

# CHARACTERISTICS OF INDIAN YOUTH AND DRUG USE

FRED BEAUVAIS, Ph.D.

*Abstract: The overall high rates of drug use found among Indian youth may be accounted for in part by lack of educational and employment opportunity and other endemic problems of Indian reservations. Individual drug involvement is most highly related to membership in drug-using peer clusters; but because of physical isolation, links between drug use and close friends are weaker for Indian youth, and family influence is felt more strongly. Anxiety, depression, and low self-esteem are not related to drug involvement, but angry youth are more likely to have drug-involved peers. Risk factors for Indian youth are low family caring, age first drunk, poor school adjustment, weak family sanctions against drugs, positive attitudes toward alcohol use, risk of school dropout, father not at home, and poor religious identification.*

Throughout this volume it has been clear that American Indian youth are more likely to be involved with drugs than are other American youth. Two interacting components probably underlie this drug involvement. One component involves those characteristics of Indian communities that increase the probability that their youth will get involved with drugs. The other involves those personal and social characteristics that make individual youth more likely to become drug involved. The two components are related, but they are not necessarily identical.

A major factor, for example, that increases the overall involvement with drugs is the lack of opportunity on reservations. When Indian youth look around them, what kind of future do they see? In some places there is almost no chance of finding a decent job; unemployment can be as high as 80%. There are few chances for higher education. There are scholarships, Indian community colleges and other assistance, but such opportunities are hard to realize for all but a few young people who have learned how to do well in the school system. Alcoholism has decimated the older population to the point where some small tribes have few elderly

people. Drugs may be dangerous, and they may prevent one from achieving in the future; but when the future looks this bleak, why not get drunk? Why not take drugs?

This lack of opportunity does hit some young people harder than others and may increase the individual risk of using drugs, but it has a more general effect as well. Lack of opportunity creates an atmosphere in which the chances for enjoyment are few and the immediate pleasure of getting high may be more important than any future problems that behavior may cause.

Another general social factor may involve the Indian boarding schools. Until recent years a large proportion of Indian youth had to attend boarding schools. On many reservations Indian families were physically isolated and were separated from facilities such as schools by miles of dirt roads that were likely to be drifted shut by winter snow and blocked by impassable mud from spring rains. Boarding schools were essential if Indian youth were to be provided with an education, but youth in boarding schools are separated from their families for much of the year. Their families cannot monitor them, teach moral lessons and provide sanctions against using drugs. Young people at a boarding school are not likely to impose strong sanctions against drug use by their friends, and the resulting high rates of use are apparent. Some boarding schools have shown the highest levels of drug use that we have measured anywhere.

Thus boarding school drug use can be a source of "infection" for Indian youth in general. Boarding school children come back to the reservation when school is out, they drop out of school, they move in with a relative and attend day school for a while, and some of them bring the boarding school drug culture with them. This influence is transmitted to the other youth who become their friends, creating the potential for high levels of drug involvement by other youth as well as in the youth who attended boarding school. Once these drug subcultures are well established among young people, they are transmitted to the next age cohort through siblings and cross-age friendships, and they are hard to eradicate. There is one tribe, for example, where opportunities tend to be high and where young people should have less need for drug involvement. But drug use rates are very high in this tribe, probably because until recently nearly all of the children attended boarding schools.

These societal factors, and probably others, are helping to create the generally high rates of drug use among Indian youth. But despite these high levels of use, some Indian youth manage to avoid drugs. What is it that makes some Indian youth more susceptible than others to drug involvement?

### Theories of Drug Use of Indian Youth

A considerable number of theories have been called on to explain drug use of American Indian youth. Many of the theories have serious limitations and do not do a very good job of explaining drug use.

#### **“Exotic” Cultural Element Theories**

Some theorists, for example, have tried to relate drug use among youth to use of drugs in traditional Indian culture. Although it is true that psychoactive substances are used by some tribes in Indian ceremonies such as vision quests and that peyote is a sacrament of the Native American Church, there is no Indian tradition of recreational use of drugs. The fallacious logic that suggests that these ceremonial uses underlie drug use among Indians would equally suggest that alcohol problems in Anglo society are caused by the use of alcohol in church communion ceremonies.

