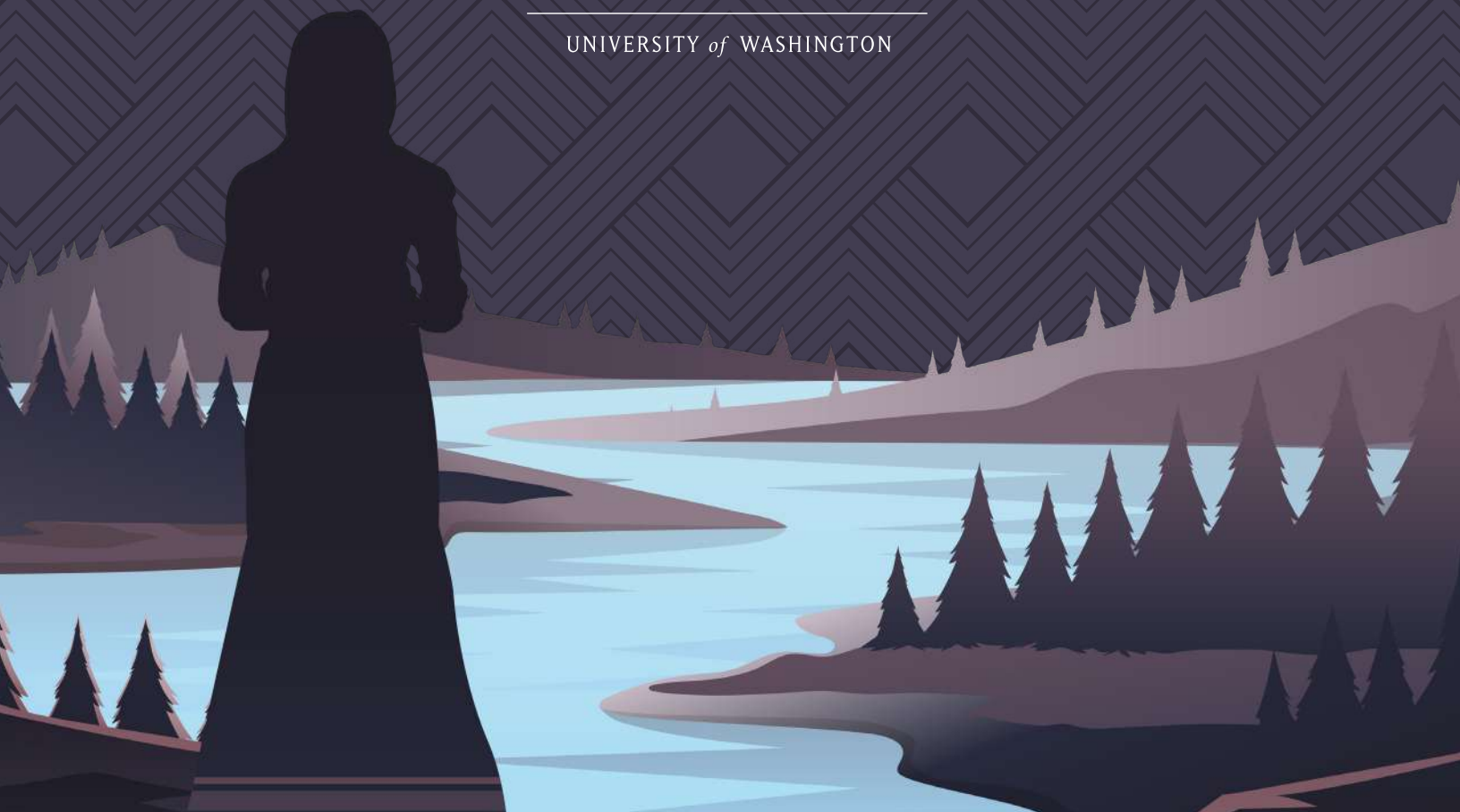
Indigenous Evaluation Toolkit: An Actionable Guide for Tribal and Urban Indian Adverse Childhood Experiences (ACEs) Prevention Programs

JULY 2024

SEVEN DIRECTIONS
A CENTER FOR INDIGENOUS PUBLIC HEALTH
UNIVERSITY of WASHINGTON



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About Seven Directions:

In August 2016, Seven Directions was founded as the first national public health institute in the United States to focus solely on Indigenous health and wellness. Our mission is to advance American Indian and Alaska Native health and wellness by honoring Indigenous knowledge, strengthening Tribal and Urban Indian public health systems, and cultivating innovation and collaboration.

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Acknowledgments

The authors and entire team at Seven Directions thank the American Indian Higher Education Consortium (AIHEC), Dr. Joan LaFrance, and Richard Nichols, whose influential work, Telling Our Story in Our Place and Time: Indigenous Evaluation Framework, serves as the conceptual foundation for our 2023 *Indigenous Evaluation Toolkit* and this adverse childhood experiences-specific companion guide. This Framework is used with permission of AIHEC. Katie M. Hess, MPH (Native Hawaiian), has over a decade of experience focused on culturally based family support services. We thank Katie for her careful review which ensured that this guide honored the gravity of adverse childhood experiences in Indigenous communities and improved the guide's utility for readers. We greatly appreciate the Seven Directions' Tribal Opioid Technical Advisory Group (OTAG) members' contribution to the development of our Indigenous evaluation body of work. In addition, this brief would not have been possible without earlier, formative work of the broader Seven Directions team including Caelin Marum and Tsering Wangmo. Finally, thanks also to our partners at the Centers for Disease Control (CDC) National Center for Injury Prevention and Control and Network for National Public Health Institutes (NNPHI) for their ongoing funding and support for this project as well as their close review of this guide to ensure relevance and accessibility for practitioners in this critical field of injury prevention.

We dedicate this guide to Indigenous ancestors and communities whose knowledge and traditions have supported the health and well-being of Indigenous peoples since time immemorial. We hope this guide will uphold these strengths and promote the imperative need for Indigenous evaluation approaches in health promotion and prevention programming.

Foreword

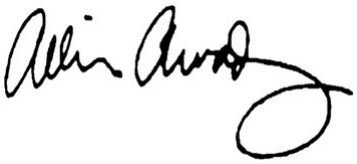
In 2023, the release of the Indigenous Evaluation Toolkit: An Actionable Guide for Organizations Serving American Indian/ Alaska Native Communities through Opioid Prevention Programming added to a growing body of resources dedicated to Indigenizing and decolonizing program evaluation approaches. We hope this 2024 update continues to build on the momentum the Toolkit generated among tribal and urban Indian overdose prevention programs as they integrate Indigenous methodologies into their program design and evaluation.

While the 2023 Toolkit encouraged widespread usage across all public health promotion activities, the examples were drawn exclusively from overdose and substance use prevention programs. In this 2024 update we are thrilled to support the expansion of the original Toolkit to encompass a broader spectrum of public health challenges faced by tribal and urban Indian communities, including reducing the risks and harms of suicide, impaired driving, and adverse childhood experiences. This update offers more opportunities for communities to address these topics using Indigenous knowledge and approaches.

We acknowledge the obstacles faced by Indigenous public health practitioners and are committed to paving the way for positive change. We aim to lead by example and begin the shift towards recognizing Indigenous methodologies as scientifically valid approaches to designing and evaluating tribal public health programs.

The Toolkit, supplements and other similar resources are a testament to our collective commitment to advancing health and wellness for American Indian and Alaska Native people. We appreciate and honor the leadership in developing these types of resources and the many tribal and urban Indian communities for sharing their experiences and contributions to the development of these resources.

