

IHCSCV CRDP Local Evaluation Report, Final Report

1. Title Page

IPP Organization Name: Indian Health Center of Santa Clara Valley

CDEP Name: Strengthening Youth and Families Project

Priority population: American Indian/Alaska Native

Time period covered by the local evaluation: March 2018-April 2021

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2. Executive Summary

The Strengthening Youth and Families Project is a prevention and early intervention program that aims to prevent and/or reduce signs of early onset mental illness for American Indian people in Santa Clara County by:

- 1) increasing knowledge of mental health factors of historical trauma, suicide prevention, and stigma and discrimination reduction,
- 2) increasing knowledge in access and linkage to treatment and wrap-around services,
- 3) increasing knowledge of cultural appropriateness of services provided, and
- 4) increasing knowledge of signs of early onset of mental illness.

The program is designed to address mental health disparities by increasing connection to community and increasing knowledge and sustainment of cultural traditions/practices and ceremonies to address the loss of culture. This will promote mental health wellbeing and increases protective factors for the American Indian community in Santa Clara County.

The evaluation questions focused on:

- the ways in which participation in cultural programs improves mental health,
- whether higher levels of participation in cultural activities result in more positive levels of mental health,
- what type of program adaptations where needed, and
- whether participants perceive that participation in cultural activities are beneficial.

The evaluation research design included a convenience sample of American Indian and Alaska Native (AIAN) youth ages 12-25 residing in Santa Clara County, and participating in a culturally-based intervention using American Indian cultural/traditional activities and teachings to increase resiliency. 57 participants completed baseline surveys and 27 completed baseline and at least one follow-up survey. Topics covered include mental health and coping strategies, cultural and traditional teachings, cultural and traditional arts and crafts, identity and life skills activities, educational support and career preparation. Meetings occurred weekly and lasted for two hours. The sample included in the analysis completed a baseline survey upon intake the program and at least one follow-up survey 6- 12 months later. The survey used measures of Generalized Self-Efficacy (GSE), Kessler Psychological Distress, and the Multi-group Ethnical Identity Measure (MEIM) Adolescent Resilience Scale.

Overall noteworthy findings include 1) that there were improvements in many mental health domains, particularly among those who engaged in more services, 2) the COVID-19 pandemic impacted engagement and outcomes as there were higher rates of substance use and lower rates of disapproval of substance use among those responding during COVID-19, 3) there was overall positive reporting of mental health knowledge levels from all participants, and 4) participants reported very positive experiences working with the staff.

3. Introduction

The Santa Clara Valley AIAN community is experiencing on-going mental health disparities due in part to historical traumas and Federal relocation policies which caused an increasing disintegration of cultural norms and role models. Because of these disparities we now have several generations of community members who are not connected to one another, their families, or the community in a cultural or meaningful way. Cultural identity is vital to our Native American community's growth and ability to make decisions to improve and excel in a positive direction.

This project, or Community Defined Evidence Project (CDEP), is designed to engage youth, parents, and community to support each other in discovering the inner beauty of their own individual behavioral health balance. The goal is to come together to collectively become a stronger community bonded in wellness through culture and tradition. The population description Native American refers to American Indians/Alaska Natives. The California Reducing Disparities Project Native American Population (CRDP NAP) report highlights the importance of "community" to Native Americans in California because it preserves a wealth of cultural understanding and practices. The community strength is adapting to urban surroundings while preserving traditional beliefs, values, culture, and identity; this is essential to our wellness. Over the years Urban Indian Health Programs (UIHP) have kept pockets of culture and identity intact with little or no support from traditional Western-based mental health services.

The CRDP NAP describes in the disparity statement section how culture is intertwined with mental health well-being. These protective factors include belonging, feeling significant, having a supportive social network, and a strong cultural identity gained through historical ceremonies. Successful Native American programs are rooted in revival and sustainment of culture while reducing isolation. Our CDEP addresses this need and is well aware through current cultural based projects that these protective factors work for the Native American community. If the disparities outlined above are not addressed, this community is at a higher-risk of mental health co-occurring disorders of substance use, violence, social isolation and other factors of cultural loss and lack of community connectedness.

The Mental Health: Culture, Race, and Ethnicity - A Supplement to Mental Health: A Report of the Surgeon General (USDHHS 2001) states overall rates of mental disorder for smaller racial and ethnic groups, most notably Native Americans, are not sufficiently studied to permit definitive conclusions. Stigma discourages help seeking and attitudes toward mental illness held by minorities are as unfavorable, or even more unfavorable, than attitudes held by whites. The report also states that mistrust of mental health services deters minorities from seeking treatment. This report's conclusions hold true for Native Americans in Santa Clara County.

In the CRDP NAP, the mental health disparities addressed are well-known to us and mirror the challenges faced by our community. This CDEP aligns with recommendations from the final CRDP Strategic Plan draft as it states the need for strengthening Native American cultural identity as a key way to promote wellness. Due to historical trauma, communities should revive and sustain cultural traditions/practices and ceremonies to address the loss of culture. Additional community approaches that reduce disparities include traditional healing practices such as talking circles, seasonal ceremonies, Powwows, drumming, smudging, and educational and cultural activities led by

traditional Native American spiritual leaders. In a 2015 Needs Assessment done with the American Indian community in Santa Clara County, the community said that families are struggling, there are not enough resources for youth, it's difficult fitting in with the mainstream, and much of Native culture is lost. But their solutions were increasing family involvement, restoring Native culture, improve community outreach, provide leadership training and expanding the youth programming.

In general, the AI/AN experience warrants attention. The United States' federal and state efforts to erode AI/AN tribal identity are well documented and have produced a lasting legacy of historical and intergenerational trauma (Weaver 2012; Hartman & Gone 2014). Urban AI/AN communities continue to experience the impact of boarding schools, relocation, and prohibition of traditional ceremonies and tribal languages. Loss in cultural identity is not the only outcome of historical trauma; AI/AN have higher rates of "substance abuse, clinical depression, posttraumatic stress, domestic violence, and suicide" compared to all other races (Gone, 2004). The urban AI/AN population experiences many of the worst health disparities of any racial or ethnic group in the country. These disparities may be best exemplified by disproportionate prevalence of chronic conditions that shorten life span, as well as much higher-than-average rates of drug/alcohol-related deaths and suicide. In fact, life expectancy for AI/AN in the US is a staggering 5.5 years less than the population as a whole.

Urban AI/AN communities, in particular, have unique needs that distinguish them from their rural or reservation counterparts. Many AI/AN youths are culturally isolated from their tribes, and from other AI/ANs, which can lead to culture loss. Youth, especially those without strong family support or strong ties to their tribe, are often left with a deficit in cultural knowledge, involvement, and connection. AI/AN youth left with little or no cultural connectedness do not have cross-cultural protective factors and are at a greater risk of developing behavioral health issues, suicidality, as well as substance abuse and conduct disorders. In 2015, most all (89.9%) of IHC's community participants reported incomes that were below 200% of the poverty level. Poverty, mixed with the lack of cultural resources, contributes to AI/AN youth being at particularly high risk for substance abuse and suicide. Linking AI/AN youth with culturally based prevention programs can increase cultural connectedness, bolstering cross-cultural protective factors that prevent substance abuse and suicide and increase overall wellness.

The evaluation findings will advance our knowledge about the value of CDEPs for AI/AN communities by providing data on the impact of culturally based interventions that strengthen Native American cultural identity. These data in combination with a broader research effort into the impact of cultural approaches on mental health, particularly for youth, can be assessed as part of a larger effort to reduce sustained and difficult to remedy inequities.

4. CDEP Purpose and Description

The Strengthening Youth and Families Project is a prevention/early intervention program that aims to prevent and/or reduce signs of early onset mental illness for American Indian people in Santa Clara County by 1) increasing knowledge of mental health factors of historical trauma, suicide prevention, and stigma and discrimination reduction 2) increasing knowledge in access and linkage to treatment

and wrap-around services 3) increasing knowledge of cultural appropriateness of services provided and 4) increasing knowledge of signs of early onset of mental illness. The CDEP is designed to address mental health disparities by increasing connection to community and increasing knowledge and sustainment of cultural traditions/practices and ceremonies to address the loss of culture. This will promote mental health wellbeing and increases protective factors for the American Indian community in Santa Clara County.

Goals:

- Prevention to reduce MHSA negative outcomes among people with greater than average risk of mental illness.
- Intervention to reduce MHSA negative outcomes among people with early onset of mental illness.
- Timely access to services for underserved populations to improve access among people from underserved populations with risk, early onset, or experience of mental illness.
- Access and linkage to treatment to improve access and reduce duration of untreated mental illness among people with a serious mental illness.
- Outreach to increase recognition of early signs of mental illness to engage people who can identify signs and symptoms to help people with risk or early onset of mental illness.
- Stigma and discrimination reduction to produce changes in attitudes, knowledge, or behaviors to help people with risk, early onset, or experience of mental illness.
- Suicide prevention to produce changes in attitudes, knowledge, or behavior to help people with risk of suicide as a consequence of mental illness.

CDEP Implementation

The Strengthening Youth and Families Project is composed of 6 different CDEP activities that are implemented year-round throughout the length of the project by IHCSCV staff. The CDEP activities are the The Gathering, Traditional Song Class, Traditional Dance Class, San Jose Native Youth Empowerment Group, Cultural Arts Classes, and Mini-Powwows. The population targeted for these activities was fairly uniform across the program: AIAN youth and adults. Implementation of these CDEP activities changed slightly after the COVID-19 pandemic to adjust to the CDC and Public Health County Guidelines.

The Gathering was an annual 4-day camp-out for families and their youth that participated in the year-round programming. The Gathering is short for the Gathering of Native Americans (GONA) which is an interactive approach to empower cultural values, traditions, and spiritual practices in AI/AN community. This Gathering followed the GONA curriculum and themes for each day, Belonging, Mastery, Interdependence, and Generosity. These cultural values are universal and apply to all other cultural approaches used in this project. Youth and their families celebrated all the accomplishments they made throughout the year at this annual camp-out in the Santa Cruz mountains. Families and youth participated in activities such as archery, stickball, cultural arts, sweat, native plant identifying hikes, fire-starting, storytelling around the campfire, etc. IHCSCV staff planned the activities and teachings for each day with a committee filled with members of the community.

The Traditional Song and Dance Class took place weekly on Tuesday evenings from 6:00pm to 8:00pm. Program participants arrived and checked-in with staff members at the Roosevelt Community Center. Once all the participants checked in, program staff gathered participants in a circle to open the space with a prayer. After the prayer, participants ate a healthy dinner provided by the staff. At 6:30pm, IHSCCV staff gathered the song participants around the drum and gathered the dance participants in the open area of the gymnasium. Both the song and dance participants participated in an icebreaker to start off the instruction. Song participants learned about the origins, history, and meaning of songs through storytelling by the instructor. The instructor taught them the beat and lyrics of the songs. While the song participants were learning and practicing the songs, the dance participants warmed up and stretched. The dance instructors taught the participants the origins, history, meaning, and choreography of the different powwow dance styles. The Traditional Song and Dance instructors planned the setlist of 4-5 songs accordingly so that the dance styles matched the song. Around 7:00pm, when both the song and dance participants were warmed up, the first song began. The singers and dancers practiced what they learned with breaks in between songs. The Traditional Song and Dance Class ended with a round dance song.

San Jose Native Youth Empowerment Group took place weekly on Thursday evenings from 6:00pm to 8:00pm. American Indian and Alaska Native Youth ages 11-17 participated in activities that would build and strengthen their cultural identity. Staff welcomed the youth that parents dropped off, and other staff picked up youth participants from their homes. The program began with a prayer and a healthy meal for youth participants. Youth participated in an icebreaker to create a sense of belonging before the activity would begin.

Cultural Arts Classes happened quarterly. The Cultural Arts Class had a designated project for participants to learn such as Basketweaving, star-quilt making, T-Dresses, Ribbon Skirts, and Moccasins. Skilled cultural arts instructors were contracted with IHSCCV to facilitate classes to give the participants an inter-tribal perspective. IHSCCV staff would also facilitate depending on the cultural arts project. Participants registered for the class in advance for staff to prepare class materials for each person. The number of 2-hour sessions depended on the length of time to complete the project.

The Mini-Powwows were special events created for the Traditional Song and Dance participants to showcase their new skills in full regalia to the community.