Even tobacco, a substance native to the Americas, was used ceremonially in Indian culture, but it was not smoked for personal pleasure. There were tribes that made corn beer, but it was not used by the individual or even by small groups; rather, it was part of a large ceremony involving everyone in the tribe. Use of tobacco by the individual and use of drugs and alcohol for recreational purposes by Indian people have been adapted from western cultures; such use is not part of Indian tradition.

#### **Genetic “Weakness” Theories**

A variety of theories have attempted to explain the high rates of alcoholism among American Indians by postulating genetic differences. Early “evolutionary” theories supposed that immigrants had a long history of exposure to “hard” alcohol and had evolved a resistance to its effects, whereas Indian people had no such history and were therefore particularly susceptible. It is doubtful that evolutionary processes could have created these genetic differences in the limited time span since the invention of distillation. Rather than serving as explanations of Indian alcohol use, these theories are better understood as attempts by the invaders to denigrate Indian people by labeling them as genetically inferior.

Recent research has examined physiological and metabolic responses to alcohol in an attempt to find differences between Indians and non-Indians. Given the current emphasis on finding genetic markers, there are almost undoubtedly researchers who are now trying to identify specific genetic markers for alcohol or drug addiction in American

Indians. If such markers exist, it might be important to know about them, as it could influence both our understanding of the addictive process and potential treatments. These types of genetic explanations, however, present a more subtle problem: an underlying tone that can all too easily be read as "blaming" Indian people for their problems. If Indians and/or alcoholics can be shown to be genetically inferior, then their problems are their fault, and little or nothing needs to be done about those problems.

Although there may indeed be some genetic traits that create a peculiar susceptibility to the effects of alcohol and some drugs, great care must be taken to avoid "blaming" existing problems on genetic weakness. There are too many other factors that underlie substance use and that need to be dealt with. Genetic susceptibility, for example, can have little to do with substance use by adolescents. With rare exceptions, they have not had enough time or enough exposure to alcohol and drugs to become "addicted." In addition, their substance use is strongly related to social and personal characteristics. Further, even if there were youth who were more susceptible to addiction, they would still need to be exposed to the substances, and that exposure is related to social characteristics, not to their physiological status.

### **Acculturation Stress Theories**

Acculturation stress theory is more acceptable since it "blames" substance use on the problems encountered in trying to adapt to a majority culture. The basic idea is that Indians are caught between Indian and Anglo cultures, that this situation creates stress and that alcohol and drug abuse occur in reaction to this stress. There is no question that American Indians are presented with a cultural-adaptation task that is sometimes a difficult one, and we have written about the problems that adolescents face in trying to adjust to two or more cultures.

As attractive as acculturation theory is, however, it does not do a particularly good job of explaining substance use. Our orthogonal cultural identification theory (Oetting & Beauvais, 1991), for example, shows that the transition between cultures does not have to be accompanied by high levels of stress. The data on cultural identification that we have collected suggest, in fact, that most Indian youth are bicultural, and with some exceptions, most youth seem to be handling the tasks of dealing with two cultures reasonably well.

The second problem with acculturation stress theory is that adolescent drug use is not related to anxiety and depression. Young people who are chronically anxious or depressed are not more likely than other youth to use alcohol and drugs.

### **Self-medication Theories**

The findings regarding anxiety and depression also create problems for another theory so widely accepted that it has almost become a cliché. Self-medication theory holds that people take alcohol and drugs in order to assuage their feelings of anxiety and depression. This is such a central belief among treatment personnel and recovering alcoholics, for example, that it is simply assumed to be the truth. Recovering alcoholics will almost invariably say, "I drank when I was depressed." The fact is that they also drank when they were happy, and they drank when they were neither happy nor sad; they simply drank all the time. Depression or anxiety might have provided an excuse, but if those feelings were not present, there were also other excuses to drink. The relationship between emotional distress and drug use will be discussed later, but that relationship is not strong enough to make self-medication a good explanation for adolescent substance use.

### **Peer-Oriented Psychosocial Theories**

If the theories I have described do not hold up well, then what does underlie drug use for Indian youth? If there is any consensus in the general studies of adolescent drug use, it is that drug use is highly related to the drug use of a youth's friends. This finding is also true for Indian youth. Although there is some exposure to alcohol through family use, getting drunk or using drugs almost always takes place primarily within the context of peer clusters, that is, small groups of close friends who do these things together.

