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The Healing Forest Environmental Prevention Process: Community Effectiveness through Coalition Program Evaluation

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I. SUMMARY OF THE WELLBRIETY® PROGRAM DEVELOPMENT

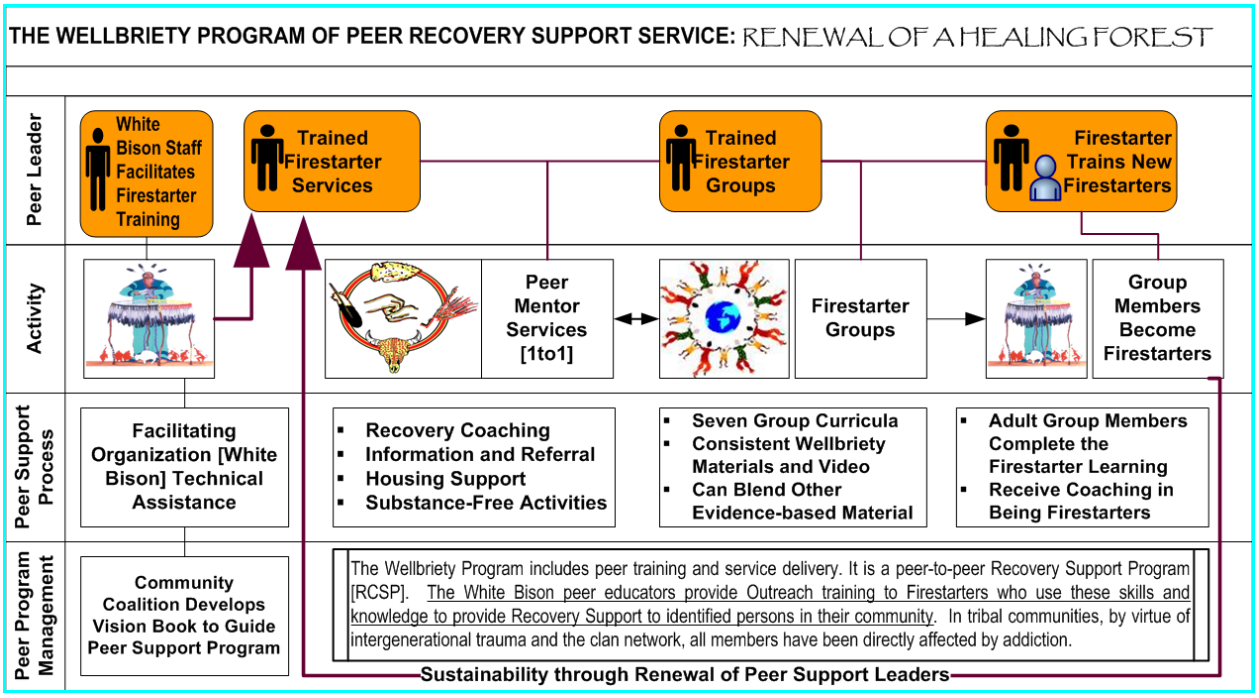
The underlying epidemiology of substance abuse, domestic violence and intergenerational trauma is the focus of Wellbriety®. Substance abuse and inter-generational domestic violence afflict communities across the country. Among the Indian Nations of North America, this is a particularly acute multi-generational trauma that infects communities through cultural gaps in the fabric of its families[1]. These community vulnerabilities can be traced to: a) the introduction of European diseases that created a crisis of untimely deaths in clan leadership; b) the dissemination of alcohol that created the spread of intoxicated behavior within clan and family[2]; and, c) the removal of future generations of Indian children to boarding schools to eliminate their culture and language before returning them to their communities to repeat a cycle of parental trauma.[3]

Wellbriety® curricula create a Healing Forest that can generate individual and community recovery and resilience. Over the course of cultural fact-finding hoop journeys [1998-2002], through the Indian Nations of North America, White Bison developed cultural teachings to replace the community vulnerabilities through a) introduction of historical teachings of the elders with talking circle groups, b) replacing alcohol use with addiction recovery and abstinent cultural activities, and c) using a Medicine Wheel 12 Step model of renewing cultural traditions in the community's youth.

The Firestarter-based Peer Recovery Community Support Program provides community ownership of the Healing Forest. In 2002, White Bison brought their initial Healing Forest curricula to a new SAMHSA initiative[1] that focused on creating Recovery Community Support Programs for substance abuse prevention and the development of peer support systems[4] to manage them. The Clan traditions of the Indian nations had a similar, community-organized, health and social support philosophy[5]. White Bison named the peers that would drive the Wellbriety® community support program "Firestarters." White Bison took part in the Recovery Summit of 2005[6] with their Firestarters' training process; using the Wellbriety® curricula and becoming an integral part of the SAMHSA RCSP movement. Firestarters, oriented to the clan model they were derived from, were also known as recovery services coaches. These men and women were trained in Wellbriety® with the facilitative and leadership skills to coordinate and deliver a range of culturally appropriate social supports for recovery in their home communities. In 2006, in tribute to the Firestarters networks being developed across the country—the health network of the Tlingit and Haida Indian Tribes[2], with clans from Australia to Washington and into their primary tribal lands of Southeast Alaska and neighboring Canada, completed the Kootéeyaa Project[7] with the raising of the Wellbriety® Totem Pole in Sitka, Alaska.

[1] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; the Center for Substance Abuse Treatment's Recovery Community Support Programs website: http://rcsp.samhsa.gov.
[2] SouthEast Alaska Regional Health Consortium [SEARHC], associated with Central Council of Tlingit and Haida Indian Tribes of Alaska [CCTHITA]; 1046 Salmon Creek Lane; Mail to 3245 Hospital Dr., Juneau, AK 99801; Phone (907)463-4000

Healing Forest community coalitions have been designed to manage the Firestarters' Networks as the Medicine Wheel curricula has been expanded to 7 unique population groups, through: a) Coalitions as Clans, and b) the Wellbriety® Seven Trainings. From 2004-2008, the Recovery Community Support Programs became standardized to manage peer support networks[8]. In structuring these coalitions, White Bison adopted the Drug Free Communities' procedures to pass ownership of the Firestarter Program to local stakeholders' management. The Community Anti-Drug Coalitions of America[9] has, on behalf of SAMHSA, published toolkits, procedural manuals and educational materials to assist communities replicate the principles of the DFC coalitions. White Bison integrated these resources into a 5-year strategic planning based on the Native Seasons of Change model.[10] As part of the community systems' needs assessment, Coalitions as Clans adopted the Readiness for Change Model[11] which has been validated for use in ethnic minority[12] and Native[13] communities. As Firestarters targeted different parts of the community, the training expanded from the 3 core Medicine Wheel Twelve Steps Curricula for Men, Women and Family-Friends. This expansion included a Youth Medicine Wheel Twelve Steps and three child-focused programs: Daughters of Tradition, Sons of Tradition and Fathers of Tradition. There were segments on maternal and paternal skills-building in the core curricula—but, as in other ethnic communities with disproportional adult addiction and parental absence in the male community [e.g. 14,15], a specific Fathers of Tradition program was developed as the 7th Training. The final, standardized, model of the Healing Forest:



Establishing reliability and validity of the Healing Forest Program through replication. A standardized program was replicated in over 30 communities over the 8 years of the Recovery Community Support Program grants. Peer leaders from 2004-2008 [N=313] responded to the Firestarter training, led by coalition plans, with: substance abstinence, improved family support systems, improved health, and personal use of recovery groups.[16] In the Healing Forest model, the new growth of children, youth and other adults requires a healthy forest of Firestarters [adult forest leadership, mentors]. This document outlines the methods that a community can use to implement, evaluate and strengthen their Healing Forest through the seasons of change.

II. THE WELLBRIETY® ENVIRONMENTAL PREVENTION STRATEGY OF THE HEALING FOREST: AN EVIDENCE-BASED PROGRAM EVALUATION MODEL

There are two primary types of evidence-based [EB] programs. Selecting one of these as a paradigm for an evidence-based, or "model", prevention program depends on whether the program target is a specific group of children, youth or adults [e.g. parenting group, life skills group, drug education class] OR an entire community [e.g. Healing Forest, Drug Free Communities Coalition, CADCA Task Force]. The evidence base to establish effectiveness in the Native Community has historically been anchored to clan systems and seasonal cycles of change. These strategies, the second EB paradigm in the world of behavioral science, are called environmental change programs. Too often, the term "evidence-based" or "model" prevention approach has become synonymous only with the first type of program paradigm. This confusion has arisen from emphasizing the experimental science of control groups being the "evidence"[17] preferred by the Substance Abuse and Mental Health Services Administration [National Institutes of Health]. Even though the United States Department of Health and Human Services [1991] understood that this model would financially and methodologically exclude community-wide programs,[18] they created an experimental design-focused process to credential programs as "Model Programs" based on the clinical model of control groups with 1 [or limited] outcome variable[s] on individual persons. This program, called the National Registry of Evidence-based Programs and Practices, was set up to ensure "scientific rigor" which largely followed clinical psychology research models—with the unexpected consequence being that state and federal funding were only tied to this prevention paradigm [NREPP history, Michele J. Eliason, 2007].[19]

At the end of the first decade of prevention science, 1980-1990, the early prevention researchers summarized their discussions about methodological considerations for what established evidence-based effectiveness.[20] In that national Monograph, community-wide measurement, exemplified by the annual tracking of baseline substance use behaviors in the "Monitoring the Future Study",[21] was in the forefront of prevention science. It drove comprehensive research on community and coalition efforts because it could be used locally for environmental prevention strategies and correlational research to monitor broad changes in the community's youth.[22] Along with experimental design of the traditional health research, the environmental epidemiologists and their quasi-experimental design were also being used to identify evidence-based success. In the next decade, with community strategies moving away from the Centers for Substance Abuse Prevention and Treatment, and into Departments of Justice and Education's funding streams, high quality quasi-experimental research tied to the health threat of substance abuse languished among discussions of delinquency, gang violence and school dropouts.

The growth of NREPP's clinical and experimental design as the most prominent evidence base within the Department of Health. Practically speaking, the NREPP experimental approach substantially overlooked some of the first research presented to the National Institute on Drug Abuse that showed communities could effectively implement programs to prevent substance use and abuse.[23] Of the two evidence-based programs presented as state-of-the-art during the late 1980s, one was not a program itself—it was a group of multiple interventions guided by community coalitions in Kansas City MO and Indianapolis IN [Journal of the American Medical Association, 1989].[24] However, shortly after, community coalition interventions' research largely left NIDA and other U.S. Department of Health and Human

Services, with congressional authorization of Drug Free Communities within the U.S. Department of Justice; where it would stay until 2003.[25]

Categorical programs, that targeted specific groups in need of treatment or prevention, stayed within the Department of Health's funding streams and the NREPP[3] community. The SAMHSA group which would come together into what is formally known as NREPP[26,27] continued to focus on the methodology of random assignment in comparing a control with an experimental group. This type of continuing behavioral health science was a response to what the U.S. Congress felt was a poorly evaluated group of prevention demonstration projects.[28] Subsequently, an ever-expanding group of these prevention programs were given the SAMHSA gold standard designation as Model Programs that had a randomized control group evidence base of effectiveness. Today, funding from the U.S. Government, state and local entities often require grantees to use an "evidence-based" prevention program—with the explanation that they are found on searchable database compiled through 20 years of the NREPP process of clinical experimental model research--http://www.nrepp.samhsa.gov. The only community coalition strategy awarded this model designation in the database was the comparison of communities that passed laws that penalized different kinds of behaviors that facilitated adolescent drinking. With the finding that if you pass enough laws, catch and punish the perpetrators, you can, at least for a while, suppress the behavior---something behaviorists have demonstrated repeatedly over the last 65 years[29]. The trick of course being to find alternative behaviors to reinforce if you actually want long-lasting change. That is what most environmental strategies started out with. The school-community comprehensive efforts represented that type of change, beginning with the Midwestern Prevention Project, and further encouraged by Congressional Passage of the Safe and Drug Free Schools and Communities Act of 1987. As noted above, the Drug Free Communities program portion of this act, funding up to 700 coalitions annually, was moved to the Department of Justice.

At the outset, the United States Department of Education was given responsibility for the community-school coalition field research, also emanating from the Indianapolis—Kansas City environmental strategy; called the Midwestern Prevention Project.[30] The schools' component became an extremely large funding stream that was split between the states to apportion and the federal discretionary grants. Awarded in many categories, the center-piece was the funding for Safe Schools & Healthy Students[4] grants that awarded between $1-3 million annually for state-of-the-art demonstration grants. In several rural grants, the 3-year grant awards could easily reach $2,000+ for every pupil in the district.

Evolution of Program Evaluation Research--Counseling Psychology's quasi-experimental design evidence base. The other major group of behavioral scientists within the American Psychological Association, outside of those in the Clinical Division, is the Counseling Psychologists of Division 17, who, in 1987, adopted program evaluation methodology as evidence-based research.[31] This is the type of real-world research which studies a field of intervention which is ideally suited for community change. Often called quasi-experimental, the Counseling Psychology Division 17 published a range of program evaluation and quasi-

[3] The NREPP Community was first organized around prevention findings in SAMHSA's High Risk Populations Demonstration Grants, better known as the HRP Databank [Brounstein et al., 1999], then gave way to the National Structured Evaluation group mandated by the U.S. Congress (U.S. Department of Health and Human Services, 1996) transitioned into NREPP within SAMHSA.

[4] Prior to this designation, the preceding funding base was a group of $500,000 annual Demonstration Grants.

experimental designs as evidence-based alternatives to the experimental research design.[32] By 1990, these quasi-experimental designs, which often measured multiple interventions and outcomes under a unified theory of change, had become part of the American Psychological Association's multi-division professional research domains.[33]

In 2005, the federal government clearly identified Program Evaluation, with or without random control design, as an evidence-based process on which to based public funding.[5] At that point, the United States Office of Management and Budget [OMB] stated that, while Program evaluation can be based on the random control trials [RCT] design, there are often ethical, measurement or cost reasons why RCT-type program evaluation is not feasible.[34] In fact, an environmental strategy like Drug Free Communities or White Bison's DFC Model of Wellbriety®, virtually prohibits a randomized control design—since the cost would be astronomical and the ethics of denying prevention to randomized groups of children or adults represent an even higher hurdle to overcome. OMB specifically states:

> "One cannot carry out a randomized control trial to evaluate the effectiveness of a health, safety, or financial regulation program because of the legal and/or ethical problems associated with denying protection to people" [page 13, ibid].

When OMB distributed an actual list of acceptable or good performance measures,[35] a majority relied on non-RCT designs to establish evidence of effectiveness. In 2005-2006, the program evaluation process was standardized into the Program Assessment and Results Tool [PART][36] and, by 2007, PART was institutionalized through web portal reporting for internal consistency across all government agencies.[37] Each funded program through the Federal Government now has an effectiveness evaluation based on the PART evidence base.

The Drug Free Communities Program, including the Wellbriety® Model, is an evidence-based prevention program as validated by the federal PART program evaluation. DFC Coalitions have shown an evidence base of success, at the 95% level of confidence or above, in three of the four core substance use indicators[38]:

- Ninety-five percent [95%] of the DFC coalitions report positive change in the age of initiation [first use] of tobacco, alcohol, or marijuana in at least two grades.
- Ninety-six percent [96%] of the DFC coalitions report positive change in youth perception of risk from tobacco, alcohol or marijuana in at least two grades
- Ninety-seven percent [97%] of the DFC coalitions that report positive change in youth perception of parental disapproval of the use of alcohol, tobacco, or marijuana in at least two grades

[5] The Government Reorganization and Program Performance Improvement Act of 2005

III. THE SERVICE TO SCIENCE INITIATIVE: STRENGTHENING THE EVIDENCE BASE FOR WELLBRIETY® BY ENHANCING THE PROGRAM EVALUATION PROCESS

With the assistance of the Native American Center for Excellence [NACE][6], White Bison has developed program evaluation instruments to give each local community the best opportunity to replicate the evidence-based success of the Healing Forest using the environmental paradigm. This document outlines two sets of program evaluation scaffolding developed by White Bison in the past two years. This coincides with publication of its successful Firestarter outcomes[39] on top of the national program evaluation validation of the Drug Free Communities effectiveness[40]. The first is the Wellbriety® Theory of Change used by DFC-structured community coalitions. Within this structure, there are multiple measurement points that allow a coalition to track progress through both process and outcome program evaluation[41] to make decisions about effectiveness and efficiency [cost]. According to the U.S. Government Accounting Office [2008], the difference in effectiveness among the Drug Free Communities is stronger internal controls on the Coalitions' following their individual plan and procedures.[42] The Centers for Disease Control provide a range of program evaluation "tool kits" that accomplish this goal[43]. The instrumentation in this document further strengthens whatever general program evaluation efforts a coalition may undertake.