Respectfully,



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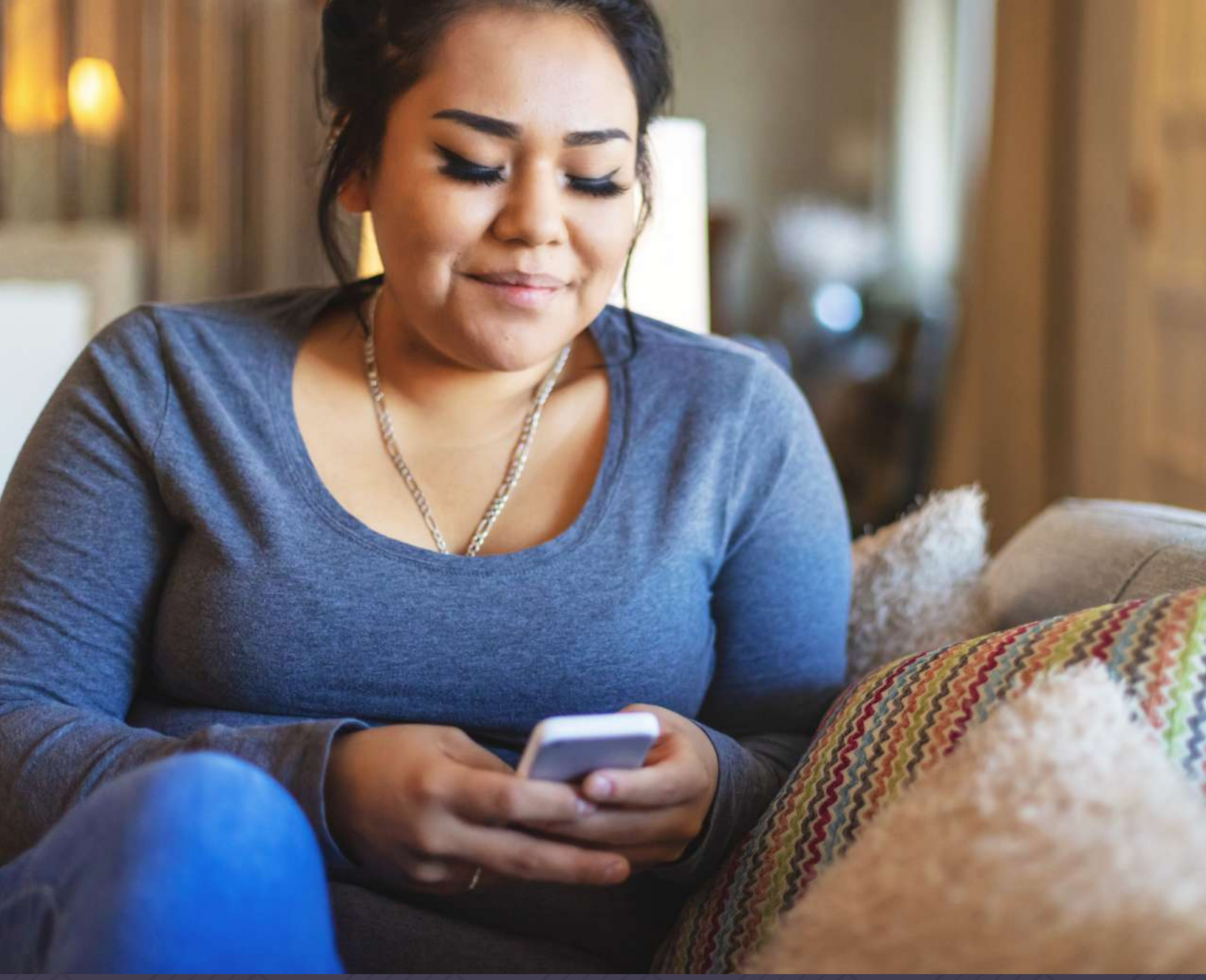


Overview

This guide encourages tribal and urban Indian communities and their partnering organizations to tell their own stories and reclaim Indigenous ways of knowing as a basis for evaluation, with the goals of increasing health and wellness and preventing adverse childhood experiences through improved programs and services.

Broadly speaking, “Indigenous evaluation” refers to the use of Indigenous ways of knowing, meaning-making, and deep community involvement when designing or evaluating an effort’s effectiveness or community impact. Indigenous communities have engaged in review and reflection to understand the impact of community decisions or activities (i.e., “evaluation”) since time immemorial. In contrast to Western research and evaluation approaches – which rely on theories and frameworks developed within European-settler contexts – Indigenous perspectives take a more holistic approach. This holistic approach differs from Western approaches, both in terms of what is knowable and measurable and in terms of who is involved in evaluation efforts.

For example, whereas Western approaches prioritize the use of empirical data and an external, objective evaluator, Indigenous evaluation prioritizes using multiple forms of knowledge as well as community ownership of and deep involvement in evaluation activities. In addition, while Western evaluation approaches may envision evaluation as a set of activities distinct from and often done *after* program design and operation, Indigenous evaluation views evaluation activities as part of a cyclical learning process, in which evaluation is interwoven with program design and implementation. It can also be viewed as a continuous learning process rather than a one-time reflection of a past state. This pairing of program and evaluation design allows communities the opportunity to infuse community values, voice and ownership throughout all aspects of a community effort.

In February 2023, Seven Directions released the Indigenous Evaluation Toolkit: An Actionable Guide for Organizations Serving American Indian/Alaska Native Communities through Opioid Prevention Programming.[1] This Toolkit was developed via collaborative, iterative, and community-based partnerships. With the support of Dr. Joan LaFrance, the Toolkit utilized the prior Indigenous Evaluation Framework developed by the American Indian Higher Education Coalition (AIHEC), in collaboration with Drs. LaFrance & Nichols (2009), as the foundation for translating Indigenous values into actionable phases and steps that teams can work through at their own pace.[2] Reception for the Toolkit was overwhelmingly positive. Feedback conveyed both appreciation for the Toolkit steps and activities, and a desire for more issue-specific examples of how other programs are utilizing Indigenous success measures, knowledge-gathering activities, or success-sharing practices in their evaluation efforts.

While the 2023 Toolkit encouraged widespread usage for all public health promotion and prevention activities, examples of ways to use Indigenous knowledge or practices in program design and evaluation were drawn from CDC-funded Opioid Overdose Prevention in Tribal Communities and other substance use prevention programs. In this 2024 update, we have developed these special interest guides to demonstrate how Indigenous evaluation approaches and the actionable steps contained in the Toolkit can be applied to an array of public health prevention efforts, including the prevention of suicide, impaired driving, adverse childhood events, and many others.

This guide focuses on the urgent need to address inequities in adverse childhood experiences (ACEs) among Indigenous communities throughout North America. ACEs are potentially traumatic events that occur in childhood (birth-17 years of age) and are associated with numerous negative health conditions, disability, and risk of addiction.[3,4,5] Studies indicate that American Indian and Alaska Native (AI/AN) children have a higher prevalence and accumulation of ACEs than the general population.[6,7] Additional surveillance data from 2011-2020 reveals that ACEs were comparatively highest among non-Hispanic AI/AN adults.[8] Despite the higher prevalence of ACEs in AI/AN populations, some studies suggest that the presence of cultural and community strengths can serve as buffers or resilience factors that can mitigate the negative impacts of ACEs among AI/AN people.[8,9]

Tribal and urban Indian ACEs prevention programs increasingly involve Indigenous community members in their program planning or incorporate cultural elements to tailor program design (See Section 2 below). However, providing structured guidance on how to integrate Indigenous knowledge, values, and community engagement principles in the design and evaluation of other ACEs prevention programs represents a critical need to ensure ACEs prevention. The purpose of this guide is to support tribes and tribal-serving organizations' inherent strengths through examination of their ACEs prevention program's design and evaluation using Indigenous approaches. **Using the structured approach described in the 2023 Toolkit, along with ACEs prevention-specific examples in Section 5 of this Guide, these materials provide tailored information for readers focused on ACEs prevention in their communities.** These materials enable teams to outline their visions, Indigenous success measures, decolonized data collection approaches, and plans to build community ownership at all phases of program and evaluation design and implementation.

This guide provides:

- An overview of the problem scope, risk factors, and protective factors in Indigenous communities shaping ACEs prevention efforts;
- Community-based examples of ways to ground ACEs prevention programming and evaluation needs in Indigenous values and knowledge;
- A companion story of an ACEs prevention team utilizing Indigenous evaluation to improve programming.
- Samples of completed worksheets for teams' reference while working through the Toolkit

Who Should Use This Guide

The primary intended audience for this guide includes any team responsible for the leadership, management, evaluation, and implementation of programs addressing ACEs prevention in tribal and urban Indian communities.