When the COVID-19 pandemic began, the CDEP activities were adjusted to meet public health and safety guidelines. The CDEP activities had a month hiatus for staff to plan accordingly. All the CDEP programs were held virtually on Zoom and the hours were reduced because of Zoom fatigue. The Song and Dance Class was held virtually on Tuesdays from 4:00pm to 5:30pm. San Jose Native Youth Empowerment Group was held virtually on Thursdays from 4:30pm to 6:00pm. Cultural Arts Classes were held virtually and class materials were delivered to participants. The Gathering was held virtually and reduced to 4 sessions of for 1.5hrs per session. IHSCCV staff adjusted GONA curriculum and themes and created core topics to fit in the small timeframe. IHSCCV staff focused on storytelling and created activities that could be done virtually on zoom. Families and their youth received GONA goodie bags, activity materials, t-shirts, and a celebration dinner delivered to their homes by IHSCCV staff.

5. Evaluation Questions

- In what ways does mental health improve with participation in the Native Youth Empowerment Group?
- In what ways does mental health improve with participation in Traditional Drum and Dance?
- In what ways does mental health improve with participation in Cultural Arts?
- In what ways does mental health improve with participation in the Annual Wellness Gathering & Powwow?
- Do higher levels of participation in cultural activities result in more positive levels of mental health?
- What adaptations are made to the program?
- Do participants perceive that participation in cultural activities are beneficial?

6. Methods

a. Evaluation Participants and Recruitment

The evaluation used convenience sampling methods inclusive of all participants in CDEP activities, with an original goal of 60 survey enrollees. All youth (ages 8-25 years) who were part of Drum and Dance Class, Youth Program, The Gathering, and Cultural Arts Class at IHSCCV during the CRDP project period were invited to be part of the evaluation. IHSCCV staff approached all first-time participants either during registration or at their first event and, using a recruitment script that outlined the details of their participation (when and how often they would be asked to complete surveys, how their information would be used and protected, and how they would be contacted), asked youth whether they were interested in participating in the evaluation. Youth who were interested were asked to provide consent/assent during either in-person or remotely. For those under the age of 18, parental consent and minor assent was obtained. Signed consent/assent was obtained separately for the local and State-Wide Evaluation (SWE) and all youth were assigned a unique participant ID number to protect the confidentiality of their survey responses. Designated IHSCCV staff conducting recruitment for the CRDP project completed human subjects research training prior to participating in recruitment activities. IRB approval was obtained through CA OSHPD in December 2017 (Protocol ID: 2017-032) and the first participants completed surveys in March 2018.

Aspects of community-based participatory research (CBPR) were integrated into the survey design methods for IHSCCV's CRDP evaluation survey. When the first survey draft was completed – including both local evaluation measures and the SWE measures – it was piloted with the San Jose Native Youth Empowerment Group. The youth pilot respondents reviewed the survey for appropriateness of language, comprehensiveness of response options, length/survey fatigue, and any other aspects of the survey that they felt was not a good fit for their culture, heritage, or age. The survey was refined based on feedback and the revisions tested until the group was happy with the final survey. Changes

that were implemented based on the group's feedback included: Revising existing survey items to be more strengths-based and/or easier to understand for youth, reorganizing the survey items to include strengths-based and otherwise positive questions in between items perceived to be more negative or stigmatizing, and reducing the length of survey by choosing only those items that were deemed most salient.

Surveys were self-administered online (using Survey Monkey software) and could be completed on their own devices or on tablets provided by IHSCCV. Youth enrolled in the evaluation study provided contact information (email, phone) to enable IHSCCV staff to locate participants for follow-up surveys even if they did not continue attending IHSCCV services or activities.

Table 7.1 describes age groups and survey completion across waves for all fifty-seven respondents who completed a survey at intake. Twenty-six respondents overall were ages 8-11 years and 74% were ages 12 years or older. Slightly more than one-third of respondents only completed an intake survey, while 5% completed intake and 6-month surveys only, 32% intake and 12-month only, and 28% completing all three waves of survey data collection. As all CDEP participants were invited to be part of the evaluation survey and we did not gather demographic characteristics of youth who chose not to complete the survey, we do not know whether the survey sample reflects the overall population of CDEP participants. Attrition (which happened with 35.1% of respondents) occurred exclusively through respondents being lost-to-follow-up, an issue that was likely exacerbated with the move to online-only activities during the onset of the COVID-19 pandemic.

A subset of the overall respondents who were ages 12+ and completed intake and at least one follow-up survey was created for analyses examining change over time. This subset contains 27 youth respondents (part of the overall sample of n=57) who were age 12 or older – as the 12+ survey contained the most complete set of measures – and who completed at least two waves of data collection. Respondents in this subset could have completed surveys at intake and 6-months or intake and 12-months, but were included as long as they had at least two survey completions. Because they have at least two complete survey time points (i.e., they are longitudinal participants), these are the respondents for whom we can assess change over time in their responses to items about mental health, cultural connectedness, substance use and other important measures that may be impacted by IHSCCV program participation.

Demographic characteristics for the 57 respondents who completed a survey at intake and the 27 youth ages 12+ who completed the longer version of the survey at both intake and at least one follow-up are presented in Table 7.2. Overall, most respondents were aged 12-18 years at intake (63%), were women/girls (67%), and identified as straight/heterosexual (58%). Most youth identified as American Indian/Alaskan Native, with more than one-third reporting both American Indian/Alaskan Native and Latino/Hispanic/Spanish race/ethnicity (37%), followed by American Indian/Alaskan Native only (28%), and American Indian/Alaskan Native and two or more other races/ethnicities (18%). The sample of respondents ages 12+ who completed an intake survey and at least one follow-up were

similar to the larger sample with regard to gender and race/ethnicity, but were slightly more likely to identify as straight/heterosexual.

Table 7.3 lists all tribal affiliations indicated by survey respondents; the total percentage is greater than 100 as each respondent could list more than one tribal affiliation.

b. Evaluation Measures and Data Collection Procedures

Youth participants completed baseline self-administered surveys at intake and then were asked to complete follow-up surveys at 6-months and 12-months after intake. Youth had the opportunity to complete follow-up surveys during subsequent in-person visits; when in-person activities were not being offered or youth were no longer attending in person, youth were able to complete their surveys through email or text message links.

The youth surveys assessed both the SWE Core Measures and a series of local evaluation items chosen to reflect the areas that IHSCCV believed were likely to be impacted by their services and activities, including connection to culture, mental health and wellness, and substance use outcomes. Surveys for youth aged 12 years and older contained all survey items, while surveys for those aged 8-11 years were shorter and completed mostly by parents.

All IHSCCV services utilized by each youth participant were tracked by IHSCCV staff utilizing existing sign-in sheet methods and the total number of services/activities participated in (dosage) was shared with the evaluation team for data analysis purposes.

All data was gathered using online survey software (SurveyMonkey) and identified only with respondents' unique participant ID, to ensure that the evaluation team could not link individual-level data to identifiable respondents. To protect youth confidentiality, data in their raw form were not shared with project staff at IHSCCV, and dosage data was identified only by participant ID when shared with the evaluation team.

Core Measures survey items from the SWE included in this report include four items assessing connection to culture as well as a series of follow-up only items assessing satisfaction/experience with services at IHSCCV and how services/activities impacted various aspects of the respondent's life (e.g., coping skills, social support, etc.). This section provides more detail on several measures that are either only part of the local evaluation survey or are considered key outcomes for the local evaluation.

Several items measured mental health and wellness among respondents. The General Self-Efficacy Scale (GSE) is a 10-item self-report measure that assesses perceived self-efficacy in goal setting, effort investment, persistence in face of barriers, and recovery from setbacks. The ten items are designed to assess successful coping. Self-efficacy is an important construct to measure because it is related to subsequent behavior and therefore is relevant for clinical practice and behavioral change (Schwarzer & Jerusalem, 1995). The GSE has been shown to have consistent Cronbach reliability, ranging from

0.76-0.90 in different international samples. The Adolescent Resilience Scale (ARS) is a 21-item scale that aims to measure one's ability to succeed despite adversity. There are three factors: novelty seeking, emotional regulation, and positive future orientation. Respondents are asked to self-report using Likert scale items, ranging from 5 = "definitely yes" and 1 = "definitely no." The total scale has strong Cronbach reliability, $\alpha = 0.85$ (Oshio et al., 2003). The Kessler Psychological Distress Scale measures general distress based on constructs of anxiety and depressive symptoms. Questions probe about the symptoms an individual has experienced in the last four weeks. The items are based on a five-point Likert Scale; 1 = "none of the time" to 5 = "all of the time" (Kessler et al., 2002).

The survey asked six questions about social connectedness loosely based on the Social Connectedness Scale (Lee & Robbins, 1995). The original scale probes the extent to which youth feel connected to others in their social environment, but all original questions are framed in the negative (e.g., "I feel disconnected from the world around me" and "I have no sense of togetherness with my peers"). Based on the recommendations of staff at IHSCSV, our modified version of the scale utilized similar concepts reworded as strengths-based questions ("I feel connected to the people around me" and "I feel a sense of togetherness with my peers"). Response options ranged from 1 = "strongly disagree" to 6 = "strongly agree," and higher scores indicate greater connectedness with others.

The original Multi-group Ethnic Identity Measure (MEIM) is a 12-item measure that assesses connection to ethnic identity and can be used with diverse groups (Phinney, 1992); we utilized a slightly modified version that asked youth to respond specifically regarding their American Indian/Alaskan Native heritage (e.g., "I have a strong sense of belonging to my American Indian/Alaskan Native heritage"). Responses to each item ("strongly agree" to "strongly disagree") are summed to create a single scale score where higher scores indicate more connection to their American Indian/Alaskan Native heritage and culture.

Finally, the survey assessed the Four Core Measures of substance use (30-day use, perception of risk, parental disapproval, and peer disapproval), which were developed for the Drug Free Communities National Evaluation in compliance with SAMHSA'S National Outcome Measures (NOMs). Thirty-day substance use asks for frequency of alcohol use (one or more drinks), smoking all or part of a cigarette, using marijuana or hashish, and using prescription drugs not prescribed to you. Response options are zero days, 1-2 days, 3-5 days, 6-9 days and 10 plus days. For analysis, responses were dichotomized into any use vs. no use. Youth were also asked about their perception of risk related to substance use. Questions probe about binge drinking once or twice a week, smoking one or more packs of cigarettes a day, smoking marijuana once or twice a week, and using prescription drugs not prescribed to you. Response categories range from 1 = "no risk" to 4 = "great risk." Next, youth are asked about parental and peer approval/disapproval of these same substance use categories (e.g., "How wrong would your parents feel it would be for you to..."). Responses for both questions ranged from 1 = "not at all wrong" to 4 = "very wrong."

c. Evaluation Fidelity and Flexibility

The Strengthening Youth and Families Project CDEP activities were documented by IHSCSV staff with weekly planning and summary sheets to maintain the consistency of program delivery. CDEP staff checked-in with participants during the 6-month and 12-month follow up surveys. Survey participants

provided feedback. CDEP staff reviewed the feedback from survey participants and made changes to programming suggested by survey participants. Survey participants suggested program ideas for the types of Cultural Arts, Traditional Powwow Song and Dance, and San Jose Native Youth Empowerment Group activities they would like to do which included activities such as beadwork, sewing ribbon skirts/ribbon shirts/star quilts, and choosing the different dance styles they wanted to learn. This flexibility allowed participants to tailor the program to fit their individual needs.

The Strengthening Youth and Families Project CDEP activities also included The Gathering which followed the Gathering of Native Americans (GONA) curriculum and fidelity tool. CDEP Staff received GONA Training of Facilitators and applied their training to each of the CDEP activities. CDEP staff adapted the CDEP activities to follow the GONA flow which is teaching Belonging, Mastery, Interdependence, and Generosity in that order. This GONA flow maintained the structure of each CDEP activity.

d. Data Analysis

Results are presented primarily descriptively throughout this report, utilizing percentages and the number of respondents with each survey response (n). Where relevant, the mean (average) and standard deviation for continuous outcomes (e.g., counts and numbers) are presented. Most of this report focuses on data collected from the 74% of respondents who were age 12 or older, as this survey was the most comprehensive.

As described in 6b, to assess for change over time, a subset of the overall respondents was created that included those who completed the intake survey and at least one follow-up survey (which could have been a 6-month or a 12-month survey). This subset contains 27 youth respondents (from the overall sample of n=57) aged 12 years and older who completed at least two waves of data collection; most results presented in this report are for these 27 respondents. Restricting the over-time respondent data presented and analyzed in this report to this sample of 27 youth ensures that changes we see from intake to follow-up are among a consistent group of respondents. Given the relatively large number of respondents who only completed intake surveys (n=20), if we did not restrict over-time analyses to those who completed at least one follow-up survey, it would be difficult to identify whether changes over time were simply due to sample attrition (e.g., examining a different group of people at follow-up vs. at intake), rather than due to the programming itself. To maximize our ability to detect change over time, we included both people with intake and 6-month surveys only (n=3) as well as those with intake and 12-month surveys (n=24). When a participant had completed both 6-month and 12-month surveys (n=11), the 12-month survey was chosen as their follow-up comparison time point.