The second scaffolding is the current, July 2010, National Registry of Evidence-based Program criteria which cites three [3] dimensions of Readiness for **D**issemination and six [6] dimensions of Quality of **R**esearch. In these revised nine criteria [noted as **D-1** to **D-3** and **R-1** to **R-6** in this document] are the fundamental principles of BOTH experimental and program evaluation research. As the document looks at the necessary scaffolding for program evaluation of Wellbriety®'s Healing Forest; the nine NREPP criteria act as a checklist to ensure all relevant evidence dimensions have been reviewed.

In order to implement and disseminate an evidence-based program, there needs to be the availability of implementation materials[7]. White Bison has gathered the wisdom of the Elders, through multiple inter-tribal hoop journeys, and compiled those findings into three resource texts for curriculum development. ***NREPP Criteria D-1****.*

The Wellbriety® Program. The Purpose of a Wellbriety® Project is to build culturally effective mentoring systems through community mobilization and a supportive infrastructure. These systems will be efficiently implemented through the multicultural SAMHSA model of community volunteerism developed in Recovery Community Support Programs [RCSP][44] using culturally appropriate practices. Wellbriety® program practices, cited by the U.S. Department of Justice as a model of promising practices[45], were developed and refined by White Bison over 13 years of Demonstration Projects in over 30 Native communities. Systems are culturally adapted at the local level and supported by cross-site diffusion of effective Indian "Clan Mentoring" practices for community sustainability.

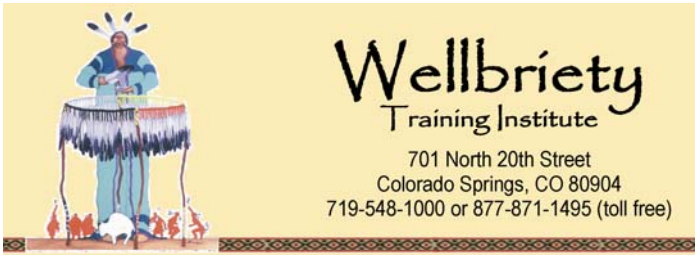
[6] http://nace.samhsa.gov/TrainingAndTechnicalAssistance.aspx
[7] Critieria 1 in the Readiness for Dissemination category of National Registry of Evidence-based Programs and Practices (NREPP), a service of the Substance Abuse and Mental Health Services Administration (SAMHSA).

"Culture-as-prevention"—Wellbriety®'s network of groups. White Bison's formative text [The Red Road] on recovery from substance abuse and its entwined community health problems of domestic violence, trauma and addictive behaviors, follows this 13-year approach.[46] Throughout this multi-tribal model, the group materials and curriculum focus on a return to traditional Native ways of children and youth development—as described in the White Bison text Understanding Native American Culture. There are special groups for children, youth and adults who have experienced substance use, the family impact of substance use and culturally-focused risk factors—particularly the impact of multigenerational trauma. The curricula for the 7 training programs have been designed with an environmental prevention focus[47] of respect, empathy and the unique spiritual roles of Native men and women. Impact indicators focus on individuals and aggregate community public health measures.

Coalitions-as-clans community sustainability. The Wellbriety® Firestarters and community stakeholders use the SAMHSA Drug-free Communities[48] structure, refined for Native communities[49], for ongoing strategic planning [Coalition Vision Book]. The environmental impact indicator of sustainability of the Healing Forest is the Tri-ethnic Center's Readiness Survey, assessed across seven domains.[50] The intergenerational trauma genesis of substance abuse and domestic violence is traced in White Bison's historical text Alcohol Problems in Native America: the Untold Story of Resistance and Recovery by Don Coyhis and William White. In addition to the U.S. DFC movement that has some communities using Wellbriety®, the country of New Zealand has also provided an evidence base for using this approach of re-orienting prevention services in a community through a coalition of traditional health care resources and Native leadership using an indigenous cultural approach[51].

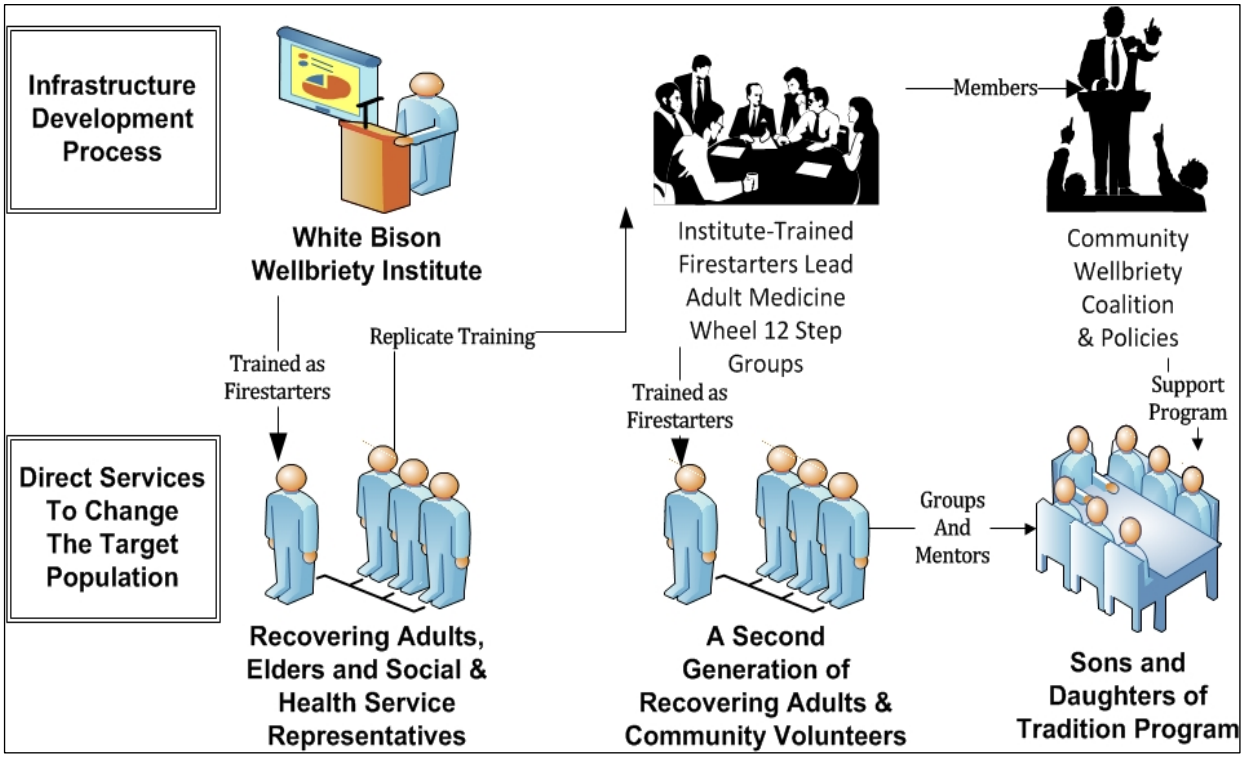
IV. INTRODUCTION TO THE WELLBRIETY® TRAINING INSTITUTE AND SUPPORT RESOURCES

White Bison has developed the availability of training and support resources *(e.g., tested training curricula, mechanisms for ongoing supervision and consultation) that are based on the structural model set out in the historical texts of the Wellbriety® Program. This includes an entire curriculum based on a Trainer's Manual, Participant's Manual and targeted videos.* ***NREPP Criteria D-2****.*



The curriculum and materials were developed around a Peer Assisted Learning model—with the Wellbriety® trainers and evaluator refining those resources according to the 24 continuous quality improvement questions outlined by Cameron and Ross (2007).[52] In the revision phase, the curriculum was infused in two Ojibwa tribes in Northern Minnesota [White Earth, Red Lake]. As a quality assurance check of convergent process validity, Wellbriety® material and instruction training was compared to curriculum effectiveness research in a similar Ojibwa community less than 200 miles away [Hermes, 2000][53] and found to contain all the qualitative dimensions. The online resources and technical

assistance, anchored to culturally competent practitioners at [or linked into] White Bison follow the proven process of weaving prevention teaching practices [e.g. video discussion and transfer of training, group cooperative learning, affective learning objectives, etc.] with culturally effective methodology [e.g. historical parables, teaching of the elders, talking circle group sharing]—often called the "Four Winds" programming originating in the University of South Dakota's behavioral sciences departments (1999).[54]



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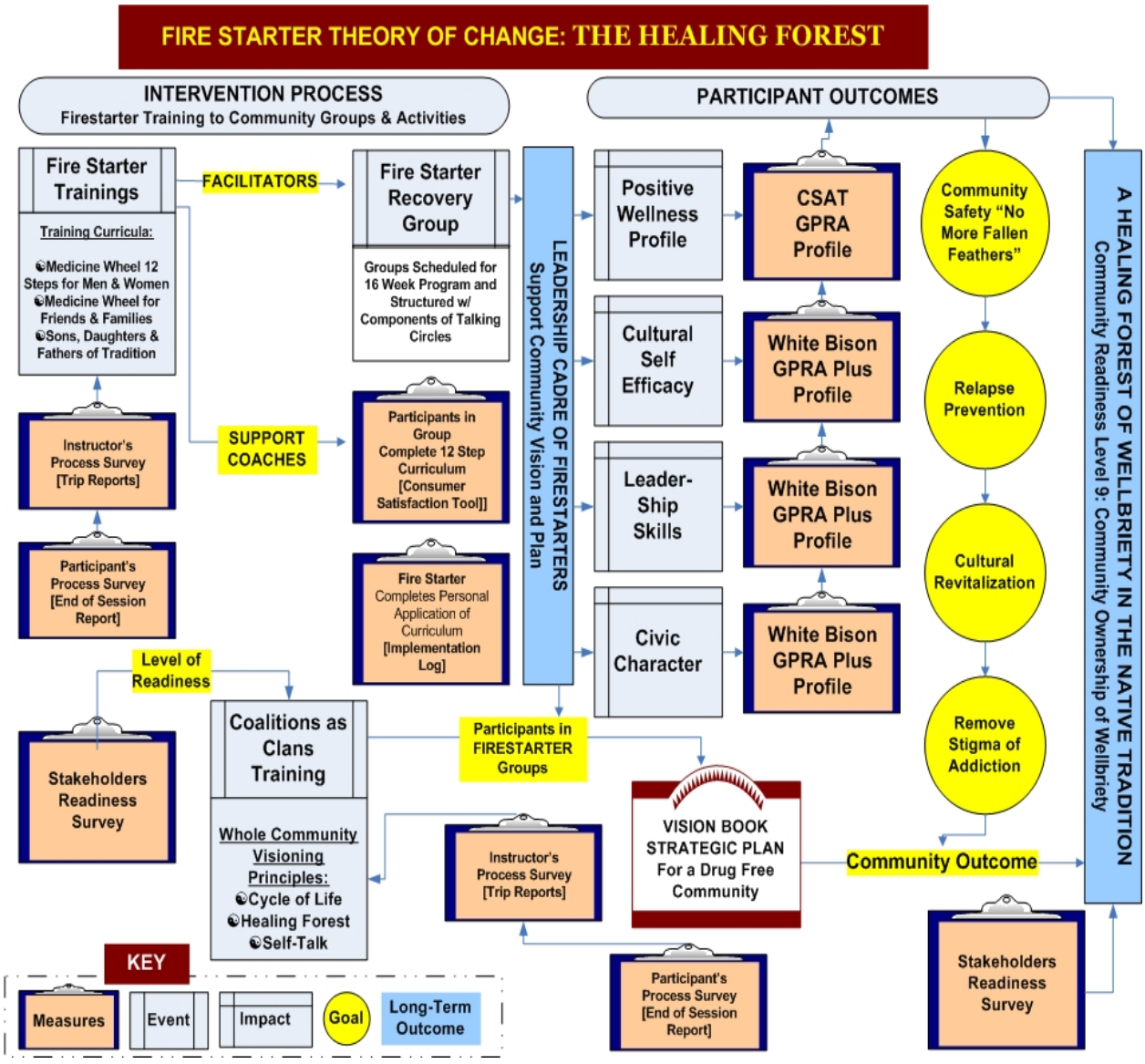
SECTION 1. THE PROCESS OF CHANGE

1.A The Theory of Change, Goals and Objectives [reference LOGIC Model on next page]

The three-step, supported, Wellbriety® infusion, moves from Firestarter Training, to Wellbriety® Network development, and then to a sustainable community health system that is overseen by a Wellbriety® Coalition founded on the clan model of leadership. The three goals of the Healing Forest and their measurable objectives [process, annual and long-term] are outlined in the LOGIC Model on Page 6. The Theory of Change also has measurement instruments, noted by clipboards. The Service to Systems project specifically refined the measurement process, which added to the: a) initial validation of the Firestarter instructors' model lifestyle[55], b) development of a comprehensive NREPP-style curricula based on the Healing Forest metaphor[56], and c) Firestarters' ability to meet learning objectives and replicate a sustainable community program.[57]



1.B. WELLBRIETY® PROGRAM IMPLEMENTATION LOGIC MODEL

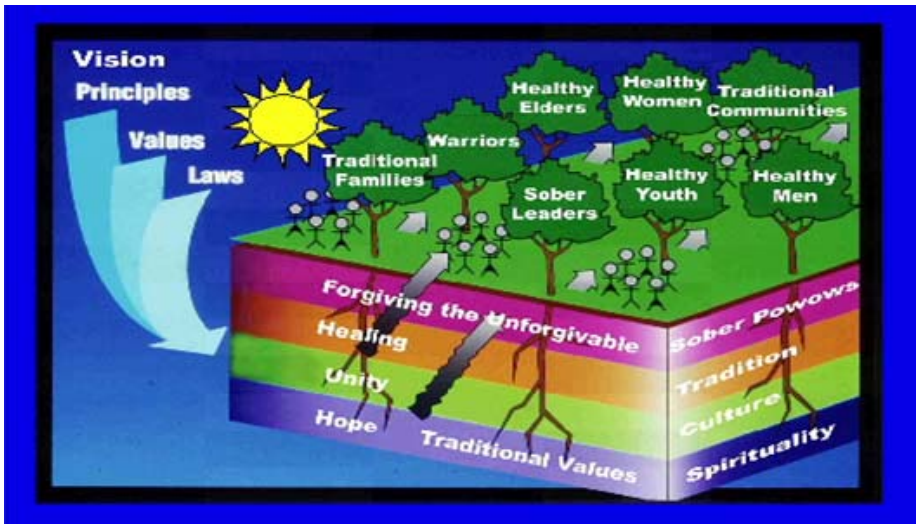
Developed with CSAT Grant # 1 H79 TI16156-02, as refined at the NACE Institute in Phoenix AZ 2/09.

