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Taking what we have and making what we need: Utilizing Natural Helping Support Networks to decrease self directed violence among Adolescents of Color.

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The National Hospital Ambulatory Medical Care Survey "estimated that in 2004, 535,000 visits to U.S. hospital emergency departments were for self-inflicted injuries" (Centers for Disease Control and Prevention [CDC], n.d., p. 1). Adding the concern, "over 70 percent of people who engage in suicidal behavior never seek health services" (CDC, n.d., p. 1). Subsequently, self-directed harm among Black adolescents is a public health concern, leading the CDC to call for interventions that address this issue (CDC, n.d.; CDC, 1998).

Social connectedness has been found to be a mitigating factor in reducing self-directed harm in adolescent youth. However, despite the strong correlation between social connectedness and lowered risk of self-directed violence, very few interventions use social connections as mediators. Henceforth, this article identifies the risk and protective factors associated with self-directed violence among Black adolescents. Moreover, this paper highlights the need to reexamine the definition of self-directed violence to include factors associated with an individual's social and physical environments.

Likewise, this article provides a brief interdisciplinary review of current trends and historical data on self-directed violence by Black adolescents. More specifically, this paper highlights the following factors: a lack of culturally appropriate interventions, mental illness, and the complex nature of social constructs in communities of color. All of these factors make solving the problem of self-directed violence difficult. Thus, this article introduces the "Taking What We Know" (TWWK) intervention model, which highlights the inherent strengths of the Black community.

Drawing from existing models, the TWWK model utilizes informal helpers as an intervention to decrease health disparities experienced by Black adolescents in self-directed harm. The TWWK is a theoretical framework and culturally tailored model that utilizes informal helping networks. The proposed framework focuses on increasing awareness and education about self-directed violence within the informal helping network while increasing adolescent knowledge about self-directed violence.

Self-Directed Harm

The Centers for Disease Control and Prevention (CDC) define self-directed violence as "suicide death caused by self-directed injurious behavior with an intent to die" and as "non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior" (CDC, 2016). The behavior need not result in injury and might involve only suicidal ideations and thinking about, considering, or planning suicide (CDC, 2016). Recent qualitative work suggests that Black cultural

definitions of suicide, which are based on religion, may explain the low suicide risk among Blacks. It has also been suggested that although Black adolescents do not commit suicide at the same rate as other groups, they engage in greater self-harm (Gratz et al., 2012; Stack, 1998), which is behavior that breaks or bruises the skin but is done without suicidal intent. Moreover, self-harm is also associated with a higher risk of suicide.

As with many health-related behaviors, consideration of cultural factors that may influence the behaviors of Black adolescents, such as religion, stigma, and other social determinants, is key for identifying meaningful solutions that will reduce self-directed harm. In 1998, the CDC published a brief report titled *Suicide Among Black Youths—United States, 1980-1995.* One of this report's recommendations for further study is that "a better understanding of the risk factors associated with suicide among Black youths is needed in order to develop appropriate prevention and treatment programs" (CDC, 1998, para. 11). The CDC also recommended that "evaluations of existing programs to prevent youth suicide should examine the potential for differential effects on black youths" (CDC, 1998, para. 10). Extending the CDC recommendations, self-directed violence research and evaluation measures and definitions should be expanded to include an assessment of the psychological and emotional distress that Black adolescents face. Based on the current trends, careful consideration as to how self-directed harm, self-violence, and suicide behaviors manifest among Black youth is an apparent need. In other words, the intent to die may in fact be present but expressed differently in communities of color. Moreover, the development of a culturally appropriated intervention model that is specifically tailored to Black adolescent youth could serve as an opportunity to effectively evaluate self-directed harm in this community. Furthermore, it is an opportunity to collect data on how self-harm behaviors present differently in Black adolescents while increasing "accurate and culturally sensitive interpretation of findings" (Hayes, 2008, p. 219).

Prevalence of Suicide and Self-Harm Among Black Youth

The rates of suicidal behaviors among Black adolescents are challenging to address. One study found that among Black youth, 3.2% reported having some suicidal thoughts during the past year and 1.4% reported attempting suicide (Joe, Baser, Neighbors, Caldwell, & Jackson, 2009).Suicide is the third leading cause of death among Black youth (Suicide Prevention Resource Center, 2013). Black teenagers are more likely to attempt suicide than their white counterparts, with 8.3% of Black

teenagers attempting suicide, compared to 6.2% of white teenagers (CDC, 2015).