Additional analyses were undertaken with this smaller sample, including descriptively assessing whether results appeared to be different for respondents with follow-ups completed during the COVID-19 pandemic. We also assessed for statistically significant change over time among these 27 respondents on the main survey outcomes; depending on the variable type, this was done with t-

tests or chi-squared tests). The impact of service dosage on these outcomes – one of the project’s main evaluation questions – was assessed (with linear or logistic regression analyses (linear for continuous outcomes and logistic for binary outcomes), controlling for survey time point. We would like to note two important statistical considerations given the small sample size of these analyses (n=27 respondents with two survey time points): 1. A p-value of <0.10 was chosen as the cut-off suggestive of statistically significant *trends*. These trends could indicate either change over time or differences by program participation (dosage) in survey outcomes. 2. Non-significant/non-trending statistical test results are not reported, as it is not possible to identify whether lack of statistical significance is due to the small sample size or a true lack of relationship between the variables of interest. For these statistical analyses, the report narrative will only discuss results where there appeared to be trends or statistically significant relationships. The reader can assume that where it is not mentioned, these analyses did not find such results.

7. Results

Results in Tables 7.1-7.4 are presented separately for the overall sample (n=57) and the subset of respondents aged 12+ with at least two survey time points (n=27), which we refer to as the longitudinal sample. Results in Tables 7.5-7.8 and Figures 7.1-7.28 present findings only for the longitudinal respondents, as these visuals and analyses were meant to examine change over time.

Service Dosage

Table 7.4 presents service dosage information for survey respondents, as gathered by sign-sheets for IHSCV activities. Most respondents (64%) were only logged as being part of a single event; however, some “single” events reflect activities that may have been many hours or days long (e.g., workforce development camp or GONA). Given this limitation, future dosage tracking will utilize hours of events in which participants took part, rather than being event-based.

Survey Findings

Cultural Connectedness

Four questions from the SWE Core Measures Survey assessed cultural connectedness. As shown in Figures 7.1-7.4, respondents’ patterns of agreement across these items varied, with increases over time in the percentage of respondents agreeing or strongly agreeing that their culture gives them strength (from 78% at intake to 85% at follow-up) and that they feel connected to the spiritual/religious traditions of their culture (from 74% to 83% agreement), while there were declines in agreement to the statements assessing whether culture was important to them (from 96% to 92%

agreement) and whether their culture helped them to feel good about who they are (from 89% to 81%). Some of these inconsistencies are perhaps due to a ceiling effect (i.e., scores at intake on these measures were already quite high, leaving little room for improvement over time), but overall these findings speak to the ability of these programs to help youth respondents maintain high levels of cultural connectedness.

CRDP activity respondents also reported on their connection to culture using a modified version of the Multi-group Ethnic Identity Measure (MEIM) that focused specifically on their American Indian/Alaskan Native heritage. As shown in Figure 7.5, while the overall scale score of the longitudinal sample did not increase between intake (mean=39.9; SD=7.98) and follow-up (mean=38.5; SD=7.68), service dosage was statistically significantly associated with higher MEIM scores, $R^2=.11$, $F(2, 48)=3.06$, $\text{coeff}=0.55$, and $p=0.019$; i.e., those youth who participated in more activities scored higher on this measure of connection to their heritage).

Social Connectedness

Respondents reported on several items about social connectedness. As shown in Figures 7.6-7.11, most of these outcomes saw improvement between intake and follow-up, with an increase in the percentage of respondents who agreed that they participate when they are with people or in groups (92% to 93%), they belonged when around people they knew (from 81% to 85%), who felt a sense of togetherness with their peers (from 85% to 92%), who felt they could relate to many different people (89% to 96%), and who have a sense of brotherhood/sisterhood with their peers (93% to 100%). These changes are not large, likely again due to the ceiling effect – as all rates of social connectedness were high at intake – but reflect on the way that program participation may help youth maintain the protective factor of social connectedness. For the item assessing feeling like they belonged around people they knew, respondents were nearly statistically significantly more likely to report agreement if they had more service dosage at IHSCSV (odds ratio: 1.35; $p=0.06$; LR $\chi^2=6.64$; Pseudo $R^2=.14$).

Substance Use

CRDP activity respondents reported on their substance use at the intake and follow-up surveys (Figure 7.12). Most substance use the past 30 days declined between intake and follow-up, with alcohol declining from 22% to 8%, cigarette use from 8% to 0%, and marijuana use from 15% to 12%, while misuse of prescription drugs increased (4% to 8%; not that the overall n is quite small, so this only represents an increase from 1 person to 2 people). While these results should be interpreted with caution, as substance use overall was low, this does suggest that prescription drug misuse may be an important target for intervention programs with this population.

Substance use rates were higher for follow-up surveys completed during the COVID-19 pandemic; for alcohol, the rate was 6% pre-pandemic and 11% after, marijuana was 0% before and 33% after, and prescription drug misuse was 0% before and 22% after.

Substance Use Perceived Risk of Harm

Respondents answered a series of items asking about their perception of substance use harm, as well as parental and peer disapproval of substance use (Figures 7.13-7.16). Respondents rated the misuse of prescription medication as being the most harmful (85% at intake and 68% at follow-up rated use as of “great risk”), followed by smoking one pack or more of cigarettes each day (great risk endorsed by 77% at intake and 72% at follow-up), and drinking 5+ drinks of alcohol once or twice a week (great risk endorsed by 46% at intake and 56% at follow-up). The decline in perceived risk of harm related to prescription drug misuse between intake and follow-up surveys may be related to the increased incidence of use seen in the previous figure. In general, marijuana use was rated as having a low risk of harm, particularly at follow-up surveys (great risk endorsement was 46% at intake and 16% at follow-up).

Participants completing follow-up surveys during the COVID-19 pandemic rated the risk of harm associated with each substance lower than those completing earlier follow-up surveys. For alcohol, 82% rated binge drinking as having moderate or great risk of harm before the pandemic, compared to 63% afterwards; 88% rated smoking one or more packs of cigarettes a day as having moderate or great risk of harm before the pandemic, compared to 75% afterwards; and 58% rated smoking marijuana once or twice a week as having moderate or great risk of harm before the pandemic, compared to only 13% afterwards. Perceived risk of prescription drug misuse did not differ before or during the COVID-19 pandemic.

Substance Use Parental Disapproval

As shown in Figures 7.17-7.20, respondents reported that their parents felt most strongly that it would be wrong to misuse prescription drugs (96% at intake and 83% at follow-up stated that their parents would feel it was “very wrong”), followed by smoking cigarettes (very wrong was indicated by 92% at intake and 80% at follow-up) and binge drinking (very wrong was indicated by 89% at intake and 75% at follow-up), with the lowest perceived disapproval associated with the use of marijuana (very wrong indicated by 77% at intake and 64% at follow-up). These numbers show that perceived parental disapproval declined between intake and follow-up surveys for all substances.

Substance Use Peer Disapproval

As shown in Figures 7.21-7.24, respondents perceived that that their peers feel it was most wrong to misuse prescription drugs (with 62% at intake and 52% at follow-up stating that their friends would feel it was “very wrong”), followed by smoking cigarettes (54% at intake and 44% at follow-up) and binge drinking (42% at intake and 40% at follow-up), with the lowest disapproval for use of marijuana (40% at intake and 30% at follow-up). In general, rates of perceived disapproval among peers were much lower than those among parents.

Respondents completing follow-up surveys during the COVID-19 pandemic reported less perceived peer disapproval for binge drinking, with 71% choosing wrong or very wrong in surveys pre-pandemic and 50% choosing those responses in surveys during the pandemic; the same trend was seen for perceived disapproval of marijuana, with wrong/very wrong responses going from 47% before COVID-19 to 38% after the start of COVID-19.

Mental Health & Wellness

Respondents answered several items at intake and follow-up that assessed mental health and wellness, including psychological distress, self-efficacy, and several aspects of resilience. Scores on these outcomes did not change significantly over time for respondents (Figures 7.25-7.26), again perhaps due to a ceiling effect. The Kessler Psychological Distress scale averaged 7.8 at intake (SD=6.33) and 8.0 at follow-up (SD=6.31) and the Generalized Self-Efficacy Scale had a mean of 33.3 at intake (SD=5.29) and 33.7 at follow-up (SD=5.36). The Adolescent Resilience Scale had a mean overall score of 79.5 at intake (SD=10.5) and 78.1 at follow-up (SD=11.1), the ARS Positive Future Orientation subscale was 20.3 at intake (SD=4.6) and 20.6 at follow-up (SD=4.2), the ARS Emotional Regulation subscale was 30.8 at intake (SD=4.5) and 30.2 at follow-up (SD=4.9), and the ARS Novelty subscale was 28.4 at intake (SD=3.7) and 27.9 at follow-up (SD=3.9). However, those with more service encounters had lower scores on the Kessler Psychological Distress Scale (an average of .39 lower points associated with each additional service encounter; $R^2=.23$, $F(2, 42)=1.53$, $p=0.09$). Given these findings, the programming at IHSCCV may play an important role in helping participants maintain protective factors for mental health and well-being, particularly during the key developmental time periods of adolescence and young adulthood.

There is some evidence that psychological distress worsened for respondents during the COVID-19 pandemic; for respondents completing both surveys prior to the pandemic there was little difference in this score between intake and follow-up (7.8 vs. 8.0), while among those completing their follow-ups during the pandemic there was an increase in psychological distress scores from 9.5 to 11.6. Similarly, resilience scores appeared to decline for respondents completing follow-ups during the pandemic in a way not seen pre-pandemic, with the overall ARS score in the first group going from 79.5 at intake to 78.0 at follow-up, while this score declined from 77.0 to 73.5 among those with follow-ups during the pandemic.

Social Networks

Respondents were asked about the characteristics of their social networks, elicited by asking them to list five people “*who are important to you, and with whom you interacted in the last 6 months. This can be anyone, including people you don’t see in person (people you only talk to online, for example), but they should be people you know who know you.*” Numbers in Table 7.5 represent the average number (out of 5 total) identified by the respondent as having each characteristic. As shown in the table, we did not see a lot of change in social network composition among all the longitudinal respondents, with the mean number of network members attending IHSCCV going from 1.9 (SD=1.7)

to 1.4 (SD=1.5), those who give advice staying at 3.4 (SD=1.6/SD=1.3), those they can count on to listen to them changing from 4.0 (SD=1.3) to 3.6 (SD=1.6), those who they have disagreements with going from 0.7 (SD=0.9) to 0.9 (0.8), those they could borrow \$100 from changing from 2.3 (SD=1.2) to 2.7 (SD=1.7), and those they consider a friend going from 3.0 (SD=1.9) to 3.2 (SD=1.7).

Not surprisingly, when we looked at dosage we found those who had more service interaction had more people within their networks who also attended events at IHCSCV (each additional event attended by an individual was associated with an increase of 0.13 in their average number of network members who also attended events; $R^2=.16$, $F(2, 50)=4.8$, $p=0.005$).

When we examined changes in social network composition separately for respondents whose follow-up surveys were before and during the COVID-19 pandemic, we found several striking differences. When looking at respondents before the pandemic, the average number of social network members from whom they received advice increased from 3.2 (SD=1.6) at intake to 3.7 (SD=1.1) at follow-up – suggesting that participation in IHCSCV events may have been positively impacting their network support. However, when looking at those respondents whose follow-up survey was during the pandemic, we saw a decline in network members providing support, going from 3.7 (SD=1.4) at intake to 3.0 (SD=1.0) at follow-up. The same pattern occurs for network members who the respondent feels they can count on to listen to them, which increased for pre-pandemic respondents (mean=3.6 and SD=1.5 at intake; mean=3.8 and SD=1.4 at follow-up), but declined sharply for those with follow-ups after the pandemic (mean=4.5 and SD=1.0 at intake; mean=3.4 and SD=1.8 at follow-ups). When we assessed a negative aspect of network – those with whom the respondent has disagreements – we find that the average number declined for pre-pandemic respondents from 0.8 (SD=0.9) to 0.7 (SD=0.5), while this average doubled for post-pandemic follow-up respondents from 0.6 (SD=1.0) to 1.2 (SD=1.1).