A Note on Terminology

"Indigenous" Community Identification

In this Toolkit, we use "Indigenous" and "tribal and urban Indian communities" broadly to refer to peoples with ancestral and cultural origins in the many territories that now make up the United States. At Seven Directions, we recognize that "Indigenous" and terminology such as "Native American, American Indian, and Alaska Native" were not chosen by sovereign Native nations and Indigenous communities, and are based in settler colonial language, grouping together vast and diverse populations into aggregate terms. The experiences and cultures of Indigenous people are heterogeneous, and each tribal nation and Indigenous community is unique. We encourage the use of the specific tribe or band name and tribal language when possible. Please see the Glossary at the end of this document for more detailed definitions.

Evaluation and Research Terms

Throughout the Toolkit, we use the term "evaluation" to describe a systematic process for collecting, analyzing, and using data and knowledge to examine the effectiveness and efficiency of a program. We differentiate this from "research," the purpose of which is to investigate materials or sources to establish fact or reach a new, generalizable conclusion, not to examine a specific program or process for effectiveness. Within both evaluation and research, different communities may use a variety of terms to describe the ways in which they obtain data or knowledge: *methodology, approach, strategy,* or simply *knowledge-gathering activities* are some examples. These terms offer a starting point; culture, language, and historical experience all impact how words are defined. We invite you to apply these terms with your own local context in mind.

See the Glossary on page 34 for additional terminology notes.

1

Background: Adverse Childhood Experiences (ACEs) as a Critical Public Health Issue in Many American Indian & Alaska Native Communities

Adverse childhood experiences (ACEs) are defined as potentially traumatic events that occur in childhood (birth-17 years of age). ACEs may include, but are not limited to, exposure to abuse (emotional, physical, sexual), neglect, food insecurity, discrimination; growing up in environments of family disruption such as divorce/separation, incarceration of a family member, parental substance abuse; and witnessing domestic violence.[10] **Studies indicate that AI/AN children have a higher prevalence and accumulation of ACEs than the general population.**[6,7] Additional surveillance data from 2011-2020, reveals that ACEs were comparatively highest among non-Hispanic AI/AN adults.[11]

The CDC-Kaiser ACEs study, published in 1998, was the first to identify a relationship between exposure to abuse and poor health outcomes in older adults.[4] The CDC reports at least five of 10 leading causes of death can be attributed to ACEs in the general U.S. population.[3] Among AI/AN populations, studies have demonstrated that ACEs are linked to chronic health problems, mental health distress, and substance misuse.[12-14] The correlation between adverse experiences in childhood and poor health outcomes throughout the lifespan can be explained, in part, through the mechanism of toxic stress.[15] Experiencing stress is normal and important for healthy development.[4] However, prolonged exposure to stress in the absence of safe, stable, nurturing relationships and environments can harm a child's developing brain, changing the way stress is handled, and weakening the body's immune system, which can have lasting health consequences across the lifespan.[15,16]

While public health information surrounding ACEs is not lacking in statistics, it is important to consider social determinants of health when contextualizing ACEs in AI/AN communities.[17] Emerging ACEs research considers the unique histories and experiences of AI/AN populations through frameworks such as the Indigenist Stress Coping Model[18] and the Framework for Historical Oppression, Resilience, and Transcendence (FHORT).[19] These models provide a lens through which historical trauma and ongoing colonial oppression are accounted for as contributors to the increased likelihood of being exposed to ACEs among AI/AN children. For example, from the late 1800s to the mid-1900s, the U.S. government enacted legislation that forcibly removed AI/AN children from their homes and placed them in Christian boarding schools. Children at these boarding schools faced malnutrition, disease, physical and sexual abuse, and severe discipline if they spoke their languages or engaged in cultural practices.[20] It was not until 1978 that AI/AN parents gained the legal right to deny their children's placement in off-reservation schools (Indian Child Welfare Act). Boarding school youth experienced ACEs and disconnection from culture, which in turn increased the likelihood of disruptions in their parenting styles and the ability to pass cultural practices to subsequent generations. These types of harmful treatment of AI/AN youth continue today with systemic prejudices perpetrated by juvenile justice, child welfare services, and the foster care system.[21,22]

Contextualizing ACEs **risk factors** specific to AI/AN communities with risk factors for the general population are important when developing prevention programming. ACEs are not often caused by a single factor. A combination of factors at the individual, relationship, community, and societal levels can increase or decrease the risk of ACEs. Importantly, no child or individual should ever be blamed or held responsible for ACEs they experience. These events are out of their control, and they likely had little power or ability to prevent them.

Studies have identified risk factors for ACES in the general population including child's age, family structure (single parent vs two-parent households), poverty, type of health insurance, and special health care needs status.[23-25] Socioeconomic status (SES) represents an important risk factor for exposure to ACEs.[26] Other studies confirm parenting stress, which includes negative feelings related to the demands of parenting, can also be an important risk factor for child maltreatment and neglect.[23] These studies explore the possibility of intergenerational transmission of ACEs. This occurs when parents who have been exposed to ACEs are more likely to expose their children to ACEs.[23,27] A study of AI/AN adolescents and young adults living in six reservation communities identified discrimination and historical loss as relevant ACE factors associated with post-traumatic stress disorder, depression, poly-drug use and suicide attempts.[28]

Key factors that may prevent ACEs (i.e. "**protective factors**") and promote positive childhood experiences in the general population include families who create safe, stable relationships, children who have positive peer networks and do well in school; children with caring adults outside of the family; communities where families have access to financial help, medical care and mental health services; and communities where residents feel connected to each other and are involved in the community.[25] These factors are supported by enacting programs and policies that promote safe, nurturing environments such as paid family leave, early learning programs, financial assistance programs, school mentoring programs, affordable childcare, after-school activities, and family-centered treatment for mental health and substance use disorders. The Indigenist Stress Coping Model proposes life stressors (e.g., historical trauma, discrimination) are moderated by cultural factors such as cultural identity and traditional health practices that can act as buffers and will strengthen mental and physical health.[18] Key protective factors for AI/AN communities include formal prevention programming[29] and informal community support that is grounded in traditional knowledge and cultural practices. Funders, federal, state and local organizations can support these protective factors by increasing awareness of historical trauma and continued structural inequities and enacting policy changes to reverse harms.

2 Indigenous Approaches for ACEs Prevention Programming Offer Opportunities for Safer Communities

Indigenous communities have begun to address ACEs and other public health issues by revitalizing Indigenous ways of knowing and focusing on the factors that contribute to improved health and wellbeing among individuals and communities. While the goal is to reduce the occurrences of maltreatment and traumatic events before they happen *(i.e., primary prevention[I])*, it is also important to identify intervention strategies to mitigate the harmful effects if individuals are exposed to ACEs *(i.e., secondary and tertiary prevention[II])*. Broadly speaking, ACEs prevention includes programs focused on: parent/caregiver education and support; family economic security; mental health services for adults and youth; domestic violence prevention services; structural support for local schools and community services.[30]

Successful **ACEs primary, secondary and tertiary prevention** efforts include:

- **Family Spirit**[31] is an evidence-based home-visiting program created by and for Indigenous families. The Family Spirit curriculum consists of highly structured maternal and child health content delivered by a trained health educator from the community. The content focuses on three domains: parenting skills, maternal drug use prevention, and positive maternal health practices and life skills. The Family Spirit Intervention has been rigorously evaluated in multiple AI/AN communities across the United States. Notable impacts include increased knowledge in parenting practices, increased belief in capacity to perform positive health behaviors by mothers, and increased home safety knowledge. The findings have also revealed cascading effects on infant health and development. Children in the intervention group experienced fewer externalizing problems (impulsivity and aggression), fewer internalizing problems (anxiety and distress), and fewer dysregulation problems (sleeping, eating, emotions). The Family Spirit intervention supports the primary prevention of ACEs by increasing parenting support and skills.