The CDC (2015) High School Risk Behavior Survey reported that 11% of Black males and 18.7% of Black females in grades 9 through 12 indicated that they had seriously considered suicide, and 7.2% of the male respondents and 10.2% of the female respondents reported that they had attempted suicide (CDC, 2015). The CDC (1998) reported that from 1980 to 1995, the suicide rate among Blacks aged 10 to 14 increased 233%, compared to a 120% increase among non-Hispanic Whites.

According to a report conducted by the International Society for the Study of Self-Injury (ISSS, 2017), 12% to 24% of young people engage in self-injury; however, much of the attention devoted to cutting focuses on the experiences of White youth, and only a small amount of the research on self-injury explores the experiences of ethnic minority youth (Gratz et al., 2012). Although the intent of self-harm is not suicide, the presence of self-harm behaviors increases the likelihood that an adolescent may consider or attempt suicide (ISSS, 2017). Researchers have found that although most acts of self-injury are not accompanied by suicidal thoughts, evidence suggests that those who have self-injured are more likely to attempt suicide than those who have never self-injured (ISSS, 2017). Engagement in self-harm increases two important risk factors for suicide among youth: 1) the experience of emotional distress and 2) the experience of inflicting pain and injury on oneself.

Turning to demographics, Black boys are the most likely to engage in deliberate self-harm, followed by White girls. Black youth in middle school reported higher rates of self-harm than their White peers. Among high school students, however, the rates of self-harm were higher for white youth, a demographic group that had shown significantly lower rates in middle school. Finally, Black adolescent males engage in self-harm behaviors at significant rates (Gratz & Tull, 2011).

Previous research indicates that suicide, self-directed violence, and self-harm among Black youth is a national concern. Accordingly, racially and ethnically centered focused research will offer more information about the differential experiences of Black adolescents with these areas of risk while offering an intervention method to reduce such occurrences. Self-harm, self-directed violence and suicide are challenging issues to address within the Black community because of cultural stigma and the community's identity, which is associated with strength for enduring and persevering amid historical and contemporary hardships. A lack of understanding about self-harm often leaves the parents of these youth at a loss, with feelings of parental failure.

Factors Influencing Current Trends

Historical adversity, including slavery, sharecropping, and race-based exclusion from health, educational, social, and economic resources, has translated into the socioeconomic disparities experienced by Black communities today. Socioeconomic status is in turn associated with mental health outcomes. People who are impoverished, homeless, incarcerated, or coping with substance use are more vulnerable to experiencing poor mental health outcomes (U.S. Department of Health and Human Services, 2001).

This section focuses on the psychological and social factors to which self-directed violence is attributed, highlighting the resulting health disparities and trends in Black adolescent communities. The World Health Organization (WHO) defines adolescence as a period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19, which represents one of the critical transitions in the human lifespan (WHO, 2017). Experts describe this transition as a critical period of preparation for adulthood during which adolescents reach several developmental milestones (WHO, 2017). It is during this phase, the appearance of certain health problems, such as substance use disorders, mental disorders and injuries, "likely reflects both the biological changes of puberty and the social context in which young people are growing up" (WHO, 2017).

Researchers have found that adolescents rely on their families, community, and schools as resources for learning how to effectively cope with peer pressures while transitioning to adulthood (WHO, 2017). The pathways by which social support influences self-harm behavior include level of family involvement in adolescent lives. Additionally, personal, family, community, and societal connectedness are all relevant factors in contributing to self-directed harm (CDC, n.d.).

During the transition to adulthood, "adolescents establish patterns of behavior and make lifestyle choices that affect both their current and future health" (CDC, 2015). Recognition that adolescents are not fully mature and are often less capable than adults in making life-changing decisions suggests that their social environments and networks are significant for helping them to make healthy lifestyle choices.

The major risk factors for self-directed violence have been identified as prior suicide attempts, substance use, mood disorders, and access to lethal means (Suicide Prevention Resource Center & Rodgers, 2011). Adding to these factors, youth in high-crime environments are more likely to suffer the loss of a loved one, to be victimized, to attend

substandard schools, to suffer from abuse and neglect, and to encounter too few opportunities for safe, organized recreation and other constructive outlets (U.S. Department of Health and Human Services, 2001).