#### **Peer Clusters and Substance Use of Indian Youth**

In the sections that follow I will discuss a long list of personal and social characteristics that can make a youth susceptible to drug use; of all these characteristics, however, adolescent drug use is most closely related to involvement in drug-using peer clusters. These peer clusters are small groups of people — best friends, couples, or small groups of close friends — who do things together. To assess a youth's involvement in drug-using peer clusters, questions are asked about how many of a youth's friends use different drugs, how much his or her friends encourage a young person to use drugs, and how much his or her friends would try to stop a youth from using drugs. Within these peer clusters drugs are made available, young people learn how to use drugs, and they talk about drugs and share their ideas so that the peer cluster develops a common set of attitudes, beliefs, values, and rationales for using drugs.

There are, of course, exceptions to any rule. We have identified a few families in which parents and children use marijuana together and at least one instance in which a family "passed the rag" (sniffed glue) after supper. These pathological families are, however, very rare. Indian parents are, almost without exception, against drug use by their children and, except for alcohol, do not use any drugs in the presence of their children.

It is not common for adolescents to use drugs when they are alone. Again there are exceptions. The youth who make up a peer cluster may decide that using marijuana while sitting alone in a field and pondering nature is the "right" way to use it. If so, then they will use the drug in that way. There will also be a few young people who begin to become dependent on a drug, and they, too, will use it when alone. But for the most part, drugs are used with other people; and those people, if you are an adolescent, will be your friends.

Peer clusters are also involved in the movement toward greater drug involvement. Either the members of a peer cluster will decide together to try a new drug or a youth will gradually merge with a different peer cluster that uses that new drug. Close friends will use essentially the same drugs; if they are using drugs, they are also likely to have other friends, not as close to them, who are using heavier drugs. If a youth has any urge to move toward heavier drug use, he or she will almost undoubtedly know someone who will provide access to those drugs.

The peer cluster provides the immediate "trigger" for drug use, but some Indian children will get involved with drug-using peers and some will not. What makes a youth susceptible to involvement in a drug-using peer cluster?

#### Problem Behaviors, Drug Use and Indian Youth

Any explanation of drug use needs to consider the fact that there are, almost certainly, different forms of drug involvement and that these forms may have different explanations and underlying roots. Drug dependency and alcohol dependency do exist; there are people who are obsessed with using these substances to the point that their use interferes with the ability of these people to function in life. There are other youth who, although not dependent, are engaged in a drug lifestyle to the point that nearly everything they do involves the use of alcohol and drugs. Young people involved with drugs this heavily are likely to have other serious problems in society as well. Drugs and alcohol, however, are also used on an occasional basis by people who do not have serious problems of any kind. Alcohol, and sometimes marijuana, can be used as part of a social life that includes parties and dating. The youth who use drugs in this way may not have any particular problems other than those inherent in being an adolescent.

Care must be used in defining problem behaviors, because a behavior that is deviant in one culture may not be deviant in another. But the kinds of problem behaviors that may be associated with heavier drug use are not acceptable in either Anglo or Indian culture — lying, cheating, stealing, or generally doing things that young people know are “wrong.” Indian youth who do these kinds of things, or who do not think that it is particularly bad to do these things are likely to get drunk more often, are more likely to use marijuana and are also likely to use other drugs.

Ten years ago marijuana was used by more than half of the youth in America. At that time, it was not at all unusual for a “good” young person to experiment with marijuana, even though he or she would not have thought of engaging in other problem behaviors. Marijuana was used in this way much as alcohol is used today. Marijuana use, however, has now become much less acceptable among American youth, and it is less likely that otherwise “good” children will experiment with it. But that change has not yet occurred among Indian youth, over one-half of whom still experiment with marijuana. That means that there are a lot of Indian youth who do not engage in other problem behaviors who are still willing to experiment with marijuana. Among younger Indian children, in fact, those who are more socially comfortable may even be somewhat more likely to try marijuana. Such children are slightly precocious socially and are imitating older children. The data on trends in use, however, show that with every year that passes American Indian children are less and less willing to experiment with drugs, including marijuana.

Although “good” kids may experiment with drugs, the regular use of marijuana or the use of other drugs is much more likely to occur among Indian youth who are also showing other problem behaviors. Those young people who are engaged in a drug lifestyle are very likely to be doing other things that are “wrong” both from an Indian and from an Anglo point of view.

