; Starkes & Baydala, 2014). Incorporating CBPR methods into the evaluation of health interventions among American Indians and Alaska Natives can take many forms, such as:

- Co-design of data collection instruments with community consultants (Gonzalez & Trickett, 2014; Johansson, Knox-Nicola, & Schmid, 2015; Perry & Hoffman, 2010);
- Empowering community members to collect and analyze evaluation data (Bowman, Francis, & Tyndall, 2015);
- Ensuring joint ownership of data between community members, researchers, and community-serving organizations (or primary/exclusive Tribal ownership with data-sharing privileges for researchers and non-Tribally-affiliated community organizations) (Pahwa et al., 2015);
- Participatory manuscript development, in which both academic and community partners contribute to manuscripts for publication of evaluation findings (Jernigan et al., 2014);
- Cooperatively applying evaluation findings to refine intervention materials, such as culturally appropriate health education media

(Burhansstipanov et al., 2014; Cueva, Cueva, Dignan, & Landis, 2016; Eschiti et al., 2014; Scott et al., 2016).

Some evaluations of Native American CBPR projects have included a measure of "project ownership" to assess the degree to which the project is community-driven. During a 3-year diabetes intervention conducted in Alaska Native communities, Cargo et al. (2011) measured academic, service provider, and community participants' perceptions of primary project ownership. At baseline (Time 1), participants perceived service providers as having primary ownership. At Times 2 and 3, however, they perceived service providers and community advisory board members as equally sharing ownership of the project, thus showing an increase in the degree to which the project was community-driven (the academic partners were not perceived as having primary ownership of the project at any point).

Other evaluation efforts have begun with a pre-intervention assessment of community climate, such as the Community Readiness Model (CRM) (Oetting et al., 1995) to elicit community members' perceptions of the health problem to be addressed, as well as their interest, engagement and potential participation in the planned intervention. The CRM uses a combination of key informant interviews and a scoring system to assess various dimensions of community readiness (Donnermeyer, Plested, Edwards, Oetting, & Littlethunder, 1997; Plested, Smitham, Thurman, Oetting, & Edwards, 1999; Thurman, Plested, Edwards, Foley, & Burnside, 2003). Its overarching purpose is to honor and incorporate the community's views on the most urgent health issues and what should be done to address them.

The Choctaw Nation of Oklahoma successfully used the CRM for pre-implementation planning of a cardiovascular disease (CVD) prevention intervention (Peercy, Gray, Thurman, & Plested, 2010). While previous studies had shown disproportionately high rates of CVD among Native Americans, the research and evaluation team wanted to learn more about Tribal members' perceptions of CVD and other health problems in their everyday lives. First, they conducted key informant interviews with Choctaw community leaders representing several community systems (e.g., health care, spirituality, social services) to elicit their views on the most pressing health

issues in the community. They then used the CRM's scoring system to gauge the community's readiness for a CVD intervention. Through the key informant interviews, they learned that methamphetamine use was of greater concern to the community than CVD, one of the distal effects of long-term methamphetamine use. Based on this information, the project team re-worked their intervention to focus on methamphetamine use and its many health consequences, including CVD. This is one example of many in the literature that shows the importance of considering community perceptions and reception of potential interventions before taking action. Community-partnered evaluation before, during, and after health interventions can help to increase their resonance and cultural appropriateness.

Summary:

- Community-based participatory research (CBPR) approaches are effective for ensuring community-driven evaluation efforts.
- CBPR principles can be incorporated into evaluation in several ways, such as inviting community members to co-create data collection instruments, participate in data collection, co-author reports of evaluation findings, and help create or revise health programs based on results.
- Some evaluators recommend measuring community "ownership" of health programs co-created by health care organizations, researchers, and community members.
- Tools such as the Community Readiness Model can help evaluators to determine community health concerns and "climate" regarding possible program or policy changes.

B. Use mixed methods

Native Vision Recommendation 3B.
Use mixed methods evaluation to ensure strongest reflection of successes and challenges. Community-based participatory research and evaluation is rapidly becoming the most valid way of reflecting information and priorities from communities; however, in order to ensure the most valid information it is often critical to use a combination of qualitative and quantitative evaluation methods. We strongly encourage the content of all evaluation to be driven by the community through a participatory process to ensure validation from a community and a scientific perspective.

Mixed-methods approaches, which combine both qualitative and quantitative methods of data collection and analysis, appear frequently in published studies regarding evaluation of community health programs for American Indians and Alaska Natives. Although quantitative tools such as survey instruments are used frequently in evaluation, they can often be strengthened and contextualized through the addition of qualitative measures. While quantitative data are necessary for describing outcomes in terms of *what* was accomplished, qualitative data can be helpful for describing *how* and *why* intervention activities contributed to observed outcomes (the latter is also known as the *theory of change* (Weiss, 1997).

Storytelling and other narrative approaches are often recommended in the program evaluation literature by American Indian and Alaska Native researchers as culturally appropriate sources of process data (Kawakami et al., 2007; LaFrance, 2004; LaFrance, Nichols, & Kirkhart, 2012; Lavallée, 2009). Narrative and conversational methods may also improve the quality of evaluation data by putting respondents at ease and allowing them the necessary space and time to reflect and express their thoughts (Bowman et al., 2015). These methods may also provide additional opportunities for community collaboration, as elders can play a pivotal role in guiding talking circles and other traditional forms of group dialogue.

Key informant interviews, or in-depth interviews with community stakeholders such as health care or social service providers, spiritual leaders, and others can support evaluation by illuminating important factors that evaluators might not think to include on survey instruments. These might include different ways of using tobacco in ceremonial versus secular contexts (Margalit et al., 2013), for instance, or diverse resilience strategies for dealing with historical trauma (Reinschmidt, Attakai, Kahn, Whitewater, & Teufel-Shone, 2016). Key informant interviews are most useful at the outset of an evaluation process, because they tend to offer a broad view of community systems. Key informants usually interact with large groups of community members and have unique perspectives on health and social issues. They can also point the evaluator toward others who might be able to share information or data relevant to the evaluation.

As an example, The Alaska Native Colorectal Cancer Family Outreach Program team used key informant interviews to examine program strengths and challenges, such as outreach response (Redwood et al., 2016). During these interviews, they learned that community members had mixed reactions to the screening outreach methods in use (e.g., cold-calling family members of cancer patients to encourage them to be screened). This information alerted the team to the need for increased staffing and training of Alaska Native patient navigators, who could approach the family members personally in a more sensitive manner.

Focus groups, which feature a facilitator who asks questions and engages in dialogue with several interviewees simultaneously, are another possibly useful component of a mixed-method evaluation plan. For example, one team that evaluated a physical activity intervention for American Indian youth used both a survey developed by their Community Advisory Board and participant focus groups to collect mixed-methods data on program effectiveness (Perry & Hoffman, 2010). The focus groups allowed youth to provide more input into the research process; for example, they described a conceptual distinction between "exercise" and "sports," which the researchers incorporated into the evaluation design. They found that youths' motivations for engaging in "exercise" versus "sports" were different, which suggested that they should be addressed in distinct ways within the intervention. Another evaluation team combined focus groups with field observations and surveys in order to triangulate (compare) individual/group and self-

report/observed data sources regarding the effectiveness of a Native women's heart health Talking Circle (Ziabakhsh, Pederson, Prodan-Bhalla, Middagh, & Jinkerson-Brass, 2016).

Qualitative approaches can also be useful for **creating, elaborating or operationalizing survey measures**. For instance, measures of cultural identity or cultural connectedness (Snowshoe, Crooks, Tremblay, Craig, & Hinson, 2015; Snowshoe, Crooks, Tremblay, & Hinson, 2017) may be included in evaluation of Native American-specific health programs as part of a decolonizing approach (Smith, 1999) to counteract the effects of historical trauma by strengthening participants' connection to traditional culture. However, cultural identity is a fluid phenomenon that shifts according to social, spatial, and temporal contexts. Quantitative measures to assess cultural identity (e.g., knowledge of traditional culture, sense of relationship to American Indian and Alaska Native communities, Tribal affiliation) may not fully capture its complexity. Supplementing these with qualitative measures (e.g., in-depth interviews with program recipients and providers, community stakeholders) may provide a fuller understanding of how community members view and live their cultural identities on an everyday basis (Jette & Roberts, 2016).

Mixed methods can enhance not only community data collection, but also **team-based self-assessment**. For instance, the Native American Cancer Prevention Model team (Trotter, Laurila, Alberts, & Huenneke, 2015) incorporated qualitative queries into their standard logic model—which included inputs/resources, activities, outputs, and outcomes—to better understand the mechanisms by which their intervention activities led to desired outcomes. They combined the qualitative queries with periodic tracking and assessment data to continuously monitor the progress of their program.