INPUTS →	**OUTPUTS →**		**→ OUTCOMES**		
Program Investments	**Activities**	**Participation**	**Process**	**Annual**	**Long-term**
GOALS	***What we do***	***Who we reach***	***MEASUREABLE OBJECTIVES***		
1) The Seven Trainings of Firestarters. 2) Post-Training support for community Wellbriety® Healing Forest development. 3) Community Coalition Building for Sustainability of Wellbriety® Healing Forest	1) Train Firestarter Group Facilitators [N=7 Trainings] 2.A] Provide 1-Month Follow-up; facilitate group implementation w/ Embedded Evaluation. 2.B] Provide 6-month Follow-up to review implementation w/ embedded Evaluation 2.C] Integrate community with national network via web portal/Indian Center 3) Coalition as Clans Training	1) Community Group Facilitators 2.A] Community Group Facilitators 2.B) Community Group Facilitators and Group Members 2.C) Tribal Community 3) Community Stakeholders	1) N>30 Trained Facilitators 2) Community-wide group plan with N>24 groups 3) Milestone: Vision Book Produced [Community Action Plan]	1) 80% Facilitators implement group facilitation action plans. 2.A] Fidelity to curriculum implementation. 2.B] Group Participant Outcomes; same as Firestarters. 2.C] Community health Wellbriety® indicators improve. 4. Community Action plan implemented in continuing 4-season Cycle of Change.	1) Documented Positive Firestarter Life Skills Maintained over time. [New combined GPRA/GPRA+ instrument]. 2.A/2.B] Group members' indicators equivalent to individual markers in 1] 2.C] Community health indicators equivalent to individual markers in 3. Community Readiness Reaches Stage capable of Sustainability

1.C. Quality Assurance Process of the Wellbriety® Program

Multi-tribal investment and recognition. Since 1988, White Bison has been creating volunteer-designed and volunteer- delivered curriculum and training programs, overseen by Elders from over 24 tribes. Beginning in 1993, the Sacred Hoop (which is the symbol of the Wellbriety® Movement) was carried to Native American Communities throughout the United States. The Sacred Hoop is a willow hoop with 100 Eagle Feathers, each of which represents a Native American community in healing. Beginning in 1999, White Bison received a series of grants that enabled us to make Four Journeys with the Sacred Hoop, taking place in 1999, 2000, 2002, and 2003. These journeys included the participation of people from 300+ local Native American communities around the United States. More than 8,000 Native American people have participated in the Wellbriety® Gatherings, Recovery Month events, Circles of Recovery, Firestarter Trainings, and the four Circles of Recovery conferences that are part of the outreach, mobilization, and support for this movement. These journeys led to the Healing Forest Vision.

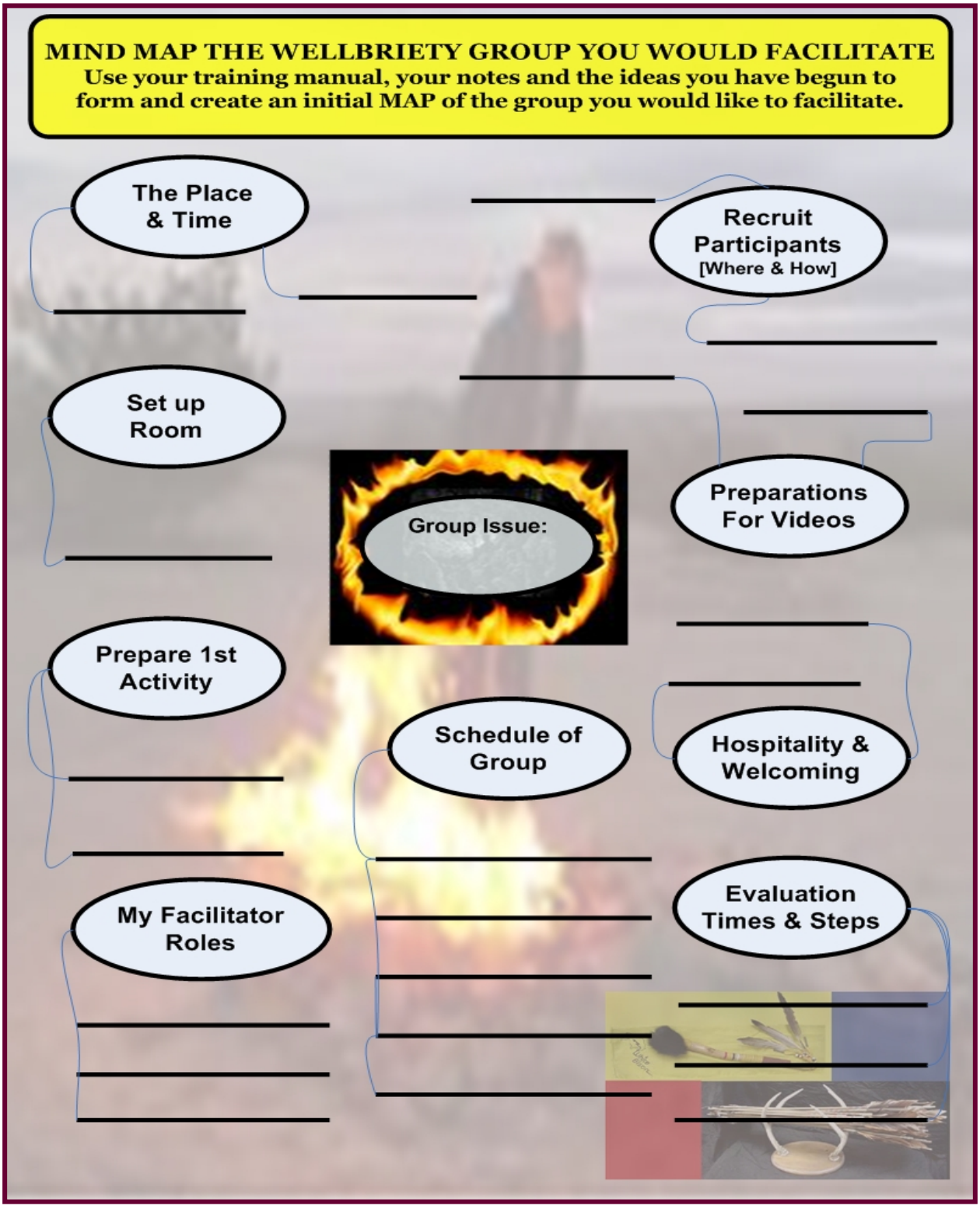
Standardized training and dissemination. The White Bison approach to peer services development and delivery is based upon Native American traditional values and Four Laws of Change provided by Native American Elders. The Firestarter training and follow-up support institutes led to annual national dissemination institutes from 2002-2003 to the 2008 Institute held in Minneapolis, including SAMHSA CSAP institutes [www.samhsa.gov/fbci/fb_training_past.aspx

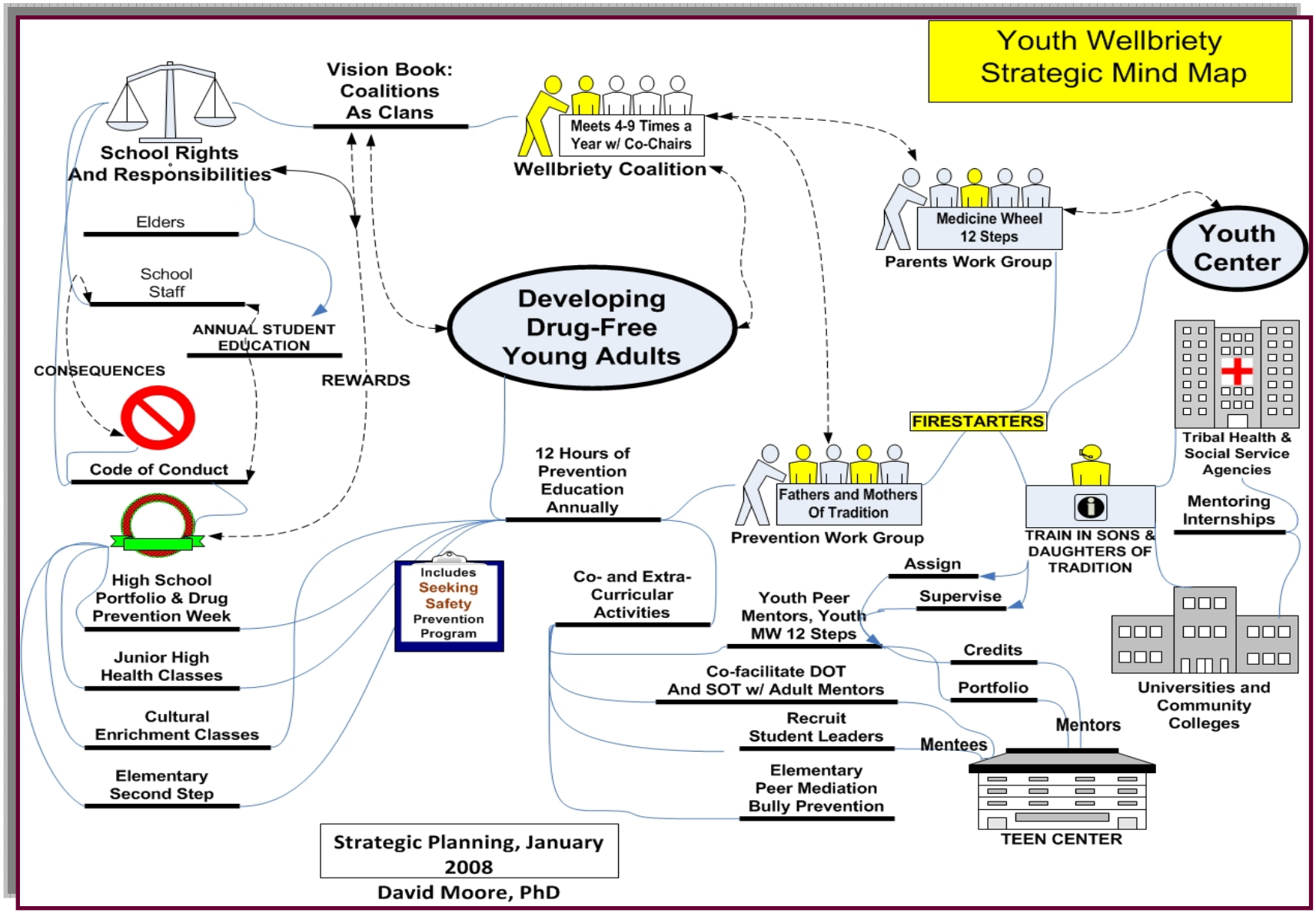


Multi-site local replication of Wellbriety® Healing Forests White Bison has a 12 year Recovery Community Support Program partnership with SAMHSA, beginning in 2002[58]; where they trained 700+ mentors and established 300+ local mentor-focused support groups in reservations, rural and urban settings. A process—outcome evaluation model, which was standardized, led to this project.[59] A subsequent 4 years of replication, in over 20 discrete communities that were monitored in quarterly reports, documented consistent success in meeting the objectives of healthy instructional role models [Firestarters], effectively trained in standardized curricula who subsequently replicated the training activities in their communities of origin.[60]

Designed on a best practices model. In the development of White Bison's training initiatives, the Department of Justice acknowledged the Firestarter Program as a Native Best Practice[61]. The goals and objectives of the Healing Forest create a local public health capacity developed by White Bison and a coalition of community stakeholders. This capacity is sustained by an establish an infrastructure that will create a continuum of culturally-competent support services based on systems procedures and a full-range of Native group leadership curriculum cited by SAMHSA as another Best Practice[62]. The Process of Change, articulated in 1.A-1.C, has the

quality assurance of multiple measures, which is anchored to an Individual Firestarter Map of planned replication [below] and a Vision Book developed from the Mind Mapping Process of the Coalitions as Clans training [example on next page]. Both serve as fidelity baselines.




Youth Wellbriety
Strategic Mind Map
Vision Book:
Coalitions
As Clans
School Rights
And Responsibilities
Meets 4-9 Times a
Year w/ Co-Chairs
Wellbriety Coalition
Medicine Wheel
12 Steps
Parents Work Group
Youth
Center
Elders
School
Staff
ANNUAL STUDENT
EDUCATION
CONSEQUENCES
REWARDS
Developing
Drug-Free
Young Adults
Code of Conduct
12 Hours of
Prevention
Education
Annually
FIRESTARTERS
Tribal Health &
Social Service
Agencies
Fathers and Mothers
Of Tradition
Prevention Work Group
TRAIN IN SONS &
DAUGHTERS OF
TRADITION
Mentoring
Internships
High School
Portfolio & Drug
Prevention Week
Includes
Seeking
Safety
Prevention
Program
Co- and Extra-
Curricular
Activities
Assign
Supervise
Youth Peer
Mentors, Youth
MW 12 Steps
Credits
Portfolio
Junior High
Health Classes
Co-facilitate DOT
And SOT w/ Adult Mentors
Universities and
Community
Colleges
Cultural
Enrichment Classes
Recruit
Student Leaders
Mentors
Mentees
Elementary
Second Step
Elementary
Peer Mediation
Bully Prevention
TEEN CENTER
Strategic Planning, January
2008
David Moore, PhD

SECTION TWO: THE ANALYSIS OF CHANGE IN THE HEALING FOREST

2.A. The Readiness Survey[63] of the Center for the Applied Studies of Ethnicity, Colorado State University

Over the multiple cadres of Firestarters, in the 2002-2008 Recovery Community Support Program RCSP], the Firestarters training and infusion of services in their communities began a community mobilization effort that created motivation for building a Healing Forest. The SAMHSA Drug Free Communities' principles and guidelines[64] were used to design coalitions to lead the planning, implementation and monitoring of Firestarter infusion programs in the last four years of the RCSP cohorts. The availability of training programs, dating to the inception of the Drug Free Communities Grants[65], allowed for White Bison to train the Firestarter Communities. This led to the Coalitions as Clans Model, using mind mapping to create Vision Books that had culturally appropriate versions of a DFC Coalition's strategic plan.

The measurement of community change through this coalition mobilization process was measured by Community Readiness surveys in two pilot communities that showed a growing overall Readiness Total Score to build a Healing Forest. The overall average of six dimensions in the communities' Readiness grew from a level of 4.1 to 5.3 [of 9 stages]. The change was led by an even higher growing "Community Knowledge Base" Dimension sub-scale [5.1 to 7.5]. Developing this knowledge base is the initial activity of the Firestarter process of peer coaching and facilitating Wellbriety® groups. It is intuitive that, when that Readiness Dimension reached a critical mass, it initiated community motivation towards further support of the Wellbriety® programming. Psychometric evaluation of repeated use of the Community Readiness survey process across many SAMHSA programs has also led to principles of participant-based strategic planning that have been widely used in Native communities. In the past two years, this Community Readiness Survey has been used by White Bison in conjunction with the strategic planning guidelines for the national Drug Free Communities Program . This hybrid community mobilization process leads to a grass roots community Vision Book [local participatory strategic plan]; which is diffused through a follow-up White Bison training to support the Firestarters' Wellbriety® efforts. As noted previously, this second generation of Wellbriety® training is called "Coalitions as Clans" and is based on a community planning to institutionalize a peer recovery support services program using the documented Firestarters leadership efforts towards a sustainable local Healing Forest.

Adaptation of the Readiness Model to Wellbriety®. Communities are at many different stages of readiness for implementing programs, and this readiness is a major factor in determining whether a local program can be effectively implemented and supported by the community. The Community Readiness Model was developed to meet research needs, (e.g., matching treatment and control communities for an experimental intervention) as well as to provide a practical tool to help communities mobile for change. The model defines nine stages of community readiness ranging from "no awareness" of the problem to "professionalization" in the response to the problem within the community. Assessment of the stage of readiness is accomplished using key informant interviews, with questions on six different dimensions related to a community's readiness to mobilize to address a specific issue. Based on experiences in working directly with communities, strategies for successful effort implementation have been developed for each stage of readiness. Once a community has achieved a stage of readiness where local efforts can be initiated, community teams can be trained in use of the community readiness model. These teams

can then develop specific, culturally appropriate efforts that use local resources to guide the community to more advanced levels of readiness, eventually leading to long-term sustainability of local community efforts. This article presents the history of the development of the model, the stages of readiness, dimensions used to assess readiness, how readiness is assessed and strategies for change at each level of readiness.[66]

2.B. The Wellbriety® Application of the Readiness Survey

The adaptation to the Readiness Survey means revising the target of "what" the community is ready to prevent. In this case substance abuse and intergenerational trauma—the target of Wellbriety®. It further means deciding who will be in the Coalition and, due to membership, also be in the population that is surveyed.