The most deviant children — those with the most serious problems — are likely to be the children involved in chronic use of inhalants. Young Indian children are much more likely than other youth to experiment with inhalants, and this early use of inhalants is a warning sign and should be treated seriously. But children can grow out of that use. If they do not, and if they are still using inhalants regularly after the age of 15, it is a sign of very serious problems. Chronic inhalant users are very likely to drop out of school and are likely to become more involved with other drugs as well. They are almost never able to get along in either Indian or Anglo society. Their lives are likely to be disasters.

### Socialization Links and Drug Use of Indian Youth

A child learns social attitudes, beliefs, values, and behaviors through involvement with other people. The immediate family is clearly

the most important socialization force in the young child's background, followed closely by the extended family. Later there is increased involvement in other subcultures — the school, religion, the community, and peers. For older Indian youth there may also be involvement in a clan or other cultural society. The community is an important factor, as it provides the surrounding environment in which all of these other interactions take place. The community that people live in has been shown to be related to drug involvement; when there is a general social pathology in the community, then drug use is related to the extent of that pathology. Problems in Indian reservation communities have already been discussed; clearly, those problems may have an influence on the overall extent of alcohol and drug use.

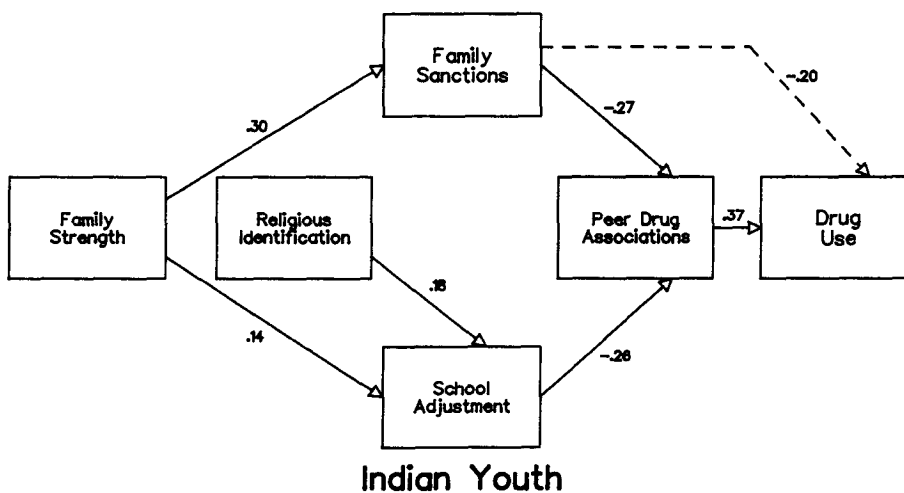
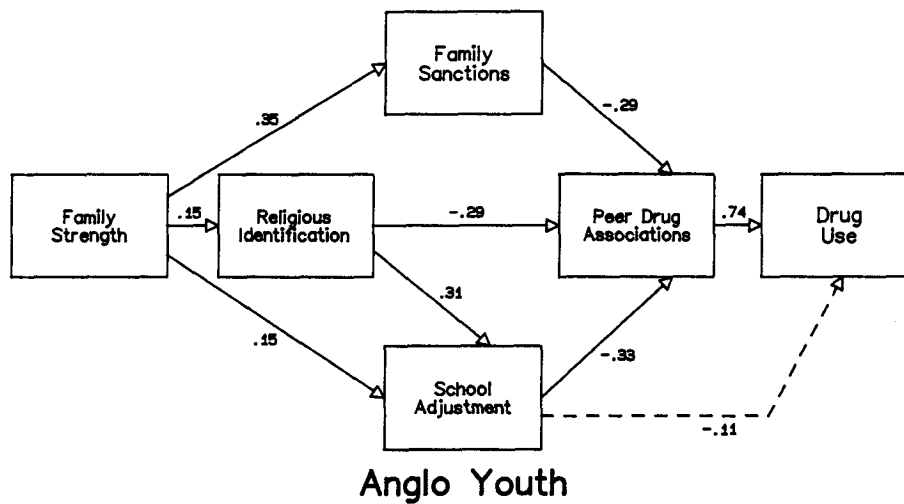
Within communities other socialization forces have a strong influence on whether a youth gets involved in drug-using peer clusters. Path diagrams are a way of illustrating how the different characteristics are linked and how they interact in relating to an outcome. The path diagram in Figure 6–1 shows how these socialization links fit together for Anglo and Indian youth. These results are valid for one set of Indian tribes; data for a different set of tribes might lead to slightly different results, but the overall patterns are likely to be similar.