- **Parenting in 2 Worlds (P2W)**[32,33] is a culturally based family-centered parenting program that aims to strengthen parenting practices, promote protective factors, and reduce adolescent health-risk behaviors. This supports primary prevention efforts because P2W programming addresses both protective and risk factors for exposure to ACEs in Indigenous communities. The program was designed for urban Indian families, and culturally adapted with a balance of general and tribally specific elements. The 10-session workshop incorporates AI/AN cultural values and worldviews on parenting. Trained community-based facilitators delivered the curriculum using various facilitation strategies to promote learning including storytelling, games, role-plays, and individual and small group activities. P2W participants reported significant improvements in parental agency, use of positive parenting practices, supervision of children, and degree of family cohesion.

- **Our Life**[34-36] was developed as a 6-month intervention for AI/AN youth and parents in the Southwest region of the U.S. Our Life provided weekly psycho-educational groups with four focuses that included a) recognition of historical trauma b) reconnection to traditional culture and language c) culturally appropriate parenting practices and youth skills and d) engagement in activities specific to community interests. Results indicated that increases in warm, involved, reasoning parenting over time along with increases in parent-child communication. This intervention supports primary prevention efforts by promoting protective factors, such as connection to culture, to reduce AI/AN families' exposure to ACEs. This intervention also supports secondary and tertiary prevention efforts when providing space to recognize and process historical trauma.

- **The Life Skills Development and THRIVE interventions**[34,37] indicate some evidence-based interventions developed for a general population may also provide benefits to Native communities. The Life Skills Development and THRIVE interventions support secondary and tertiary prevention efforts by utilizing cognitive-behavioral therapy (CBT) approaches designed to decrease symptoms of depression, anxiety and post-traumatic stress disorder among AI/AN adolescents exposed to ACEs. CBT principles emphasize decreasing negative thoughts and feelings, recognizing risk behaviors, and increasing coping/self-regulation strategies.

The studies noted above are a non-exhaustive list of programs that successfully include Indigenous approaches and cultural components for ACEs prevention. Importantly, while Evidence-Based Practices (EBPs) offer helpful components, there is sometimes an overemphasis on their benefits for Native communities as well as unhelpful funding requirements upheld by Western-based institutions.[34] This actionable guide encourages prioritizing Indigenous ways of knowing and learning into program creation and evaluation practices.

I Primary prevention efforts aim to prevent outcomes from ever occurring.
II Secondary and tertiary prevention efforts aim to reduce the harmful effects of outcomes that have already occurred. Secondary prevention efforts prioritize early detection and/or screening efforts to prevent outcomes from progressing, while tertiary prevention efforts focus on reducing the impacts of the ongoing occurrence and its lasting effects.

Indigenous Evaluation Approaches for ACEs Prevention

3

Many of the culturally tailored ACEs interventions were designed using community-based participatory research principles (CBPR).[31-32] Additionally, ACEs prevention programs have incorporated Indigenous knowledge and worldviews into both programming and their evaluation practices for over twenty years. This includes **prioritizing deep community engagement in the planning and evaluation process, centering cultural values, and ensuring data sovereignty**. These activities reflect the core tenets of Indigenous evaluation.

Evaluation of culturally tailored ACEs interventions included the use of Western-based **measures and measures developed specifically for AI/AN communities and/or made AI/AN or tribe specific adaptations to measures designed for diverse populations broadly**.[31,32,34] Programs also incorporated **multiple ways of gathering knowledge**, such as conducting interviews and focus groups with both community members and participants.[35,37] Additionally, research teams highlight deep community engagement as a strength of their interventions.[34,37]

- **The Life Skills Development**[37] intervention prioritized engagement with community throughout the planning and evaluation process, collaborating with a wide range of community representatives for review and input related to the course materials and program evaluation. Researchers ensured that community members, teachers, and caregivers had a meaningful voice throughout the project and its evaluation.

- The **THRIVE**[34] intervention was also developed with feedback and support from a Community Advisory Board (CAB) who met regularly to review program implementation and evaluation measures. This process also led to the **development of outcome measures for cultural appropriateness** and inclusion of a strength-based competency in response to community concerns. The research team also prioritized data sovereignty and transparent evaluation reporting. During the implementation planning process, researchers maintained community confidentiality throughout presentations, reports, and publications. Results of the study were also made available to the CAB and community members.

- The CBPR-driven design of the **Parenting in 2 Worlds (P2W)**[32] intervention centered communities' cultural values and incorporated traditional parenting practices into the program design. P2W's lessons included participatory activities that prioritized participants identifying their cultural values and establishing community. Evaluation of the P2W intervention also drew on **connection to culture as the primary measure of success**, which aligns with Indigenous beliefs of culture as medicine and research supporting cultural connectedness as a protective factor for ACEs.

- The **Our Life**[35] intervention also measured connection to culture in their evaluation and included **additional measures related to feelings about historical loss/trauma and community involvement.** Evaluation efforts prioritized collecting qualitative data to gain a deeper understanding of the intervention's impact on participants. Using quantitative and qualitative data helped support evaluation findings and allowed storytelling to report on the impact of a culturally grounded intervention.

These culturally tailored ACEs interventions provide strong examples of programs utilizing Indigenous evaluation approaches for over two decades. These are excellent examples that may help provide ideas for how similar efforts can be employed in other settings.

Using this Guide Together with the 2023 Indigenous Evaluation Toolkit

4

Readers should use this guide as a companion to the 2023 Indigenous Evaluation Toolkit, which provides step-by-step guidance to incorporate Indigenous evaluation approaches into program design, implementation, success measurement, and ongoing programming assessment and improvement.

The Indigenous Evaluation Toolkit utilizes LaFrance & Nichols' Indigenous Evaluation Framework for AIHEC (2009) and translates its five foundational values into actionable approaches that teams can work through at their own pace. In Indigenous evaluation, evaluation activities are viewed as part of a cyclical learning process, in which evaluation is interwoven with program design and implementation. It can also be viewed as a continuous learning process rather than a one-time reflection of a past state.

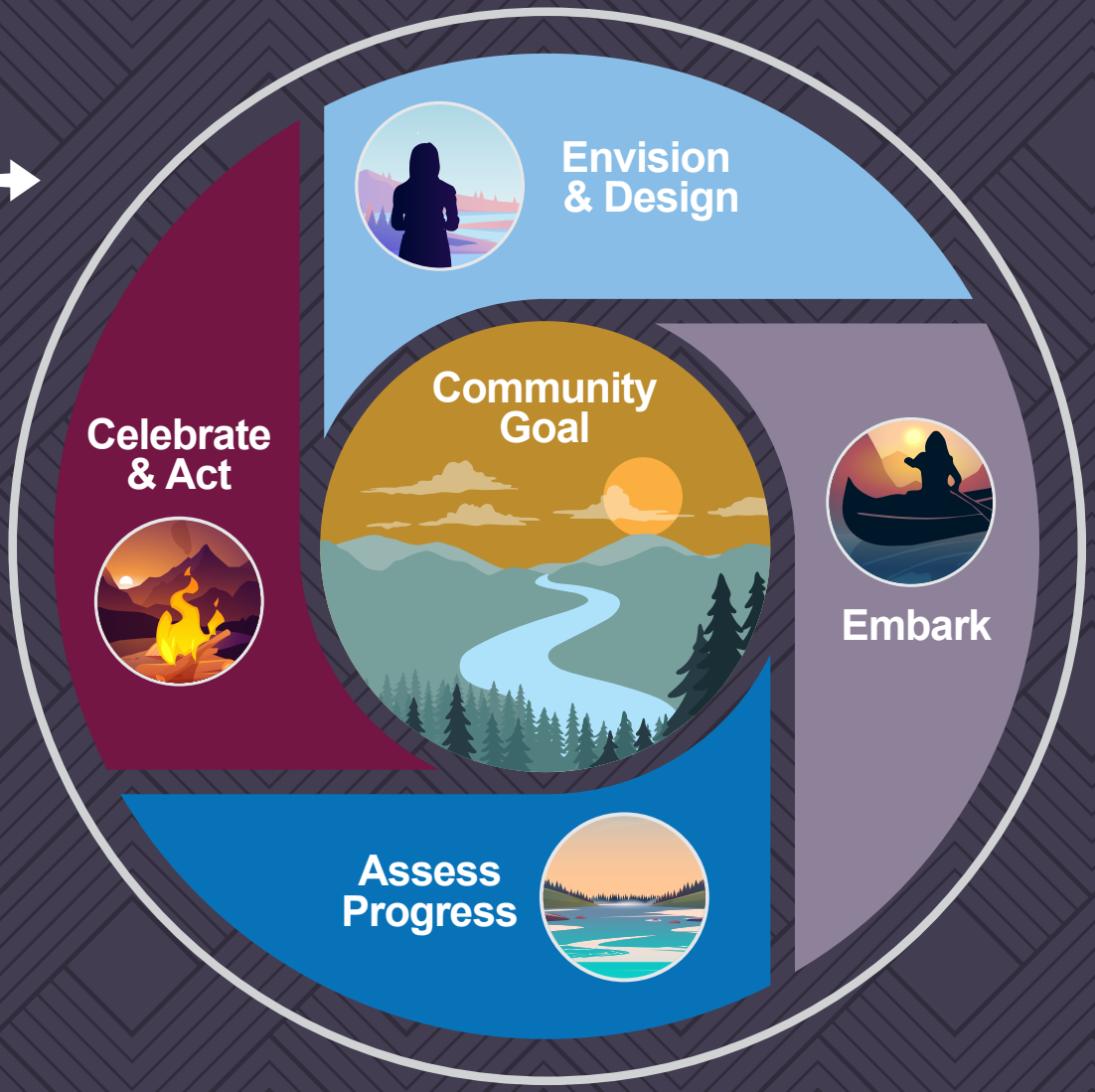
Figure 1 below illustrates how this Toolkit translates core Indigenous evaluation values into a continuous learning cycle.