Experiences with Services at IHCSCV

At follow-up only, respondents reported on experiences with staff and services at IHCSCV. Figures (7.27-7.28) report on responses from the longitudinal respondents aged 12+. Across all indicators, respondents agreed or strongly agreed that they had positive experiences with staff and services at IHCSCV. Of particular note are the statements where 100% of respondents agreed or strongly agreed: that they were satisfied overall with the services they received, they got the help they wanted, they got the help they needed, and that staff treated them with respect. Other measures asked whether “the people helping me stuck with me no matter what” (92% agreed or strongly agreed), whether they “felt I had someone to talk to when I was troubled” (96% agreed or strongly agreed), if they received the services that were right for them (96% agreed or strongly agreed), the location of services was convenient (83% agreed or strongly agreed), the time of services was convenient (92% agreed or strongly agreed), staff respected their religious beliefs (96% agreed or strongly agreed), staff spoke in a way they understood (96% agreed or strongly agreed), and staff were sensitive to their cultural or ethnic background (96% agreed or strongly agreed).

For youth aged 8-11, the questions about overall experiences with services and staff were worded slightly differently and asked of their parents (Table 7.6). Items where the highest percentage of parents agreed that services had been positive (with 90% agreement with each) included overall satisfaction with services, that they got they needed for their child, that staff treated them with respect, that staff respected religious/spiritual beliefs, staff spoke to them in a way they understood, and that staff were sensitive to their ethnic/cultural background. Other indicators asked whether “the people helping my child stuck with us no matter what” (70% agreed or strongly agreed), whether they felt their child had someone to talk to when they were troubled (60% agreed or strongly agreed), the services were right for their family (80% agreed or strongly agreed), the location was convenient (70% agreed or strongly agreed), the times were convenient (80% agreed or strongly agreed), and they got the help they wanted for their child (80% agreed or strongly agreed).

Respondents at follow-up were also asked to reflect on how their lives had changed because of their involvement with services at IHSCCV. As shown in Table 7.7, across all items the vast majority of respondents agreed or strongly agreed that services had improved their lives in general, including their ability to cope, get along with others, and to find support and connection. Five specific items assessed outcomes related to IHSCCV’s programming: knowledge about historical trauma, suicide prevention, stigma and mental illness, discrimination’s relationship to mental health, and the early signs of mental illness. The items where respondents aged 12+ reported the highest levels of agreement included that they are more knowledgeable about historical trauma (100% agreement), that they get along better with other people (96%), have people who will listen and understand them when they need to talk (96%), are more knowledgeable about how discrimination can affect their mental health (92%), have people with whom to do enjoyable things (96%), have support they would need in a crisis (92%), and have people that they are comfortable talking about problems with (92%). Other measures assessed whether respondents were better at handling daily life (87% agreed or strongly agreed), were doing better in school or work (78% agreed or strongly agreed), were better able to cope when things go wrong (87% agreed or strongly agreed), were satisfied with family life (87% agreed or strongly agreed), were better able to do things they want to do (87% agreed or strongly agreed), were more knowledgeable about suicide prevention (83% agreed or strongly agreed), were more knowledgeable about stigma and mental illness (87% agreed or strongly agreed), and were more knowledgeable about the early signs of mental illness (87% agreed or strongly agreed).

For youth aged 8-11, the questions about changes related to IHSCCV service were worded slightly differently and asked of their parents. For these (Table 7.8), the majority of parents also agreed that services had a positive impact on their child’s life across these different domains. The items with the highest level of parental agreement included that their child gets along better with friends and other people (100% agreement) and that the parents had people with whom they could do enjoyable things (100%). Other parental items asked if their child was better at handling daily life (90% agreed or strongly agreed), got along better with family members (90% agreed or strongly agreed), was doing better in school or work (80% agreed or strongly agreed), was better able to cope when things go wrong (70% agreed or strongly agreed), if the parent was satisfied with family life (90% agreed or strongly agreed), if their child was better able to do things they want to do (90% agreed or strongly

agreed), if they know people who will listen and understand them (90% agreed or strongly agreed), if they have people they are comfortable talking to about their child's problems (80% agreed or strongly agreed), in a crisis they would have the support they need (90% agreed or strongly agreed), and their child is more knowledgeable about historical trauma (90% agreed or strongly agreed), suicide prevention (90% agreed or strongly agreed), stigma and mental illness (80% agreed or strongly agreed), discrimination's effect on mental health (90% agreed or strongly agreed), and the early signs of mental illness (70% agreed or strongly agreed).

Meta-Analysis Table

Meta-analysis details are in Table 7.9. These findings are restricted to respondents aged 12 years and older who completed each measure at both intake and 12-month surveys. Please note that – as described above – additional exploratory analyses found suggestive evidence that scores of both psychological distress and resilience worsened for respondents during the COVID-19 pandemic, which is not reflected in the way the meta-analytic details are presented.

8. Discussion

The Strengthening Youth and Families Project was designed to address a needs assessment that was done in 2015 with the AIAN community in Santa Clara County. The community identified the needs for more resources for AIAN youth, expanding youth programming, increasing family involvement, and restoring lost AIAN culture to promote mental health and wellbeing of the AIAN community. The goal of this project was to reduce mental health disparities by increasing connection to community, increasing knowledge and sustainment of cultural traditions/practices and ceremonies to address the loss of culture, and strengthen mental health protective factors. The Strengthening Youth and Families Project evaluation measured connection to culture, substance use, perceived risk of harm of substance use, perception of parental and peer disapproval of substance use, mental health and wellness, and social networks.

In regards to connection to culture, the results indicate that those who participated more in CDEP activities scored higher in measures of both social and cultural connectedness. Each of the CDEP activities intentionally used the GONA principles of Belonging, Mastery, Interdependence, and Generosity to create a stronger connection to culture and community. For example, the Traditional Powwow Song and Dance Class adapted the GONA principles to fit into the class structure. Belonging is created with an opening prayer, an icebreaker, and eating dinner together. Mastery is taught with sharing the history, knowledge, and meaning of songs and dances. Interdependence is formed when the singers come together at the drum to sing songs for the dancers to practice with the beat of the drum. Generosity is shown when participants showcased what they learned at Mini-Powwows in regalia that participants created in a Cultural Arts Class. All the CDEP activities, except for the San Jose Native Youth Empowerment Group, are intergenerational which builds a stronger community for the youth. Youth learn from and collaborate with adults and elders. The San Jose

Native Youth Empowerment Group strengthens cultural identity by giving youth a safe space to learn and express their culture with their peers.

For substance use, perceived risk of harm, and perception of parental/peer disapproval, the results showed differences over the time of the study such as before and after the pandemic. Although low to begin with, overall, substance use declined among participants in every measure except prescription drug use, which increased from 1 to 2 participants. However, the time frame in which some of these data were gathered was during the COVID-19 pandemic, a time of increased stress and anxiety for everyone, particularly youth who were out of school and cut off from many social activities. Although the CDEP activities adapted to the COVID-19 pandemic and social distancing by switching to virtual activities over zoom, many of the participants were unable to join online. Part of this was due to not having access to technology and internet. Other reasons included participants experiencing “zoom fatigue”. The perceived risk of harm of substances declined between the end measures and earlier follow up surveys. Youth responded that cigarettes use, binge drinking alcohol and marijuana use were less of a risk at follow up, with a big decline in perceived risk of marijuana use. Only perceived risk of prescription drug use did not change. Perceived risk of marijuana changes could be related to legalization and increased use – along with more public dialogue, public health messaging and understanding of risk. Or, because marijuana is legal, there might be more reporting of use and understanding of risk in general.

Mental health and wellness scores (measured by Kessler Psychological Distress scale, the Generalized Self-Efficacy Scale, and Adolescent Resilience Scale, ARS Emotional Regulation subscale, and the ARS Novelty subscale) did not change much over time for respondents, perhaps due to a ceiling effect. However, those who participated more in the CDEP activities had lower scores on the Kessler Psychological Distress Scale. Some participant scores were worse during the pandemic, compared with those who completed both surveys prior to the pandemic. Although the scores were slightly worse for those participants that completed the follow-up surveys during the pandemic, CDEP activities continued to provide protective factors for mental health and wellbeing. Participants were able to join the adapted virtual CDEP activities during the COVID-19 pandemic. Participants were able to learn coping skills during the CDEP activities, especially during the COVID-19 pandemic. CDEP activities turned towards topics of historical trauma and discussed the resiliency of AIAN ancestors that experienced historical pandemics. The results show that 87% of participants agreed or strongly agreed that they were better able to cope when things go wrong. This may have prevented participants from experience higher psychological distress levels.

As for social networks, not a lot of change was seen. However, there was a dose effect. Those who had more service interaction had more people within their networks who also attended CDEP activities. Attendance is important in building strong social networks and community. Participants that attend our CDEP activities are usually invited to the annual family 4-day campout in Santa Cruz, which is called, “The Gathering.” At The Gathering, participants and their families celebrate their accomplishments from the year. During the 4-day activity, the GONA principles and activities that are taught throughout the year are taught in depth creating a stronger community made of many families. Several measures of change in social network composition were more positive for respondents before the pandemic than those during the pandemic.

Limitations

The Strengthening Youth and Families Project evaluation had a small sample size to determine if our outcomes are true findings. The small sample size is due in part to convenience sampling and recruiting youth that participated in any of the CDEP activities at least once. Most youth did not complete a follow-up survey that would be administered 6-months or 12-months later. These youth that did not complete a follow up survey may have aged out of the youth programming, attended college, moved away, stopped attending CDEP activities, or were unreachable via phone or email especially when the COVID-19 Pandemic started. The COVID-19 pandemic created challenges for IHSCSV staff with outreach, recruitment, retention, and follow-up of participants. Outreach of our programs was limited to social media, emails, and phone calls. Previously, we were able to outreach at in-person community, county, and powwow events. Recruitment of new participants in our programs was low due to moving all programming to an online format. Our participants do not always have access to devices. Our prior outreach was not geared towards online programming. If people planned on attending in person, but had yet to do so, it is less likely they would join after programming moved online. It is also harder to reach people when you cannot go to them in-person. Follow-up with survey participants was also difficult. Survey participants had to be contacted via email, text message, and phone calls. Before COVID-19 follow-up surveys were conducted in person at the CDEP activity.

9. Conclusion

The goal of the Strengthening Youth and Families Project was to reduce mental health disparities by increasing connection to community, increasing knowledge and sustainment of cultural traditions/practices and ceremonies to address the loss of culture, and strengthen mental health protective factors. The CDEP activities in the Strengthening Youth and Families Project were prevention and early intervention programs for participants that may not have had existing mental health disparities or substance use. Because of the impact of the COVID-19 pandemic and a small sample size, the data is hard to interpret the small changes that are seen. The main findings showed consistently that high dosage of engagement in cultural activities provided protective factors and maintained mental and wellbeing in participants. Those who participated the most saw the greatest benefits of social and cultural connectedness, such as coping skills, social support, and a stronger cultural identity. While psychological distress scores worsened for some respondents during the COVID-19 pandemic, generally participants' health and wellness scores held steady over time. The CDEP activities may play an important protective role for mental health and well-being of adolescents and young adults. This finding is consistent with messaging heard from AIAN communities and supports further research and inquiry into culturally-based approaches to mental health prevention and promotion.

Although the changes were small, the perceived risk of harm of substances declined among youth participating in this survey between baseline and follow ups. In the future, this could be an important area to focus intervention and education efforts, and help youth understand the risks of substance use.

Across all indicators, respondents agreed or strongly agreed that they had positive experiences with staff and services at IHSCCV. Of note are the statements where 100% of respondents agreed or strongly agreed: that they were satisfied overall with the services they received, they got the help they wanted, they got the help they needed, and that staff treated them with respect. Other measures indicating program support had very high levels of agreement. This shows that these CDEP activities are needed and wanted by the AIAN community of Santa Clara County.