In many ways the path diagrams for Anglo and Indian youth are similar. They show that the most important factor in determining drug use is whether the youth has "peer drug associations," that is, whether an adolescent is involved with drug-using friends. In showing this link, the models illustrate peer cluster theory — that is, when drugs are used, they are likely to be used with friends.

The models for Anglo and Indian youth are also similar in other ways. Drug use may be a direct consequence of having drug-involved friends, but what determines whether an adolescent will build relationships with other youth who use drugs? Among both Indian and Anglo youth, the two socialization factors that have the most potency for preventing involvement with drug-using friends are school adjustment and family sanctions against drugs. A glance at the models shows that having a strong family can be the basis for both of these factors: the strong family is likely to provide support and encouragement for its children to improve school adjustment, and the strong family is likely to provide strong sanctions against drug use.

Young people who are having trouble in school tend to find each other. They are not getting any rewards from school, and they frequently have other problems as well. They are likely to form peer clusters that have a high potential for deviance, including alcohol and drug use. The same thing is likely to happen if the family does not provide strong messages against using drugs. Nearly every Indian family is against drug use, but some families get this message across to their children better

Figure 6-1  
Path Models Linking Socialization  
Characteristics to Drug Use



than others. Adolescents from families that do not provide strong sanctions against drug use are likely to find each other, and the resulting peer clusters also have a higher potential for deviance and the abuse of alcohol and drugs.

Family strength is the foundation of both the Indian and the Anglo diagrams. A youth from a strong family is likely to do better in school and to have received strong messages against drug use. Good school adjustment and strong family sanctions against using drugs are the major socialization forces that act to prevent peer drug associations. Children from strong families are likely to make friends with each other instead of making friends with youth who have problems, and the resulting peer clusters are likely to avoid getting involved with drugs.

Although the basic relationships between socialization links and drug use are the same for Indian and Anglo youth, there are also some differences that can be important. Peer clusters are the primary source of drug involvement for Indian youth, but the relationship is not quite as strong as it is for other youth. Reservation Indian youth are likely to be physically isolated, making it more difficult to get together with friends. Because of the isolation, reservation youth are also more likely to depend on similar-age relatives for shared activities. They may use drugs with these family members; if they are drug involved, they may use drugs when they get together with other drug-using youth whether or not their friends are present. Therefore the direct links between peer clusters and drug use are not quite as strong among Indian youth. This may also explain why family sanctions have a direct effect on the drug use of Indian youth in addition to the effect of peer influence. This link is not present for Anglo youth. It is possible that this direct influence of the Indian family is another result of relative isolation, so that Indian adolescents associate more with family members and spend more time with same-age relatives than other youth do.

Religious identification also has less influence among Indian youth. Anglo youth who label themselves as religious and who participate heavily in religious activities are likely to make friends who have the same values. These peer clusters are likely to avoid drug use. Religious involvement, defined in this way, does not have the same effect for Indian youth, a factor that may be related to Indian culture. In the tribes that participated in this particular study, some Indian youth belong to formal churches and others do not. Many Indian youth participate in cultural activities and tribal ceremonies having an Indian religious meaning suggesting that being religious and participating in religious activities may have a different meaning to Indian youth from these tribes.

Despite the differences, the general principles hold up well for both Indian and Anglo youth. A strong family underlies and is related to doing well in school and to providing strong sanctions against drug use — factors that, in turn, help adolescents form friendships with other youth

who are less likely to use drugs. The better the youth's relationships with the various socialization links in his or her life, the less likely that youth is to get involved with drugs.

#### Emotional Distress and Drug Use of Indian Youth

Self-medication theory implies that people who take alcohol or drugs do so to get rid of their negative feelings. Although it has never held up well in research studies, this theory has such a strong following that it is difficult to argue against it. The theory has some apparent logic, which begins with the assumption that the people who have problems in society are more likely to get involved with alcohol and drugs. People who are having problems must feel bad about those problems; they must, therefore, suffer from anxiety, depression, and low self-esteem. Drugs and alcohol, at least initially, make people feel good. Because taking drugs makes people feel good, and people with problems must be feeling bad, then the reason that they use drugs is to make themselves feel better. This logical chain appears to be reasonable, but research results do not confirm it.