2.B.1 The General Community Readiness Survey Model

In a Community Readiness Survey, a minimum of six community members are selected to be participants in a 34-question survey to evaluate the level of community readiness to address a prevention issue. After these participants complete the survey, their responses are scored which lead to placement in one of nine levels of Community Readiness. In the next subsection, 2.b.3, the target is described in the same manner as it is explained to those who are taking the survey.

2.B.2 The Drug Free Communities Target Health Issue—Protocol to Introduce Substance Abuse as the First Readiness Issue

In this case, **Substance Abuse** has been selected as the health issue to be consistent with the Drug Free Communities coalition's focus on individual, family and community problems with alcohol and other drugs of abuse.

In order for the participant to understand and synthesize this health issue definition, the survey is preceded by the following interactive script with each participant: **In this survey, we would like to ask your feelings about Wellbriety® in your community.** This is a word, developed by Native people. It is the movement to healing our whole community by creating a Healing Forest. A Healing Forest program emphasizes **positive cultural supports for families** and **reducing drug abuse through prevention and treatment.** When you think of **Wellbriety®,** we would like you to think of both of these issues linked together. Here is our description of each issue. First I would like to describe Positive Cultural Supports ➔

1. **POSITIVE CULTURAL SUPPORTS** means a return to the natural family and community networks, such as ways of raising children, that existed before the external damage caused by the European American settlement and ongoing control of what is now the 50 United States. In tribal communities, we often call that damage "intergenerational trauma." Most historians, including those in the white community acknowledge this damage done to minority communities' cultures through both subtle institutional racism in school systems and courts, as well as the more obvious trauma caused by confiscating land, enslaving persons as property, imprisoning whole groups of people due to heritage in wartime internment camps and forcing children into boarding schools to unlearn their own culture.
   Now I will describe Preventing and Treating Alcohol or Other Drug Abuse ➔

2. **PREVENTING AND TREATING ALCOHOL AND OTHER DRUG ABUSE.** While different people may debate where drug abuse starts, **Wellbriety®** sees it as the greatest threat to our communities' families. It destroys families, turns anger into rage, increases depression to suicide, leads people to treat others as objects and drains us of the strengths of our youth.

2.b.3 The Drug Free Communities Participant Selection Option

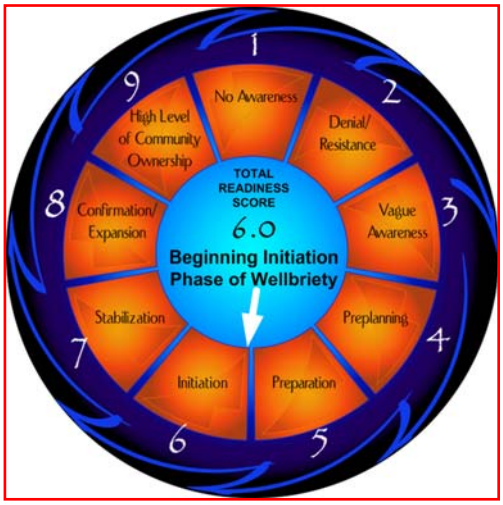
The Drug Free Communities' model for community coalitions requires representation from 12 sectors of the community. The Coalition may wish to expand from the standard number of stakeholders and somewhat random selection of the community sectors they represent, to a fuller and specific "Drug Free Communities" sampling.

In a DFC Community Readiness Survey, a formal or informal leader from each of these sectors completes the participant survey. In the White Bison model, the local sector which is individualized to the unique DFC [labeled "Other"] is defined as two members from the Native community. There are a total of 13 participants who complete the Drug Free Communities' Readiness Survey which is designed to be culturally competent and appropriate for communities with significant Native population:

- Elder ["Other" in the standard DFC guidelines—to target unique local needs]
- Youth
- Parents
- Business community
- Media
- Schools
- Youth-serving organizations
- Law enforcement agencies
- Religious or fraternal organizations
- Civic and volunteer groups
- Healthcare professionals
- State, local, and/or tribal governmental agencies

2.C. Community Vision Statement

In order to select a Vision, the community discusses its stage of readiness. In one tribal community, they were at the Initiation Phase of Wellbriety®. The Readiness Survey looked at six dimensions of community-building and program development to create an individualized Wellbriety® Movement for the Tribe.



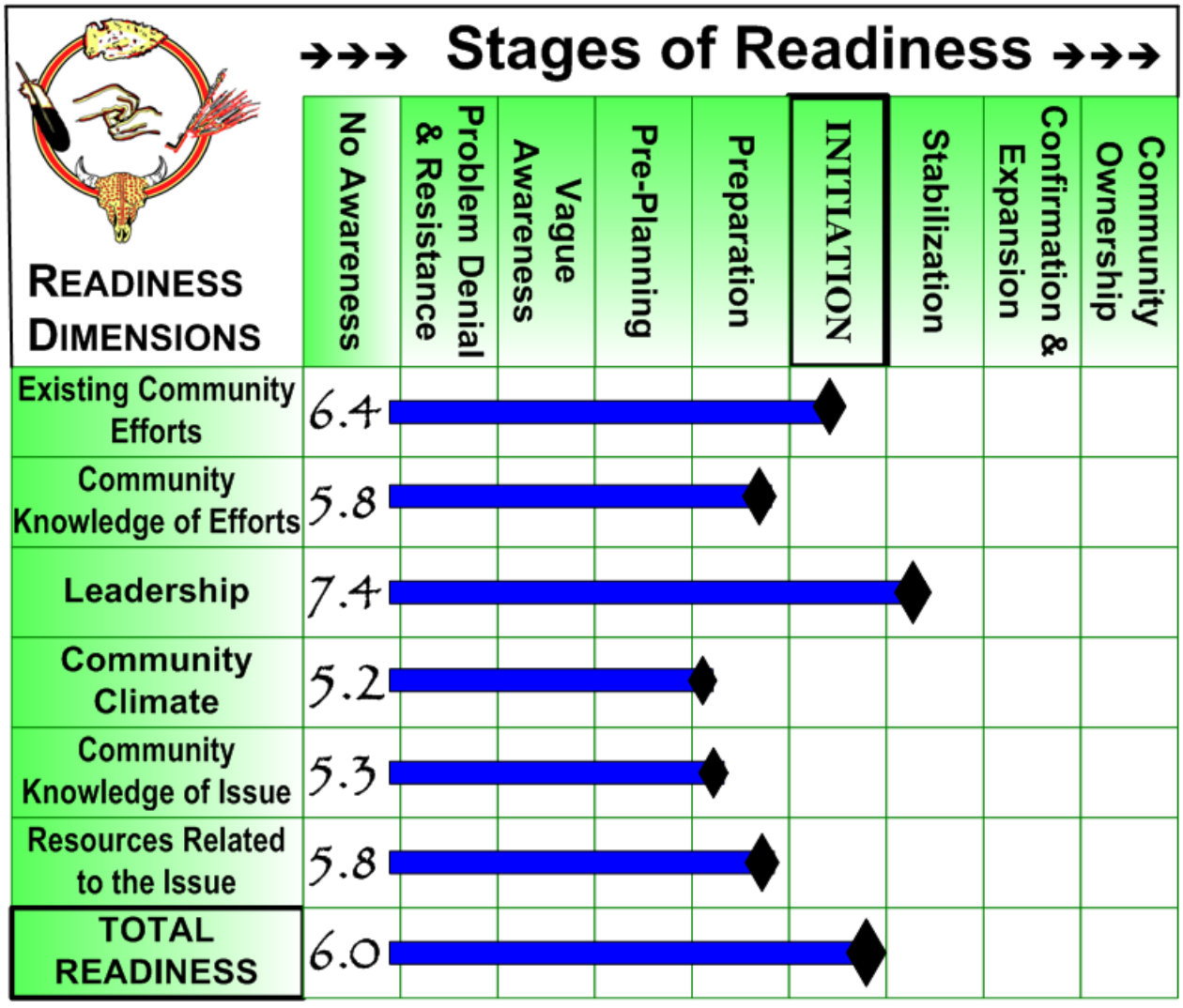
The total Wellbriety® Readiness Score of 6.0 *indicates the tribal community has reached a stage to initiate Wellbriety® Programs throughout the community.*

The Initiation Phase can best be described as:

- Tribal information is available to justify the efforts
- Activity and action is underway, but still viewed as a new effort
- Community members are being trained
- Great enthusiasm in leaders, as limitations and issues has yet to be met.
- Improved attitude in community members is reflected by continued modest support

By using the Coalitions as Clans visioning book and further subdividing the Wellbriety® Readiness findings into the six dimensions, a strategic plan and Vision Mind Map [see example on Page 14] can be developed to lead the community's Firestarters and their actions.

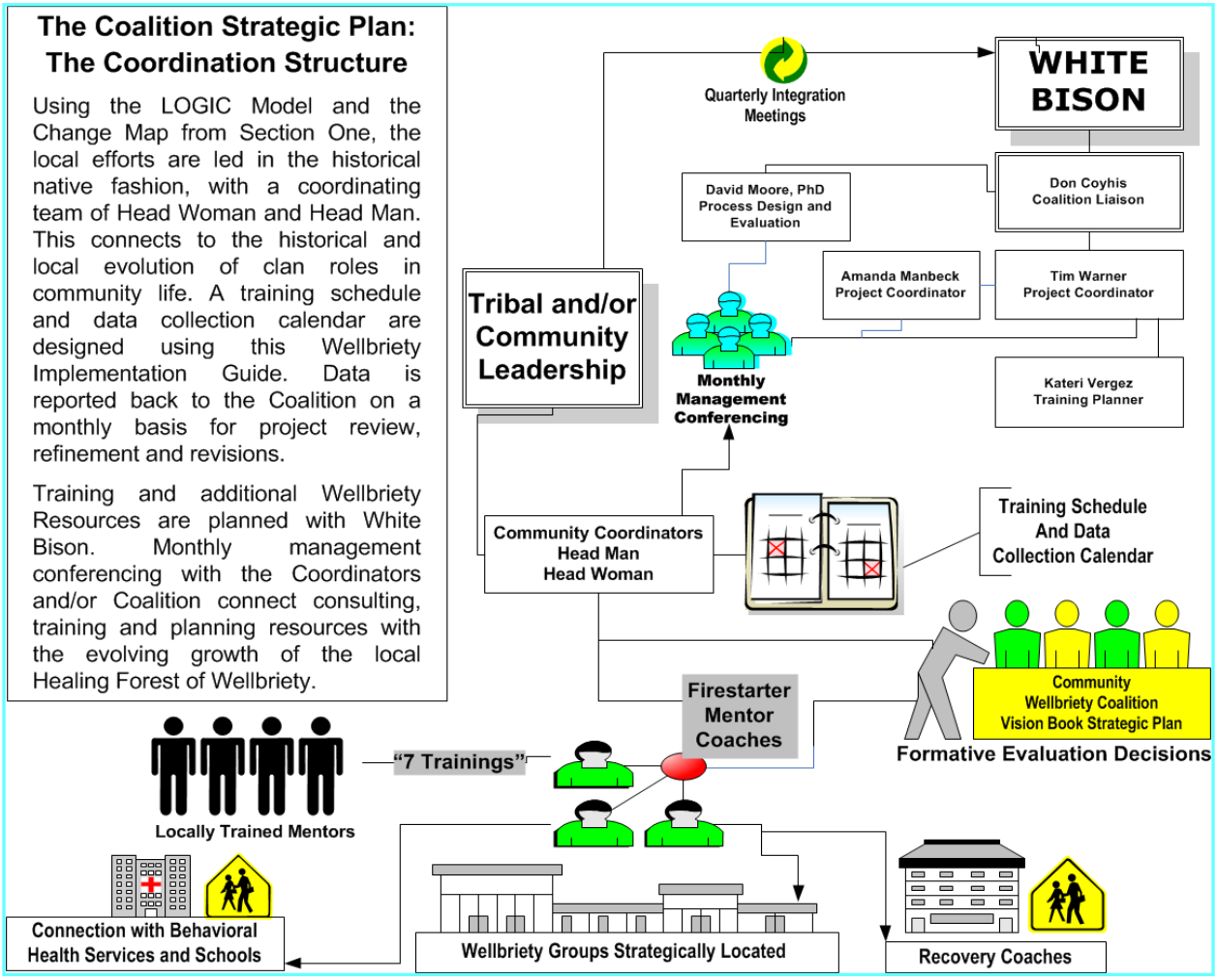
In the same tribe, the Readiness Scores in each key strategic planning area had different levels of development. As can be seen in the planning matrix, the community climate and community knowledge of Wellbriety®, while in the Preparation Phase, would need additional social marketing activities to rise to the level of implementation. Likewise, additional resources would be necessary to maximize the implementation efforts. The Readiness Model has a robust set of planning strategies that are keyed to the Dimensions and Stages of Readiness.



SECTION THREE: PROGRAM MONITORING BY THE COMMUNITY COALITION

3.A. The Coordination of the Vision Book Strategic Plan and Formative Evaluation

The Mind Map developed by the Coalition in the "Clans" training [example on page 15] can be transposed onto the Healing Forest Impact diagram [Page 11]. From there, an individualized LOGIC Model can be developed for the project [Page 12]. Traditionally, a local coordination team composed of Head Woman and Head Man oversees the day-to-day project implementation on behalf of the Coalition.



3.B. The Management Information System to Maximize Data Collection and Usefulness

The Training Schedule and Data Collection Calendar [above graphic] is developed through the Wellbriety® Measurement Guide [Page 21] and the Wellbriety® Evaluation Schedule Planner [Page 22]. This allows for developing job descriptions for the Head Woman and Head Man, along with the persons that will be gathering the data. Analysis and evaluation support comes from White Bison's Process and Evaluation Designer [above] and other consulting staff. This also allows for meeting the NREPP guidelines for the monitoring of program participant

WELLBRIETY® MEASUREMENT GUIDE: Developing the Management Information System

A. Performance Measures (***What is the intended impact of your program efforts?***)	1. Strengthen community health. 2. Increase the capacity and knowledge of community mentors/facilitators to implement the concepts of the Healing Forest; particularly facilitation of the seven different groups. 3. Increase the social connectedness of participants. 4. Increase the cultural connectedness of participants. 5. Increase positive indicators of life skills related to leadership, character, health, behavioral health, employment and/or education, and pro-social behavior [arrests🡻].
B. Define Success (***What are the visible results of your program efforts?***)	1. Social support is more available as evidenced by increased post measures of social connectedness. 2. Cultural ties are stronger as evidence by increased post measures of cultural connectedness, self-efficacy, leadership and civic character. 3. Facilitators who are strengthened to be role models in the community as evidenced by levels of comfort in presenting the concepts of Healing Forest and modeling those concepts in their own daily lives.
C. Available Evidence (***What type of existing evidence would reflect these visual results?***)	1. GRPA+ [Items from SAMHSA's online GPRA monitoring and additional items from A.3-A.5. 2. Pre and Post Measures of satisfaction and competency/comfort with teaching/sharing Healing Forest concepts. These also become continuing education guides for the Institute to help individual Firestarters. 3. Participant Learning Objective Knowledge Test at the end of training or group.
D. Collection Process ***(How will you collect the evidence?)***	1. Data Collection Timeline will be established based on strategic planning and requirements of funding sources or external monitoring. 2. Primary data collection method will utilize paper and pencil response to items by respondents. Follow-up data collection will be re-administration of the items telephonically. 3. An automated audience response system, developed by Colorado State University [CASAE] may be used for large scale Community Readiness measurement or similar instrumentation.
E. Intended Use ***(What will you do with the evaluation results; or how will the evaluation results be used to improve effectiveness?)***	1. Evaluation results will increase the potential for sustaining the Healing Forest project. 2. Evaluation results will be used to provide credibility to tribal councils, administration and to community members. 3. Evaluation results will be used to modify and revise program elements that are found to be challenging or less effective. [Formative Evaluation]. 4. Evaluation results will be used for publication of results, replication of programming and public relations. [Summative Evaluation].