10. References

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11. Appendices

Appendix I: Tables

Table 7.1. IHSCCV Completed Surveys by Wave and Age

	n	%
Total Respondents	57	100.0%
Ages 8-11	15	26.3%
Ages 12+	42	73.7%
Intake Only	20	35.1%
Ages 8-11	5	
Ages 12+	15	
Intake & 6m Only	3	5.3%
Ages 8-11	0	
Ages 12+	3	
Intake & 12m Only	18	31.6%
Ages 8-11	5	
Ages 12+	13	
All 3 Waves	16	28.1%
Ages 8-11	5	
Ages 12+	11	

Table 7. 2. Respondent Characteristics

	% (n)	
	Overall Sample (n=57)	Longitudinal 12+ sample (n=27)
Age		
8-11 years	26.3 (15)	---
12-18 years	63.2 (36)	81.5 (22)
19-25 years	10.5 (6)	18.5 (5)
Gender		
Girl/woman	66.7 (38)	70.4 (19)
Boy/man	31.6 (18)	25.9 (7)
Another gender identity	1.8 (1)	3.7 (1)
Sexual Orientation		
Straight/heterosexual	57.9 (33)	66.7 (18)
Bisexual/pansexual	12.3 (7)	25.9 (7)
Unsure	1.8 (1)	3.7 (1)
Not asked or not answered	28.1 (16)	3.7 (1)
Race/ethnicity		
American Indian/Alaskan Native Only	28.1 (16)	33.3 (9)

American Indian/Alaskan Native & Latinx	36.8 (21)	37.0 (10)
American Indian/Alaskan Native & White	3.5 (2)	3.7 (1)
American Indian/Alaskan Native & Native Hawaiian/Pacific Islander	1.8 (1)	0 (0)
American Indian/Alaskan Native & 2+ Other Races/Ethnicities	17.5 (10)	18.5 (5)
Latinx/Hispanic/Spanish	8.8 (5)	7.4 (2)
Native Hawaiian/Pacific Islander and Latinx	3.5 (2)	0 (0)

Table 7.3. Tribal Affiliation (categories not mutually exclusive)

	% (n)
Sioux (Lakota, Oglala, Cheyenne River)	28.1 (16)
Apache	22.8 (13)
Navajo	17.5 (10)
Chumash	7.0 (4)
Osage	5.3 (3)
Mexica	5.3 (3)
Blackfoot	3.5 (2)
Purepecha	3.5 (2)
Yaqui	3.5 (2)
Yakut	3.5 (2)
Otomi	3.5 (2)
Aztec	1.8 (1)
Cherokee	1.8 (1)
Seminole	1.8 (1)
Creek	1.8 (1)
Inupiat	1.8 (1)
Luiseno	1.8 (1)
Maya	1.8 (1)
Plains Cree	1.8 (1)
Houma	1.8 (1)
Western Shoshone	1.8 (1)
Cora	1.8 (1)
Nahuatl	1.8 (1)
Yurok	1.8 (1)
Huichol	1.8 (1)

Table 7.4. Number of events attended

	Overall Sample	Longitudinal respondents
1	64.3 (27)	48.2 (13)
4	4.8 (2)	7.4 (2)
5	4.8 (2)	7.4 (2)
6	2.4 (1)	3.7 (1)
8	4.8 (2)	7.4 (2)

9	7.1 (3)	7.4 (2)
11	2.4 (1)	3.7 (1)
13	9.5 (4)	14.8 (4)

Table 7.5. Social Networks	Mean number of people out of 5 (SD)	
	Intake	Follow-Up
Who on this list also attends activities at the Indian Health Center?	1.85 (1.70)	1.42 (1.53)
Who on this list has given you advice or information to help you solve a problem in the past 6 months?	3.41 (1.55)	3.44 (1.28)
Who can you count on to listen to you when you need to talk?	3.96 (1.34)	3.63 (1.57)
Who do you have unpleasant disagreements with, or makes you angry or upset?	0.74 (0.94)	0.89 (0.80)
Who could you borrow \$100 from if you needed it?	2.30 (1.23)	2.74 (1.65)
Who on this list do you consider a friend?	2.96 (1.91)	3.19 (1.71)

Table 7.6. Experiences among Longitudinal Respondents Ages 8-11

	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	Not applicable
Overall, I am satisfied with the services my child received.	0% (n=0)	0% (n=0)	10% (n=1)	30% (n=3)	60% (n=6)	0% (n=0%)
The people helping my child stuck with us no matter what.	0% (n=0)	0% (n=0)	10% (n=1)	20% (n=2)	50% (n=5)	20% (n=2)
I felt my child had someone to talk to when they were troubled.	0% (n=0)	0% (n=0)	10% (n=1)	10% (n=1)	50% (n=5)	30% (n=3)
The services my child and/or family received were right for us.	0% (n=0)	0% (n=0)	10% (n=1)	30% (n=3)	50% (n=5)	10% (n=1)
The location of services was convenient for us.	0% (n=0)	0% (n=0)	20% (n=2)	20% (n=2)	50% (n=5)	10% (n=1)
Services were available at times that were convenient for us.	0% (n=0)	0% (n=0)	10% (n=1)	40% (n=4)	40% (n=4)	10% (n=1)
My family got the help we wanted for my child.	0% (n=0)	0% (n=0)	10% (n=1)	40% (n=4)	40% (n=4)	10% (n=1)
My family got as much help as we needed for my child.	0% (n=0)	0% (n=0)	0% (n=0)	40% (n=4)	50% (n=5)	10% (n=1)
Staff treated me with respect.	0% (n=0)	0% (n=0)	0% (n=0)	20% (n=2)	70% (n=7)	10% (n=1)
Staff respected my family's religious / spiritual beliefs.	0% (n=0)	0% (n=0)	0% (n=0)	20% (n=2)	70% (n=7)	10% (n=1)
Staff spoke with me in a way that I understood.	0% (n=0)	0% (n=0)	0% (n=0)	20% (n=2)	70% (n=7)	10% (n=1)
Staff were sensitive to my cultural / ethnic background.	0% (n=0)	0% (n=0)	0% (n=0)	20% (n=2)	70% (n=7)	10% (n=1)

Table 7.7. Services Impact among Longitudinal Respondents Ages 12+

	Strongly disagree	Disagree	Undecided	Agree	Strongly agree
I am better at handling daily life.	4.4% (n=1)	0% (n=0)	8.7% (n=2)	39.1% (n=9)	47.8% (n=11)
I get along better with other people.	0% (n=0)	0% (n=0)	4.4% (n=1)	47.8% (n=11)	47.8% (n=11)
I am doing better in school and/or work.	0% (n=0)	0% (n=0)	21.7% (n=5)	52.2% (n=12)	26.1% (n=6)
I am better able to cope when things go wrong.	0% (n=0)	0% (n=0)	13.0% (n=5)	47.8% (n=11)	39.1% (n=9)
I am satisfied with my family life right now.	0% (n=0)	4.4% (n=1)	8.7% (n=2)	56.5% (n=13)	30.4% (n=7)
I am better able to do things I want to do.	0% (n=0)	0% (n=0)	12.5% (n=3)	41.7% (n=10)	45.8% (n=11)
I know people who will listen and understand me when I need to talk.	0% (n=0)	4.2% (n=1)	0% (n=0)	54.2% (n=13)	41.7% (n=10)
I have people that I am comfortable talking with about my problem(s).	0% (n=0)	4.2% (n=1)	4.2% (n=1)	50.0% (n=12)	41.7% (n=10)
In a crisis, I would have the support I need from family or friends.	0% (n=0)	0% (n=0)	8.3% (n=2)	45.8% (n=11)	45.8% (n=11)
I have people with whom I can do enjoyable things.	0% (n=0)	0% (n=0)	4.2% (n=1)	62.5% (n=15)	33.3% (n=8)
I am more knowledgeable about historical trauma as it relates to my AI/NA history.	0% (n=0)	0% (n=0)	0% (n=0)	45.8% (n=11)	54.2% (n=13)
I am more knowledgeable about suicide prevention.	0% (n=0)	8.3% (n=2)	8.3% (n=2)	41.7% (n=10)	41.7% (n=10)
I am more knowledgeable about stigma and mental illness.	0% (n=0)	4.2% (n=1)	8.3% (n=2)	41.7% (n=10)	45.8% (n=11)
I am more knowledgeable about how discrimination can affect my mental health.	0% (n=0)	4.2% (n=1)	4.2% (n=1)	50.0% (n=12)	41.7% (n=10)
I am more knowledgeable about the early signs of mental illness.	0% (n=0)	13.0% (n=4)	0% (n=0)	43.5% (n=10)	43.5% (n=10)

Table 7.8. Longitudinal Respondents Ages 8-11

	Strongly disagree	Disagree	Undecided	Agree	Strongly agree
As a result of the services my child received: My child is better at handling daily life.	0% (n=0)	10% (n=1)	0% (n=0)	50% (n=5)	40% (n=4)
My child gets along better with family members	0% (n=0)	0% (n=0)	10% (n=1)	50% (n=5)	40% (n=4)
My child gets along better with friends and other people.	0% (n=0)	0% (n=0)	0% (n=0)	60% (n=6)	40% (n=4)
My child is doing better in school and/or work.	0% (n=0)	10% (n=1)	10% (n=1)	50% (n=5)	30% (n=3)

My child is better able to cope when things go wrong.	0% (n=0)	10% (n=1)	20% (n=2)	30% (n=3)	40% (n=4)
I am satisfied with my family life right now	0% (n=0)	10% (n=1)	0% (n=0)	40% (n=4)	50% (n=5)
My child is better able to do things they want to do.	0% (n=0)	0% (n=0)	10% (n=1)	50% (n=5)	40% (n=4)
I know people who will listen and understand me when I need to talk.	0% (n=0)	0% (n=0)	10% (n=1)	40% (n=4)	50% (n=5)
I have people that I am comfortable talking with about my child's problem(s).	10% (n=1)	0% (n=0)	10% (n=1)	20% (n=2)	60% (n=6)
In a crisis, I would have the support I need from family or friends.	0% (n=0)	0% (n=0)	10% (n=1)	30% (n=3)	60% (n=6)
I have people with whom I can do enjoyable things	0% (n=0)	0% (n=0)	0% (n=0)	50% (n=5)	50% (n=5)
My child is more knowledgeable about historical trauma as it relates to our AI/NA history.	0% (n=0)	0% (n=0)	10% (n=1)	40% (n=4)	50% (n=5)
My child is more knowledgeable about suicide prevention	0% (n=0)	0% (n=0)	10% (n=1)	50% (n=5)	40% (n=4)
My child is more knowledgeable about stigma and mental illness.	0% (n=0)	0% (n=0)	10% (n=1)	50% (n=5)	30% (n=3)
My child is more knowledgeable about how discrimination can affect their mental health	0% (n=0)	0% (n=0)	10% (n=1)	60% (n=6)	30% (n=3)
My child is more knowledgeable about the early signs of mental illness.	0% (n=0)	0% (n=0)	30% (n=3)	40% (n=4)	30% (n=3)

Table 7.9. IHSCSV Results for SWE Meta-Analysis (n restricted to participants aged 12+ who completed both an intake and 12-month follow-up survey)

Measure Name	Modified Y/N	Pre Mean score	Pre score SD	Pre N	Post Mean score	Post score SD	Post N	Correlation between Pre and Post Mean score (r)	Cohort	Age group
Generalized Self-Efficacy (GSE)	N	32.94	5.47	17	34.35	4.33	17	0.74	n/a	Adolescent
Kessler Psychological Distress	N	8.00	5.86	18	7.89	6.24	18	0.76	n/a	Adolescent

Multi-group Ethnic Identity Measure (MEIM)	Y	38.86	8.57	21	38.76	7.99	21	0.32	n/a	Adolescent
Adolescent Resilience Scale	N	78.94	10.63	18	18.39	10.49	18	0.73	n/a	Adolescent