For the qualitative component, they convened their community partnership team (consisting of academic researchers and a community advisory board) and asked the team questions such as: "Is the program working as planned?" and "To what extent and in what time frame are the three primary programs being implemented as planned? (Trotter et al., 2015, p. 3) Their multi-pronged self-assessment approach was designed to periodically monitor progress and facilitate real-time adjustments in the intervention.

Whether evaluating the effectiveness of an intervention or their own team, evaluators can consider using a variety of methods as needed to honor and reflect the social, cultural, and political contexts within which they work. While quantitative methods may be normative within Western scientific discourse and practice, Indigenous Evaluation Frameworks (LaFrance & Nichols, 2008) call for the elevation of culturally appropriate qualitative methods to equal status within evaluation research.

Summary:

- The use of "mixed methods" (quantitative and qualitative ways of collecting information) can strengthen evaluation findings.
- Quantitative data can tell us "how much or how many," while qualitative data can tell us "why or how."
- Examples of quantitative data collection include surveys, program enrollment counts, and calculating rates of specific health diagnoses from medical records.
- Examples of qualitative data collection include individual or focus group interviews, observations, and documentation of oral traditions such as storytelling.

C. Community consent

Native Vision Recommendation 3C.
Gather consent from communities as well as individuals. It is essential to gather consent from the communities where the work occurs. Much akin to the research world's Ethical Review Board, nearly every California Native American community has a panel of elders, council members, or community members who serve in this role within the community. It is important to respect the nature of Native Communities and engage the community leaders to ensure work is in alignment with community priorities. This is particularly relevant as we move toward evaluating best/promising practices that may be culturally based and provoke ethical sensitivities around documentation and evaluation.

The literature on ethics in research conducted with Indigenous communities stresses that individual and community consent are equally important (Brant Castellano, 2004; Dunbar & Scrimgeour, 2006; Flicker & Worthington, 2012; Wax, 1991). Community consent, often granted through Tribal research review boards, is an expression of Tribal sovereignty and Indigenous peoples' self-determination (LaFrance, 2004). Flicker & Worthington (2012) note that obtaining community-level consent may be less straightforward for research and evaluation conducted in diverse urban environments where there is no single entity authorized to represent the community's interests vis-à-vis knowledge production. In such cases, research review boards at local academic institutions or clinical agencies may be able to partner with community organizations to carry out ethics review of planned evaluation activities (Hicks et al., 2012).

Some Tribal review boards require that researchers protect the identities of not only individual study participants but also of the tribe or tribes (Morton et al., 2013), particularly in research concerning stigmatizing conditions (Norton & Manson, 1996). Indian Health Service guidelines specify that Tribal communities should not be identified in results without their explicit consent (Freeman, 2004). Aggregating Tribal health data is one method that has been used successfully, following Tribal leaders' input, in order to preserve the confidentiality of research participants from smaller tribes and avoid directly identifying the participating tribes (Van Dyke et al., 2016).

The process of obtaining community consent provides yet another opportunity to use a community-driven approach. Prior to drafting consent protocols and presenting them to Tribal or associated IRBs, researchers and evaluators can consult with community stakeholders about ethical concerns. Benefits of pre-IRB community consultation include the following:

- Community consultants can alert researchers to areas of ethical concern they may not have considered, and suggest ways to minimize potential risks and hazards.
- Community consultants can recommend ways to enhance potential benefits to communities that elect to participate in intervention and evaluation activities.
- Engaging in community consultation can increase the legitimacy of the informed consent process by allowing community members to consider and make changes to the IRB protocol prior to submission.
- Community consultation can help to increase community members' sense of shared responsibility for the proposed intervention, and perhaps encourage them to participate in the conduct of research and evaluation activities (Dickert & Sugarman, 2005).

To ensure that research and evaluation are conducted in an ethical way that benefits the community, Indigenous researchers recommend obtaining pre- and post-intervention testimonials from community stakeholders regarding the potential for community benefit (pre-intervention) and the extent to which these benefits actually accrued to the community (post-intervention) (Ball & Janyst, 2008).

Summary:

- When conducting research with Indigenous communities, obtaining informed consent from the community is often as important as obtaining it from the individual.
- If there is no Tribal institutional review board (IRB), evaluators can sometimes partner with academic agencies to have their IRBs review the research plan.
- Before submitting materials to an IRB (Tribal or otherwise), evaluators ideally should show their research plans to local community stakeholders and request their input on the appropriateness of planned measures and safeguards for confidentiality.

D. Safeguard tradition

Native Vision Recommendation 3D.
Set strict criteria for evaluation of cultural and traditional practices. It is essential to protect the integrity of Native American ceremonial knowledge. For evaluation purposes, when a ceremony is administered it must only report the input and outcomes. The ceremony itself may be described as to the purpose, but not the details. The leadership must set strict criteria for evaluation and description of cultural and traditional practices for entities reporting findings as part of the CRDP project.

American Indian and Alaska Native researchers have reflected extensively on the different values governing Western/academic versus Native American/traditional cultural contexts (Deloria, 2003; Hernandez-Avila, 1996). While Western academic and scientific culture demands detailed empirical descriptions of events with an eye toward comparative study and replicability, American Indian and Alaska Native scholars emphasize the need to preserve traditional culture and respect its origins:

> ...even though in the world of academia I might feel I had not done anything improper in describing [a sweat lodge ceremony], I know that in the Native American community, among the elders, I could not say the same thing. ...just as there would be readers who would be truly respectful of the information, there are those who would feel that my description of details gave them permission to appropriate [the tradition] (Hernandez-Avila, 1996, p. 331).

Asking what can and cannot be included. In the course of demonstrating the effectiveness of culture-driven health programs, evaluators must describe their components. If community organizations and/or service providers wish to register these programs as evidence-based practices (EBP), their components should be defined clearly enough to facilitate replication in other communities (with appropriate adaptation to the unique characteristics of each community). However, evaluators must be careful not to expose sacred knowledge or rites in the process of describing program components. To that end, early discussions with community stakeholders about what can and cannot be included in data collection and reports should be a part of inclusive evaluation design. According to Bowman and colleagues, "…information gleaned in a sacred space like a sweat lodge or teaching circle may not be available to or shared with outside investigators

and the wider world in the way that information from more public ceremonies or discussions might be" (Bowman et al., 2015, p. 345).

Upholding sovereignty and traditions. This guideline also speaks to the importance of acknowledging each Tribal community's unique sovereign knowledge and traditions, the importance and inimitability of elders' wisdom, and the need to carefully adapt program content with community input prior to replication attempts in other communities. However, the meaning of "tradition," and the determination of which traditions are amenable to incorporation and adaptation for public health purposes, are not clear-cut. Sometimes adaptation of cultural traditions occurs in unexpected ways. In Australia, for example, Aboriginal providers of substance abuse treatment have widely adopted the North American sweat lodge rather than incorporating local healing traditions into their programs (Brady, 1995). The sweat lodge model, argues Brady, is more easily adapted to group therapy than Australian Aboriginal healing ceremonies, which tend to be private and involve only the traditional healer and the person seeking help. She describes how Aboriginal treatment providers have consulted Canadian First Nations Tribal healers for guidance in the proper incorporation of sweat lodge practices, and conferred with them regarding respectful adaptation to local community contexts.

Acknowledging intracultural variation. In other instances, cultural symbols and practices that are meaningful for one community (or a group of communities) might not resonate with others. Further, there is often a great deal of intracultural variation (differences within the same culture) in how individual members of the same community respond to particular cultural symbols (Kumanyika, 2003). An example of intracultural variation is described by a team of evaluators and program designers who created an intervention to help prevent diabetes in Southwestern American Indian communities (Willging, Helitzer, & Thompson, 2006). They designed educational materials that featured two cultural symbols assumed to be relevant to people from a wide range of Tribal backgrounds: the Storyteller (present in the traditional lore of many Southwestern tribes) and the Medicine Wheel (prominent within Northern Plains traditional healing practices). To ensure cultural relevance, the evaluation team conducted focus groups to pilot test the educational materials with members of the intended audience: local American Indian women from diverse Tribal backgrounds. In so doing, they discovered

that the women had varied reactions to the symbols which were magnified by generational, Tribal, and urban/rural differences. Many younger women thought the Storyteller image reinforced stereotypes about traditional femininity and motherhood with which they did not identify. The Medicine Wheel did not resonate with many of the women from Southwestern tribes, while others disliked the fluorescent colors the designers had used for the Wheel image. With the focus group participants' input, the team was able to revise the materials using strategies such as vignettes of local community members describing how they incorporated healthy eating and exercise into their daily routines.

Summary:

- Evaluators should be careful not to reveal any sacred knowledge or details of sacred ceremonies when documenting cultural practices.
- Cultural traditions vary substantially between communities.
- Even within the same community, ideas about what constitutes tradition, and which traditions can be incorporated or adapted for public health purposes, may vary among individuals.
- It is important to consult with community members, and especially the target audience for a health program, during the planning stages in order to ensure that the program is relevant and relatable from their perspectives.