Figure 1. Translating Indigenous Evaluation Values to a Continuous Learning Process

INDIGENOUS EVALUATION VALUES

- Indigenous Knowledge
- People of a Place
- Centering Family and Community
- Honoring Our Gifts
- Respecting Sovereignty

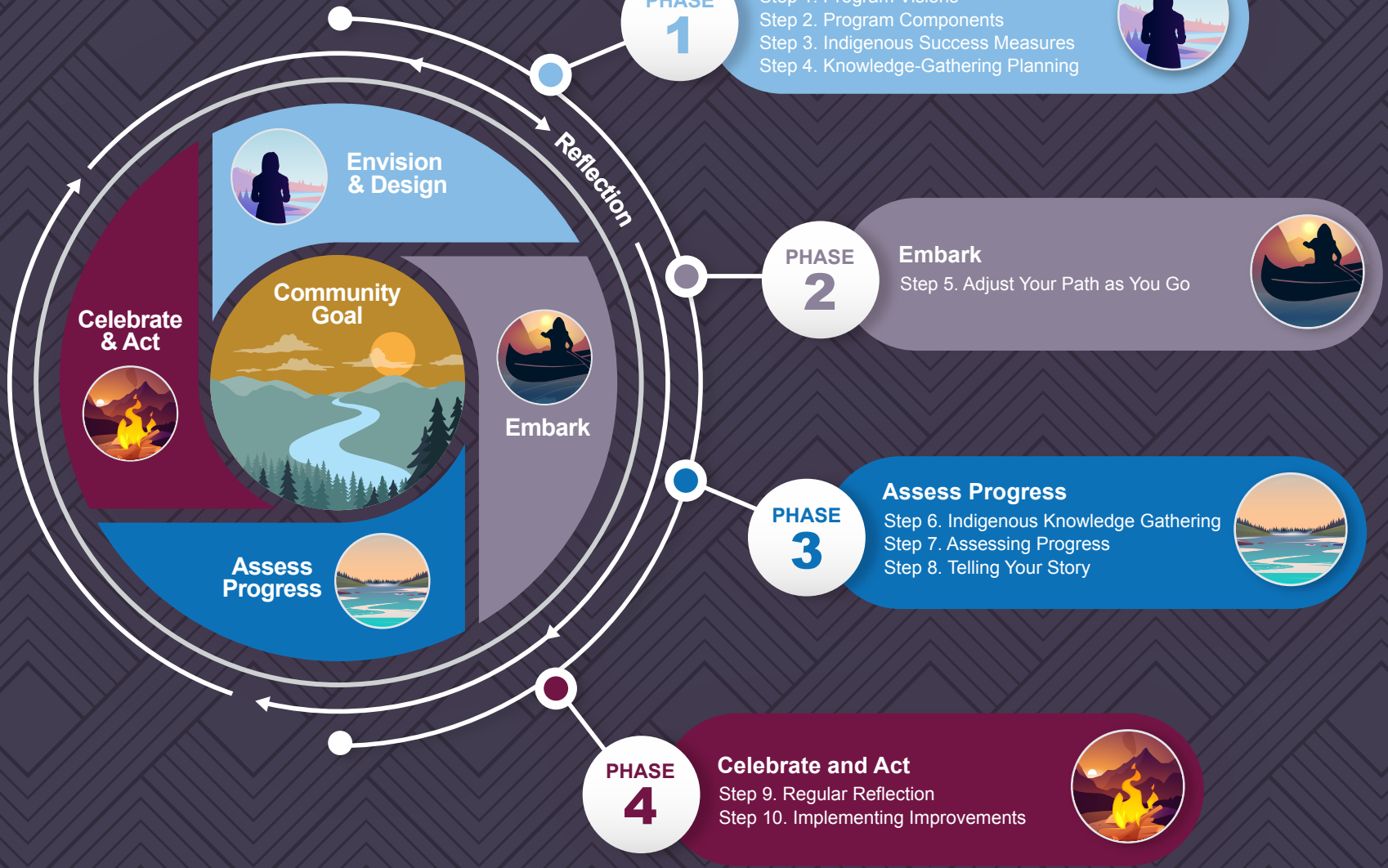
CONTINUOUS LEARNING PROCESS



(LaFrance & Nichols, 2009)

The Toolkit organizes this continuous learning circle into four key phases, which can be further broken down into ten steps that programs can take to implement Indigenous evaluation approaches over the course of that cycle (See Figure 2 below). As illustrated by the circle surrounding all phases, teams should imagine a constant thread of "reflection" inherently woven throughout the process:

Figure 2. List of all Steps by Phase.



The Toolkit includes a series of worksheets, resource links, and questions to consider as your team works through integrating these Indigenous evaluation approaches. The 2023 Toolkit also provides:

- A detailed introduction to Indigenous Evaluation approaches
- Additional background on LaFrance & Nichols' 2009 Indigenous Evaluation Framework for AIHEC, and the development of Seven Directions' 2023 Toolkit
- Suggestions for preparing for emotionally challenging work with your team;
- Discussion of key considerations when conducting Indigenous Evaluation approaches (e.g., cultural humility, data sovereignty);
- The full set of Toolkit worksheets and completed example versions drawing from substance use prevention examples.

Readers interested in more detailed guidance about each step should refer to the 2023 Indigenous Evaluation Toolkit.