Appendix II: Figures

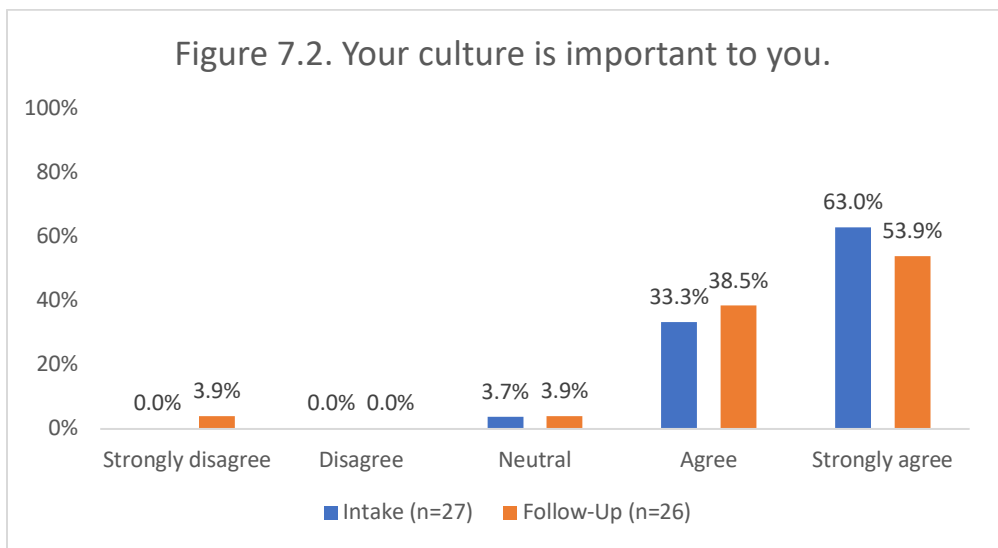
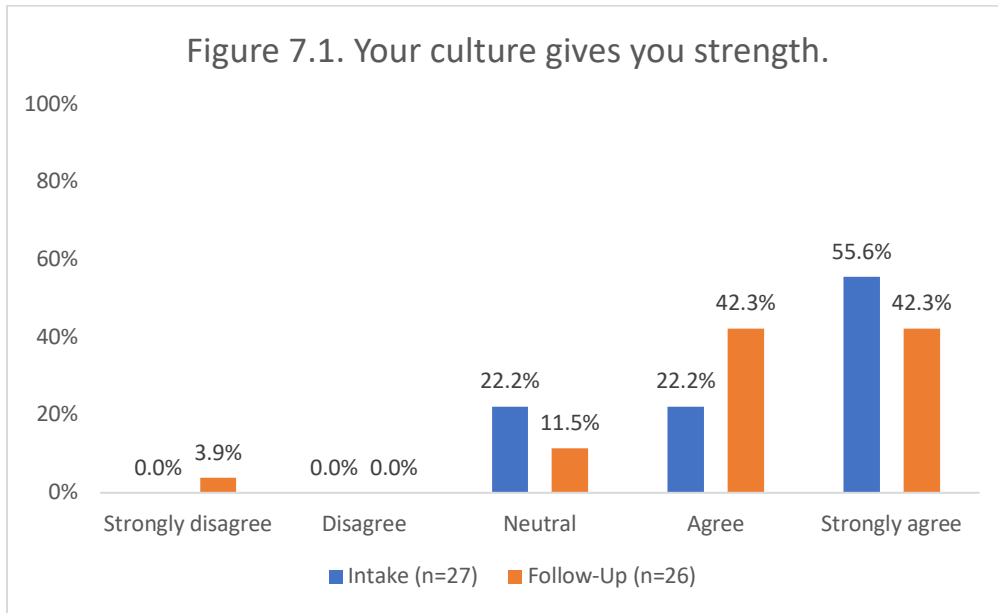


Figure 7.3. Your culture helps you to feel good about who you are.

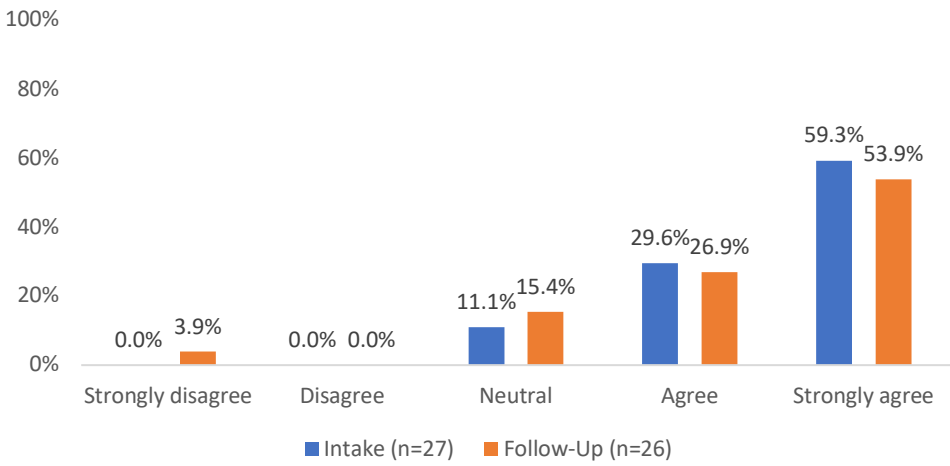


Figure 7.4. You feel connected to the spiritual/religious traditions of the culture you were raised in.

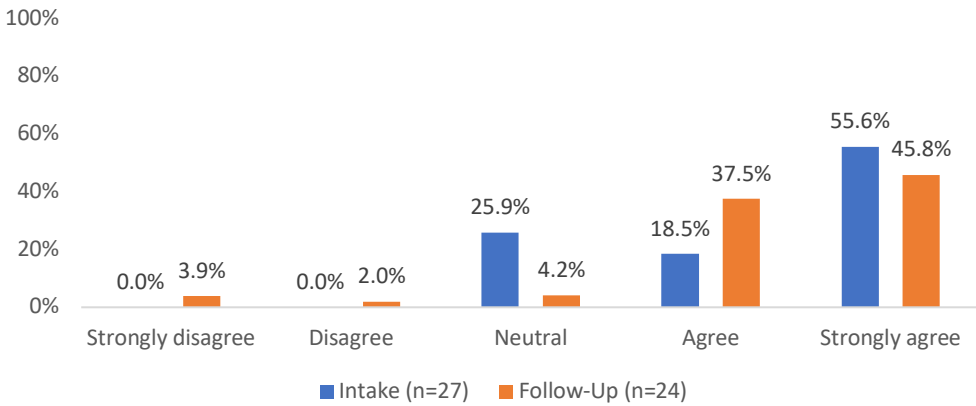


FIGURE 7.5. MULTIETHNIC IDENTITY MEASURE (MEIM) SCORE OVER TIME

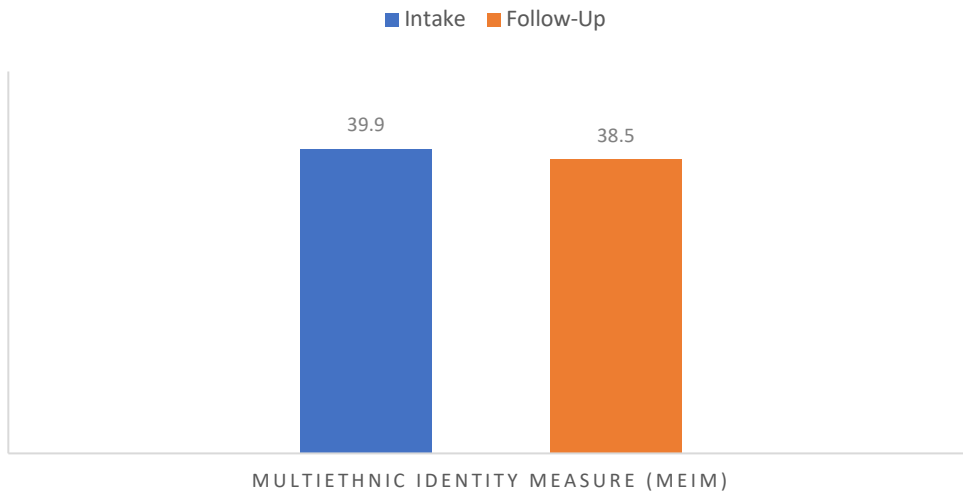


Figure 7.6. I feel connected to the people around me.

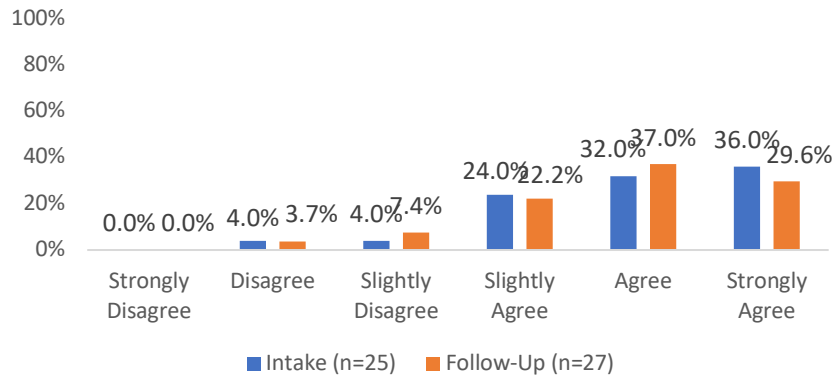


Figure 7.7. When I'm around people I know, I feel I really belong.

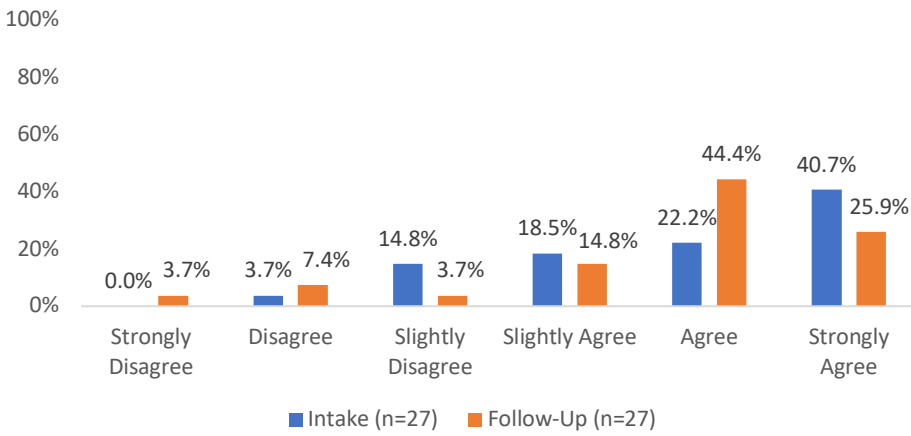


Figure 7.8. I feel a sense of togetherness with my peers.

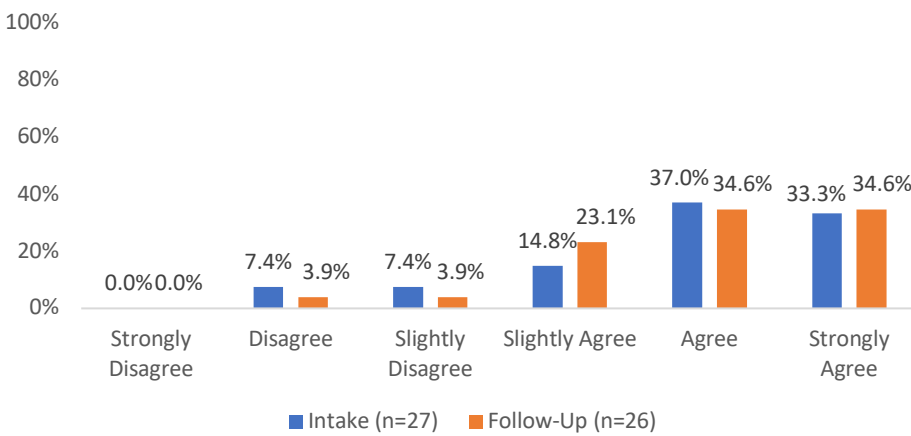


Figure 7.9. I feel I can relate to many different people.

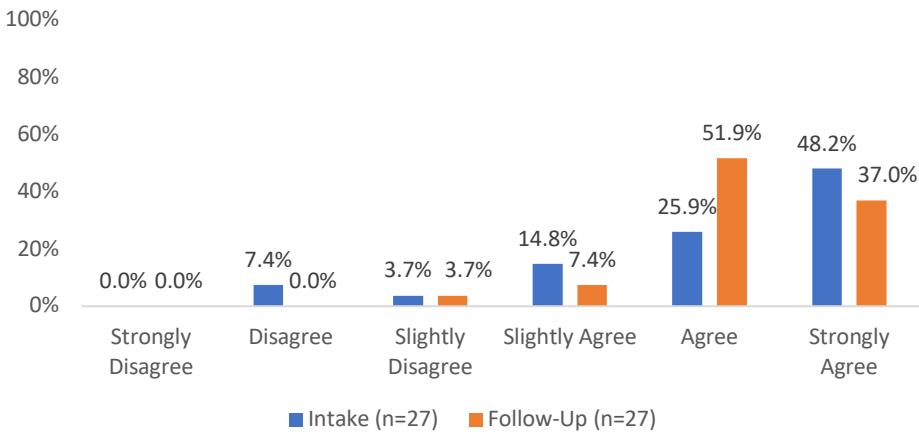


Figure 7.10. I have a sense of brotherhood/sisterhood with my friends.