E. Locally attuned evaluation

Native Vision Recommendation 3E.
Utilize a consultant who is experienced conducting evaluation in Native American communities. Community-based participatory evaluation focuses on involvement, development, participation, and empowerment, where the community is seen as the expert with the best ability to identify issues and solutions. This approach can be time-consuming and requires a unique set of evaluation skills on the part of the evaluation team. It is important that whoever is hired in this capacity has experience working in the Native American community and is familiar with the strong similarities between community-based participatory methods and cultural norms relating to evaluation methods. This approach, coupled with mixed-methods evaluation, will ensure that practice-based evidence is evaluated at the standard of evidence-based practices without sacrificing the integrity and need for community-driven evaluation questions and analysis.

It is important for evaluators of American Indian and Alaska Native CDEPs (community-defined effective practices) to have a deep understanding not only of colonial history and abuses vis-à-vis Indigenous communities, but also of the traditions and values of the communities with which they partner (Johnston-Goodstar, 2012). Perhaps most importantly, they should be aware of the complex history between researchers and Indigenous communities. Too often, "helicopter researchers" (so named because they seemingly fly in and fly out without returning to share their findings) have collected data without proper informed consent, then used this data in ways that either do not benefit the community directly, or even cause harm (Oberly & Macedo, 2004; Robertson, Jorgensen, & Garrow, 2004).

With these complexities in mind, Indigenous researchers have identified a number of "best practices" for evaluation in Indigenous communities. LaFrance & Nichols (2008, p. 22) created an Indigenous Evaluation Framework consisting of four key values: "being people of a place," "recognizing our gifts," "honoring family and community," and "respecting sovereignty" (see Table 2, below).

The first value refers to situating evaluation within the specific geographic, historical, social, and cultural context of the community partners. Evaluators should resist the

tendency to distill community members' stories and wisdom into de-contextualized units of data. Combining vignettes and de-identified interview quotes with survey data can bring the numbers to life, as can the inclusion of community members' own photos and videos to document health program activities (as long as proper consent is obtained to record or take photographs for evaluation purposes). Rather than focusing on "universalizing" the program for replicability, evaluators should consider, along with their community partners, about how and why the program worked in a particular community context (LaFrance et al., 2012). They might ask, for instance, how the program reflects core community values or honors aspects of the community's history or geographical setting.

The second value in the Indigenous Evaluation Framework is the importance of recognizing individuals' unique gifts, accomplishments, and contributions to the evaluation process. This value has implications for evaluation, because it encourages holistic methods. For example, rather than isolating a single characteristic such as age, a holistic approach considers multiple aspects of a person. While statistical techniques such as regression models "control" for certain variables (i.e., examine an isolated variable's effect on outcomes while holding other variables constant), these can be enriched by adding case studies that tell the *story* of a participant and how the health intervention impacted his or her life. The third value is engaging communities, not just individuals, in the evaluation process. This value speaks not only to gaining community consent for research, but also inviting community members to participate as equals in the design and conduct of evaluation. The fourth value emphasizes Tribal/community ownership of information gleaned from evaluation and advocates for ethical research practice.

Summary:

- Evaluators working with Indigenous communities should be aware of the complex historical relationship between tribes and researchers.
- Given this complex relationship, evaluators should take special care to share research findings with community members.
- The Indigenous Evaluation Framework (LaFrance & Nichols, 2008) provides best practices to orient evaluators working with Indigenous communities.

Table 2. Core Values and Evaluation Practice (LaFrance & Nichols, 2008)

Core Values	Indigenous Evaluation Practice
Indigenous knowledge creation context is critical	o Evaluation itself becomes part of the context; it is not an "external" function o Evaluators need to attend to the relationships between the program and community o If specific variables are to be analyzed, care must be taken to do so without ignoring the contextual situation
People of a place	o Honor the place-based nature of many of our programs o Situate the program by describing its relationship to the community, including its history, current situation, and the individuals affected o Respect that what occurs in one place may not be easily transferred to other situations or places
Recognizing our gifts — personal sovereignty	o Consider the whole person when assessing merit o Allow for creativity and self-expression o Use multiple ways to measure accomplishment o Make connections to accomplishment and responsibility
Centrality of community and family	o Engage the community, not only the program, when planning and implementing an evaluation o Use participatory practices that engage stakeholders o Make evaluation processes transparent o Understand that programs may focus not only on individual achievement, but also on restoring community health and well-being
Tribal sovereignty	o Ensure Tribal ownership and control of data o Follow Tribal Institutional Review Board processes o Build capacity in the community o Secure proper permission if future publishing is expected o Report in ways meaningful to Tribal audiences as well as to funders

F. Community reflection

Native Vision Recommendation 3F.
Ensure that each local community is reflected uniquely in its own evaluation process. Local community driven input and direction should be gathered for each community to reflect the range of values and issues seen as important for mental health prevention and early intervention. Information from each of these communities should be integrated to form a quantitative and qualitative evaluation that can be used statewide.

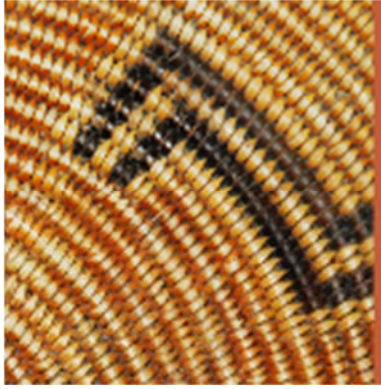
This guideline reflects the holistic nature of the *Native Visions* report, in that it incorporates elements of previous guidelines concerning the importance of community-driven and mixed-methods approaches to evaluation. The guidelines cannot be considered in isolation from one another, as they contain overlapping elements that are linked organically within diverse American Indian and Alaska Native value systems. Guideline 3F also illustrates a challenge for evaluators of CDEPs: the need to situate evaluation findings within the context of the community or communities in which the intervention occurred, versus the expectation within public health practice that effective interventions can be readily adapted and transferred to other communities. American Indian and American Indian-collaborating evaluation teams have grappled with this challenge in various ways.

In their description of a CBPR project designed to prevent alcohol abuse and suicide, Gonzalez & Trickett (2014) emphasize the importance of incorporating each community's unique characteristics into assessment measures. In their project, they worked with two closely related Alaska Native (Yup'ik) communities with different prevalence and incidence rates of suicide. One community with no recent suicides feared that asking direct questions about suicide might empower its spiritual essence and cause suicide to be revisited on the community. The university/community co-researchers engaged in careful deliberation to resolve this issue, eventually deciding to replace suicide risk measures with a Reasons for Life scale (their culturally-informed adaptation of an existing measure). This decision was practical in that it allowed evaluators to indirectly assess suicide risk via a related construct that was culturally appropriate across

Yup'ik communities. Of course, different approaches might be necessary for assessing suicide risk for other Native communities, given their social, cultural, and political contexts. This case illustrates the importance of obtaining community input at the beginning of evaluation efforts, and avoiding assumptions regarding the cultural views of communities.

Summary:

- Evaluations should reflect the local character of the community.
- This involves, for instance, collecting information about social and historical context and how this might affect community members' reception of the health program being evaluated.
- Previous recommendations, such as mixed-methods data collection and engaging community members in the evaluation process, will help to ensure accurate reflection of the local community in evaluation reports.



G. Advice from the community

Native Vision Recommendation 3G.
Develop a community advisory board to ensure evaluation integrates traditional and culturally based services and ensure appropriate community involvement. Many counties do not have a clear understanding of what Native American culturally based services are and how they relate to Native American mental health, best practices, or even community-based evaluation processes. We recommend Native American organizations/ tribes do their own evaluation without relying on state or county evaluators who may not know about Native American issues. It is important that Native American grantees/ contractors not be forced into a prepackaged evidence-based service delivery system that is top down and culturally disengaged.

Research and evaluation efforts that employ a community-driven approach often seek the input and guidance of a community advisory board (CAB) or, more specific to evaluation, an evaluation advisory group (EAG). EAGs may include community elders, Tribal council members, and representatives of diverse community systems, such as social or health services, spiritual or religious life, and others depending on the focus of the program being evaluated. If the program serves a subgroup of community members, such as youth or LGBTQ, the EAG might also include members of that subgroup to ensure their voices are heard.