Racial inequality theories suggest that racial and economic oppression experienced by Black youth may increase their vulnerability to self-directed violence (Spann, Molock, Barksdale, Matlin, & Puri, 2006). Social factors such as poverty, unemployment, mass incarceration, residential segregation, and low-quality education act as "social multipliers" that alter the ability of the village to carry out its major functions and, as a byproduct, lead to an increase in self-directed violence (Wilson, 1987). Black adolescents who live in environments where they are exposed to community violence, criminal and gang activity, drug use, and poverty have a higher risk of mental illness, including depression (Ofonedu, Percy, Harris-Britt, & Belcher, 2013).

One of the most cited risk factors for suicide is a history of mental disorders, particularly depression. During the 12 months before the CDC's 2015 survey, 29.9% of students nationwide had felt so sad or hopeless nearly every day for two or more weeks in a row that they stopped engaging in some of their usual activities. Feeling sad or hopeless was more prevalent among female students. Additionally, the age or grade of a student was an indicator of his or her feeling of hopelessness. Ninth-grade males had less intense feelings of hopelessness than older 12th-grade males. In contrast, 41.5% of the 9th-grade females had feelings of hopelessness, compared to 36.3% of the 12th-grade females. When mental illnesses such as depression go untreated, suicide is often the outcome. Depression is the most significant biological and psychological risk factor for teen suicide (Galaif, Sussman, Newcomb & Locke, 2007). Depression often leads to death for younger victims and is an even more serious health concern for our youth.

Untreated mental illness has been linked to an increased risk of substance use, which is another risk factor for suicide. Storr, Pacek, and Martins (2012) reported that there is a direct correlation between comorbid disorders and adolescents suffering from substance abuse. They supported this finding by assessing youth in substance treatment facilities. They found that an estimated 70% to 80% of youth seeking substance abuse treatment have one or more comorbid disorders (Storr, Packet, & Martins, 2012). Adolescents suffering from substance abuse are more likely to be arrested, to exhibit reduced work productivity, and to be school dropouts or truants (Storr et al., 2012). Additionally, adolescents who engage in substance use are more likely to experience psychosocial

burdens, suicidal ideations, and higher levels of psychopathology (Storr et al., 2012).

The findings of a study that looked at gender and age differences in the beliefs, attitudes, and coping mechanisms of Black men and women suggest that Blacks harbor beliefs related to stigma, psychological openness, and help-seeking that affect their coping behaviors (Ward, Wiltshire, Detry, & Brown, 2013). Generally speaking, the participants in this study were not very open to acknowledging psychological problems. They shared wariness about interacting with mental health professionals, due to concerns regarding their cultural competence and the challenges of navigating the mental health system. However, despite these concerns, the participants in the study were somewhat open to mental health services and expressed a willingness to seek some form of help.

Factors that substantially decrease the risk of an adolescent engaging in self-harm, self-directed violence, or suicidal behaviors are labeled protective factors. Protective factors can be biological psychological, ancestral, and relational components that are associated with a lower likelihood of problem outcomes or that reduce the negative impact of a risk factor on problem outcomes (Suicide Prevention Resource Center & Rodgers, 2011). Major protective factors include access to effective mental health care, contact with caregivers, good coping skills and problem-solving skills, and engagement and connections in two or more of the following contexts: in school, with peers, in athletics, in employment, in religion, in culture, and in feelings of connectedness to individuals, family, community, and social institutions (CDC, 2015; National Research Council and Institute of Medicine, 2009). Black adolescents face disproportionate exposure to risk factors. Additionally, there is a historical precedence that exists within the Black community that can serve as an influential protective factor; this includes a strong sense of connectedness within the community.

Natural Helping Support Networks: A Protective Factor for Black Youth

Just as risk factors indicate when it is more likely for Black youth to engage in suicidal behaviors, protective factors indicate when the youth are less likely to engage in suicidal behaviors. The major protective factors include: effective clinical care for mental, physical, and substance abuse disorders; easy access to a variety of clinical interventions and support for help-seeking; family and community support (connectedness); support from ongoing medical and mental health care relationships; skills in problem solving, conflict resolution, and nonviolent ways of handling

disputes; and cultural and religious beliefs that discourage suicide and support instincts for self-preservation (U.S. Department of Health and Human Services, 2012).

Natural helping and support networks are defined as relational connections that exist among kin, fictive kin, friends, and acquaintances (Watson & Collins, 1982; Wilson & Musick, 1997). Natural helpers are members of a community in which people are in fellowship with one another and experience relational connections that produce common attitudes, interests, and goals. Natural helping networks are instrumental in providing assistance, emotional support, companionship, and information-sharing for members of their "village" (Wilson & Musick, 1997). Natural helping networks have the ability to increase a sense of social connectedness among their members. Being members of the same "village" does not refer to physical location but rather the quality of the relationships that are experienced and how individuals socially engage (Friedman, 2005).