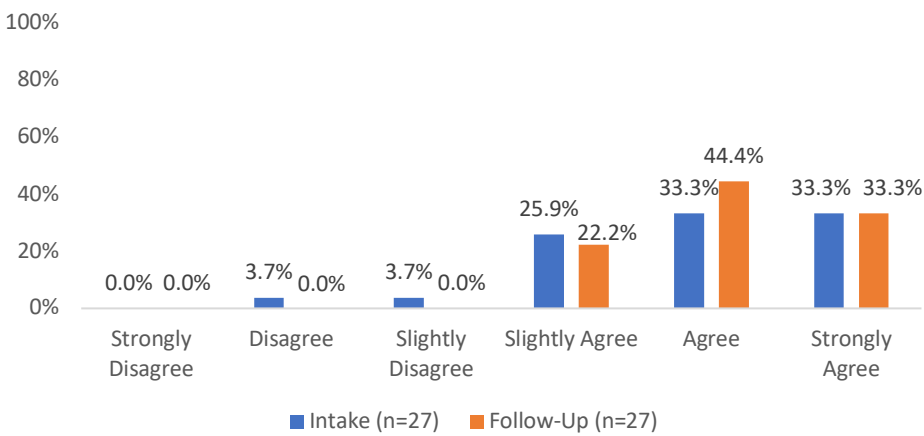


Figure 7.11. I feel I participate when I'm with people or in groups.

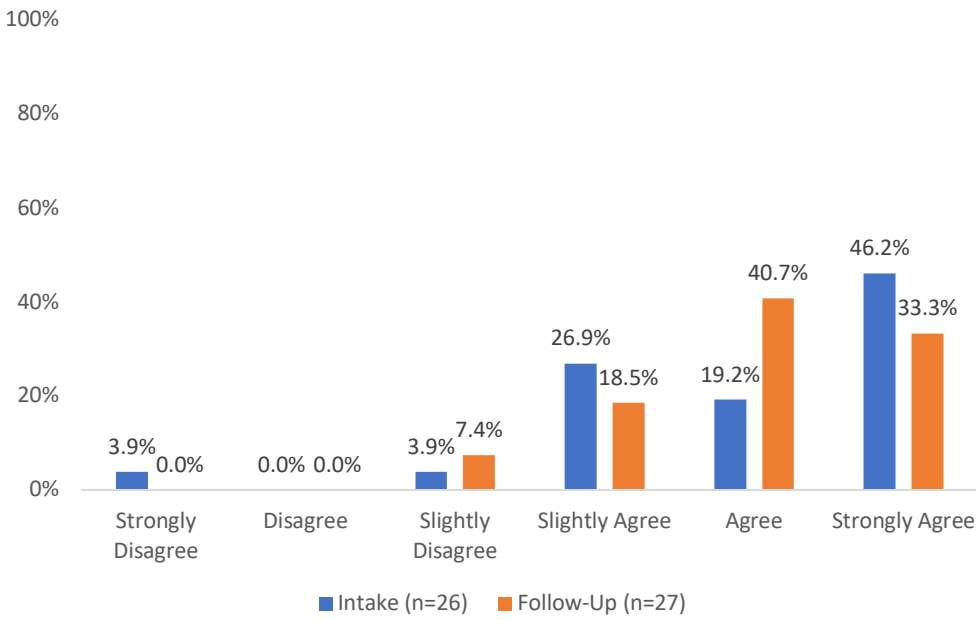


Figure 7.12. Past 30-Day Use

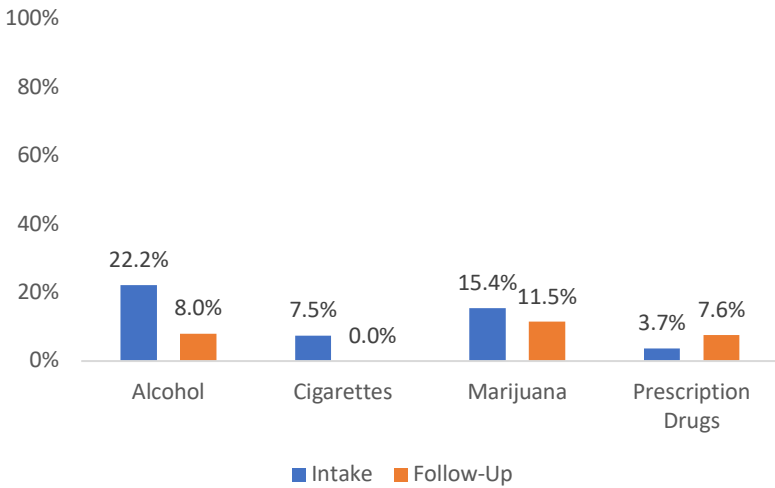


Figure 7.13. How much do you think people risk harming themselves if they have five or more drinks of alcohol once or twice a week

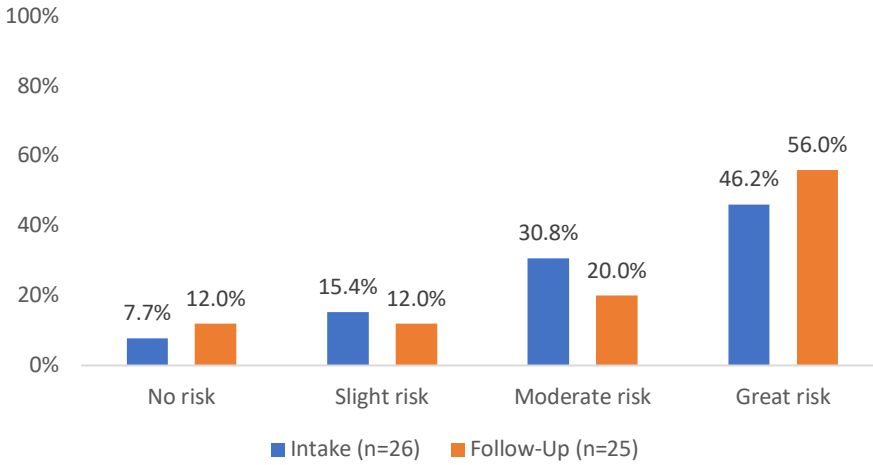


Figure 7.14. How much do you think people risk harming themselves if they smoke one or more packs of cigarettes a day?

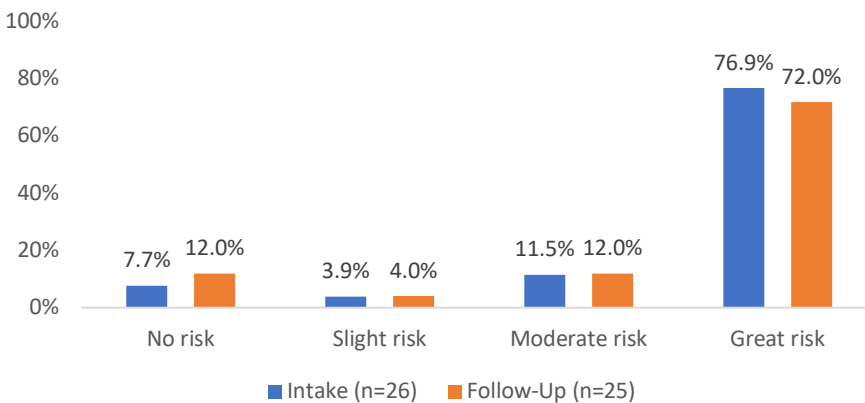


Figure 7.15. How much do you think people risk harming themselves if they smoke marijuana once or twice a week?

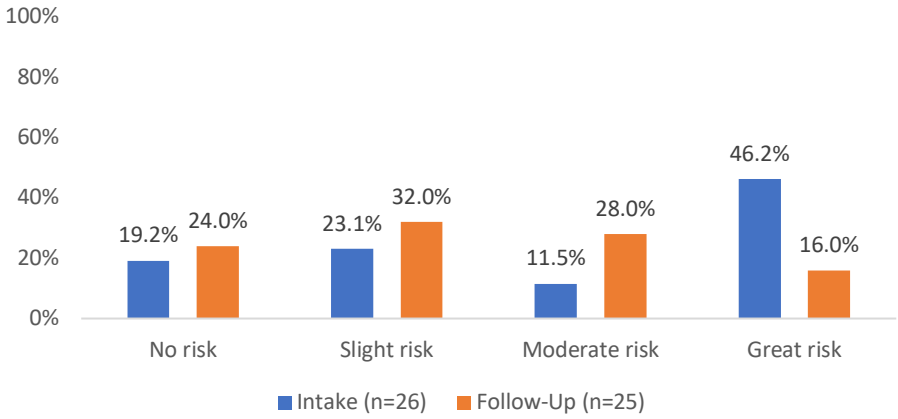


Figure 7.16. How much do you think people risk harming themselves if they use prescription drugs not prescribed to them?

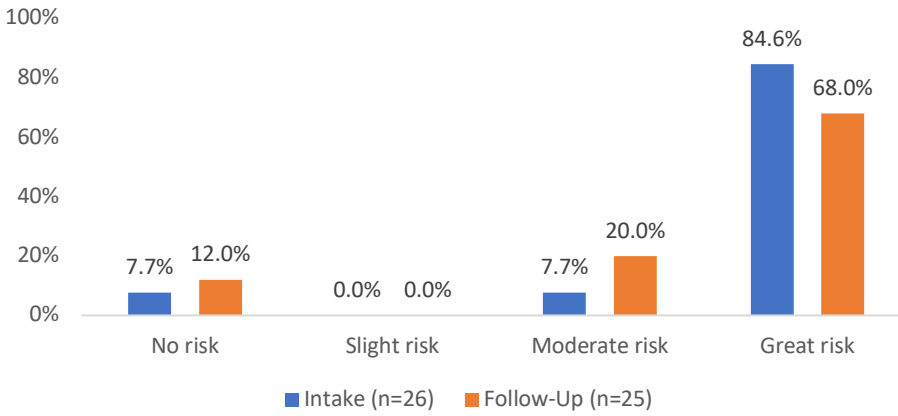


Figure 7.17. How wrong would your parents feel it would be for you to have one or two drinks of alcohol nearly every day?

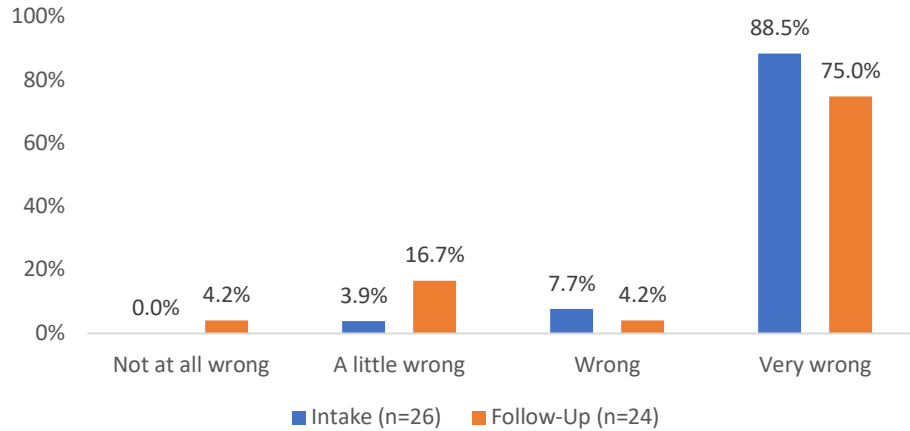


Figure 7.18. How wrong would your parents feel it would be for you to smoke tobacco?

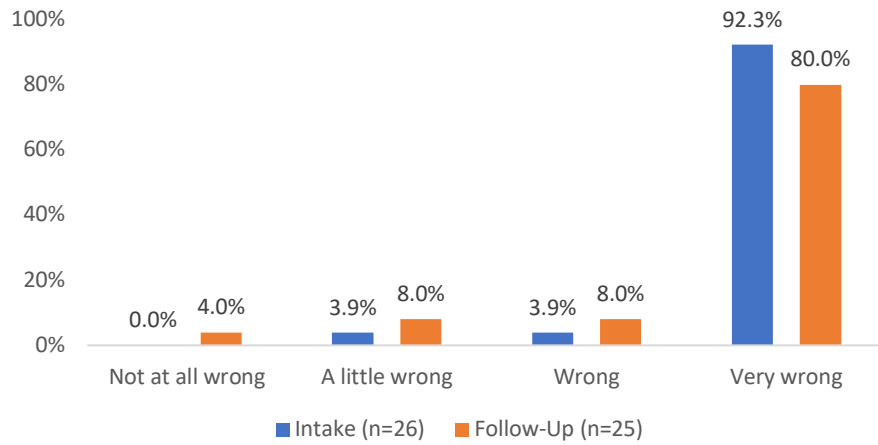


Figure 7.19. How wrong would your parents feel it would be for you to smoke marijuana?