WELLBRIETY® EVALUATION SCHEDULE PLANNER

EVALUATION QUESTIONS *(identification of target problem)*	**INDICATORS** *(knowledge or attitude provided to target population)*	**TIMING** *(when and how often is your assessment used)*	**DATA COLLECTION**			
			APPROACH *(what method are you using)*	**PROVIDER** *(who administers the instrument(s))*	**SAMPLE SIZE** *(no. of clients / participants)*	**INSTRUMENTS** *(what type of evaluation tool is used)*
Facilitator Skills with Training Curricula	*High degree of skill level in presentation of curriculum concepts*	*TBD when training timeline is established in Strategic Plan*	*Pre/Post-testing*	*White Bison Staff*	*95% Pre/Post Training.*	• *Competencies Self-Appraisal Test* • *Post-training Knowledge Test.*
Facilitator Fidelity to Training Curricula	*High degree of fidelity to presentation of curriculum concepts*	*TBD when evaluation timeline is established in Strategic Plan*	*Post-test Fidelity Mind Map*	*White Bison Staff*	*Minimum of 80% of trained Firestarters*	• *Fidelity Instrument based on Mind Mapping & Planned Service Delivery* • *Competencies Self-Appraisal Test [Re-administration]*
Individual and Community Support System	*Social Connectedness*	*Participant program entry for baseline, @ 6 months*	*Pre/Post-test and follow-up @ 6 months and annual*	*Site Facilitator and local Evaluation Staff*	*Goals and Objectives: Section 2*	• GPRA + Instrument
Cultural Disconnectedness	*Cultural Connectedness*	*Participant program entry for baseline, @ 6 months*	*Pre/Post-test and follow-up @ 6 months and annual*	*Evaluation Staff and Site Facilitator*	*Goals and Objectives: Section 2*	• GPRA + Instrument
Leadership/Character of Facilitators	*Firestarter Training*	*Participant program entry for baseline, @ 6 months*	*Pre/Post-training, end of 6 session test, 30 day follow up and 6 month follow up*	*Evaluation Staff and Site Facilitator*	*Goals and Objectives: Section 2*	• GPRA + Instrument • Focus Groups
Health Behaviors	*Healing Forest Curriculum*	*Participant program entry for baseline, @ 6 months*	*Pre/Post-test and follow-up @ 6 months and annual*	*Evaluation Staff and Site Facilitator*	*Goals and Objectives: Section 2s*	• Youth Risk Behavior Survey GPRA+ Instrument

SECTION FOUR: GROWTH OF THE INDIVIDUAL HEALING FOREST

4.A. Wellbriety® Training Template

Traditionally, the external validity of importing the Wellbriety® Program into a community comes from matching demographics from the demonstration communities and the new community. However, at a deeper level of environmental prevention and epidemiological approaches, Wellbriety® has developed a set of goals and objectives to design the training process for a new community. These goals and objectives, which can be revised or refined through tasks selected to carry out the objectives, come from a national needs assessment that led to the Healing Forest Paradigm of prevention programming.

While it is true that the over 500 Indian Nations of the United States are unique, there are very common histories of alcoholism[67], inflicted trauma to eradicate their cultures[68] and public school systems that used brutal methods of control and dehumanization.[69] Most also have common connections of community oral histories, clan extended families and spiritual practices—which are ideal for an inter-tribal youth development program that is often called the "Healing Forest[70]" of Wellbriety. The training template for infusion of Wellbriety, is based upon the 12 years of federally funded Recovery Community Support Program demonstration grants and knowledge.[8] The national needs assessment for Wellbriety® has resulted in a standardized and evidence-based[71],[72] Native training and curricula that can be adapted to the specific local needs of a project community from the knowledge accumulated from training 700+ mentors and establishing 300+ local mentor-focused support groups in reservations, rural and urban settings.

There is an established need for all Native People to recover from the extensive multigenerational developmental process of abusive childhood boarding schools and coercive distribution of alcohol which infected the tribes of North America and Hawai'i through involuntary occupation by European and Asian settlers. This multigenerational trauma is not bound to a local community need, as noted above; but resides in the Native population as a whole and their struggles to effectively raise their children with traditional family supports. What each local community can do is, with the help of culturally competent services, return to a state of recovery and wellness ["Wellbriety"].

Community-building training in Wellbriety® replicates the unique mentoring networks of historical clan support found in the Native communities. The diversity of our communities is extensive. One thing they all have in common is the clan model of mentoring---which makes identity-building small group mentoring as important as the one-to-one role model mentoring found in all cultures. Whether watching the adult mentor drum for the youth dancing the story of their Turtle Clan at Celebration[73] in Alaska or the adult mentor watching his native tutor group recognized at the annual "Honoring our Youth" gathering in Los Angeles[74]--the mentoring traditions of clans are embodied in Wellbriety's Medicine Wheel 12 Step groups of adult and adolescents, as well as the developmental "Sons and Daughters of Tradition Mentor Groups" developed from 1998-2009 with standardized, culturally appropriate, facilitator training and youth curricula.[75],[76] The original adult mentor training program—Firestarters [Men's/Women's Medicine Wheel Groups] were cited by the U.S. Department of Justice as a Promising Practice for substance use prevention[77]

[8] Working Manual for Recovery Community Support Programs, August, 2007. Washington D.C.: Altarum Inc.

The children, youth and family development problems and substance abuse plight of the Native community seen in the local data on poverty and substance use, call for systems with strong roots in the Native clan model of social support traditions rather than behavioral health medicine. At the core of the clan and tribal needs is the current lack of role models to mentor youth experiencing the early steps towards youth substance abuse and/or delinquency. The initial 30+ communities that developed the Wellbriety® Training Template agreed with the national Native literature indicating a crisis in teen drug use and youth development risks[78],[79],[80]; see it being as great [if not greater] in a needs assessment of their local communities, and endorsed the prioritization of building Wellbriety® mentoring systems to serve their children, youth and families' through adding sustainable Wellbriety® networks to their local systems of care as the evidence-based practice of choice to match Native youth traditions.[81] In addition, there are three categorical curriculums that have the SAMHSA Model Program designation, which can naturally connect to the Wellbriety® programs and be used within the community groups:

Motivational Enhancement Therapy. MET and the counseling as usual (CAU) therapy sessions (three 50-minute sessions in each condition) both resulted in reductions in substance use during the 4-week therapy phase ($p < .001$). MET participants, however, sustained these reductions in substance use for the subsequent 12 weeks of follow-up, CAU participants did not.

Seeking Safety. Seeking Safety is a present-focused therapy designed to help people attain safety from both PTSD and substance abuse. The Native recovery groups must have the capacity to resolve historical [and current] trauma problems as well as substance abuse. The substance use and trauma outcomes substantiated by NREPP were reductions in: substance use and anxiety-provoked acting out delinquent behaviors seen in victim-aggressor cycles.

Too Good for Drugs. Too Good for Drugs has outcomes of resilience and cognitive change that are needed for any level of youth substance risk or involvement. TGFD has developmentally appropriate curricula for each grade level. Outcomes establish preventing future substance use and developmental gains in drug-free lifestyle choices, including pro-social activities [non-delinquent]. There are parent and family "take-home" activities.

GOALS AND OBJECTIVES TEMPLATE BASED ON FIVE NATIONAL EPIDEMIOLOGY NEEDS

 Goal 1: Develop a core group of Mentoring Services Coaches to increase the children, youth and family mentoring capacity in project communities. [**Need 1**: "There is the need for culturally competent community-supported children and youth mentoring systems throughout the Native communities—a "Healing Forest".] The measurable objectives developed to meet this goal:

Objective 1.A: Each community will receive training for a minimum of 30 Mentoring Services Coaches ["Firestarters"]. Subsequently 95% of the Coaches will assist in systems-building, 80% will provide direct mentoring services and 50% will provide group services within 12 Months.

Objective 1.B: Each Mentor Coach ["Firestarter"] will receive 4 days of training, which includes a 3-day initial training and post training follow-up session; which will include the successful attainment of coaching skills for: a) family support strategies, b) school and job search activities, and c) integration into the mentoring group network. This will be measured by Likert Scale scores exceeding 4 on a 5-point scale on a Competencies Self-Appraisal Test, an 80% score on the Facilitator Knowledge Test and anonymous baseline and GPRA+ 6-month follow-up Mentor behavioral self-report instrument establishing: a) improved family integration by a

minimum of 10% from baseline, b) improved school and job indicators by 10% from baseline, and c) a minimum of 95% rate of personal abstinence from alcohol and drug use.

 Goal 2: Create a sustainable continuum of children and youth mentoring across multiple wellness areas, using SAMHSA's evidence-based Drug Free Communities' coalition-building. [**Need 2:** "The Native population, their clans and their community have extensive family support needs from historical addiction and multi-generational trauma issues "] The measurable objectives for this goal are:

Objective 2.A. The community will develop a Mentoring Vision Book which is a culturally competent strategic plan for a local Wellbriety® system built from the Colorado State University's evidence-based Readiness Survey . The Milestone for this plan is completion within the initial 3 months after Firestarter Training. This will result in a 1-year change of at least one full Readiness Level towards sustainability in the survey's Community Leadership Domain.

Objective 2.B. Each Vision Book will develop a participatory coalition where all 12 SAMHSA Drug Free Community Sectors will be represented, including specific MOUs for the members. The participatory coalition, meeting at least quarterly, will implement environmental strategies to support a mentoring mission targeting drug risk and abuse: "To prevent substance use by youth and, over time, reduce the abuse of alcohol and drugs by adults in the community [Drug Free Communities' mission]." Evidence of this support will be a 2-year improvement in the four youth GPRA targets of the Safe & Drug Free Schools and Communities Act.

 Goal 3: Develop an institutionalized Readiness capacity in the project community through culturally competent norms of substance use prevention and Wellness [Wellbriety]. [**Need 3**: "In order to build new, "Healing Forest" norms, there is the need for a culturally-appropriate community mentor mobilization response.] The measurable objectives:

Objective 3.A: The Coalition-supported Firestarters in each community will create a mentoring network with a consistent message and evidence-based methods promoting alcohol and other drug-free Wellbriety® youth activities appropriate to the local culture. [N=__] youth will receive services, from the core 30 Mentor Coach Firestarters implementing the network and [N=__] additional mentors receiving training from White Bison & Mentor Coaches.

Objective 3.B: The network will provide a Healing Forest Model of groups for youth and their families affected by trauma and addiction. The Forest, built from White Bison's "7 Trainings", will create a network of groups to serve a subsequent 80 adult community clan members annually, which supports group and individual mentor services for the youth [Goal 4]. The impact of the network development will be a minimum average change of one level, across all six domains, of the Community Readiness survey instrument [Colorado State University].

 Goal 4: Create a sustainable local community mentoring network by linking juvenile justice, school dropout prevention and behavioral health facilities to mentoring support services by tribal and community policies. [**Need 4:** "In our most challenged youth, there is a special need to implement a social, community-centered, mentor response that is effective for youth re-entering society from residential treatment , incarceration or self-imposed periods of tribal estrangement. " The measurable objectives selected for Goal 4 are:

Objective 4.A: The Firestarters will provide evidence-based support groups to address both healthy development and recovery from the impact of substance use, historical trauma and adult

support deficits. A minimum of [N=__] high risk and multi-problem youth will be served by Firestarter mentors. They will receive mentoring support groups including **Seeking Safety** , a SAMHSA Model addiction and trauma recovery group process, within the culturally appropriate infrastructure of Sons and Daughters of Tradition group.

Objective 4.B: The Firestarters in each community will provide evidence-based mentoring to youth and coaching adult family members to assist with transitional support beyond small mentor groups [4.A and 4.C]. A sub-population [of Objective 4.A] of [N=__] youth will receive mentoring with **Motivational Enhancement Therapy** , [SAMHSA Model Program].

Objective 4.C: The Firestarters in each community will provide evidence-based mentoring groups for early intervention for youth whose risk or substance use problems do not require intensive services. A minimum of [N=__] youth referred for school or community counseling due to risk or use, will receive parallel referral to Sons or Daughters of Traditions Mentoring Groups. The group members will receive prevention-intervention education using **Too Good for Drugs** , [SAMHSA Model Program]. [N=__] of these youth will receive individual mentoring by adults from the Fathers or Mothers of Tradition group training.

 Goal 5: Develop a training, implementation and sustainability plan with White Bison's Wellbriety® Indian Center for cross-site peer support & technical assistance by linking staff and volunteers trained in goals 1-4 through a culturally competent web portal. [**Need 5:** "There are extensive epidemiologic reasons , established by the Centers for Disease Control, validating the very important need for culturally relevant mentor services.] Objectives to implement this goal:

Objective 5.A: The Indian Center will ensure fidelity to the program and curricula implementation. A formative, process evaluation, of the site implementation will include annual process evaluations based on each site's Vision Book, re-assessment of community readiness and implementation standards for evidence-based curricula [7 Trainings, Seeking Safety, Motivational Enhancement Therapy & Too Good for Drugs.]. These findings will be provided to the Community Coalition at required intervals, with fidelity improvements, as "lessons learned."

Objective 5.B: The Indian Center will ensure efficiency of activities designed to create the Community Healing Forest, including a consultation plan to support evaluation of the Firestarters responsible for the Mentoring system. The Firestarters will be tracked, using the SAMHSA online GPRA reporting and added cultural instrument [see Evaluation Section], at baseline, 6 months and 12 months post-training. Findings from that tracking will include revisions to the Firestarter training process and continuing education methods using the White Bison Web Portal.

Objective 5.C: The Indian Center will ensure effectiveness of activities in the Community Healing Forests by assisting with both process and outcome evaluation design. This can include an impact study through randomized GPRA+ reporting of 30% of the Mentors in the 1 to 1 and group mentoring services; as well as an annual non-random sample of [@ N=40] of youth group service recipients. Aggregate results from this design would be available in Coalition or funder reports & integrated with program refinement suggestions as included in the Section Three evaluation schedule.

Objective 5.D: The Indian Center will support a 24-hour nationally-approved curriculum and in the project community with enrollment of Firestarters receiving 24 hours of education approved

by National Association of Alcohol and Drug Abuse Counselors [NAADAC]. Eighty percent [80%] will complete the certificate program and among the graduates, within 6 months, 50% will be employed or volunteering in facilitating groups that can, with additional training or Facilitator growth[9] replicate Firestarter Training at a community level that will create an annual sustainability.

4.B. Fidelity to the Vision Statement [NREPP Criteria R-3]

The Performance Assessment Plan instrumentation at an individual and community level is outlined in Section Two. Section Three shows how to adapt that instrumentation to a Management Information System [MIS] that is embedded in the tasks of the project which are anchored to a Vision Book and LOGIC Model Strategic Plan [Section One]. Project Timelines, for the first year, can be linked to a Master Schedule developed with the Coalition partners. The implementation and evaluation activities span the 5 Goals through a Management by Objectives [MBO] process which provides continuous quality improvement. A standardized White Bison training schedule that integrates with those 5 areas is as follows:

Flow Process of Trainings	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Monthly Implementation Process for Year One of Wellbriety® Infusion	O	N	D	J	F	M	A	M	J	J	A	S
White Bison and Head Man & Head Woman coordinate for project events	→	→	→	→	→	→	→	→	→	→	→	→
Firestarter Training				**X**								
Coalition Training & Return Follow-up					**X**				**X**			
Infuse Additional Curricula and Coach Head Man & Head Woman Coordinators					**X**	**X**			**X**	**X**		
7 Trainings (Builds on Firestarter Training)						**X**				**X**		
Support Through Indian Center @ www.whitebison.org					→	→	→	→	→	→	→	→
GPRA+ data entry Baseline, & 6mo, 12mo follow-up; Additional Data in Schedule from **SECTION THREE**			→	→	→	→	→	→	→	→	→	→

Wellbriety® Training and Implementation Management Team Responsibilities

In order for a community change process to be infused in a new community, a year of technical assistance will improve both fidelity to the local plan and is necessary for the trainings. After the first year, the Head Man and Head Woman take the place of White Bison staff—though they maintain connection to the national Wellbriety® movement and peer cross-site assistance through the White Bison web portal.