There are other reasons that people want to believe in self-medication theory. Recovering alcoholics and drug addicts remember getting high when they felt bad. Their recovery programs emphasize this relationship and try to prepare them to fight it — a reasonable goal for treatment programs because alcoholics will find any excuse to drink and “feeling bad” is a marvelous excuse. If recovering addicts were not convinced already, their treatment programs ensure that they will become convinced that negative feelings were the reason they used alcohol and drugs.

Psychologists and psychiatrists in western society also have a vested interest in self-medication theory. Their basic model is one of personal responsibility; a patient's problems occur because of a deficiency in the patient and are treated by getting rid of that deficiency. Theories of personality and psychotherapy held by psychologists and psychiatrists emphasize the importance of personality traits as sources of the deficiency and view behavior as growing out of those personality traits, so self-medication theory fits in with the professionals' own theories very well. American Indian theories of illness, however, are less likely to place the burden of responsibility for his or her illness on the patient and may be less congruent with self-medication theories.

Self-medication undoubtedly does occur. There are people who chronically feel bad and who find that alcohol or a particular drug assuages that feeling. The best example may be the tranquilizers, which sooth tension and smooth out the rough ups and downs of emotions. People under chronic stress may find tranquilizers valuable or even essential to getting along. The few people who find that an illicit drug provides this relief are in grave danger of becoming dependent on the drug.

Adolescents who are into a drug lifestyle do take drugs when they feel bad, but self-medication is only one of many reasons for their taking drugs. The most common reason for using drugs is to "have fun." Adolescents use drugs as part of being at a party. They take drugs in order to do something with friends that feels good and that involves sharing something secret. They use drugs together to rebel against the adults they are often battling. It is fun to get high, to share the wild feelings and jokes and to talk about it afterward. Adolescents even use alcohol and drugs because "there is nothing else to do around here." If these are the reasons that adolescents use drugs, then drug use is related to peer clusters and not to self-medication.

The path models provided in figure 6-2 show how emotional distress relates to drug use and are essentially the same for Indian youth and for Anglo youth. These path models show that being emotionally distressed does not directly increase the use of drugs; peer drug associations are still the major factor related to use of drugs. Drug use is a peer activity for both Indian and Anglo youth, not a response to feeling bad. Furthermore, being anxious, depressed, or having low self-esteem does not directly increase the chances that a youth will become involved in a drug-using peer cluster. The only emotional element that increases involvement with drug-using peers is anger. Angry youth may tend to find other angry youth and form peer clusters with them that are more likely to be drug involved.

Although the basic path structures are essentially the same, there are some differences between Anglo and Indian youth. As expected from the studies of socialization links, the relationship between peer drug use and drug involvement is somewhat weaker for Indian youth, but it is still the dominant relationship. The only other difference occurs in relation to depression and anxiety. Being emotionally distressed does increase the chances that a youth will also be angry, but among Anglo youth anxiety is more likely to lead to anger whereas among Indian youth depression is more likely to lead to anger. There is not enough information available at this time to explain why these paths differ for Anglo and Indian youth. The most important finding is that self-medication theory, for all of its popularity, is not a good explanation for the drug use of Indian youth.

### Risk Factors and Drug Use of Indian Youth

The previous sections of this paper have indicated that there are a number of different factors that increase the risk of drug use for Indian youth. In our studies we have examined the following: (1) peer drug associations, (2) deviance, (3) low family caring, (4) age first drunk, (5) poor school adjustment, (6) weak family sanctions against drug use, (7) positive attitudes toward alcohol use, (8) risk of school dropout, (9) father

not at home, (10) anger, (11) depression, (12) anxiety, (13) low self-esteem, and (14) poor religious identification. The emotional distress characteristics had such low correlations with drug use that they were dropped from further analyses. Once those variables were dropped, the number of different risk factors present was directly related to the chances that a youth would be involved with alcohol or drugs.

As might be expected, a few of the youth who had none of these risk factors did use drugs. A fair number used alcohol and got drunk, and a few had tried marijuana or even another drug. Alcohol and drug use, particularly at parties, tends to be socially acceptable among Indian youth, and some of the adolescents who do not have problems and are not deviant in any way will try drugs in social circumstances.