As highlighted above, ACEs prevention programs in AI/AN communities may already utilize Indigenous ways of knowing in their program design and evaluation practices. However, some tribal program staff may find this structured framework useful as it offers a guide for integrating Indigenous knowledge and community ownership across evaluation activities. **This ACEs Prevention-specific Guide tailors the information presented in the original Toolkit for readers focused on ACEs prevention in their communities through community-specific examples and context.**

ACEs-specific Context and Examples in this Guide

The following sections provide:

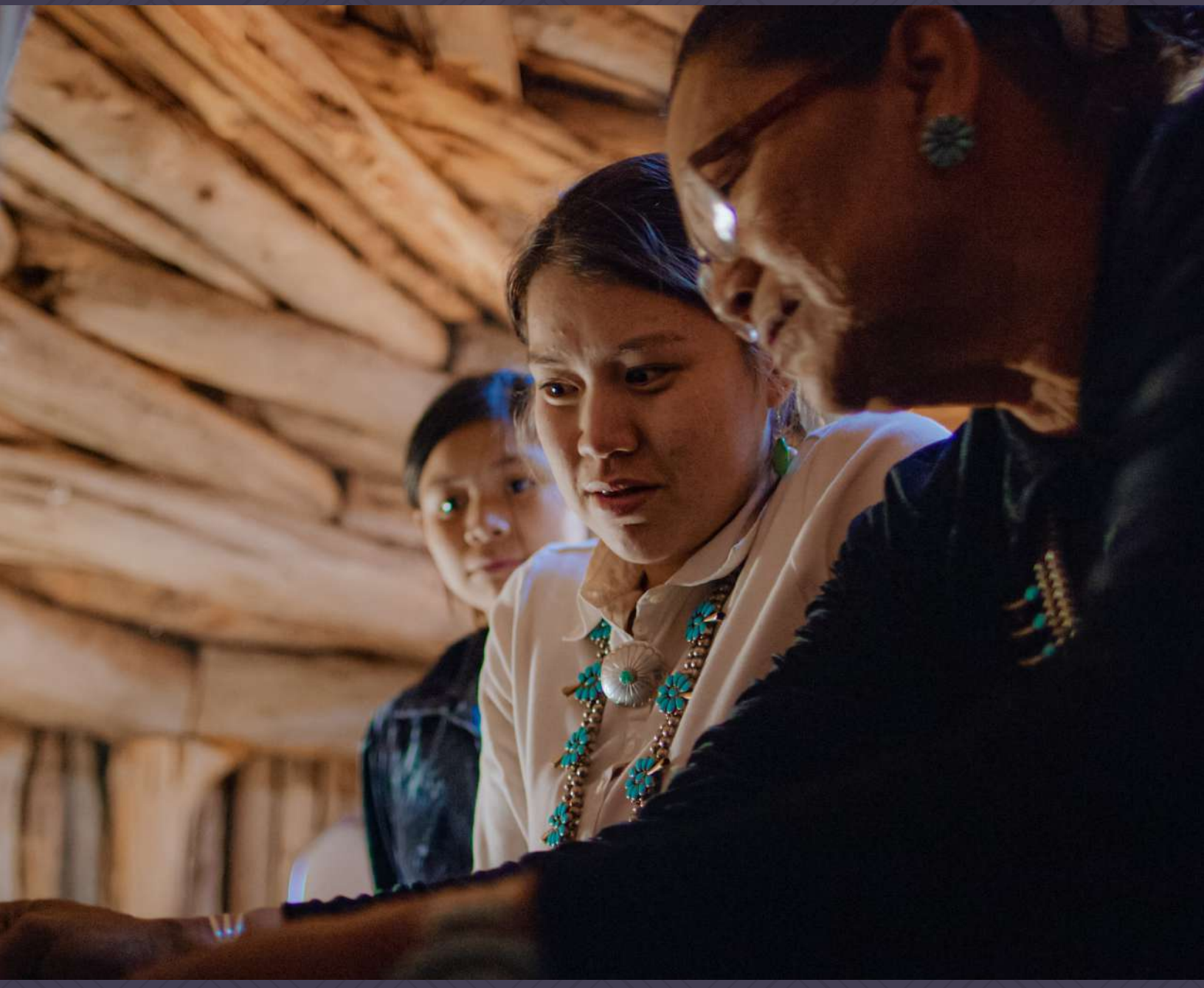
- **a short story about a fictional ACEs prevention program** working through the Toolkit; and
- a selection of the fictional program's **completed activity worksheets as examples** to support readers' understanding.

These modifications are designed to help readers more clearly envision the application of Indigenous evaluation concepts to their ACEs prevention work. For example, completed worksheets might help readers brainstorm such questions as, *"What is an Indigenous knowledge-gathering activity we might use to assess how our program is contributing to community connection, to prevent ACEs?"* We encourage program teams to refer to the vignette and completed worksheets as you work through the steps and activities contained in the Toolkit itself. Readers are encouraged to reference and use these materials as inspiration in their step-by-step journey using Indigenous evaluation approaches. We encourage teams to work through these steps as it makes sense to you and your team.

Again, readers interested in more detailed guidance about each step should refer to the 2023 Indigenous Evaluation Toolkit.

5

ACEs Prevention
Companion Story & Completed Worksheet Examples



Introduction to the Fictional Companion Story: "Changeable House"

The following story provides a narrative about a fictional tribal behavioral health center and their journey utilizing the original 2023 Indigenous Evaluation Toolkit in their family health programming. The story and the accompanying completed example worksheets that follow are designed to use ***storytelling*** *to help teams envision how they would incorporate the information presented in the Toolkit using the blank activity worksheets it contains.*

Changeable House Part 1:
Staff at the Family Health Department of an Urban Indian Health Clinic in Arizona have received federal funding to create a program that targets prevention of adverse childhood experiences (ACEs). They saw Indigenous youth and young adults experiencing the downstream effects of ACEs as adults (e.g., substance use, poor health). With family input, they began to look for upstream solutions. The staff saw trends in which adult patients were bringing in their children for treatment of physical and mental health conditions. This reminded them of the intergenerational nature of trauma which ignited a commitment to do more to support parents, extended family members and caregivers to reduce the risk of ACEs among youth. Olivia, the senior program manager, is accompanied by Peter, a social worker, and Kai, a health educator. They are supported by Winona, an Elder experienced in family support. These four are tasked with planning the program and providing progress updates to their funding source.

The group took time to reflect on the impact of colonization and displacement that specifically impacts urban-located Native people. They identified the historical and generational trauma caused by displacement as important contributors to the stress in their community. Olivia noted that current caregivers of youth in their community may be reminded of their own adverse childhood experiences, namely those who were impacted by the boarding school era, and she felt they could benefit from a referral point to additional services. Winona told a story about her great-grandmother who used to bring the family together to share traditional songs and stories. She remembered her mother sharing how happy and safe she felt as a child and young adult being surrounded by these strong women and music from their culture. She shared that she has noticed, especially in their urban environment, the new generation of parents and family members don't have the opportunities to come together in the same way and may be releasing some of their own stress or trauma upon their children as a result. She had heard from the parents of their interests in opportunities for cultural gathering. She noted the need for more opportunities for families to be in community with one another. This opening provided the grounding for Olivia to introduce Phase 1 of the Toolkit, which provides structure as teams navigate the challenging task of designing an ACEs prevention program.

After speaking about their values as outlined in Step 1, the group began planning program activities and deciding how to engage community members, particularly caregivers and family members of youth under age 18. Peter said that **creating a space for caregivers to come together and receive support, while also reconnecting them and their children with culture,** should be a key program component. Winona shared that other Elders in the area wanted to pass on their knowledge to youth to help them and their children protect against ACEs. To end their meeting, the group used **Worksheet 4: "Planning Our Journey"** as a guide to **write three driving visions for their program**.

Worksheet 4 below illustrates an example Visioning exercise, completed as part of Step 1 by our fictional ACEs prevention program (see "Changeable House" story above).

Planning Our Journey

Purpose: To outline your driving motivations or visions for doing this prevention work, now that you understand where you are starting and what your group's values are.

Instructions: List your program's three driving visions for doing this work. How do you envision the program or project you are planning improving lives in your community?

What are your three underlying visions for this project or program?

VISION 1	VISION 2	VISION 3	OTHER VISIONS
Parents, grandparents, and caregivers understand different adverse childhood experiences and can take steps (independently and communally) to address them.	*Parents,grandparents, and caregivers have a community of peers and identified resources on which they can rely, to prevent adverse childhood experiences for their children.*	*Both caregivers and youth see culture as a tangible intervention to bridge generational gaps, communicate, and heal (e.g., prevent/mitigate ACEs).*	*Our community reduces stigma around accessing mental health or other services to cope should a traumatic family event occur. Youth in our area, from birth to age 18, are exposed to much less/ no adverse childhood experiences.*

Changeable House Part 2: Program Design and Success Measures Informed by Community Feedback on Visions and Values

At the next meeting, the team shared their insights from speaking with community members about the program's visions and values. This discussion revealed that caregivers and family members needed more support to reduce the risk of ACEs. They wanted information on specific examples of ACEs, how to identify warning signs for themselves and other adults around them, how to talk about difficult issues, and how to get support from others going through similar challenges at home. Kai shared that youth wanted to feel more connected to their culture, with an emphasis on cultural teachings. Youth also shared that the adults did not listen to them or their needs.