EAGs can aid research and evaluation efforts in American Indian and Alaska Native communities in several ways (Johnston-Goodstar, 2012). At the beginning of the project, they can be invaluable in helping to define which health problems are the most urgent to the community. EAG members can also help to establish legitimacy of the evaluation efforts vis-à-vis the community, resulting in stronger community buy-in and participation. Further, they can assist in the design of evaluation instruments by advising evaluators on the "right" questions to ask and how to ask them; and on appropriate dissemination of findings via community venues. For example, in their evaluation of a public safety program undertaken by the Oglala Sioux Tribe, Robertson and colleagues utilized the local Tribal community radio station to share details of the program and evaluation findings (Robertson et al., 2004). During the Yup'ik Experiences of Stress and

Coping project (Rivkin et al., 2013), the research team followed community guidance on how best to disseminate findings (via community-wide presentations and discussions) and include community members in the process of translating research findings into an intervention (via Community Planning Group meetings). In these and other cases, assembling an EAG or community advisory board helped to establish a consistent conduit for dialogue between community stakeholders and evaluators on the best ways to conduct evaluations in local communities.

Summary:

- Whenever possible, American Indian and Alaska Native professionals should conduct evaluation of health interventions in Indigenous communities.

- Even when evaluators come from the same community where the research is taking place, they can benefit from the guidance of an Evaluation Advisory Group (EAG).

- EAGs consist of community leaders and stakeholders, and can offer advice regarding pressing community health problems, how best to engage community members, and ethical research practice.

Making the case

One of the overarching goals of the CRDP is to acknowledge the value of community-defined effective practices (CDEPs) for promoting community mental health and preventing mental health problems. Too often, CDEPs have been overshadowed by the dominant paradigm within Western scientific discourse of evidence-based practice (EBP). Although communities are the most well-informed on their specific mental health needs and which practices work best to meet those needs, prevailing health policy and funding structures privilege and support the use of EBPs, even when they may not be an ideal fit for local communities (Echo-Hawk, 2011).

When seeking appropriate support for their CDEPs, American Indian and Alaska Native-serving health organizations often find themselves obligated to provide evidence of their programs' effectiveness in ways that may not honor or reflect Indigenous ways of knowing and Tribal sovereignty (Cochran et al., 2008; Simonds & Christopher, 2013; Walker, Whitener, Trupin, & Migliarini, 2015). Indigenous researchers and evaluators argue that in order to overcome the divide between Western and Indigenous epistemes (knowledge systems), and the privileging of the former to the detriment of the latter, a paradigm shift is necessary (Kawakami et al., 2007; LaFrance & Nichols, 2008). In these guidelines, we have discussed some ways that American Indian and Alaska Native evaluators and their collaborators have begun to make this paradigm shift, such as incorporating traditional forms of knowledge sharing (e.g., storytelling) as data sources within evaluation reports.

Publication is a first step toward "making the case" for CDEP effectiveness. American Indian and Alaska Native research and evaluation teams have published extensively within public health journals, describing their interventions as well as their evaluation designs and findings. Examples in the literature include (among others): The Canoe Journey, a substance use prevention intervention in Pacific Northwest Tribal communities (Donovan et al., 2015); FORGE AHEAD, a community-driven quality

improvement initiative to improve chronic disease care for Alaska Natives (Hayward, Paquette-Warren, Harris, Naqshbandi Hayward, & Forge Ahead Program Team, 2016); Circle of Life, a Native American-specific HIV prevention intervention (Kaufman et al., 2014); CONNECT, a youth suicide prevention intervention developed with the Cherokee Nation (Komro et al., 2015); the Parenting in Two Worlds intervention for American Indian families (Kulis, Ayers, Harthun, & Jager, 2016) the Diabetes Prevention Project for American Indians and Alaska Natives in urban settings (Rosas et al., 2016); an entrepreneurship training intervention to prevent substance use and suicide among American Indian and Alaska Native youth (Tingey et al., 2016); an American Indian-specific substance abuse intervention combining motivational interviewing and the Community Reinforcement Approach (MICRA) (Venner et al., 2016); and the Youth Leaders Program, a school-based intervention to prevent substance use, violence, and ultimately suicide among Alaska Native youth (Wexler et al., 2016). Although this is nowhere near an exhaustive list, it provides some examples of where and how research teams have published (often mixed-methods) data on the effectiveness of interventions designed specifically for Native communities.

Summary:

- Increasingly, funding for community health services depends on the use of "evidence-based practices."
- Although evidence-based practices may be effective for some communities, they may not work as well in all communities.
- Many American Indian and Alaska Native community health providers are making the case for their own culturally appropriate CDEPs (community-defined effective practices).
- Collecting and publishing evaluation data of CDEPs in public health journals is an important step toward gaining recognition of their effectiveness and funding support in order to sustain them.

References cited

Ball, J., & Janyst, P. (2008). Enacting Research Ethics in Partnerships with Indigenous Communities in Canada: "Do it in a Good Way". *Journal of Empirical Research on Human Research Ethics, 3*(2), 33-51.

Baydala, L., Ruttan, L., & Starkes, J. (2015). Community-based participatory research with Aboriginal children and their communities: Research principles, practice and the social determinants of health. *First Peoples Child & Family Review, 10*(2), 82-94.

Bowman, N. R., Francis, C. D., & Tyndall, M. (2015). Culturally Responsive Indigenous Evaluation: A practical approach for evaluating indigenous projects in tribal reservation contexts. In S. Hood, R. Hopson & H. Frierson (Eds.), *Continuing the Journey to Reposition Culture and Cultural Context in Evaluation Theory and Practice* (pp. 335–359). Charlotte, NC: Information Age Publishing.

Brady, M. (1995). Culture in treatment, culture as treatment. A critical appraisal of developments in addictions programs for indigenous North Americans and Australians. *Social Science & Medicine, 41*(11), 1487-1498.

Brant Castellano, M. (2004). Ethics of Aboriginal research. *International Journal of Indigenous Health, 1*(1), 98.

Burhansstipanov, L., Krebs, L. U., Dignan, M. B., Jones, K., Harjo, L. D., Watanabe-Galloway, S., Petereit, D. G., Pingatore, N. L., & Isham, D. (2014). Findings from the Native Navigators and the Cancer Continuum (NNACC) study. *Journal of Cancer Education, 29*(3), 420-427.

California Reducing Disparities Project. (2012). Native Vision: A Focus on Improving Behavioral Health Wellness for California Native Americans. Retrieved from

http://www.nativehealth.org/sites/dev.nh.edeloa.net/files/native_vision_report_compressed.pdf

Cargo, M. D., Delormier, T., Lévesque, L., McComber, A. M., & Macaulay, A. C. (2011). Community capacity as an "inside job": evolution of perceived ownership within a university-aboriginal community partnership. *American Journal of Health Promotion, 26*(2), 96-100.

Cochran, P. A. L., Marshall, C. A., Garcia-Downing, C., Kendall, E., Cook, D., McCubbin, L., & Gover, R. M. S. (2008). Indigenous Ways of Knowing: Implications for Participatory Research and Community. *American Journal of Public Health, 98*(1), 22-27.

Cueva, K., Cueva, M., Dignan, M., & Landis, K. (2016). Print Material in Cancer Prevention: an Evaluation of Three Booklets Designed with and for Alaska's Community Health Workers. *Journal Of Cancer Education, 31*(2), 279-284.

Deloria, V. (2003). *God is red: A native view of religion*. Golden, CO: Fulcrum Publishing.

Dickert, N., & Sugarman, J. (2005). Ethical Goals of Community Consultation in Research. *American Journal of Public Health, 95*(7), 1123-1127.

Donnermeyer, J. F., Plested, B. A., Edwards, R. W., Oetting, G., & Littlethunder, L. (1997). Community Readiness and Prevention Programs. *Journal of the Community Development Society, 28*(1), 65-83.

Donovan, D. M., Thomas, L. R., Sigo, R. L. W., Price, L., Lonczak, H., Lawrence, N., Ahvakana, K., Austin, L., Lawrence, A., Price, J., Purser, A., & Bagley, L. (2015). Healing of the Canoe: Preliminary results of a culturally grounded intervention to prevent substance abuse and promote tribal identity for Native youth in two Pacific Northwest tribe. *American Indian and Alaska Native Mental Health Research, 22*(1), 42-76.

Dunbar, T., & Scrimgeour, M. (2006). Ethics in Indigenous Research – Connecting with Community. *Journal of Bioethical Inquiry, 3*(3), 179-185.

Echo-Hawk, H. (2011). Indigenous communities and evidence building. *Journal of Psychoactive Drugs, 43*(4), 269-275.

Eschiti, V., Lauderdale, J., Burhansstipanov, L., Weryackwe-Sanford, S., Weryackwe, L., & Flores, Y. (2014). Developing Cancer-Related Educational Content and Goals Tailored to the Comanche Nation. *Clinical Journal of Oncology Nursing, 18*(2), E26-E31.

Flicker, S., & Worthington, C. A. (2012). Public Health Research Involving Aboriginal Peoples: Research Ethics Board Stakeholders' Reflections on Ethics Principles and Research Processes. *Canadian Journal of Public Health, 103*(1), 19-22.