Having two or three risk factors, no matter what they were, considerably increased the chances of an Indian youths' getting drunk or using marijuana but only moderately increased the chances of using other drugs. With each increase in the number of risk factors above two or three, however, the chances of heavy drug use increased greatly. Youth with five or more risk factors were likely to be in trouble, less than 2% remained entirely drug free. More than one-fourth of the youth with six or seven risk factors were using multiple drugs and were using drugs so heavily that they were probably involved in a drug lifestyle; taking drugs was a part of almost everything that they did with their friends.

Our list of risk factors is probably not exhaustive; there are likely other risk factors that we have not considered that also increase the chances of drug use. But despite that qualification, this list is important. A major point is that these are the same factors that increase drug use of non-Indian youth. Young people who have problems are more likely to get drug involved, whether or not they are American Indians. Furthermore, it is not the exact nature of the risk that is important, it is whether that risk is there. The more problems that adolescents have, the greater the chance that they will increase their problems even further by using drugs.

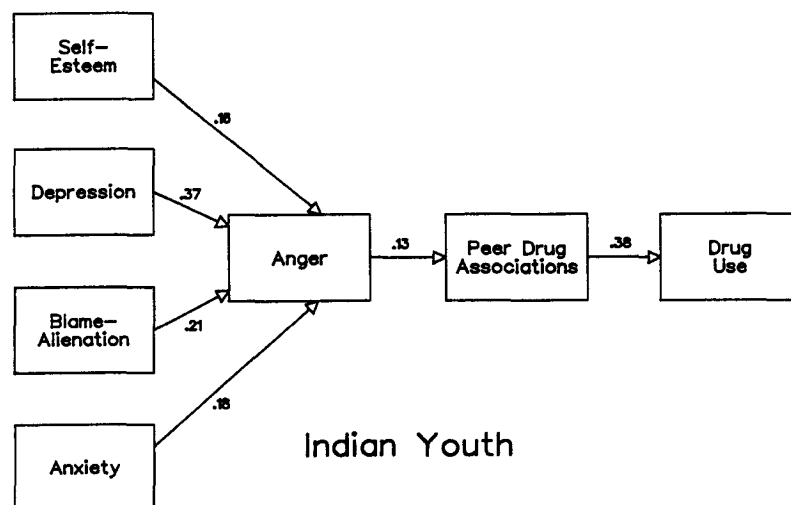
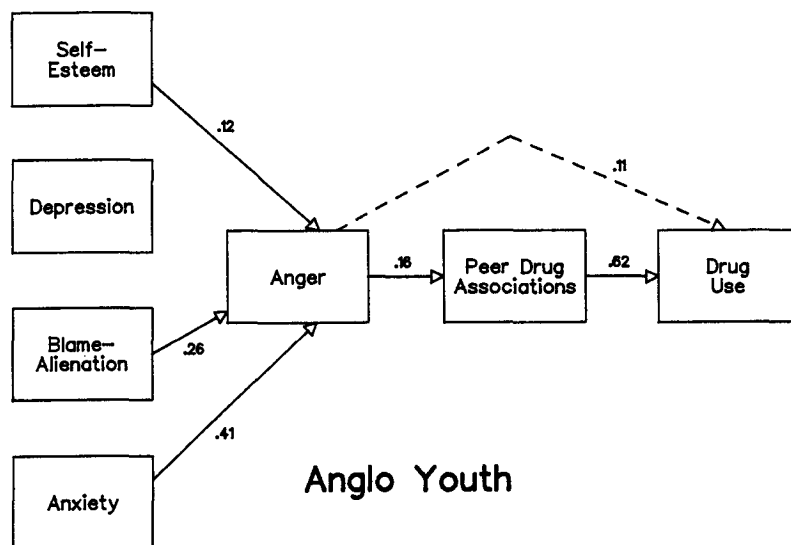
### Preventing Drug Use of Indian Youth

There are two types of factors that underlie the drug use of Indian youth: (1) community characteristics that create an environment where drug use is high and (2) personal and social characteristics that increase the risk for individual Indian youth. In order to reduce the demand for drugs, it will be necessary to attack the problem at both levels.