White Bison staff and management positions are noted on Page 20. Those designations are included in the Task Chart responsibilities that are cued to the Project Objectives. Tasks with process evaluation components are noted in gray and bold on the task timeline strategy table, below. Fidelity and implementation instruments for the three NREPP programs have been validated by the SAMHSA model program reviewers. [**Project Task Chart on next page**].

[9] There is a five-stage process that Firestarters can go through to reach a level of Mastery and provide ongoing training of new facilitators in their community. White Bison technical assistance can support this process.

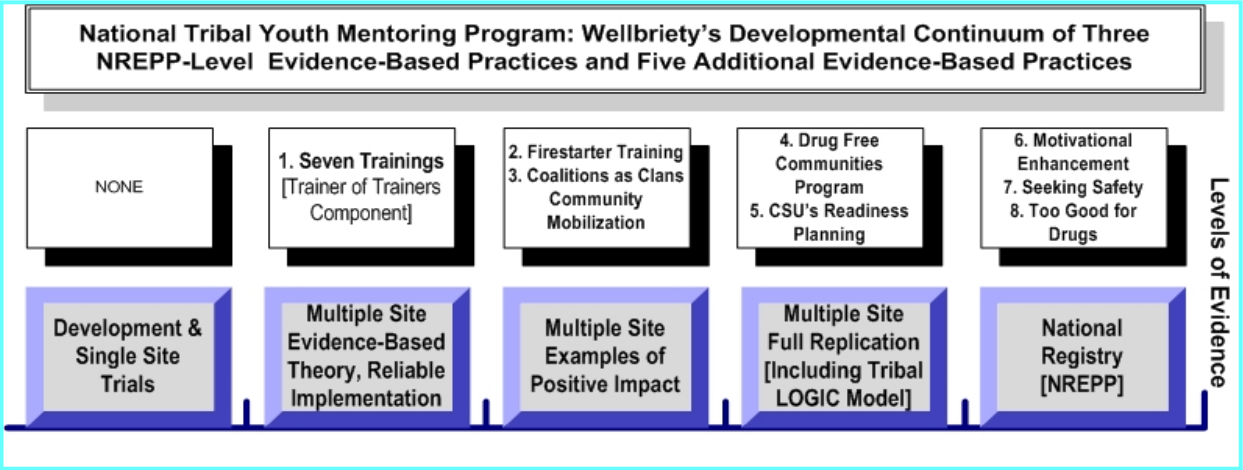
PROJECT TASK CHART

OBJ	TASK	TIMELINE	RESPONSIBLE
ADMIN	**Negotiate Scope of Work**	**First 30 Days**	**Project Director**
ADMIN	New Grantee Conference	Per DOJ	P. Director/Evaluator
1.A	Master Schedule of Trainings	See Next Chart, below	Project Coordinator
1.A-5.C	**Cohorts 1-4: Follow Schedule**	As Noted Below	P.Director/Coordinator
ADMIN	Tribes Add Scope of Work to MOAs	Post-Schedule,<60 Days	P. Director
1.A	Initiate Firestarter Mentor Training	<120 Days	Training Coordinator
1.B [1]	**Conclude 1st Cohort w/ Followup**	1.A w 30 & 60 Day	Coordinators
1.B [2]	[Include NREPP Program Training]	1.A Plus 30 & 60 Days	P.Director/Evaluator
2.A	Cohort 1: Introduced to Planning	During 1.A	P. Director
2.B	Cohort 1: Coalition Vision Book	During 1.B	P. Director
3.A	Communitywide 7 Trainings	1.A Plus 60 Days	Training Coordinator
3.B [1]	**Readiness Survey of Stakeholders**	During 2.A	Coordinators/Evaluator
3.B [2]	**Readiness Survey Feedback to Plan**	During 2.B	Evaluator/P. Director
3.B [3]	**Re-administer Survey 6 & 12 Mos.**	See Evaluation Plan	Coordinators
4.A [1]	Seeking Safety Training	During 1.A Plus 30	Evaluator/Trainers
4.A [2]	**Seeking Safety Fidelity Check**	During 1.A Plus 60	Evaluator/Coordinators
4.B [1]	MET Training	During 1.A Plus 30	Evaluator/Trainers
4.B [2]	**MET Fidelity Check**	During 1.A Plus 60	Evaluator/Coordinators
4.C [1]	Too Good for Drugs Training	During 3.A	Evaluator/Trainer
4.C [2]	**Too Good for Drugs Fidelity Reports**	See Evaluation Plan	Evaluator/Coordinators
5.A [1]	**Evaluate Activity Data**	As Tasks Documented	Evaluator/Data Staff
5.A [2]	**Reporting to External Funders**	See Evaluation Plan	P. Director/Evaluator
5.B [1]	**Evaluate Process> Project Standards**	Annual Reports	Evaluator/P Director
5.B [2]	**Report to Elders for Project Revision**	w/in 30 Days of Report	Elders/P. Director
5.C [1]	**Evaluate Process> Project Standards**	Annual Reports	Evaluator/P Director
5.C [2]	**Reporting to External Funders**	See Evaluation Plan	P. Director/Evaluator
5.D [1]	**Evaluate Process> Project Standards**	Annual Reports	Evaluator/P Director
5.D.[2]	**Reporting to External Funders**	See Evaluation Plan	P. Director/Evaluator

SECTION FIVE: RELIABILITY AND VALIDITY OF THE HEALING FOREST

5.A. The Evidence Base of the Goals, Objectives and Tasks of Sections One-Four

There are eight structural elements that comprise Wellbriety® and the Replication Template outlined in Section Four. Five of the elements have levels of evidence [reliability and validity of



findings] that are in the Program Evaluation range and the three recommended categorical curricula that have a Randomized Control Group [NREPP] evidence base. The critical difference in the evidence base for Wellbriety® is that, instead of studying different group and individual **activities** of the Firestarters for outcomes, Wellbriety® studied the Firestarters as **model mentors** to deliver a variety of Healing Forest components.

In the Native evaluation paradigm, this represents the strongest evidence for inclusion in the community's recovery and prevention programming. Wellbriety, as noted above, is a lifestyle of sobriety and overall wellness which was measured in the 326 trained Firestarters at the six-month post-training milestone, with 309 participants adopting a lifestyle of alcohol and drug abstinence [96.9%], 5 [1.5%] experiencing 1-2 days of intoxication and 2 experiencing 1 day of illicit drug use on a monthly basis. No participant had more than 2 days of drinking 5 drinks, drinking less but feeling "high" or using illicit drugs in the month preceding a six-month follow-up survey. In terms of overall wellness, only 5 Firestarters rated their health as "poor" [1.5%] and 275 [86.2%] rated their overall health as "good", "very good" or "excellent".

SAMHSA social growth indicators of the Firestarters' lifestyle.

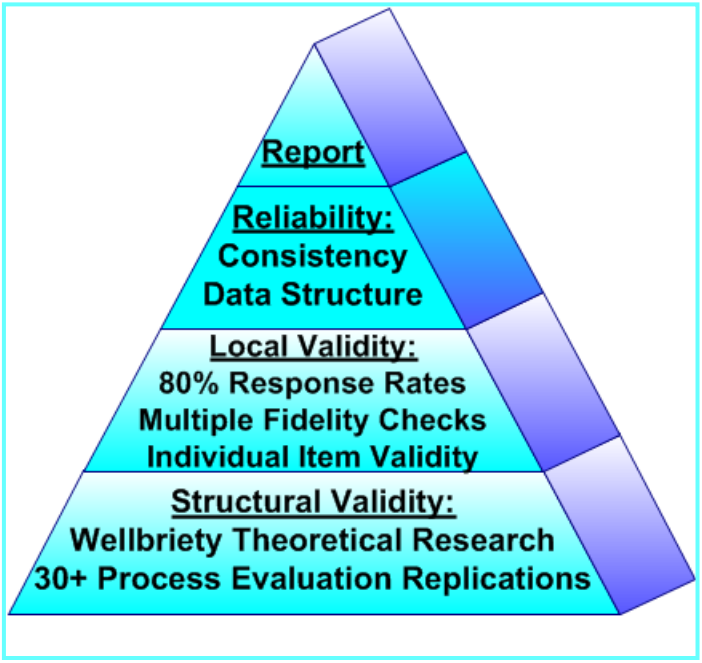
Behavior	**Baseline**	**Six-Month Follow-up**
Pro-social indicator by a crime-free lifestyle.	93.3%	96.3% [3.2%↑]
Employment and/or School enrollment level.	80.7%	85.9% [6.4%↑]
Negative substance-related personal and social consequences.	99.0%	99.3% [3.3%↑]

5.B. Qualitative Data and Program Evaluation

Qualitative analysis uses systematic, verifiable methods to distill complex, lengthy data, such as the data from different parts of a program's process and outcome, into a meaningful account of change within a community. The purpose of analyzing the focus group data was to accurately summarize the perspectives of the student participants.

The GPRA + Instrument has been summarized in a Code Book [Page 52] to provide consistency in entering data and allows for, item by item, a review of behaviors related to Wellbriety® that may be measured in the Firestarters or those they assist in group or individual support.

In order to maximize reliability of the information, White Bison has standardized implementation into a multi-level evaluation of the data, internal consistency of response items, and inter-rater reliability—replicating findings across 24 cohorts in the Recovery Community Support Program. The greater the reliability of the data, the greater the validity of the findings. Mind mapping the data and looking at multiple different Wellbriety® Behaviors is akin to integrating Focus Group data. The "long-table" approach, as described in the standard work on focus groups (Krueger & Casey, 2000), was used to analyze the data.



The GPRA+ set of items and instruments for fidelity checks have been given pre- and post- at six month intervals in 24 cohorts from 2004-2009. They have been collected in the manner described in Chapter 7 as outlined in the **" Follow-up Instrument with GPRA+".**

Prior to each training, participants completed a standardized instrument of health and social behaviors capable of tracking federal peer recovery program markers; commonly called "GPRA" [Government Performance and Results Act] indicators. In addition, cultural character, leadership and cultural competency items were added to the instrument—leading to the name GPRA+. Data staff re-administered these instruments, six months post-training, in a manner of semi-anonymity through using matching code numbers. In order to minimize error and maximize reliability in evaluating pre- and/or post-testing, the data was entered in the Center for Substance Abuse Treatment's web-based management information system which develops multiple recovery science reports for quasi-experimental evaluation.[82] The Firestarter cohorts of 388 trained volunteers were tracked through this repeated measurement process and 326 [84%] remained in the project at the six-month milestone; as measured by continuing voluntary contact with the trainers in the ongoing evaluation process.

In addition to the report on behavioral change, the data instruments allow for describing the Wellbriety® field of study where change will be expected to take place. Deficits in this field can

be addressed by additional continuing education—this ongoing Program Evaluation with quality improvement cycles, though quasi-experimental in nature, allows for an environmental change approach that can be refined as the project goes forward.

Wellbriety® Field of Study [Example data presentations from different cohorts].

⇨ Who was in the Firestarter Group**? Example:** Of the 30 participants, 27 completed a SAMHSA survey [GPRA Indicators] and 25 completed four enhanced scales [GPRA+]. Factoring in participants who refused to answer questions: Twelve [N=12, 44%] were male and fifteen [N=15 56%] were female. Eighteen of those identifying their ethnicity were Native Americans [N=18, 67%], seven [N=7, 26%] were European Americans ("White"), two [2, 7.5%] were Latino and one [4%] identified as "other". Twenty [N-20, 74%] were parents and seven [N=7, 26%%] had never had children. Twenty-seven [N=27, 100%] were High School graduates, twenty [N=20 88%] completed at least two years of College and eleven [N=11, 41%] had a four-year degree. Four [N=4, 16%] were currently in school or vocational training.

⇨ What was the state of the Group's own Behavioral Health? **Example:** None of the participants had consumed alcohol no participants acknowledged any illicit drug use—reflecting the growing focus on Wellbriety® work as being abstinence-based, even if the person was not a recovering alcoholic or addict. In the area of other behavioral health problems: two [N=2, 7.5%] had experienced recent serious depression, three[N=3, 11%] were involved in the legal system, none had been arrested in the previous month, none acknowledged significant anxiety, one [N=1, 5%] experienced significant cognitive confusion, eight [N=8; 29%] reported unprotected sex in the past month, none had a problem with controlling violent behavior and no participant acknowledged suicidal behavior. Twenty-four [N=24, 89%] rated their "overall health" of "Good" or above. One participant [N=1, 3.7%] had received physical, outpatient health care, two [N=2, 7.5%%] had received outpatient mental health. None had gone to the Emergency Room.

⇨ **What was the level of Cultural Self-Efficacy, Leadership and Character Building?**
Example: The Firestarter group had strong Leadership Skills and high levels of Character needed for being Firestarters. They entered the training with a moderate amount of Cultural behaviors needed to effectively function as Firestarters—which will be reviewed after a six-month implementation.

In the Firestarter Training, White Bison administered items to measure four capacities: cultural self-efficacy, coordinator leadership skills, facilitator character and healthcare usage frequency. Questions 1-11 measure key cultural behaviors that describe the level of Native identity relevant to Wellbriety® skills[10], Questions 12-16 describe the level of Leadership skills relevant to coordinating and delivering Wellbriety® groups and services, Questions 17-21 describe the Character needed to facilitate Wellbriety® groups and services and Question 22-28 ask the frequency in which participants seek healthcare. It is given at the training and at the 6 month follow-up. The scores of this cohort of Firestarters were higher, in all 3 areas, than the previous group tested by this instrument, though they were all within 1 raw scale unit:

- Cultural Self-Efficacy Average: 54.5% [Mean=6.0 of 11]
- Leadership Average: 88.0%. [Mean=4.40 of 5 Likert Scale]
- Character Average: 90.6% [Mean=4.53 of 5 Likert Scale]

[10] Behavioral measures ["walking the walk"] describe self-efficacy; whereas knowledge describes understanding. *Self-efficacy is people's confidence in their ability to behave is a necessary manner which comes by living the skill.*

- Healthcare Usage Frequency: The measurement is being developed

The Firestarter Training Process

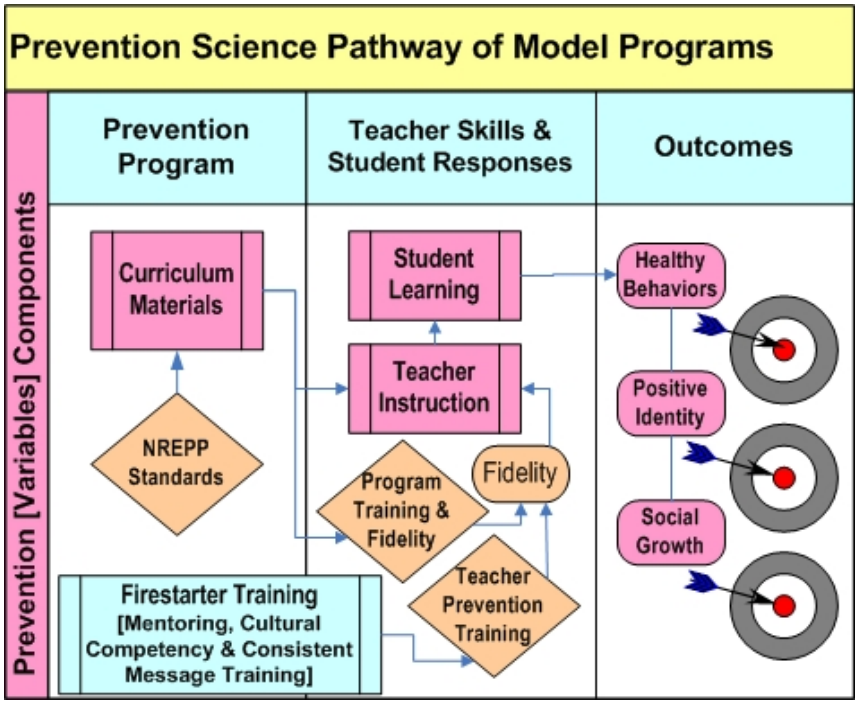
The Participant Satisfaction rating of the participants for the overall 3-day training process was a 4.93 on a Likert Scale of 1-5; where 5=Very Satisfied, 1=Very Dissatisfied and 3 was a mid-point. Rating range was: 25=5; 2=4.