Little literature has been devoted to natural support networks, and the studies that do exist were produced between the late 1970s and the mid-1990s (Watson & Collins, 1982). This time frame is consistent with the shift toward empiricism and the medical model becoming the default paradigm within the soft sciences. The medical model viewed life issues as symptoms that could be diagnosed and cured by trained professionals. A desire for many of the soft sciences to enjoy the same esteem as the hard sciences was one of the motivating factors behind the creation of a divide between natural helping networks and professional helpers. Discussions of the importance of helping support networks can be related to the social and political shift that was occurring from the late 1970s through the mid-1990s. This was also the era of political emphasis on "personal responsibility," individualism, and material gains, values that conflict with the values in the "village," which focuses on social connection and cohesion. Thus, natural helping relationships were not viewed as critical to the health of community members and were therefore deemed nonessential. Societal and historical trends of racial and class oppression, such as the "war on drugs," which led to the mass incarceration of many people of color, undermined the function of helping support networks and crippled the concept of a "village."

The function of natural helpers has been replaced with professionals and formal interventions in which families have become "cases" and life issues are labeled as "symptoms" of dysfunction. Contemporary ideas of helping include viewing "helpers" as highly specialized, degree-holding, credentialed professionals (Friedman, 2005).

These modern, formal, professional "helpers" represent different professional disciplines and do not share the same professional views regarding how to support and work with families and communities. This shift to formal/professional helping has led to decreased utilization of the natural helping networks that exist within communities. The natural networks have been dismissed as counterproductive and harmful to the health of families. This tension between the formal and natural helping networks has caused the natural network to function at minimal capacity.

Natural helping networks exist within every community; however, their level of effectiveness and engagement will vary. Natural helping networks serve five major functions that can decrease adolescents' risk of self-directed violence. Natural helpers can act as buffers between adolescents and the sources of stress. They can provide social and emotional support in the absence of parental support. They can function as lay consultants and sources for information and referrals to professionals. They can act as safety nets that keep adolescents who are demonstrating high-risk behaviors and who have an increased risk of self-directed violence from falling through the cracks and not receiving treatment. Finally, they can encourage adolescents to participate in and comply with services that address mental health issues and can reduce the risk of self-directed violence (Watson & Collins, 1982).

Existing Models

Health practitioners made significant strides in creating models and strategies that address the mental and social well-being of adolescent youth. These models include the systems-of-care model, social development strategy, and the Communities That Care model.

The systems-of-care model is a community-based method to deliver children's mental health services. The model is guided by a set of key principles, including 1) attention to the individual needs, preferences, and cultural characteristics of the child and family; 2) use of a strengths-based, rather than deficits-based, perspective; 3) involvement of families in their children's care and in program and system development; 4) cross-agency coordination and collaboration in service system management and service delivery; and 5) use of the least-restrictive service setting that is clinically appropriate (Stroul, Blau, & Friedman, 2010).

The social development strategy model focuses on fostering the success and health of young people at every stage of development (Communities That Care, 2017). Social development strategy has five components: providing the adolescent with opportunities to participate in prosocial interactions with others; providing skill enhancement learning

opportunities; providing the adolescent with feedback and recognition for effort, improvement, and achievement; acknowledging and supporting the adolescent's efforts to engage in positive bonding with community members; and providing the adolescent with clear expectations about social standards that will result in positive relationships with the community to whom they are bonded. The social development strategy has been rigorously tested in longitudinal studies and experimental trials. This research has shown that the social development strategy model can accurately predict adolescent behavior (Catalano et al., 2003; Hawkins et al., 1999; Hawkins, Guo, Hill, Battin-Pearson, & Abbott, 2001; Huang, Kosterman, Catalano, Hawkins, & Abbott, 2001; Lonczak, Abbott, Hawkins, Kosterman, & Catalano, 2002; Lonczak et al., 2001). The social development strategy is the founding framework for the Communities That Care intervention model.