### Community Factors

At the community level, it is essential to build a basic community structure that offers future opportunities for youth — chances for employment and for rewarding involvement in community activities and Indian

Figure 6-2  
Path Models Linking Emotional  
Distress to Drug Use



culture. Indian communities still experience great problems in social, economic and environmental domains, and many of the problems constitute critical obstacles severely blocking potential for both tribal and individual success. Further, many Indian communities are often geographically isolated, restricting access to the economies that provide better employment, enhanced job training, and quality educational opportunities. It is essential to emphasize the development of basic opportunity within these Indian communities. In order to make progress in reduction of destructive behaviors, a primary goal must be to provide an environment that offers a secure future for American Indian youth and their families. Further, the opportunity structure of the community needs to be congruent with Indian values and goals. American Indians must be allowed to acquire the skills, expertise and proficiencies of the dominant culture without losing their identities or cultural support systems.

### **Reducing Risk Factors**

Beyond that, if the personal demand for drugs is to be reduced for high-risk Indian youth, it is essential to develop programs that will identify youth at risk and that will alleviate the damaging effects of the risk factors that underlie drug use of Indian youth.

The family is a critical component, a source of strength and a potential source of problems. It is essential to create an atmosphere receptive to both the immediate and the long-term needs of American Indian families. This atmosphere can evolve through collaborative community efforts that begin with a local task force or council to assess community needs, identify challenges and develop strategies to plan positive actions. These partnerships should include elders, tribal programs, cultural centers, school staff, the tribal newspaper, council members, families, and youth. Cultural themes can be used for community events — art shows, children's events, family events, tribal awards, and ceremonies, fun runs or walks for wellness, and youth involvement in media efforts. Businesses and tribal agencies can be encouraged to offer support for higher education, job training, employment "internships," and "jobs for a day" for both youth and parents.

Schools must develop a written policy on drug and alcohol use that is adhered to at all times and in all instances and one that is aimed toward positive outcomes rather than strictly punitive efforts. For instance, a first offense might require an in-home family visit to apprise parents of the situation and offer prevention information. The consequence of second offense might be a family visit to the drug and alcohol center for a full assessment of the youth and his or her use. One problem is that Indian families often have weak bonds with the schools. School-family advocates should be trained and used to increase parent-school bonding, thus

allowing opportunity for greater success due to decreased dropout and school failure. Advocates might need to make home visits to get to know parents, eat with them and visit in a relaxed atmosphere in order to provide efficient community and tribal referrals for services if needed.

Curricula should not be the only intervention provided by schools, but curricula used must be culturally significant for the area and comprehensive and must focus on interpersonal and relationship skills, family communication, health and wellness, tribal traditions, decision making, stress and coping, and job readiness. Counseling efforts could include focus groups with various life skills themes and early intervention in problem behaviors. Some schools have successfully used peer leader programs and other cultural activities such as sports, dance troupes, drumming, singing traditional songs, and cooking area Indian foods.

It is essential to provide early identification and intervention at the younger ages — in preschool or Head Start programs — and to continuously track “signal events” (Pink, 1984) that initiate and establish school failure among American Indian students. Prevention of school failure and enhancement of school success for Indian youth are imperative if potential for opportunity is to be realized later.

Programs for parents might offer a “Parents’ day out” and entertainment and recreational events that allow family members to enjoy one another in a tribal or community atmosphere. Prevention messages can be subtle, with the primary focus on family and perpetuation of tradition. Opportunities must also be created for parents through job enhancement training, communication and decision-making activities. Home videos or fun workbooks can be provided for parents who find it difficult to attend because of limited transportation, but special efforts should continue to be made to get these isolated families to come to programs.

Finally, elders are often overlooked as valuable and vital resources for an Indian community. The experience and wisdom of elders can offer a wide range of insight and support in a variety of settings. Elders can teach tradition and provide positive identity models, offer family support, and teach social and moral values through storytelling and other traditions. Elders can accept the challenge of teaching American Indian youth to adopt the attitudes and characteristics that make the Indian culture valued and unique.

When these types of community interventions are implemented, they can positively impact the personal and social factors that lead to problem behaviors. There is strong evidence regarding the interrelationship between problem behaviors and the application of a multiple-risk-factor model for American Indian adolescent substance use. This evidence supports current prevention theories, stressing the need for multidimensional and traditional approaches that are focused on peers, family, school, and community. Given the level of substance use and

dropout statistics among American Indians as compared to non-Indians, it is urgent and imperative that we address the lack of opportunity for Indian youth. Although this problem certainly presents a major challenge, it is one that must be met soon in order to see positive impact in American Indian communities.

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