Freeman, W. (2004). The protection of potential individual volunteers and tribal communities in research involving the Indian Health Service (IHS). Retrieved from http://www.npaihb.org/images/epicenter_docs/irb/docs/Protections_fr.pdf

Gonzalez, J., & Trickett, E. J. (2014). Collaborative measurement development as a tool in CBPR: Measurement development and adaptation within the cultures of communities. *American Journal of Community Psychology, 54*(1-2), 112-124.

Hayward, M. N., Paquette-Warren, J., Harris, S. B., Naqshbandi Hayward, M., & Forge Ahead Program Team. (2016). Developing community-driven quality improvement initiatives to enhance chronic disease care in Indigenous communities in Canada: the FORGE AHEAD program protocol. *Health Research Policy & Systems, 14*, 1-12.

Hernandez-Avila, I. (1996). Mediations of the Spirit: Native American Religious Traditions and the Ethics of Representation. *American Indian Quarterly, 20*(3/4), 329-352.

Hicks, S., Duran, B., Wallerstein, N., Avila, M., Belone, L., Lucero, J., Magarati, M., Mainer, E., Martin, D., & Muhammad, M. (2012). Evaluating community-based

participatory research to improve community-partnered science and community health. *Progress in Community Health Partnerships: Research, Education, and Action, 6*(3), 289.

Jernigan, V. B. B., Brokenleg, I. S., Burkhart, M., Magdalena, C., Sibley, C., & Yepa, K. (2014). The implementation of a participatory manuscript development process with Native American tribal awardees as part of the CDC Communities Putting Prevention to Work initiative: Challenges and opportunities. *Preventive Medicine, 67*(Suppl 1), S51-S57.

Jernigan, V. B. B., Peercy, M., Branam, D., Saunkeah, B., Wharton, D., Winkleby, M., Lowe, J., Salvatore, A. L., Dickerson, D., Belcourt, A., D'Amico, E., Patten, C. A., Parker, M., Duran, B., Harris, R., & Buchwald, D. (2015). Beyond Health Equity: Achieving Wellness Within American Indian and Alaska Native Communities. *American Journal of Public Health, 105*(S3), S376-S379.

Jette, S., & Roberts, E. B. (2016). 'We usually just start dancing our Indian dances': Urban American Indian (AI) female youths' negotiation of identity, health and the body. *Sociology of Health & Illness, 38*(3), 396-410.

Johansson, P., Knox-Nicola, P., & Schmid, K. (2015). The Waponahki Tribal Health Assessment: Successfully using CBRP to conduct a comprehensive and baseline health assessment of Waponahki tribal members. *Journal of Health Care for the Poor and Underserved, 26*(3), 889-907.

Johnston-Goodstar, K. (2012). Decolonizing evaluation: The necessity of evaluation advisory groups in indigenous evaluation. *New Directions for Evaluation, 136*, 109-117.

Kaufman, C. E., Whitesell, N. R., Keane, E. M., Desserich, J. A., Giago, C., Sam, A., & Mitchell, C. M. (2014). Effectiveness of Circle of Life, an HIV-preventive intervention for American Indian middle school youths: A group randomized trial in a Northern Plains tribe. *American Journal of Public Health, 104*(6), e106-e112.

Kawakami, A. J., Aton, K., Cram, F., Lai, M. K., & Porima, L. (2007). Improving the Practice of Evaluation Through Indigenous Values and Methods: Decolonizing Evaluation Practice—Returning the Gaze From Hawaiÿi and Aotearoa. *Hulili: Multidisciplinary Research on Hawaiian Well-Being, 4*(1), 319-348.

Komro, K. A., Wagenaar, A. C., Boyd, M., Boyd, B. J., Kominsky, T., Pettigrew, D., Tobler, A. L., Lynne-Landsman, S. D., Livingston, M. D., Livingston, B., & Molina, M. M. M. (2015). Prevention trial in the Cherokee Nation: Design of a randomized community trial. *Prevention Science, 16*(2), 291-300.

Kulis, S. S., Ayers, S. L., Harthun, M. L., & Jager, J. (2016). Parenting in 2 worlds: Effects of a culturally adapted intervention for urban American Indians on parenting skills and family functioning. *Prevention Science, 17*(6), 721-731.

Kumanyika, S. K. (2003). Commentary: cultural appropriateness: working our way toward a practicable framework. *Health Education & Behavior, 30*(2), 147-150.

LaFrance, J. (2004). Culturally competent evaluation in Indian Country. *New Directions for Evaluation, 102*, 39-50.

LaFrance, J., & Nichols, R. (2008). Reframing evaluation: Defining an Indigenous evaluation framework. *The Canadian Journal of Program Evaluation, 23*(2), 13.

LaFrance, J., Nichols, R., & Kirkhart, K. E. (2012). Culture writes the script: On the centrality of context in indigenous evaluation. *New Directions for Evaluation, 135*, 59-74.

Lavallée, L. F. (2009). Practical Application of an Indigenous Research Framework and Two Qualitative Indigenous Research Methods: Sharing Circles and Anishnaabe Symbol-Based Reflection. *International Journal of Qualitative Methods, 8*(1), 21-40.

Margalit, R., Watanabe-Galloway, S., Kennedy, F., Lacy, N., Red Shirt, K., Vinson, L., & Kills Small, J. (2013). Lakota Elders' Views on Traditional Versus

Commercial/Addictive Tobacco Use; Oral History Depicting a Fundamental Distinction. *Journal of Community Health, 38*(3), 538-545.

Morton, D. J., Proudfit, J., Calac, D., Portillo, M., Lofton-Fitzsimmons, G., Molina, T., Flores, R., Lawson-Risso, B., & Majel-McCauley, R. (2013). Creating research capacity through a tribally based institutional review board. *American Journal of Public Health, 103*(12), 2160-2164.

Norton, I. M., & Manson, S. M. (1996). Research in American Indian and Alaska Native communities: Navigating the cultural universe of values and process. *Journal of Consulting and Clinical Psychology, 64*(5), 856-860.

Oberly, J., & Macedo, J. (2004). The R word in Indian country: Culturally appropriate commercial tobacco-use research strategies. *Health Promotion Practice, 5*(4), 355-361.

Oetting, E. R., Donnermeyer, J. F., Plested, B. A., Edwards, R. W., Kelly, K., & Beauvais, F. (1995). Assessing Community Readiness for Prevention. *International Journal of the Addictions, 30*(6), 659-683.

Pahwa, P., Abonyi, S., Karunanayake, C., Rennie, D. C., Janzen, B., Kirychuk, S., Lawson, J. A., Katapally, T., McMullin, K., Seeseequasis, J., Naytowhow, A., Hagel, L., Dyck, R. F., Fenton, M., Senthilselvan, A., Ramsden, V., King, M., Koehncke, N., Marchildon, G., & McBain, L. (2015). A community-based participatory research methodology to address, redress, and reassess disparities in respiratory health among First Nations. *BMC Research Notes, 8*(1), 1-11.

Peercy, M., Gray, J., Thurman, P. J., & Plested, B. (2010). Community readiness: An effective model for tribal engagement in prevention of cardiovascular disease. *Family & Community Health, 33*(3), 238-247.

Perry, C., & Hoffman, B. (2010). Assessing Tribal Youth Physical Activity and Programming Using a Community-Based Participatory Research Approach. *Public Health Nursing, 27*(2), 104-114.

Plested, B., Smitham, D. M., Thurman, P. J., Oetting, E. R., & Edwards, R. W. (1999). Readiness for Drug Use Prevention in Rural Minority Communities. *Substance Use & Misuse, 34*(4-5), 521-544.

Redwood, D., Provost, E., Lopez, E. D., Skewes, M., Johnson, R., Christensen, C., Sacco, F., & Haverkamp, D. (2016). A Process Evaluation of the Alaska Native Colorectal Cancer Family Outreach Program. *Health Education & Behavior, 43*(1), 35-42.

Reinschmidt, K. M., Attakai, A., Kahn, C. B., Whitewater, S., & Teufel-Shone, N. (2016). Shaping a stories of resilience model from urban American Indian elders' narratives of historical trauma and resilience. *American Indian and Alaska Native Mental Health Research, 23*(4), 63-85.

Rivkin, I., Trimble, J., Lopez, E. D. S., Johnson, S., Orr, E., & Allen, J. (2013). Disseminating research in rural Yup'k communities: challenges and ethical considerations in moving from discovery to intervention development. *International Journal of Circumpolar Health, 72*, 1-8.

Robertson, P., Jorgensen, M., & Garrow, C. E. (2004). Indigenizing evaluation research: How Lakota methodologies are helping "raise the tipi" in the Oglala Sioux Nation. *American Indian Quarterly, 28*(3), 499-526.