Communities That Care (CTC) is a prevention-based intervention model that provides a community-based organization with a process to promote the reduction of adolescents' participation in harmful activities such as underage drinking, tobacco use, crime, and violence. The CTC model has five phases that can be implemented by a community organization (Communities That Care, 2017). Research indicates that the CTC model is effective in reducing substance, alcohol use, and delinquency among youth (Hawkins et al., 2009; Kim, Gloppen, Rhew, Oesterle, & Hawkins, 2015; Kuklinski, Briney, Hawkins, & Catalano, 2012; Kuklinski, Fagan, Hawkins, Briney, & Catalano, 2015; Rhew et al., 2016; Shapiro, Oesterle, & Hawkins, 2015). While the TWWK model possesses some comparable elements, it diverges from the CTC model because the centralizing component focuses on racial and ethnic social patterns and development. In this way, the TWWK model centers the engagement initiatives and specific intervention techniques on the knowledge of the unique cultural experiences of the Black community. The process of creating the proposed model was to integrate the successful elements of the systems of care, social development strategy, and the empowerment theory around the centralizing theme of racial and ethnic cultural social patterns.

The Making of "What We Need"
With the "Taking What We Know" Model

Grounded in the empowerment theory, TWWK model is a movement that is an "intentional, ongoing process centered in the local community" (Zimmerman, 2000, p. 43). This process involves "mutual respect, critical reflection, caring, and group participation" through which "people lacking

an equal share of valued resources gain greater access to and control of those resources" (p. 43). TWWK specifically focuses on psychological empowerment, where beliefs about one's competence and "efforts to exert control and an understanding of the socio-political environment" are critical (p. 46). Regarding psychological empowerment, Zimmerman (2000) suggested that individuals should "analyze and understand [their] social and political situation" (p. 47). These skills are developed "through participation in activities and organizations" in which individuals "model others or gain experience by organizing people, identifying resources, or developing strategies of social change" (p. 47). Measures of psychological empowerment include perceived control, critical awareness of one's environment, and citizen participation. Thus, TWWF primary outcomes include sense of control, critical awareness, and participatory behaviors.

The primary goal of the TWWK model is to take what we know about helping networks and use that information to build upon the strengths of the existing community. More often than not, academics and agencies provide rigid definitions and frameworks that can be intimidating and make natural helpers feel inferior or inadequate in comparison to formal helpers. Consider how a cross-sectional study on community-based partnerships revealed dissatisfaction between community partners and an academic medical center (Safo et al., 2016). Experts interviewed 17 Centers for AIDS Research (CFAR) community advisory board (CFAR CAB) members. The members consisted of 11 African Americans and 9 women. Researchers from the academic medical center worked with community-based organizations (CBOs) that provide HIV services in The Bronx, New York. An inductive thematic analysis revealed that CBOs lacked trust in researchers and felt that researchers' lacked respect for them. The CBOs also indicated that they felt researchers paid inadequate attention to building trust. CAB members also felt that they were inferior token members and that there was lack of communication between partners that led to disempowerment (Safo et al., 2016). These feelings can cause participant disengagement or give the appearance of noncompliance in formal helping programming. The grounding belief for this framework is that communities are full of strengths and have the ability to provide care for the community's members if they are empowered to do so. Furthermore, the social helping patterns of the Black community are largely shaped by the historical and cultural experiences of the Black community.

Not everyone wants to start a nonprofit organization, but many are willing to assist in leading a movement to produce change in their

communities. The basis of the TWWK model is not a data-driven movement but rather a movement focused on community engagement, empowerment, and individual grassroots efforts. The goal is not to train individuals to become "experts" on mental health issues but rather to empower them to act as safety nets for the youth in their communities. The TWWK model seeks to empower natural helpers to provide social support, emotional support, safety nets, and encouragement in order to specifically meet the needs of adolescents of color who are at risk of self-directed harm. The TWWK model was developed as a renaissance of social movements. The model was patterned after the legacy of natural helping within the Black community, such as the free negro school programs that were developed during the Reconstruction Era and the Black Panthers' free breakfast program in the late 1960s. Natural helpers within the Black community have traditionally been at the forefront of social movements.

The TWWK model adapts principles from other models such as the Communities That Care model, which strengthens the perspective of communities. For example, the CTC model calls for a small group catalyst to identify community leaders to form a board. The methods of delivery in the TWWK do not call for the creation of a board; instead, the goal is to engage natural helpers within the community who have frequent social interactions with adolescents. The TWWK model moves away from the service orientation seen in the CTC model and toward a serving model, where natural helpers are not providing a service based on a menu of options but are leading a movement by becoming stewards and/or servers in their community. Additionally, the TWWK model does not propose having formal service providers come into the community to impose interventions but rather proposes empowering members of the community with the idea of moral stewardship and motivating them to recognize the power and impact they have over the lives of the youth within their community. The final departure from CTC is that racial and cultural social patterns are at the foundation of the TWWK, while CTC marks them as values.