With these insights in mind, the group brainstormed the services, resources, or messages they wanted to include in their new program. Olivia and Peter recently connected with staff from the Urban Indian Coalition of Arizona to learn about their Parenting in 2 Worlds (P2W) intervention; the team decided they would replicate a similar program in their area, with a focus on ACEs rather than substance use prevention, for caregivers and family members of youth aged 10-18. The program would entail a 10-week, 10-workshop curriculum, using a variety of facilitation strategies (lessons, discussions, and activities) to address **building their parenting community of support, understanding their family traditions and values, and communication with their children**, including how to support youth through difficult stages of life. The program would provide free food and on-site childcare for participants and be operated at neighborhood libraries; some childcare would feature the games and songs shared in the course, to pass that knowledge onto young children.

Peter also encouraged the team to have referrals to other services ready in case family members had traumatic memories resurface. The group decided to call their curriculum "Changeable House," a reference to an element of the Navajo (Diné) creation story and to underscore the fact that each family, or house, can change for the improvement of their family and future generations. Winona noted that they should recruit educators representing the major tribal groups of the area so as many local cultures could be represented as possible. Those who completed the curriculum would receive (in addition to the worksheets, games, and songs learned through the course) a tote bag featuring the Changeable House name, a gift card to a grocery store, and art from a local Indigenous designer to put up in their home, as a symbol of graduation and ongoing reminder of what was learned. The team used their federal funding to cover training and development of the curriculum and partnered with a local university to secure grant funding for incentives, gifts, food, and childcare.

After determining the program components (Step 2), the team identified the **success measures, or "landmarks,"** they would use to identify if they were working toward their visions, making sure to draw on various forms of **Indigenous knowledge**—*empirical, traditional, and revealed* (*See page 62 of the Indigenous Evaluation Toolkit for more information*). Finally, they mapped out the **Indigenous or Decolonizing data collection methods** they would use to assess progress toward each of these landmarks (See Worksheet 9 below).

Worksheet 7 below illustrates the success measures, or "landmarks" identified per Vision by the fictional "Changeable House" team as well as which type of Indigenous knowledge that they felt best represented each landmark (i.e., empirical, traditional, revealed); the team used abbreviations (E, T, and R, respectively) in the worksheet to indicate their types of knowledge. Certain landmarks can fall under multiple types of Indigenous knowledge (e.g., traditional and revealed).

Worksheet 9 below maps out the Indigenous or Decolonizing data collection methods our fictional ACEs prevention program would use to assess progress toward each of their landmarks, as well as when or how often they plan to collect knowledge about each landmark. (See *Step 4 of the Indigenous Evaluation Toolkit* for more information).

Landmarks: How Will You Know Where You're at?

Purpose: To outline Indigenous indicators that you will use to measure progress toward your vision.

Instructions: As you make your way downriver, how will you know where you're at? Look out for information, knowledge, wisdom, conversations, stories, or data that will help you know if you are making progress. Be as specific as possible- who or what will help you understand where you are at on your journey toward each vision?

VISION 1

Vision 1 from worksheet #6

Parents understand/ recognize ACEs.

LANDMARKS

How will you know where you're at?

Conversations with parents reveal increased understanding of all ACEs, and specific challenges of their youth (R/E).

Curriculum is well-attended (E).

Youth and parents report using prayer (in their traditional language), and share the practice is comforting (T).

VISION 2

Vision 2 from worksheet #6

Parents have support to prevent ACEs.

LANDMARKS

How will you know where you're at?

Parents take trips to sacred areas and/or seek spiritual guidance; they share a stronger connection to spiritual ways (R/T).

Increased use of other community-based services for parents (food, finance, housing, etc.) (E).

Conversations with parents reveal improved familv and peer connections (R)

VISION 3

Vision 3 from worksheet #6

Parents/youth use culture to prevent or mitigate ACEs.

LANDMARKS

How will you know where you're at?

Increased number of parents and their kids at cultural events (E).

An Elder shares that he had a dream about his grandmother, who told him he needed to support current parents to prevent ACEs from harming the next generation (R/T).

Conversations with parents and youth reveal cultural activities bring them closer (R/T).

OTHER LANDMARKS

How will you know where you're at?

High-level vision(s): Less stigma around accessing support for ACEs. Youth are no longer exposed to ACEs in our area.

Elders and leaders talk openly about responding to traumatic events as a community (R)

Requests to perform the healing song (ex., a youth group sings the healing song at a school assembly, students/parents approach them after asking to learn (R/T).

Decrease in hospital visits, referral to child/family services, etc. (E).

Worksheet 9: Knowledge-Gathering Calendar

VISION 1

Vision 1 from worksheet #6

Parents understand/ recognize ACEs.

Landmarks (see Worksheet #7):

Conversations with parents reveal increased understanding of all ACEs, and specific challenges of their youth.

Curriculum is well-attended.

Youth and parents report using prayer (in their traditional language), and share the practice is comforting.

How will you gather the information (e.g. talking circles, surveys, community meetings)?

When will you look for each of these markers? (e.g., 6 mos. post- launch, every two weeks)

During talking circles with parents and youth, held twice during the 10-week curriculum.

Taking attendance at the classes each week.

VISION 2

Vision 2 from worksheet #6

Parents have support to prevent ACEs.

Landmarks (see Worksheet #7):

Parents take trips to sacred areas and/or seek spiritual guidance; they share a stronger connection to spiritual ways.

Increased use of other community-based services for parents (food, finance, housing, etc.).

Conversations with parents reveal improved family and peer connections.

How will you gather the information (e.g. talking circles, surveys, community meetings)?

When will you look for each of these markers? (e.g., 6 mos. post- launch, every two weeks)

During talking circles with parents and youth, held twice during the 10-week curriculum.

Attending community meetings to hear from social service partners, and by reviewing service usage information. Will conduct inquiries quarterly (once per season)

Worksheet 9: Knowledge-Gathering Calendar

VISION 3

Vision 3 from worksheet #6

Parents/youth use culture to prevent or mitigate ACEs.

Landmarks (see Worksheet #7):

Increased number of parents and their kids at cultural events.

An Elder shares that he had a dream about his grandmother, who told him he needed to support current parents to prevent ACEs from harming the next generation.

Conversations with parents and youth reveal cultural activities bring them closer.

How will you gather the information (e.g. talking circles, surveys, community meetings)?

When will you look for each of these markers? (e.g., 6 mos. post- launch, every two weeks)

Taking attendance at cultural events; they occur once per season.

Listening to Elders speak at cultural events (quarterly); attending community meetings and taking notes (quarterly).

During talking circles with parents and youth, held twice during the 10-week curriculum.

VISION 4

Vision 4 from worksheet #6

Stigma reduction; an end to ACEs.

Landmarks (see Worksheet #7):

Elders and leaders talk openly about responding to traumatic events as a community.

Requests to perform the healing song (ex., a youth group sings the healing song at a school assembly, students/ parents approach them after asking to learn.

Decrease in hospital visits, referral to child/ family services, etc.

How will you gather the information (e.g. talking circles, surveys, community meetings)?

When will you look for each of these markers? (e.g., 6 mos. post- launch, every two weeks)

Listening to Elders speak at cultural events (quarterly); attending community meetings and taking notes (quarterly).

Will ask during talking circles with parents and youth, held twice during the 10-week curriculum.

Attending community meetings to hear from social service partners, and by reviewing service usage information. Will conduct inquiries quarterly (once per season).

A Note on Knowledge-Gathering:
You can use one form of gathering information to assess progress towards multiple landmarks at the same time!

For example (in Worksheet 9): one conversation or talking circle could reveal that parents have a greater understanding of ACEs, and improved family and peer connections. Similarly, you could count the number of youths attending cultural events while Elders are speaking at those events.