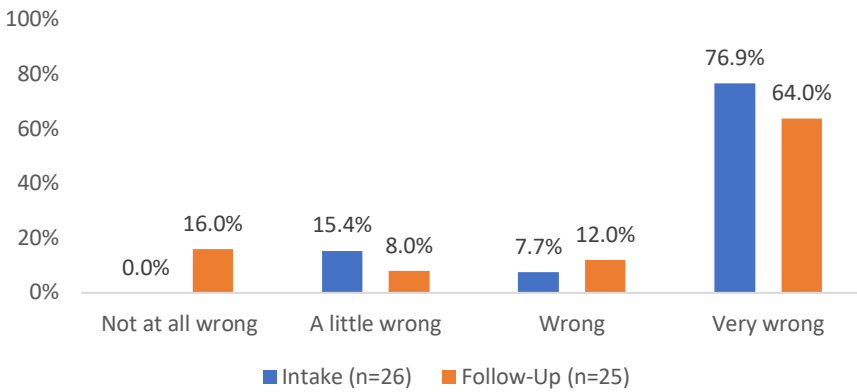


Figure 7.20. How wrong would your parents feel it would be for you to use prescription drugs not prescribed to you?

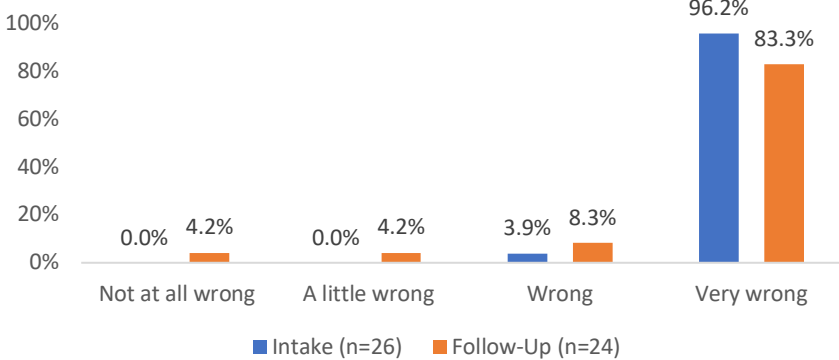


Figure 7.21. How wrong would your friends feel it would be for you to have one or two drinks of alcohol nearly every day?

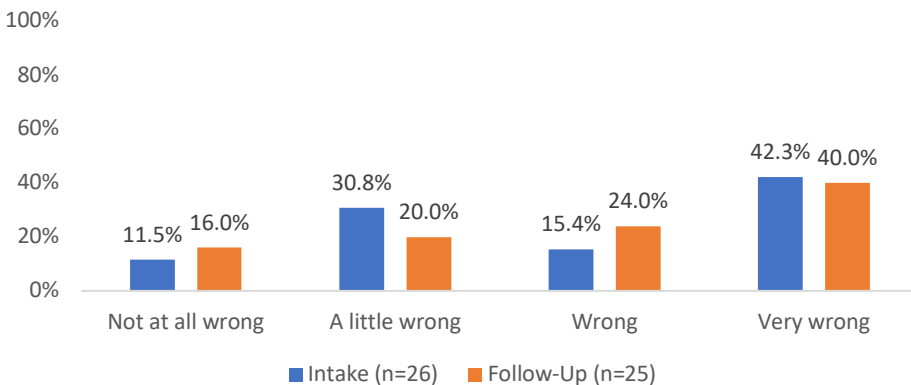


Figure 7.22. How wrong would your friends feel it would be for you to smoke tobacco?

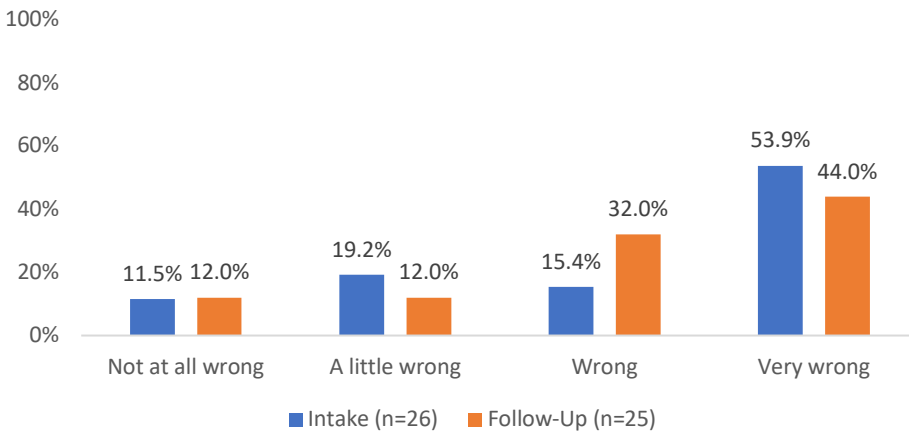


Figure 7.23. How wrong would your friends feel it would be for you to smoke marijuana?

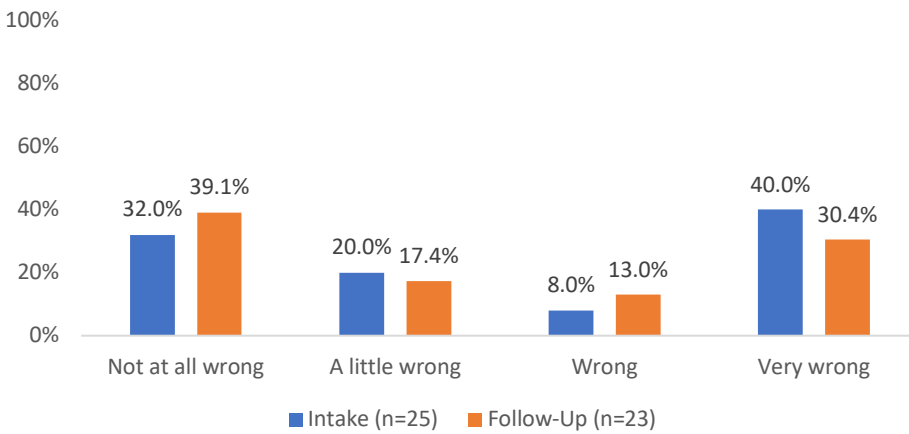


Figure 7.24. How wrong would your friends feel it would be for you to use prescription drugs not prescribed to you?

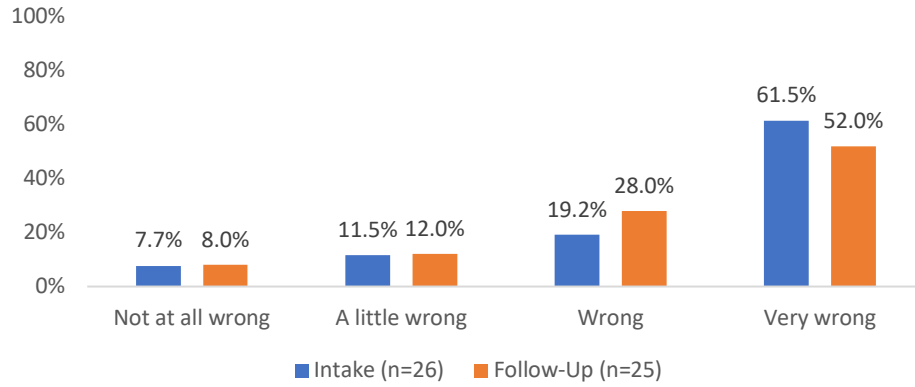


Figure 7.25. Average Scores on Mental Health and Wellness Measures

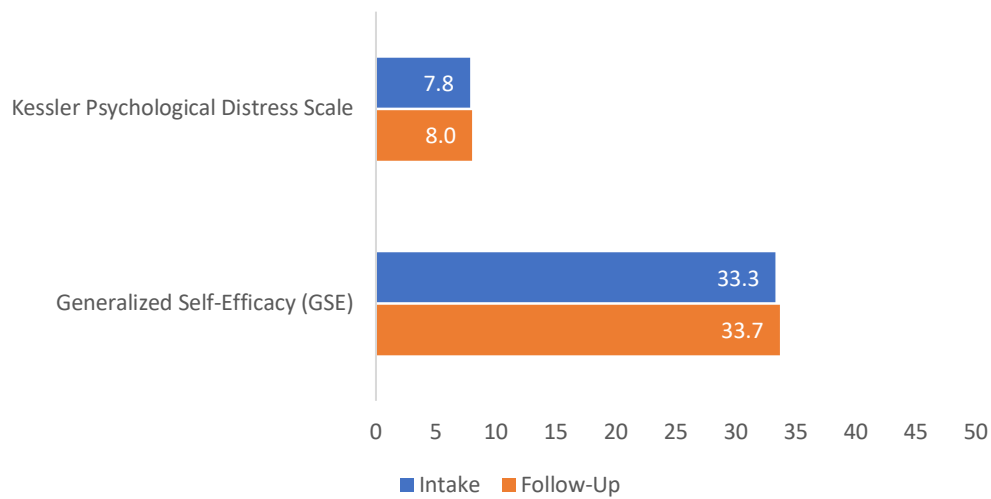


Figure 7.26. Average Scores on the Adolescent Resilience Scale (ARS) and Subscales

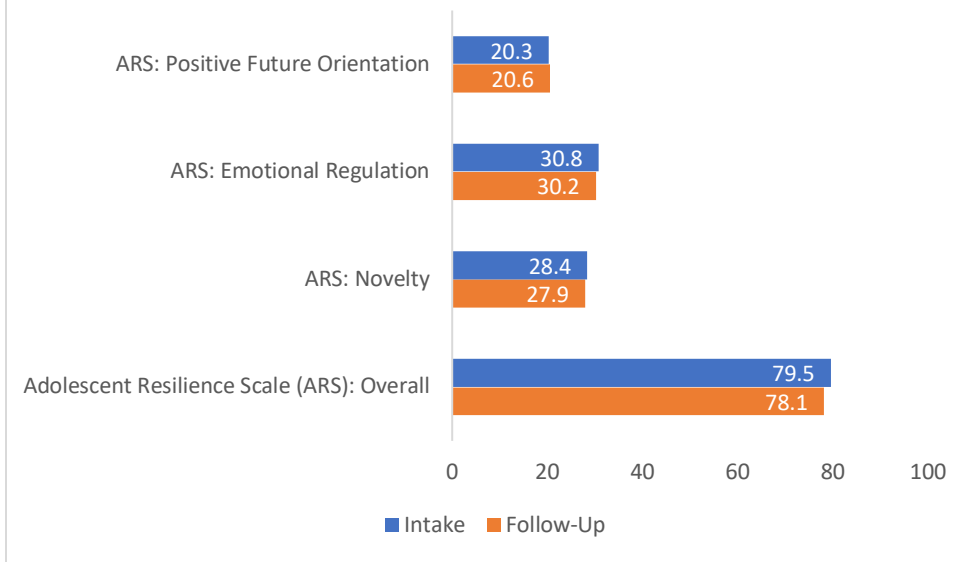


Figure 7.27. Respondent Experiences with Indian Health Center

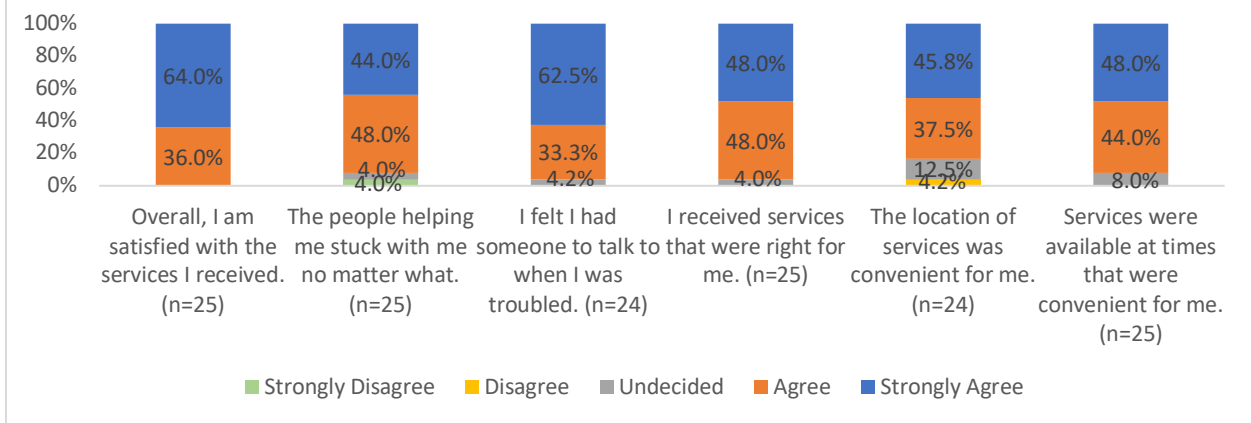


Figure 7.28. Respondent Experiences with Indian Health Center