Within the TWWK model, natural community helpers are at the forefront of the progression of the initiative. Although the words "influence" and "leadership" are often used interchangeably, one can be a leader or have a position without having influence. This may prove to be a challenge to sustaining the CTC model. The CTC model relies heavily on the ability of a small group of identified leaders' willingness to serve. The TWWK model focus is not on community position or title but rather on uncovering individuals' capacity to influence while empowering them to

engage in their community, thus increasing the numbers of community members involved in the intervention. Additionally, the TWWK model is designed to empower willing individuals within the community to utilize and act on their influence. This psychological empowerment strategy can serve as a powerful preventive intervention for adolescent self-directed harm in Black communities while subsequently increasing overall community awareness and knowledge of resources to address self-directed harm.

Cultural identity is "central to health education and, indeed, all public health research and intervention" (Airhihenbuwa & Okoror, 2008, p. 47). Cultural identity and competence serve as a guiding principle of the TWWK model. Despite the important work of previous models such as Communities That Care, we all too frequently have poorly culturally informed definitions of leadership that may not always reflect how people of color define or see leaders. As a result of historical injustices, Blacks define and experience leadership differently than other groups (Forsythe, Dennis, 1972). In regard to the function of Black leadership, Forsythe indicated that "leaders are more often than not the tongue of the people" (p. 22). He also argued that "the story of the outstanding black leaders of the centuries" is a "chronicle of an arduous fight against racism, suffering and injustice" (p. 22). In other words, leadership in the Black community includes individuals who are "constantly aware of the interests of the community and [are] sensitive to group needs as well as to the currents of the environing milieu" (p. 26). Institutions such as the church have also served as leadership hubs in the Black community.

Forsythe asserted, "The Church has been the Negro's sanctuary, his tactical headquarters and a crucial means of communication between Negro leaders and the masses" (p. 25). He also pointed to the power of the church, indicating that in "1963 there were some 55,000 Negro churches in America, or one for every 200 Negroes compared to one for every 400 whites" (p. 25). The historical legacy and power of the Black church can serve as a potential leadership resource. Understanding the nature and dynamics of leadership in Black communities, while noting the difference between influence and leadership, is critical when developing interventions in communities of color. Therefore, the TWWK model expands beyond decision-makers to include those with positional influence in Black adolescent lives. For example, the TWWK model recognizes the power of the Sunday school teacher who is just as important as a church leader or decision-maker such as a pastor. This is because Sunday school teachers often have a closer connection to youth, which provides them with a unique perspective and position of influence in

the youth's lives. The nature of community building requires a broad base of community participation; therefore, the community model involves stakeholders from all sections of the community, including lay church members. This model is appropriate for individuals who are both directly and indirectly affected by self-directed harm in Black communities, from parents to salon owners.

TWWK Model Description

The "Taking What We Know" (TWWK) model is a community-based intervention system that provides natural helpers within communities the tools necessary to address self-directed violence and suicide among Black youth. TWWK focuses on the unique social patterns of minority racial and ethnic groups. While the model emphasizes Black youth, the model can be adapted to serve in other racial and ethnic minority communities. The TWWK model can be implemented and integrated in various centralized community settings. Individuals who participate should in some way be connected to the community as natural helpers. These individuals can include members of neighborhood groups, teachers, parents, youth leaders, peer youth leaders, church teachers, local barbers and salon owners, community businesspeople, and more. The most important factor here is not to identify individuals with titles but rather to empower individual contributions in the broader community.

The organizers would need to have a deep knowledge and understanding of the social and developmental patterns of the minority group. The TWWK model will provide natural helpers in "High Touch" areas—social gathering places within the community that have a significant meaning within the Black community and that are regularly frequented by Black adolescents. Examples of natural helpers within "High Touch" areas include local churches, recreational sports leagues, beauty salons, and barbershops. Based on the theoretical similarities of TWWK to the CTC model, observable community-level change may take two to five years after the intervention is initiated. The specific goals of increasing awareness and natural helper participation will be set based on the specific community need and demographics.