Rosas, L. G., Vasquez, J. J., Naderi, R., Jeffery, N., Hedlin, H., Qin, F., LaFromboise, T., Megginson, N., Pasqua, C., Flores, O., McClinton-Brown, R., Evans, J., & Stafford, R. S. (2016). Development and evaluation of an enhanced diabetes prevention program with psychosocial support for urban American Indians and Alaska natives: A randomized controlled trial. *Contemporary Clinical Trials, 50*, 28-36.

Scott, S., D'Silva, J., Hernandez, C., Villaluz, N. T., Martinez, J., & Matter, C. (2016). The Tribal Tobacco Education and Policy Initiative: Findings From a Collaborative, Participatory Evaluation. *Health Promotion Practice*.

Simonds, V. W., & Christopher, S. (2013). Adapting Western Research Methods to Indigenous Ways of Knowing. *American Journal of Public Health, 103*(12), 2185-2192.

Smith, L. T. (1999). *Decolonizing methodologies: Research and indigenous peoples*. London: Zed Books.

Snowshoe, A., Crooks, C. V., Tremblay, P. F., Craig, W. M., & Hinson, R. E. (2015). Development of a Cultural Connectedness Scale for First Nations youth. *Psychological Assessment, 27*(1), 249-259.

Snowshoe, A., Crooks, C. V., Tremblay, P. F., & Hinson, R. E. (2017). Cultural connectedness and its relation to mental wellness for First Nations youth. *The Journal of Primary Prevention, 38*(1-2), 67-86.

Starkes, J. M., & Baydala, L. T. (2014). Health research involving First Nations, Inuit and Métis children and their communities. *Paediatrics & Child Health, 19*(2), 99-102.

Thurman, P. J., Plested, B. A., Edwards, R. W., Foley, R., & Burnside, M. (2003). Community readiness: the journey to community healing. *Journal of Psychoactive Drugs, 35*(1), 27-31.

Tingey, L., Larzelere-Hinton, F., Goklish, N., Ingalls, A., Craft, T., Sprengeler, F., McGuire, C., & Barlow, A. (2016). Entrepreneurship education: A strength-based approach to substance use and suicide prevention for American Indian adolescents. *American Indian & Alaska Native Mental Health Research, 23*(3), 248-270.

Trotter, R. T., II, Laurila, K., Alberts, D., & Huenneke, L. F. (2015). A diagnostic evaluation model for complex research partnerships with community engagement: The partnership for Native American Cancer Prevention (NACP) model. *Evaluation and Program Planning, 48*, 10-20.

Van Dyke, E. R., Blacksher, E., Echo-Hawk, A. L., Bassett, D., Harris, R. M., & Buchwald, D. S. (2016). Health Disparities Research Among Small Tribal Populations: Describing Appropriate Criteria for Aggregating Tribal Health Data. *American Journal of Epidemiology, 184*(1), 1-6.

Venner, K. L., Greenfield, B. L., Hagler, K. J., Simmons, J., Lupee, D., Homer, E., Yamutewa, Y., & Smith, J. E. (2016). Pilot outcome results of culturally adapted evidence-based substance use disorder treatment with a Southwest Tribe. *Addictive Behaviors Reports, 3*, 21-27.

Walker, S. C., Whitener, R., Trupin, E. W., & Migliarini, N. (2015). American Indian perspectives on evidence-based practice implementation: results from a statewide tribal mental health gathering. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(1), 29-39.

Wax, M. L. (1991). The Ethics of Research in American Indian Communities. *American Indian Quarterly, 15*(4), 431-456.

Weiss, C. H. (1997). How can theory-based evaluation make greater headway? *Evaluation Review, 21*(4), 501-524.

Wexler, L., Poudel-Tandukar, K., Rataj, S., Trout, L., Poudel, K. C., Woods, M., & Chachamovich, E. (2016). Preliminary evaluation of a school-based youth leadership and prevention program in rural Alaska Native communities. *School Mental Health, advance online*, 1-12.

Willging, C. E., Helitzer, D., & Thompson, J. (2006). 'Sharing wisdom': Lessons learned during the development of a diabetes prevention intervention for urban American Indian women. *Evaluation and Program Planning, 29*(2), 130-140.

Ziabakhsh, S., Pederson, A., Prodan-Bhalla, N., Middagh, D., & Jinkerson-Brass, S. (2016). Women-centered and culturally responsive heart health promotion among indigenous women in Canada. *Health Promotion Practice, 17*(6), 814-826.

Appendix

We offer here a series of six evaluation instruments that have been useful for other projects serving American Indians and Alaska Natives. Some of these instruments have been used extensively and evaluated with Indigenous populations; others, less so. We have included the instruments here under three categories: 1) Instruments used frequently in research with American Indians and Alaska Natives, 2) Instruments suggested by Office of Health Equity Native American Implementation Pilot Project grantees, and 3) Instruments used by our network of colleagues doing similar work with American Indian and Alaska Native populations. This is not intended to be a comprehensive list, but rather a list of instruments that may be useful for evaluating your projects.

Category 1: Instruments used frequently in research with Native Americans

1. and 2. Historical Losses and Historical Losses Associated Symptoms Scales (Whitbeck et al., 2004.)

Category 2: Items suggested by OHE NA IPP Grantees

3. Cultural Connectedness Scale-CA (localized from Snowshoe, [2015] by the Native American Health Center for use with California Native American populations)

4. Herth Hope Index (Abbreviated Herth Hope Index) and Scoring Instructions (Herth, 1991; copyrighted and permission from the author must be obtained prior to use.)

Category 3: From network of colleagues doing similar work

5. Reasons for Life Scale (Positive measures opposed to suicide factors. Designed for Alaska Yup'ik Natives by James Allen and the People Awakening Team)

6. Perceived Discrimination Measures (Whitbeck et al., 2001)

References

Allen, J. and People Awakening Team Reasons for Life Scale.

Herth, K. (1991). Development and refinement of an instrument to measure hope. *Research and Theory for Nursing Practice*, *5*(1), 39-51.

Herth, K. (1992). An abbreviated instrument to measure hope: Development and psychometric evaluation. *Journal of Advanced Nursing*, 17, 1251-1259.

Native American Health Center. Cultural Connectedness Scale-CA.

Snowshoe, A. (2015). "The Cultural Connectedness Scale and its Relation to Positive Mental Health among First Nations Youth." Electronic Thesis and Dissertation Repository. 3107. http://ir.lib.uwo.ca/etd/3107

Whitbeck, L. B., Adams, G. W., Hoyt, D. R., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology*, 33, 119–130. http://dx.doi.org/10.1023/B:AJCP.0000027000.77357.31

Whitbeck, L., Hoyt, D., McMorris, B., Chen, X., & Stubben, J. (2001). Perceived Discrimination and Early Substance Abuse among American Indian Children. *Journal of Health and Social Behavior*, 42, 405-424.

1. Historical Losses and 2. Historical Losses Associated Symptoms Scales

Whitbeck, L. B., Adams, G. W., Hoyt, D. R., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology*, *33*, 119–130. http://dx.doi.org/10.1023/B:AJCP.0000027000.77357.31

Table A1: Historical Losses Scale, Whitbeck et al., 2004, p. 128

HG1. American Indian people have experienced many losses since we came into contact with Europeans (Whites). Please read the types of losses that people have mentioned to us (the scale developers), and I would like you to circle how often you think of these losses, from never thinking about them to thinking about them several times a day. DK/REF means you don't know or refuse to answer that particular item.

Table A1. Historical Losses Scale

		Several times a day	Daily	Weekly	Monthly	Yearly or only at special times	Never	DK/REF
A	The loss of our land	1	2	3	4	5	6	9
B	The loss of our language	1	2	3	4	5	6	9
C	Losing our traditional spiritual ways	1	2	3	4	5	6	9
D	The loss of our family ties because of boarding schools	1	2	3	4	5	6	9
E	The loss of families from the reservation to government relocation	1	2	3	4	5	6	9
F	The loss of self respect from poor treatment by government officials	1	2	3	4	5	6	9
G	The loss of trust in whites from broken treaties	1	2	3	4	5	6	9
H	Losing our culture	1	2	3	4	5	6	9
I	The losses from the effects of alcoholism on our people	1	2	3	4	5	6	9
J	Loss of respect by our children and grandchildren for elders	1	2	3	4	5	6	9
K	Loss of our people through early death	1	2	3	4	5	6	9
L	Loss of respect by our children for traditional ways	1	2	3	4	5	6	9

Table A2: Historical Losses Associated Symptoms Scale, Whitbeck et al., 2004, p. 129

HG2. Now, I would like to ask you about how you feel when you think about these losses. How often do you feel…

Table A2. Historical Losses Associated Symptoms Scale[a]