The participants also rated 2 areas critical to the training learning objectives. The entire 24 items of these three scales is found in Attachment Four. The average of each scale is as follows:

- Replication Confidence=4.2 [Nine items identifying the participant's confidence in being able to replicate a portion of the program when facilitating their own Wellbriety® Group].
- Curriculum and Resource Confidence=4.29 Five items identifying the participant's confidence in effectively using the curriculum and resources of the Wellbriety® Group: Training Component Helpfulness=3.7. Participants rated 10 strategies they learned to implement the curriculum and instruction when providing Wellbriety® Groups. All strategies were rated above a 4.0 except the "Cycles of Life" instruction [3.9].

Summary of the Program Evaluation History of the Wellbriety® Firestarters' Program

Wellbriety® Group Facilitator training, and the Coalitions as Clans strategic planning that creates an environmental prevention effort, offers an evidence-based structure of mentoring and culturally competent peer support groups, operated by Instructors who are healthy role models, which can be infused with a categorical curriculum suited to the needs of the community—usually taken from SAMHSA's model or promising programs list and CSAT's Best Practices. This pre-service Prevention Training develops *the community capacity*, through a growing cadre of trained Instructors—that is often missing in the *planning and implementation* of evidence-based curriculum.



This support follows the SAMHSA Prevention Platform and ensures this cadre is culturally competent with Native and other family/clan-focused cultures. It further represents an implementation cost that is sustainable; since a trained facilitator can act as an Instructor for a variety of categorical prevention curricula.

5.C. Technical Assistance, Wellbriety Training Institute & Firestarter Steps to Mastery

White Bison's Firestarter Training Program includes linkage of the Firestarters, across many communities, together through the White Bison web portal [www.whitebison.org]. The Wellbriety Training Institute [http://wellbrietytraining.com] provides ongoing community and individual support resources that can assist a Firestarter to achieve a Master Firestarter Certification where they have the needed competencies to train new facilitators. In this way, communities can build a cadre of program educators in their own locale. The process is as follows:

Phase 1: Complete application* and attend the 3 day training (receive a certificateo of attendance).

Phase 2: Firestarter Level 1—Personally make the journey through the Medicine Wheel 12 Steps (notify WhiteBison)

Phase 3: Firestarter Level 2—After completing Phase 2 and successfully facilitating one group and complete GPRA+ followup survey (implement pre/post test and submit to White Bison, Inc.)

Phase 4: Firestarter Level 3—Facilitate Medicine Wheel 12 Steps for 4 groups (Repeat Phase 3 step for 3 additional groups).

Phase 5: Participants receive a Master Firestarter Certification upon successful co-facilitation of a 3 day train-the-trainer with White Bison faculty.

VI. THE WELLBRIETY® PROGRAM EVALUATION INSTRUMENTS

Community Readiness Survey

GPRA +

Follow-up Instrument with GPRA+

Facilitator Knowledge of the Core Teachings of Wellbriety®

Competencies Self Appraisal

Wellbriety® Training Evaluation

Firestarter Training Codebook for GPRA + Responses

White Bison, Inc.
Community Readiness Survey: Wellbriety® Interview Questions

Beginning Note: In the introduction, give your definition of **Wellbriety®** through Steps A through D. Repeat Step D again **before** Dimension D questions.

Step A: In this survey, we would like to ask your feelings about Wellbriety® in your community. This is a word, developed by Native people. It is the movement to healing our whole community by creating a Healing Forest. A Healing Forest program emphasizes **positive cultural supports for families** and **reducing drug abuse through prevention and treatment.** When you think of **Wellbriety®,** we would like you to think of both of these issues linked together. Here is our description of each issue. First I would like to describe Positive Cultural Supports ➔

3. **POSITIVE CULTURAL SUPPORTS** means a return to the natural family and community networks, such as ways of raising children, that existed before the external damage caused by the European American settlement and ongoing control of what is now the 50 United States. In tribal communities, we often call that damage "intergenerational trauma." Most historians, including those in the white community acknowledge this damage done to minority communities' cultures through both subtle institutional racism in school systems and courts, as well as the more obvious trauma caused by confiscating land, enslaving persons as property, imprisoning whole groups of people due to heritage in wartime internment camps and forcing children into boarding schools to unlearn their own culture.
   Now I will describe Preventing and Treating Alcohol or Other Drug Abuse ➔
4. **PREVENTING AND TREATING ALCOHOL AND OTHER DRUG ABUSE.** While different people may debate where drug abuse starts, **Wellbriety®** sees it as the greatest threat to our communities' families. It destroys families, turns anger into rage, increases depression to suicide, leads people to treat others as objects and drains us of the strengths of our young people.

Step B. So, when we ask you about **WELLBRIETY®,** we are asking about your community's efforts to **reduce substance abuse** and **connect positive cultural supports** to that effort.

Step C. Would you like me to re-read the description of **Positive Cultural Supports** or **Preventing & Treating Drug Abuse** again? **Yes**—re-read. **No**—go on to Step D.

Step D. Was I clear enough in my explanation that, when we say the word **Wellbriety®,** we mean building programs to **reduce drug abuse** and **connecting positive cultural supports** to those programs**? Yes**—go on to Survey on the next page**. No**—say "If you have time, I'd like to read the description again" **Then re-read the description.**

Summary of any confusion: If you think the person does not connect both issues in their mind, please tell us why you think that and how it may have impacted the survey here:

A and B. Community Efforts and Knowledge of Efforts

On a scale of 1-10, how much of a concern is improving the Wellbriety® in your community (with 1 being "not at all" and 10 being "a very great concern")? Please explain. *(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)*

Do you have programs, events, activities that address Wellbriety®, such as: the prevention or treatment of substance abuse, domestic violence, intergenerational trauma, suicide, mental health, child abuse, physical health or spiritual health in your community?

If yes, are there:

less than 3 efforts
4 to 10 efforts
More than 10 efforts

3. How long have these efforts been going on in your community? (A)

1 to 3 years
4 to 10 years
Over 10 years

Who can receive services from these efforts? (adults, youth, age range, etc.)

5. What are the strengths of these services?

6. What are the weaknesses of these services?

8. Using a scale from 1 to 10, how aware is the community of these services? (With 1 being "not at all' and 10 being "very aware")

9. What does the community know about these services? (Prompt: who they serve, what services they provide, how to access services, etc.)

C. Leadership

10. Using a scale from 1 to 10, how concerned are your leaders about the Wellbriety® of your community? (with 1 being "not at all" and 10 being "a very great concern")

11. How are these leaders involved in efforts regarding improving the Wellbriety® of your community?
Please explain.

12. Would the **l**eadership support additional efforts to address Wellbriety® in your community? Please explain.

Possibility: Insert the definition of Wellbriety® here and read to the participant again as a reminder.

D. Community Climate

13. What is the community's attitude about Wellbriety®?

14. How does the community support these efforts?

15. What are the primary obstacles to Wellbriety® efforts in your community?

16. Is there ever any circumstance in which members of your community might think that unhealthy behavior should be tolerated? Please explain.

E. Knowledge of the Issue

17. How knowledgeable are community members about Wellbriety®? Please explain.

18. What type of information is available in your community regarding Wellbriety®? i.e. communication skills, relationship issues, positive parenting, etc.

19. What local data are available on the Wellbriety® (health) of your community?

F. Resources

17. What is the community's attitude about getting involved (e.g., volunteering time, financial donations, providing space) in improving the Wellbriety® efforts?

18. How knowledgeable is the community on how to obtain resources for Wellbriety® efforts?

19. Are you aware of current efforts to obtain additional resources? If yes, please explain.

20. Do you know if any of the current efforts are being evaluated? (If yes, on a scale of 1 to 10, how far along is the evaluation effort; with 1 begin "not at all" and 10 being "very far along") (F)

White Bison Inc.

Date:	
Client ID:	
Please put the Client ID ↑ number on the bottom of each page of this form.	

GPRA+: HEALTH AND SOCIAL ACTIVITY SURVEY

All questions contained in this questionnaire are strictly confidential and will only be identified by your Client ID Number.

Name *(Last, First, M.I.):*	☐ **M** ☐ **F**	**DOB:**
Marital Status➔	☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**	
Ethnicity ➔ (Optional)	☐ **African American** ☐ **Latino [Hispanic]** ☐ **Native (Tribe_____)** ☐ **Caucasian/White** ☐ **Pacific Islander** ☐ **Asian** ☐ **Multiracial (_____),** ☐ **Other (_____)**	

Please choose one answer ➔	**First Time Taking Survey** ☐	**Second Time Taking Survey** ☐	**Third Time Taking Survey** ☐

Turn to the next page and complete the remaining questions on the survey.

When you complete the survey, please return it to the group leader.

Thank you!

PERSONAL HEALTH HISTORY

1. How would you rate your overall health right now?

- ☐ EXCELLENT
- ☐ VERY GOOD
- ☐ GOOD
- ☐ FAIR
- ☐ POOR

2. In the last 30 days, NOT due to alcohol or drug use, how many days have you: [Mark down a number from 0-30]

Example	Went to the market to pick up food?	[0|5]
a.	Experienced serious depression?	[__|__]
b.	Experienced serious anxiety or tension?	[__|__]
c.	Experienced serious problems concentrating, understanding or other memory problems?	[__|__]
d.	Experienced trouble controlling violent behavior?	[__|__]
e.	Thought of a plan to commit suicide?	[__|__]

3. In the last 30 days how many days have you: [Mark down a number from 0-30]

a.	Drank an alcoholic beverage for any reason [socially, with a meal, recreationally, etc]?	[__|__]
b.	Drank at least five beers, shots or glasses of wine in an evening?	[__|__]
c.	Smoked marijuana without a prescription?	[__|__]
d.	Used chew or “smokeless” tobacco?	
e.	Smoked cigarettes?	[__|__]
f.	Smoked 4 or more cigarettes?	[__|__]
g.	Used an illegal drug to get high [not mentioned above]?	[__|__]
h.	Used Oxycodone, Oxycontin, Vicadin or other pain medication without a prescription?	[__|__]
i.	Had sex in a way that risked passing sexual infections between you and your partner?	[__|__]
j.	Became so upset that you yelled at your partner or a family member in an aggressive manner?	[__|__]
k.	Became so upset that you pushed or hit your partner or family member in an argument?	[__|__]
l.	Experienced a partner or family member yelling at you in an aggressive manner?	[__|__]
m.	Experienced being pushed or hit by your partner or family member in an argument?	[__|__]

Please turn to next page ⇨⇨⇨⇨

PERSONAL IDEAS ABOUT CULTURE

4.A. How would you describe your culture to someone who lived outside your community? **[Please take a minute to write one or two sentences for that description]:**

B. How connected is your family to its cultural heritage?

- ☐ Strongly Disconnected
- ☐ Somewhat Disconnected
- ☐ Neither connected or disconnected
- ☐ Somewhat connected
- ☐ Strongly Connected

C. How well do you know your family's traditional celebrations, cultural practices or ceremonies?

- ☐ Don't know at all
- ☐ Slightly know them
- ☐ Know at an average level for someone my age
- ☐ Know at a level above average
- ☐ Know at a level very much above average.

D. How well do you know your ancestral history?

- ☐ Don't know at all
- ☐ Slightly know them
- ☐ Know at an average level for someone my age
- ☐ Know at a level above average
- ☐ Know at a level very much above average.

E. How connected do you feel to your cultural heritage?

- ☐ Strongly Disconnected
- ☐ Somewhat Disconnected
- ☐ Neither connected or disconnected
- ☐ Somewhat connected
- ☐ Strongly Connected

5. How well do you know about traditional activities [arts, crafts, food gathering and preservation].

- ☐ Don't know at all
- ☐ Slightly know them
- ☐ Know at an average level for someone my age
- ☐ Know at a level above average
- ☐ Know at a level very much above average.

Please turn to next page ⇨⇨⇨⇨

HOW YOU MAKE DECISIONS

⇨ 5. On a scale of 1-5, how often would a friend say <u>each sentence</u> describes how you make decisions (choose a number between 1 and 5)?

1 =0-10%, 2 =25%, 3 =50% 4 =75%, 5 =90-100%

☐ **A.** Once you tell people the decision you have made—it is important to you to stick with that decision.

☐ **B.** In a group, you are often a person who believes there is a positive solution to a crisis.

☐ **C.** You enjoy encouraging others to get out of their comfort zone and try something new.

☐ **D.** You begin discussions about spiritual principles to encourage others to share their spiritual beliefs.

☐ **E.** People turn to you to negotiate solutions and resolve conflict among others in a group.

☐ **F.** You feel it is important to understand why another person's opinion is different from yours.

☐ **G.** People would be surprised if you said you would do one thing and then did something else.

☐ **H.** You think what a person says with their body and voice is as important as the words they speak.

☐ **I.** You enjoy talking to people who have more experience than you when making important choices.

☐ **J.** You enjoy the experience of being part of a group effort more than whether a group wins a contest.

Please turn to next page ⇨⇨⇨⇨

CONNECTIONS AMONG YOUR FAMILY

➔ 6. Look at each statement about your family and rate how true it is for you. Rate each statement from "Not True"

not true or hardly ever true= 1 *, sometimes true=* 2 *true about half of the time=* 3
true a lot of the time= 4 *, always true or almost always true=* 5

☐	A. We can easily think of things to do together as a family
☐	B. Family members feel very close to each other
☐	C. Family members ask each other for help
☐	D. I am available when others in the family want to talk to me
☐	E. Family members like to spend free time with each other
☐	F. I listen to what other family members have to say, even when I disagree

ONLY ANSWER IF YOU ARE A MEMBER OF A PARENT & CHILD COUPLE IN YOUR HOME ["PARENT" INCLUDES THE ADULT IN THE HOME RESPONSIBLE FOR A CHILD]

Whether you are the parent or the child, rate the following statements about the parent-child relationship in your house last month

7-point scale: *always* **=①,** *almost always=②,* *fairly often=③,* *about half the time=④,* *not too often=⑤,* *almost never=⑥,* *never=⑦*

During the past month, when the parent-child couple spent time talking or doing things together, how often did the parent:

☐	get angry at the child?
☐	let the child know the parent really cared about him or her?
☐	shouted or yelled at the child because the parent was mad at him or her?
☐	acted loving and affectionate towards the child?
☐	let the child know that the parent appreciated him/her, his/her ideas or things he/she does?
☐	yell, insult, or swear at the child when the parent disagreed?

Follow-up Instrument With GPRA+

Name of Training [and color code]_____

1. **Demographics:**
age, gender, ethnicity, tribal affiliation, role in community, years in community

2. Facilitator Skills Using the following scale, please rate your confidence level in being able to do parts of the training you have received when you are back in your community. [Need new Likert Scale—put in after each item]

___Helping others work through the curriculum (workbook, syllabus, videos)

___Confident in recruiting participants to join a group like this.

___How confident are you that you will be able to find the resources to run a group like this.

___Completing the activities of the Workbook in your own life.

___Would it be appropriate for an opening ceremony to be held in your community before a group. If yes, how confident are you in being able to provide an opening ceremony

3. Cultural Connectedness
Cultural self-efficacy scale now on the GPRA+
4. Leadership
On GPRA+
5. Civic Character
On GPRA+
6. Social Connectedness
GPRA G.1 to G.5---on G.5 Use "all that apply" no "select only one" Add persons
7. Behavioral, Social and Physical Health Profile Items
30-day Use—Just yes or no B.1 and B.2, put them together.