The TWWK intervention model is organized into four phases. There are identified outcomes for each phase, which will serve as indicators for intervention effectiveness. The key roles in the TWWK model include Community Organizers (COs) and Strong Ties Helpers (STHs). Cos are members of the community who are also connected to a formal human service system. COs are trained professionals who specialize in child and adolescent mental health and can organize in the

community. Examples of potential COs include school guidance counselors, human service professionals, school nurses, teachers, school administrators, and medical professionals. These professionals can serve as a liaison between the formal and informal helping networks. Community organizers are responsible for bringing community members together to begin the process. The most critical role of the community organizers is their role in educating and ensuring that natural helpers are equipped with resources on mental health services and provided with education on self-directed harm in communities of color. The COs will also assist in the community assessment, planning, implementation, and evaluation of the intervention based on the community's need and characteristics.

The Strong Ties Helpers (STHs) are members of the community who will work with the COs to identify natural helpers who possess a high level of influence within the community. The STHs are responsible for conducting an assessment at the community level to identify the places, times, and people within the community that have the greatest reach to adolescents of color as potential community partners for joining the movement. Once the assessment is complete, the STHs will develop a plan to disseminate the information and follow up with check-in sessions with the natural helpers. The STHs serve as the bridge between the COs and the natural helpers.

- **Phase 1: Introduction and Community Assessment Phase.** Community organizers will introduce the model to the STHs, working as process facilitators, information sources, and expert support. The COs and STHs will complete a community assessment. Assessment will occur in three forms: assessing the community to identify the influential community natural helpers; assessing the community for High Touch locations with the greatest reach to the target population; and assessing which time provides the greatest access. Here are two examples: 1.) at some churches the third Sunday of the month may be youth Sunday, so there will be more youth in church, 2.) youth are more likely to visit salons and barber shops during the back-to-school season. COs and STHs will complete the Youth Mental Health First Aid training course, which will equip them with the relevant information on how to assist when an adolescent is experiencing a mental health crisis. The COs and STHs work together to compile educational materials regarding how to spot an adolescent in the community who may be engaging in self-directed violent behaviors.

- **Phase 2: Planning/Strategy Phase.** In this phase, the STHs develop a community-wide strategy on how to disseminate information in High Touch locations. The planning and strategy phase will include identifying the most effective way to reach natural helpers—for example, through social media, email, block parties, or door-to-door introductions—to provide them with the necessary educational information about self-directed violence among teens. This phase will also include planning how to contact and garner support and participation from the High Touch areas. Finally, incorporating identification of the High Touch locations in the planning phase will assist the group in identifying the most effective time to roll out the initiative. An example of an engagement strategy is contacting a local business within the community to host a social event for the influential natural helpers. The STH can disseminate the educational information and the local mental health resource referral list. The CO can respond to questions, concerns, and possible solutions about the information provided and encourage conversation about the information provided on the warning signs for adolescents who may be engaging in self-directed violent behaviors. The COs can provide assistance with challenging situations and can address challenges that may arise in disseminating the information to the community. Thus, the COs should remain available for support and as a point of contact for updated educational materials and troubleshooting questions and concerns.

- **Phase 3: Implementation Phase.** In this phase, planning initiatives and timelines are executed. The STHs will engage the identified natural helpers in the High Touch areas and provide them with educational materials and information about local mental health resources for youth who are experiencing self-directed violence or self-harm. These natural helpers will be encouraged to participate in a local mental health first aid course, although this will not be mandatory. In this phase, the COs will survey the identified natural helpers before they have interacted with the STHs to assess their baseline knowledge about self-directed violence and self-harm and their readiness to engage in conversation with youth about those risk areas. The implementation will vary greatly from community to community. Two examples of how this might be implemented are hosting "in-service" style meetings in the High

Touch locations and providing the information to the staff during a lunch break. Another example would be to ask the pastor of the local church to allow discussion time during one of the church staff meetings. Another engagement method could be to contact the recreational sports organizing headquarters, such as the YMCA, and request time during a meeting with all the coaching staff in attendance. This model leaves room for COs and STHs to take their knowledge of what specifically works in their community and tailor the implementation to capitalize on that understanding. It is worth emphasizing that the proposed framework is not a program but a strategically focused empowerment movement. The TWWK model acknowledges that there is no "one-size-fits-all" way to carry out this important work. This strength-based perspective is a renaissance of the community-based "it-takes-a-village" perspective.