Changeable House Part 3: Program Adjustments Based on Early Experiences:
After many weeks of planning the program and its evaluation, the Family Health Department launched its program. Following their first 10-week session, the team reflected on the program's community impact. Older family members appreciated Peter's referrals to support for adults realizing their own struggles with ACEs. The curriculum was well-received, though Olivia noted fewer sign-ups for the second session of the curriculum. Kai recommended sharing their promotional materials with other urban-Native-focused organizations in the city to boost participation. Olivia noted the need for new grant funding to continue providing incentives and sustain the program beyond this year. The team planned to seek additional funding through university partners, using the worksheets from their evaluation thus far in their applications to justify the necessity of their program. Community feedback led to two program adjustments:

- First, attendees wanted the ability to stay connected beyond the 10-week groups, so Kai created a Facebook group for the course and calendar alert system for Urban-Indian family events in their community.
- Second, many family members requested a similar program for youth, combining the same cultural information with resources offered by the city to support them. Although Changeable House initially focused on adults, the team saw this as a meaningful way to progress towards one of their visions, youth cultural immersion. They decided to develop a shortened (1-hour, every-other week for 5 weeks), youth-focused version of the courses led by Kai, to start after the next 10-week session allowing time to gather local resources for youth.

Changeable House Part 4: Decolonizing data collection and sharing success stories:
After adapting the programming, the team sought to assess their progress on their journey. They used their knowledge collection calendar (see Worksheet 9 above), obtained approval from the Elders' council at a community center, advertised their efforts, and prioritized Indigenous or Decolonizing data collection approaches. For instance, AmeriCorps volunteers interviewed family members and analyzed hospital admission data to integrate multiple forms of knowledge and build local evaluation capacity. Additionally, the volunteers attended community meetings to hear mental health service usage information from social service partners. Olivia's team trained these volunteers.

When Olivia, Peter, Kai, and Winona felt they had made significant progress in their journey, they were eager to share their findings with the broader community. The Family Health Department team scheduled meetings with families and Elders to determine the best formats for sharing information. Children of the parent participants preferred social media posts highlighting key lessons from the Changeable House program. Parents, caregivers, and Elders appreciated updates on the Urban Indian Health Center website, at council meetings, and at local community events. Both caregivers and youth requested materials that included stories from the program and examples of how to talk about difficult topics. The stories were also compiled into a pamphlet for distribution at council meetings, community events, and by mail.

Because this program encompassed perspectives from many different Indigenous communities in the urban area, the team reviewed this plan at a meeting of the Indian Health Board. Following advice from Elders and community leaders at this meeting, the team produced an English and several tribal language versions of all materials.

Changeable House Part 5: Reflecting on the first year of programming; Acting on lessons learned: After months of collecting and reflecting on data collected, Olivia led her team and several "graduates" of the Changeable House curriculum through a guided talking circle based on "Worksheet 12: "Making Camp" (below). She asked participants to share their proudest moments and key insights from the first year. For example, the team took pride in their decision to create a Facebook group and text alert system, which increased program participation through word of mouth. They noted the value of the youth curriculum, the ingenuity of creating a youth curriculum part way through the program, and the need to plan for community connection and youth programs in future budgets, given the potential absence of AmeriCorps volunteers.

In early fall, the Family Health Center team celebrated a year of their curriculum with the Urban Indian Health Center staff. They highlighted the progress of several graduating families who were comfortable participating in a special honoring ceremony. At the event, they distributed pamphlets detailing their findings, Changeable House tote bags, local art, and promotional materials for the coming year. Urban Indian Health Center employees shared how this program shifted conversations in their own homes, helping them discuss difficult ACEs topics and connect to trusted resources when needed. The team also celebrated increased referrals to mental health care and services due to the community's enhanced understanding of ACEs. Feeling refreshed, they were ready to begin their second year.

Worksheet 12 below summarizes our fictional ACEs prevention program's lessons learned in their first year of implementation and plans to act on those lessons as they continue their journey.

Making Camp: Celebrating And Preparing To Continue

Purpose: To orient yourself toward the next portion of your journey and honor the knowledge you've gained.

Instructions: As you celebrate your progress and begin to re-renter the planning phase, consider resting and making camp, so you can look back on how far you've come and reflect on the knowledge you've gained. What can you DO with this knowledge as you continue on your journey toward other visions?

What knowledge have you gained through this process?	How will you use this knowledge as you continue your journey?
"Many more people signed up once we started holding the curriculum for the kids. I think it shows that parents want their kids to access the same resources they're learning, to have a communal language. The songs shared in childcare courses made it so an could learn something." *"I think this also justifies to our funding sources that providing these type of incentives are important to the program Peter and Olivia, during reflection session.* *"It can be really hard to access cultural practices in the city These classes made it easy, and made my kids excited about our culture, which felt like a win-win." - parent feedback during listening sessions.* *People were proud to graduate from this program! We saw people carrying tote bags at cultural events.*	*We will work on a longer-term agreement of funding with our federal and university partners to sustain the parts of our program (e.g., childcare, food) that rely on this support.* *We will write a plan for social media outreach (either v olunteers or paid into future plans and budgets. We will also plan ahead for the youth curriculum to start at the same time as the parents; it was important to add those classes and we should be proud of them.* *We could consider new designs of t-shirts, or different types of merchandise (mugs, notebooks, etc.) to differentiate between years of the curriculum, however, it was most important to offer childcare and grocery gift cards.* *Sharing the stories and lessons learned from this program was an important component; we will consider new ways to shares this knowledge with the larger community.*

Conclusion

As Indigenous communities, tribal leaders, tribal health organizations, and partnering programs continue to develop ACEs prevention programs focusing on individual and community resilience, our hope is that the driving-specific content and examples provided in this guide —used in conjunction with the step-by-step activities in the 2023 Toolkit —offer teams a starting point for designing program and evaluation components that honor their cultural traditions, ancestral knowledge, and community visions for success. Teams should feel free to adapt these materials for their communities and, above all, include as many members of their community as possible throughout all phases of program and evaluation design, implementation, and ongoing reflection. We look forward to hearing how your Indigenous evaluation journeys continue to unfold. Please stay in touch with Seven Directions!
https://www.indigenousphi.org/contact

Glossary

American Indian/Alaska Native (AI/AN): This term is commonly used in federal law and public health contexts to refer to the broad range of Indigenous peoples (see below) in North America and South America (including Central America) who maintain tribal affiliation or community attachment. In this Toolkit, we recognize that the term originates from settler colonial histories of misidentification. We place preference on the term "Indigenous" or on specific tribal community names where feasible.

Indigenous is a global term that acknowledges the "first" peoples or communities who maintain ancestral connection to the lands and ways of being impacted by colonization, as well as their inherent sovereignty and rights to self-determination. "Indigenous" is often used to abbreviate this term. AI/ANs are Indigenous peoples. This guide acknowledges that "AI/AN" and "Indigenous" may not be preferential terms. We support individuals and communities using their identification language of choice.

Indigenous Knowledge: This Toolkit prioritizes a breadth of Indigenous knowledge types as outlined by LaFrance and Nichols (2009) (see below) and encourages framing all Indigenous knowledge as data that could be used in Indigenous evaluation.

- **Empirical knowledge**: Knowledge gained from observation and experiences
- **Revealed knowledge**: Knowledge gained from spiritual or ancestral interaction such as through dreams, ceremonies, visions, etc.
- **Traditional knowledge**: Knowledge that is passed down from generation to generation that conveys traditional values and beliefs

Adverse Childhood Experiences (ACEs): ACEs are potentially traumatic events that occur in childhood (birth – 17 years of age). ACEs may include, but are not limited to, exposure to abuse (emotional, physical, sexual), neglect, food insecurity, discrimination, and growing up in environments of family disruption such as divorce/separation, incarceration of a family member, parental substance abuse and witnessing domestic violence.

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Indigenous Evaluation Toolkit:
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Tribal and Urban Indian Adverse Childhood Experiences (ACEs) Prevention Programs

JULY 2024

SEVEN DIRECTIONS
A CENTER FOR INDIGENOUS PUBLIC HEALTH

UNIVERSITY of WASHINGTON