	Feeling	Never	Seldom	Sometimes	Often	Always	DK/REF
A	Sadness or depression	1	2	3	4	5	9
B	Anger	1	2	3	4	5	9
C	Anxiety or nervousness	1	2	3	4	5	9
D	Uncomfortable around white people when you think of these losses	1	2	3	4	5	9
E	Shame when you think of these losses	1	2	3	4	5	9
F	A loss of concentration	1	2	3	4	5	9
G	Feel isolated or distant from other people when you think of these losses	1	2	3	4	5	9
H	A loss of sleep	1	2	3	4	5	9
I	Rage	1	2	3	4	5	9
J	Fearful or distrust the intention of white people	1	2	3	4	5	9
K	Feel like it is happening again	1	2	3	4	5	9
L	Feel like avoiding places or people that remind you of these losses	1	2	3	4	5	9

Source:

Whitbeck, L. B., Adams, G. W., Hoyt, D. R., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology, 33,* 119–130. http://dx.doi.org/10.1023/B:AJCP.0000027000.77357.31

3.1 Cultural Connectedness Scale (CA)

Snowshoe, A. (2015). The Cultural Connectedness Scale and its Relation to Positive Mental Health among First Nations Youth. *Electronic Thesis and Dissertation Repository*. 3107. http://ir.lib.uwo.ca/etd/3107

Adaptation: Native American Health Center. Cultural Connectedness Scale-CA

Cultural Connectedness Scale – Urban California_____ (Revised January 26, 2017)

Age: _____ **Gender: _____**

Tribe(s): _____

Please place an 'X' next to the most accurate statement for each category relating to the Tribal Affiliation you indicated above. (Pick only one statement per category)

Self

___ I **have not** lived in the geographic location where my tribe is from.

___ I **have lived** in the geographic location where my tribe is from for **15 years or less**.
[Please indicate number of years _____]

___ I **have lived** in the geographic location where my tribe is from for **16 or more years**.
[Please indicate number of years _____]

Parents

___ I do not know if my parents lived in the geographic location where my tribe is from.

___ One or both of my parents lived in the geographic location where my tribe is from.
I do not know how long they lived there.

___ One or both of my parents lived in the geographic location where my tribe is from for **15 years or Less**.

___ One or both of my parents lived in the geographic location where my tribe is from for **16 years or More**.

Grandparents

___ I do not know if my grandparents lived in the geographic location where my tribe is from.

___ One or more of my grandparents lived in the geographic location where my tribe is from.
I do not know how long they lived there.

___ One or more of my grandparents lived in the geographic location where my tribe is from for **15 years or Less**.

___ One or more of my grandparents lived in the geographic location where my tribe is from for **16 years or More**.

[For Questions 1 – 11, circle Yes, NO or *NA*]

1. I know my cultural, spirit, Indian or Traditional name. **Yes** **No**
   (*Not Applicable. We don't use these names.*) ***NA***

2. I can understand some of my Native American/Indigenous words or languages. **Yes** **No**

3. I believe things like animals, rocks (and all nature) have a spirit like Native American /Indigenous People. **Yes** **No**

4. I use ceremonial/traditional medicines (See Examples **List 1**) for ***guidance or prayer or other reasons.*** (See Examples ***List 2*****)** **Yes** **No**

5. I have participated in a **traditional/cultural ceremony or activity.** (See Examples **List #3**) **Yes** **No**

6. I have helped prepare for a **traditional/cultural ceremony or activity** in my family or community. (See Examples **List #3**) **Yes** **No**

7. I have shared a meal with community, offered food or fed my ancestors for a traditional/cultural or spiritual reason. (See Example **List #4**) **Yes** **No**

8. Someone in my family or someone I am close with attends **traditional/cultural ceremonies or activities**. (See Examples **List #3**) **Yes** **No**

9. I plan on attending a **traditional/cultural ceremony or activity** in the future. **Yes** **No**
(See Examples **List #3**)

10. I plan on trying to find out more about my Native American/Indigenous culture, such as its history, Tribal identity, traditions, customs, arts and language. **Yes** **No**

11. I have a **traditional person, elder or other person** who I talk to. **Yes** **No**
(See Examples **List #5)**

[Please go to next page]

[For Questions 12 – 29 on the next two pages, place an X in the appropriate circle.]

	Strongly Disagree	Disagree	Do Not Agree or Disagree	Agree	Strongly Agree
12. I have spent time trying to find out more about being Native American/Indigenous, such as its history, Tribal identity, traditions, language and customs.	⬭	⬭	⬭	⬭	⬭
13. I have a strong sense of belonging to my Native American/Indigenous family, community, Tribe or Nation.	⬭	⬭	⬭	⬭	⬭
14. I have done things that will help me understand my Native American/Indigenous background better.	⬭	⬭	⬭	⬭	⬭
15. I have talked to community members or other people (See Example **List #5**) in order to learn more about being Native American/Indigenous.	⬭	⬭	⬭	⬭	⬭
16. When I learn something about my Native American/Indigenous culture, history or ceremonies, I will ask someone, research it, look it up, or find resources to learn more about it.	⬭	⬭	⬭	⬭	⬭
17. I feel a strong connection/attachment towards my Native American community or Tribe.	⬭	⬭	⬭	⬭	⬭
18. If a **traditional person, counsellor or Elder** who is knowledgeable about my culture, spoke to me about being Native American/Indigenous, I would listen to them carefully. (See **List #5**)	⬭	⬭	⬭	⬭	⬭
19. I feel a strong connection to my ancestors and those that came before me.	⬭	⬭	⬭	⬭	⬭
20. Being Native American/Indigenous means I sometimes have a different perception or way of looking at the world.	⬭	⬭	⬭	⬭	⬭
21. The eagle feather (or other feathers) has a lot of traditional meaning for me. (See Examples **List #6**)	⬭	⬭	⬭	⬭	⬭

[Please go to next page]

	Strongly Disagree	Disagree	Do Not Agree or Disagree	Agree	Strongly Agree
22. It is important to me that I know my Native American/Indigenous or Tribal language(s).	⬭	⬭	⬭	⬭	⬭
23. When I am physically ill, I look to my Native American/Indigenous culture or community for help.	⬭	⬭	⬭	⬭	⬭
24. When I am overwhelmed with my emotions, I look to my Native American/Indigenous culture or community for help.	⬭	⬭	⬭	⬭	⬭
25. When I need to make a decision about something, I look to my Native American/Indigenous culture or community for help.	⬭	⬭	⬭	⬭	⬭
26. When I am feeling spiritually ill or disconnected, I look to my Native American/Indigenous culture or community for help.	⬭	⬭	⬭	⬭	⬭

	Never	Once/ Twice in Past Year	Every Month	Every Week	Every Day
27. How often do you offer a **ceremonial/traditional medicine** for cultural/traditional purposes? (See Examples **List 1**)	⬭	⬭	⬭	⬭	⬭
28. How often do you use **ceremonial/traditional medicines**? (See Example **List #1**)	⬭	⬭	⬭	⬭	⬭
29. How often does someone in your family or someone you are close to use **ceremonial/traditional medicines**? (See Examples **List #1**)	⬭	⬭	⬭	⬭	⬭

[Please go to next page]

EXAMPLE LISTS 1 – 6

Cultural Connectivity Scale – Urban California [Revised January 16, 2017]

#1 **Ceremonial & Traditional Medicines**	#2 **Uses of Ceremonial & Traditional Medicines**	#3 **Traditional, Tribal & Cultural Ceremonies or Activities**	#4 **Cultural Uses of Food**	#5 **Traditional Persons, Elders & Leaders**
• Angelica Root • Bear Root • Cedar • Corn Pollen • Copal • Greasewood • Jimson • Milk Weed • Mountain Tea • Mugwort • Palo de Santo, • Peyote • Sage • Sweetgrass • Tobacco • Women's Tea	• Asking for a blessing in a sacred manner, • Calmness • Cultural connections • Gifting to show respect • Give thanks • Guidance • Help Sleeping • To honor • Personal Healing • Prayer • Smudge • Spiritual connections • Spiritual Offerings • Steady Mind • Talk to the creator • Keep bad spirits away	• Acorn Ceremony • Beading Class • Bear Dance, Sun Dance, Round Dance or other Cultural Dance • Big Time • Burning of Clothes • Coming of Age • Deer Gathering • Drumming • Feast Giveaway • Fiesta (South of Kern Valley) • GONA • Longhouse • Moon Ceremony • New Years • Pot Latch • Pow Wow • Puberty Ceremony • Repatriation • Running is my High • Spring Ceremony • Story Telling • Sunrise Ceremony • Sun Rise (Alcatraz) • Sweat Lodge • Traditional Tattoo • Washing of the Face • Wiping of Tears • Young Men's Ceremony • Yuwipi	• Spirit Plate • Thank You Ceremony • Special Feast • Community Feed • Other….	• Ceremonial Leader • Cultural Teacher • Doctor • Elder • Father • Feather Man • Feather Woman • God Father • God Mother • Head Heir • Head Man • Head Woman • Medicine People • Mother • Mother Bear • Regalia Leader • Spiritual Person • Timiiwal • Top Doc

Example List #6
• Eagle Feather • Condor • Flicker • Humming Bird • Raven • Hawk • Turkey • Quail • Woodpecker

4. Herth Hope Index (Abbreviated Herth Hope Index) and Scoring Instructions

(Permission from the author must be obtained prior to use)

Herth, K. (1992). An abbreviated instrument to measure hope: Development and psychometric evaluation. *Journal of Advanced Nursing*, *17*, 1251-1259.