- **Phase 4: Evaluation, Check-In, and Ongoing Support Phase**. Evaluation for this model is not a scientific process but rather observational experience and an integral part of the process as a whole. The effectiveness of the model is measured through an increase in natural helpers' knowledge of how to identify adolescents who are experiencing self-harm or self-directed violence, an increase in their readiness to engage these youth in conversations on these topics, and an increase in their knowledge of and willingness to refer adolescents to local mental health services for youth. COs and STHs can decide what was effective and where there are opportunities for improvement in the engagement of natural helpers and dissemination of information. COs and the STHs can decide to survey the identified natural helpers at the six-month post-implementation phase and then annually thereafter to monitor outcomes. This data can be used to adjust the strategy and content of the intervention to meet the unique needs of their changing communities. For example, the effectiveness of the model can be examined by assessing STHs' sense of control regarding addressing self-directed harm, critical awareness of the community needs and self-directed harm in adolescents and their level of participation in community activities addressing self-directed harm. This assessment could include a thematic analysis through qualitative data and a quantitative assessment of knowledge of self-directed harm and community resources for youth engaging in self-directed violent behaviors.

The COs and STHs should keep in mind the nature of this framework as a movement rather than a program, and the primary evaluation should ensure sustainability and growth. Evaluation should be a continual process throughout the movement.

Discussion

According to the WHO (n.d.), community empowerment is "more than the involvement, participation or engagement of communities" and implies "community ownership and action that explicitly aims at social and political change". The WHO also finds that "power is a central concept in community empowerment and health promotion invariably operates within the arena of a power struggle"). The TWWK framework's primary focus is on empowering communities to act on what they already know and have the ability to do. Although training is provided, the TWWK focus is less about providing training and more about motivating and empowering—and often challenging—natural helping networks to use their influence and power to change the outcomes for youth in their community. This is a call for an uprising of natural helping networks to serve as the safety net for the kids they come into contact with every day. This model empowers natural helpers to use their influence and direct it toward the prevention of self-directed violence among youth. The model will provide the natural helpers with information regarding self-directed harm, and they can then develop solutions within the scope of their influence.

The TWWK model is unique from past models because it links historical information about "helping" in the Black community with contemporary concern for Black youth. This model is centered on what types of "helping" are racially and ethnically effective. TWWK focuses on the uniqueness of cultural social patterns and places that are at the forefront of the movement. The model shifts away from scientific methods of evaluation, as that method of evaluation may not provide the most culturally relevant evidence of the model's effectiveness. However, historical evidence of social movements within the Black community suggests that a renaissance of community-led action will lead to the desired positive outcomes.

There are several identified areas of concern with models like TWWK. Sustainability is one of those concerns. TWWK, like previous models, is volunteer-based. The progression of this model relies heavily on the willingness and availability of community members to serve as COs and STHs. However, this model diverges from previous models because it considers the fluidity of "community" concept. The goal is to increase the knowledge of all members of the community. This goal of increased

community knowledge and awareness will not be contingent upon maintaining the same group of COs or STHs. The goal is for this core group to initiate the movement and then for the conversation to spread organically through the community. This model relies heavily on the idea that members of the community want to live in a safe and healthy environment and are willing to provide support for other members of their community.

Another potential concern is the community's readiness to engage in activities or discussion around these sensitive issues. As previously discussed, there are cultural barriers around topics such as mental health, self-harm, and suicide. Some communities where these issues have been shown to be a significant problem may not be willing or ready to address such issues. In this case, COs would need to spend more time organizing and identifying methods of developing rapport with potential STHs prior to initiating the movement.

Conclusion

There is a great opportunity to access natural helping networks as a powerful first line of defense for combating self-directed harm in Black adolescents. Natural helpers are a protective factor and a key contributor in reducing self-directed harm. As social workers, health educators, and community activists seek to identify methods of combat, the TWWK model is a proposed mechanism for confronting the problem.

Comparatively, the use of a natural helping model as a means for reducing self-directed harm in Black adolescent communities opens an opportunity to add to the limited research on self-directed harm among Black adolescents. This framework also moves away from service-led models where communities choose from a menu of services provided by practitioners and toward a serving-oriented model where members of the community lead a movement by becoming stewards and/or servers in the community. Rather than providing a service, they serve and work on behalf of the community. Lastly, this framework specifically targets the informal network, a group to which most Black adolescents already turn for help, while providing a new model that supports the importance of informal networks as a protective factor against self-directed harm. A renaissance of community empowerment is arguably the most significant factor in this model. Through empowering the natural helpers within the community, these helpers can have a significant impact in effectively engaging helping networks to reduce self-directed violence among the adolescent Black youth in their community.

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