Employed/school D.1 and D.3
Arrested in the past 30 days E.1
Mental/Physical Health:

- F.1 Overall Health
- F.3.b Unprotected Sex Days
- F.4.a-f [drop c]

Facilitator Knowledge of the Core Teachings of Wellbriety®

TEACHING: THE FOUR LAWS OF CHANGE

1. The first Law of Change is that "Change is from within". Please put a check [☒] next to the THREE teachings that are included in this law. Leave the other three blank [☐]:

☐ Everything begins with who we are connected to in this world.

☐ Inside of every human being is the knowledge of his or her own well-being.

☐ All permanent and lasting change starts on the inside, then works its way out.

☐ We must each understand the forest and waters to know others.

☐ A journey is never a straight path.

☐ To ensure permanent change for a person, it must happen on the inside first.

TEACHING: THE HEALING FOREST

2. When we talk about a community as a forest, we can see how that forest can be healthy or unhealthy. Please look at the following statements and mark if the statement is TRUE if it is important to understanding the Healing Forest. Mark it FALSE if it is not important to understanding the Healing Forest.

A. An important part of whether a child grows to be a healthy member of the community forest is whether there is a way to overcome the roots of anger, guilt, shame and fear that is passed down over the generations in an unhealthy forest.

☐ True
☐ False

B. If there are the four elements of water, air, fire and trees, then the child trees will be nurtured even if the old forest is barren.

☐ True
☐ False

C. Lightning of inter-tribal war and the dead limbs of poor food cause young child trees to be stunted or broken.

☐ True
☐ False

D. Traditional cultural practices [such as ceremonies, teachings of the elders, understanding of one's place in the Mother Earth] can provide a healing forest environment for individuals to make positive and healthy choices about their lives.

☐ True
☐ False

E. If the community is to change, it must happen at the root level where values, culture, spirituality, teachings and ethics must replace the anger, guilt, shame and fear.

☐ True
☐ False

F. If the community is to change, it must allow the dead leaves of winter to be replaced by the new buds of spring where elections, crops, reservation independence and national symbols create health.

☐ True
☐ False

G. It is our role as parents and grandparents, community leaders and Elders to create a healing forest for our children grounded in love, respect forgiveness and acceptance.

☐ True
☐ False

H. When allow our children to make new choices, without undue influence of past sayings and spiritual principles, then they will have a new Healing Forest.

☐ True
☐ False

TEACHING: THE CYCLE OF LIFE

3. The cycle of life teachings explain the development of eight thought patterns and the feelings that go with them as a person experiences the healthy path from baby, to youth, to adult, to elder.

A. Sometimes these are called stages of life because they develop in a sequence over time.

☐ True
☐ False

B. The first and most important stage is

☐ Identity [knowing "who I am"]
☐ Accomplishment [being good at something]
☐ Trust [feelings of security]

C. When we talk about a child starting to do things on his or her own, with the help of family and community, that child is experiencing the feeling of [mark the one best answer]:

☐ Connectedness
☐ Autonomy
☐ Self-actualization

D. When adults reach the place of being Elders among our community, what stage of the cycle of life supports the role of the Elder [mark the one best answer]

☐ Initiative behaviors and feeling able to take a risk
☐ Integrity and feeling confident in what to do—even when no one is watching.
☐ Identity behaviors and feeling like I know who I am.

E. It is a natural role in the cycle of life to be supportive parents when you know the behaviors of Generativity, or understanding the intergenerational responsibility to give back what I have learned.

☐ True
☐ False

TEACHING: TALKING CIRCLES

4. Talking Circles have, over time, developed principles that ensure respectful conversations that are important in maintaining community harmony in different types of settings.

A. Please put a check ☒ next to one of four principles found in Talking Circles. If something is not a basic principle of a Talking Circle, leave it blank ☐. You should have marked exactly four principles when you complete this question.

☐ A circle is formed and equal numbers of people sit at each point of the compass.
☐ A circle is formed and people speak one at a time.
☐ The circle is formed outside, in nature, with rain, snow or sun accepted as just part of the circle.
☐ Everyone in the circle would have his or her say. Nobody would be passed over if they wished to speak.
☐ The leader speaks and calls on the two smartest group members to share their opinions with others. Then a vote is taken over which person is correct.
☐ People are not interrupted while they are speaking.
☐ The facilitator uses a timer and each person is given an exactly equal amount of time. People can give their time to someone else to add to their speaking time.
☐ The Talking Circle has an even number of members, but never more than 20 members, including the leader.

COMPETENCIES SELF-APPRAISAL

Location of Training: Date of Training:		Program you attended: Trainer:

Thank you for attending this White Bison Trainings Event. To assist us in maintaining the quality of our Trainings program, please complete the following evaluation of the 3- day event.

1. **Please rate your overall satisfaction with this event (Check the one that best describes your experience):**

____5= very satisfied; ____4= satisfied; ____3= okay; ____2= not satisfied; ____1= very dissatisfied

Please provide comments here that you think will better explain your rating:

2. Identify the program you attended this time:

___MW12 Steps for men
___MW12 Steps for women
___MW12 Steps for friends and family members/adult children of alcoholics
___Other_____

3. Using the following scale, please rate your confidence level in being able to do parts of the training you have received when you are back in your community.

5 = I can do this now 4 = I can do this with a little practice 3 = I can do some things; not others 2 = I do not feel confident at this time 1 = I don't know where to start

Please rate each of these activities 1, 2, 3, 4 or 5:

___Facilitating a group like this in my own community

___Helping others work through the curriculum (workbook, syllabus, videos)

___Inviting others to participate in a group like this

___Engaging community members to help sponsor a group like this

___Explaining the teachings of the Elders to others

___Applying the teachings to my own life

___Understanding the importance of creating trust within the group

___How to introduce local cultural themes, practices, activities into my groups

___How to conduct an opening ceremony for each session

5 = I can do this now 4 = I can do this with a little practice 3 = I can do some things; not others 2 = I do not feel confident at this time 1 = I don't know where to start

4. Using the same scale as Question 2, above, please rate your level of confidence in being able to use the following resources using a rating of 1, 2, 3, 4, or 5:

___Workbook (or activity booklets)

___Facilitator's Manual

___Videos

___Discussion board at the White Bison website

___The Website Demonstration is something you can do with your own group

5. Using the same scale above, please rate the helpfulness of each of the following themes:

___Opening Ceremony

___Recovery Services Coach [Warrior Down] Overview

___Overview of the Wellbriety® Movement

- ___Teachings of the Medicine Wheel
- ___Cycle of Life Teachings (8Thoughts/8Feelings)
- ___Video—Journey of the Sacred Hoop
- ___Four Laws of Change
- ___Healing Forest Model

___Talking Circles

___Mind mapping

6. Please describe your purpose for attending this three day event (check all that apply):

___To become familiar with the various program
___To learn to be a facilitator for the Medicine Wheel and 12 Steps
___To become a Firestarter
___To learn how to provide a service in my community
___To learn how to facilitate a youth program
___To learn how to use culturally appropriate resources in the work that I do

___To learn how to facilitate a family in recovery program
__To learn about the Wellbriety® Movement so I can promote it in my community

7. If you intend to be a Firestarter, are you able to make a four year commitment to serve as a facilitator and recovery services coach? _____yes _____no

What plans will you need to make to be able to succeed at this commitment?

What will you need from White Bison to be able to succeed at this commitment:

8. How do you intend to implement the program that you attended?

9. What possible difficulties in implementation do you think might happen and how do you plan to overcome those difficulties?

9. What was the most important learning that you would like to share with others?

10. What do you think the most important knowledge, skills, or capabilities are for implementing this program in your community? Please name at least two.

11. What comments do you have for the local organizers of the three day event?

12. What recommendations do you have for White Bison to improve the program?

13. If someone was considering taking this training in the future—What would you like to tell that person about this training?

Thank you for completing this survey.

FIRESTARTER TRAINING CODE BOOK FOR GPRA+ RESPONSES

V01 Gender

- 99 No Answer
- 1 Male
- 2 Female

V02 DOB

V03 Marital Status

0. 99 No Answer
1. 1 Single
2. 2 Partnered
3. 3 Married
4. 4 Separated
5. 5 Divorced
6. 6 Widowed

V04 Ethnicity

0. 99 No Answer
1. 1 African America
2. 2 Latino (Hispanic)
3. 3 Native (Tribe _____)
4. 4 Caucasian/White
5. 5 Pacific Islander
6. 6 Asian
7. 7 Multiracial (_____)
8. 8 Other

V05 Time Taking Survey

0. 99 No Answer
1. 1 First Time
2. 2 Second Time
3. 3 Third Time

V06 Overall Health

0. 99 No Answer
1. 1 Excellent
2. 2 Very Good
3. 3 Good
4. 4 Fair
5. 5 Poor

V07 Serious depression

99 No Answer

00-31

V08 Serious anxiety

99 No Answer

00-31

V09 Serious memory/concentration problems

99 No Answer

00-31

V10 Trouble controlling violent behavior

99 No Answer

00-31

V11 Thought of suicide plan

99 No Answer

00-31

V12 Drank Alcohol for any reason

99 No Answer

00-31

V13 Drank at least five units in an evening

99 No Answer

00-31

V14 Smoked marijuana

99 No Answer

00-31

V15 Chewed tobacco

99 No Answer

00-31

V16 Smoked cigarettes

99 No Answer

00-31

V17 Smoked 4 or more cigarettes

99 No Answer

00-31

V18 Used illegal drug not mentioned above

99 No Answer

00-31

V19 Used oxycodone or other pain medication w/o prescription

99 No Answer

00-31

V20 Had risky sex

99 No Answer

00-31

V21 Yelled aggressively at a partner or family member

99 No Answer

00-31

V22 Pushed or hit a partner/family member

99 No Answer

00-31

V23 A partner/family member yelling at you

99 No Answer

00-31

V24 Pushed or hit by a partner/family member

99 No Answer

00-31

V25 DESCRIBE CULTURE TO AN OUTSIDER

V26 Family connectedness to heritage

0. 99 No Answer
1. 1 Strongly disconnected
2. 2 Somewhat disconnected
3. 3 Neither connected nor disconnected
4. 4 Somewhat connected
5. 5 Strongly connected

V27 Family traditions, cultural practices, or ceremonies knowledge

0. 99 No Answer
1. 1 Don’t know
2. 2 Slightly know
3. 3 Average
4. 4 Above average
5. 5 Very much above average

V28 Ancestral history knowledge

0. 99 No Answer
1. 1 Don’t know
2. 2 Slightly know
3. 3 Average for someone my age
4. 4 Above average
5. 5 Very much above average

V29 Connectedness to cultural heritage

0. 99 No Answer
1. 1 Strongly disconnected
2. 2 Somewhat disconnected
3. 3 Neither connected nor disconnected
4. 4 Somewhat connected
5. 5 Strongly connected

V30 Traditional activities knowledge

0. 99 No Answer
1. 1 Don't know
2. 2 Slightly know
3. 3 Average level for my age
4. 4 Above average
5. 5 Very much above average

V31 Important to you to stick with your decisions

0. 99 No Answer
1. 1 0-10%
2. 2 25%
3. 3 50%
4. 4 75%
5. 5 90-100%

V32 Believe in positive solutions to group crisis

0. 99 No Answer
1. 1 0-10%
2. 2 25%
3. 3 50%
4. 4 75%
5. 5 90-100%

V33 Encourage others to try something new

0. 99 No Answer
1. 1 0-10%
2. 2 25%
3. 3 50%
4. 4 75%
5. 5 90-100%

V34 Begin spiritual discussions to encourage others to share

0. 99 No Answer
1. 1 0-10%
2. 2 25%
3. 3 50%
4. 4 75%
5. 5 90-100%

V35 People turn to you to resolve group conflict

0. 99 No Answer
1. 1 0-10%
2. 2 25%
3. 3 50%
4. 4 75%
5. 5 90-100%

V36 You feel it is important to understand differing opinions

0. 99 No Answer
1. 1 0-10%
2. 2 25%
3. 3 50%
4. 4 75%
5. 5 90-100%

V37 It would be surprising if you said one thing and did another

0. 99 No Answer
1. 1 0-10%
2. 2 25%
3. 3 50%
4. 4 75%
5. 5 90-100%

V38 You think body language and voice is as important as words spoken

0. 99 No Answer
1. 1 0-10%
2. 2 25%
3. 3 50%
4. 4 75%
5. 5 90-100%

V39 You enjoy talking to more experienced people when making important choices

0. 99 No Answer
1. 1 0-10%
2. 2 25%
3. 3 50%
4. 4 75%
5. 5 90-100%

V40 You enjoy experiencing group efforts more than whether a group wins a contest

0. 99 No Answer
1. 1 0-10%
2. 2 25%
3. 3 50%
4. 4 75%
5. 5 90-100%

V41 Easy to think of family activities

0. 99 No Answer
1. 1 Not true or hardly ever true
2. 2 Sometimes true
3. 3 True about half of the time
4. 4 True a lot of the time
5. 5 Always or almost always true

V42 Family members feel close

0. 99 No Answer
1. 1 Not true or hardly ever true
2. 2 Sometimes true
3. 3 True about half of the time
4. 4 True a lot of the time
5. 5 Always or almost always true

V43 Family members ask for help

0. 99 No Answer
1. 1 Not true or hardly ever true
2. 2 Sometimes true
3. 3 True about half of the time
4. 4 True a lot of the time
5. 5 Always or almost always true

V44 Available to other family members

0. 99 No Answer
1. 1 Not true or hardly ever true
2. 2 Sometimes true
3. 3 True about half of the time
4. 4 True a lot of the time
5. 5 Always or almost always true

V45 Family likes to spend free time together

0. 99 No Answer
1. 1 Not true or hardly ever true
2. 2 Sometimes true
3. 3 True about half of the time
4. 4 True a lot of the time
5. 5 Always or almost always true

V46 I listen to family, even when I disagree

0. 99 No Answer
1. 1 Not true or hardly ever true
2. 2 Sometimes true
3. 3 True about half of the time
4. 4 True a lot of the time
5. 5 Always or almost always true

V47 Parent got angry with the child

0. 99 No Answer
1. 1 Always
2. 2 Almost always
3. 3 Fairly often
4. 4 About half of the time
5. 5 Not too often
6. 6 Almost never
7. 7 Never

V48 Parent let child know they really cared

0. 99 No Answer
1. 1 Always
2. 2 Almost always
3. 3 Fairly often
4. 4 About half of the time
5. 5 Not too often
6. 6 Almost never
7. 7 Never

V49 Parent yelled at child

0. 99 No Answer
1. 1 Always
2. 2 Almost always
3. 3 Fairly often
4. 4 About half of the time
5. 5 Not too often
6. 6 Almost never
7. 7 Never

V50 Parent was loving/affectionate toward child

0. 99 No Answer
1. 1 Always
2. 2 Almost always
3. 3 Fairly often
4. 4 About half of the time
5. 5 Not too often
6. 6 Almost never
7. 7 Never

V51 Parent let child know he/she was appreciated

0. 99 No Answer
1. 1 Always
2. 2 Almost always
3. 3 Fairly often
4. 4 About half of the time
5. 5 Not too often
6. 6 Almost never
7. 7 Never

V52 When parent disagreed, yelled/insulted/swore at child

0.	99	No Answer
1.	1	Always
2.	2	Almost always
3.	3	Fairly often
4.	4	About half of the time
5.	5	Not too often
6.	6	Almost never
7.	7	Never

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