Study No. _____

HERTH HOPE INDEX

Listed below are a number of statements. Read each statement and place an [X] in the box that describes how much you agree with that statement right now.

	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
1. I have a positive outlook toward life.				
2. I have short and/or long range goals.				
3. I feel all alone.				
4. I can see possibilities in the midst of difficulties.				
5. I have a faith that gives me comfort.				
6. I feel scared about my future.				
7. I can recall happy/joyful times.				
8. I have deep inner strength.				
9. I am able to give and receive caring/love.				
10. I have a sense of direction.				
11. I believe that each day has potential.				
12. I feel my life has value and worth.				

1999 items 2 & 4 reworded

SCORING INFORMATION FOR THE HERTH HOPE INDEX (HHI)

Scoring consists of summing the points for the subscale and for the total scale. Subscales are based on the three factors (see Table 2 in 1992 publication). Total possible points on the total scale is 48 points. The higher the score the higher the level of hope.

Note the following items need to be reversed scored: 3, 6. Score items as follows:

Strongly Disagree = 1
Disagree = 2
Agree = 3
Strongly Agree = 4

HHI has been translated into Arabic, Bangla, Brazilian, Chinese, Dutch, Filipino, French, German, Hebrew, Icelandic, Italian, Japanese, Korean, Malay, Norwegian, Persian, Polish, Portuguese, Russian, Slovenian, Spanish, Swahili, Swedish, Tai, Turkish, and Urdu.

Herth, K. (1992). Abbreviated instrument to measure hope: Development and psychometric evaluation. *Journal of Advanced Nursing*, *17*, 1251-1259.

Seven major instrument textbooks including Simmons, C. & Lehmann, P. (2013). *Tools for Strengths-Based Assessment and Evaluation.* New York, NY: Springer Publishing Co., Elsevier volume on *Measures of Personality and Social Psychological Constructs* by Fred Bryant and Patrick Harrison, and Schutte, N. and Malouff, J. (2014). *Assessment of Emotional Intelligence.*

TIME: Toolkit of Instruments to Measure End-of-Life Care. *http://www.chcr.brown.edu/pcoc/toolkit.htm*

International Centre for Socioeconomic Research Compendium of Quality of Life Instruments, the International Complementary and Alternative Medicine (CAM) Outcome Measures Data Base http://www.IN-CAMoutcomesdatabase

Pocket-sized reference book for physicians and other healthcare professionals edited by C. Porter Storey, MN titled: UNIPAC OR: *A Quick Reference to the Hospice and Palliative Care Training for Physicians.*

e-version of UNIPAC 2: *Alleviating Psychological and Spiritual Pain*.

American Psychological Association's PsycTESTS database.

Update 9/28/16

5. Reasons for Life Scale

Allen, J. Reasons for Life Scale.

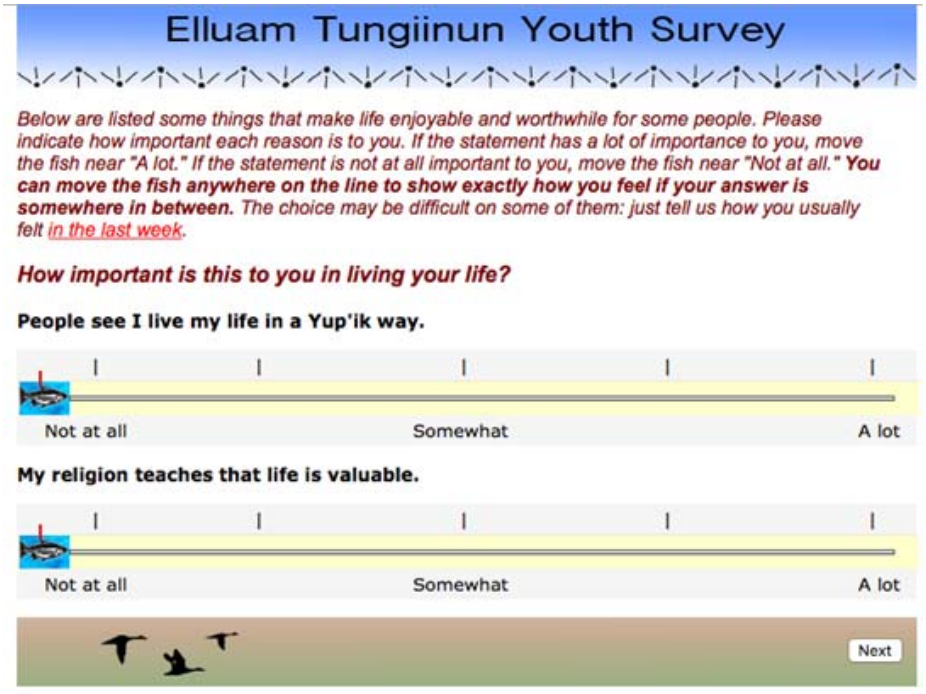
Reasons for Life (*Yuuyaraqegtaar*: "A way to live a very good, beautiful life")–(12 items, previous 9 item version, α=.79). This measure is an extension of constructs tapped in the Brief Reasons for Living Inventory for Adolescents (1), itself a modification of an adult measure, the Reasons for Living Inventory (2). Reasons for Life assess beliefs and experiences that make life enjoyable, worthwhile, and provide meaning. Subscales tap *Others' Assessment of Me, Cultural and Spiritual Beliefs,* and *Personal Efficacy*, and 2 new items are added to increase reliability. The measure provides a positive psychology approach to assessing Alaska Native cultural values associated with protection from suicide (3). [Self-report measure]

1. Osman A, Kopper BA, Barrios FX, Osman JR. The Brief Reasons for Living Inventory for adolescents (BRFL-A). Journal of Abnormal Child Psychology: An official publication of the *International Society for Research in Child and Adolescent Psychopathology*. 1996 Aug;*24*(4):433-43. PubMed PMID: 1996-01625-003. English.

2. Linehan MM, Goodstein AJ, Nielsen SL, Chiles JA. Reasons for staying alive when you are thinking about killing yourself: The reasons for living inventory. *Journal of Consulting and Clinical Psychology*. 1983;*51*:276-86.

3. Allen, J., Mohatt, G.V., Fok, C.C.T., Henry, D., Burkett, R., & People Awakening Team. A protective factors model for alcohol abuse and suicide prevention among Alaska Native youth. *American Journal of Community Psychology.* 2014;*54*(1-2):125-139.

Variables	Type
People saw I live my life in a good way.	Slider
People saw I live my life in a Yup'ik way.	Slider
People saw me do good things to help others.	Slider
People saw that I am strong and care about others.	Slider
My Yup'ik Elders taught me that my life is valuable.	Slider
I believed I must live to be an Elder.	Slider
No matter how hard things got, I believed God wanted me to live.	Slider
My religion taught me that my life is valuable.	Slider
I had the courage to face life's hardest moments.	Slider
I believed I can help others fix their problems.	Slider
I believed I can fix my problems.	Slider
I believed I can make things work out for the best even when life gets difficult.	Slider



6. Perceived Discrimination Measures (Whitbeck et al., 2001)

Whitbeck, L., Hoyt, D., McMorris, B., Chen, X., & Stubben, J. (2001). Perceived Discrimination and Early Substance Abuse among American Indian Children. *Journal of Health and Social Behavior*, *42*, 405-424.

Perceived Discrimination (response to each item 1 “never” through 3 “always”)

Global Discrimination

1. How often have other kids said something bad or insulting to you because you are a Native American?
2. How often have other kids ignored you or excluded you from some activities because you are a Native American?
3. How often has someone yelled a racial slur or racial insult at you?
4. How often has someone threatened to harm you physically because you are a Native American?
5. How often have other kids treated you unfairly because you are Native American?

Authority Discrimination

1. How often has a store owner, sales clerk, or someone working at a place of business treated you in a disrespectful way because you are a Native American?
2. How often have adults suspected you of doing something wrong because you are a Native American?
3. How often have the police hassled you because you are a Native American?

School Discrimination

1. How often have you encountered teachers who are surprised that you as a Native American person did something really well?
2. How often have you encountered teachers who didn’t expect you to do well because you are a Native American?

Prevention Research Center

Pacific Institute for Research and Evaluation

180 Grand Avenue, Suite 1200, Oakland, CA 94612 Phone: (510) 486-1111