**IHCSCV CRDP Local Evaluation: 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:** July 2024-May 2025

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# 2. Table of Contents

# 3. Glossary of Terms

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|---|---|
| AIAN | American Indian and/or Alaska Native |
| ARS | Adolescent Resilience Scale |
| CDEP | Community Defined Evidence Project |
| CRDP | California Reducing Disparities |
| IHCSCV | Indian Health Center of Santa Clara Valley |
| GONA | Gathering of Native Americans |
| GSE | General Self-Efficacy Scale |
| MEIM | Multi-group Ethnic Identity Measure |
| NOMs | National Outcome Measures |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SCC | Santa Clara County |
| SCS | Social Connectedness Scale |
| SWE | Statewide Evaluation |
| TAY | Transitional-aged youth |

# 4. 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 by:

- increasing knowledge of mental health factors of historical trauma, suicide prevention, stigma and discrimination reduction,
- increasing knowledge in access and linkage to treatment and wrap-around services,
- increasing knowledge of cultural appropriateness of services provided, and
- increasing knowledge of signs and 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. Cultural traditions/practices and ceremonies include the Traditional Song Class, Traditional Dance Class, San Jose Native Youth Empowerment Group, Cultural Arts Classes, and Mini-Powwows, and The Gathering. These activities promote mental health wellbeing and increase 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 were needed, and
- whether participants perceive that participation in cultural activities is beneficial.

The evaluation research design used a convenience sample of American Indian and Alaska Native (AIAN) individuals aged 8 and older residing in Santa Clara County who participated in a culturally based intervention using American Indian cultural/traditional activities and teachings to increase resiliency. Thirty-one participants completed baseline surveys, and 16 completed both the baseline and the six-month follow-up survey. The survey asked participants to self-report mental health and coping strategies, cultural and traditional teachings, cultural and traditional arts and crafts, identity and life skills, educational support, and career preparation. The analysis includes only participants with matched (paired) baseline and 6-month follow-up surveys. This study used measures of General Self-Efficacy Scale the Adolescence Resilience Scale, Social Connectedness Scale, and the Multi-group Ethnic Identity Measure.

Key findings from the evaluation include:

- Cultural connectedness remained high from baseline to follow-up. All participants (100%) agreed and strongly agreed that their culture gives them strength, is important to them, and helps them feel good about who they are.
- Social connectedness outcomes showed mixed results. While participants' sense of participation in groups was unchanged (86% at both time points), several other indicators showed a decrease in agreement from baseline to follow-up. The largest decrease was in having a sense of brotherhood/sisterhood with my friends, which decreased from 100% agreement at baseline to 64% at follow-up.
- Self-Efficacy scores demonstrated improvements within individual questions, but not on the overall scale. The proportion of participants who indicated "I can usually handle whatever comes my way" as exactly true increased by 29 percentage points (43% at baseline vs 71% at follow up). Also, the statement "If I am in trouble, I can usually think of a solution," "When I am confronted with a problem, I can usually find several solutions," and "I can remain calm when facing difficulties because I can rely on my coping abilities" had an increase of 43 percentage points with 79% stating the statement is exactly true at follow-up while 36% stated it was exactly true at baseline.
- Mental Health outcomes showed mixed changes, including some positive shifts. Reports of little to no feelings of hopelessness increased from 79% at baseline to 93% at the follow-up, and fewer participants reported less frequent feelings of nervousness with an improvement from 43% to 57%.
- Satisfaction with IHCSCV services among youth aged 12-17 was high with 100% satisfaction reported for the services they received, feeling the services they received were right for them, the staff respected their religious beliefs, staff spoke to them in the way they understood, and staff were sensitive to their cultural/ethnic background.

With these findings IHCSCV offers the following recommendations. First, The CDEP activities are needed and wanted by the AIAN community of Santa Clara County and further investment is needed in sustaining programs like this to meet the needs of the community. Second, the findings are consistent with messaging heard from AIAN communities and support further research and inquiry into culturally based approaches to mental health prevention and promotion. Third, engage in-person recruitment approaches more strongly and spend more time directly engaged with the community and participants around evaluation. Fourth, develop a qualitative follow-up study to review and more deeply understand how these various CDEP components and the CDEP overall impacts mental health prevention and promotion.

# 5.Introduction

The Santa Clara Valley AIAN community is experiencing on-going mental health disparities due to historical trauma and Federal relocation policies which caused an increasing disintegration of cultural norms and role models (Guenzel & Struwe, 2019). Because of these disparities there are now 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 the Native American community's growth and ability to make decisions to improve and excel in a positive direction. Community strength is adapting to urban surroundings while preserving traditional beliefs, values, culture, and identity; this is essential to Native wellness (John-Henderson et al., 2023).

This Strengthening Youth and Families 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 to improve mental health outcomes. The population description Native American refers to American Indians/Alaska Natives. The California Reducing Disparities (CRDP) report highlights the importance of community and culture to Native Americans in California because it preserves a wealth of cultural understanding and practices.

Culture is intertwined with mental health well-being. These protective factors included 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. This CDEP addresses this need through current culturally based projects that these protective factors work for the Native American community. If the disparities outlined above are not addressed, this community is at 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. Additionally, stigma discourages help seeking and attitudes toward mental illness held by minorities are as unfavorable, or even more unfavorable, than attitudes held by Whites. Due to historical trauma, communities should revive and sustain cultural traditions/practices and ceremonies to address the loss of culture (John-Henderson et al., 2023). Additional community approaches that reduce disparities include traditional healing practices such as talking circles, seasonal ceremonies, Powwow, drumming, smudging, and educational and cultural activities led by traditional Native American spiritual leaders (Koithan & Farrell, 2010).

**Mental health disparities of urban AIAN**

In general, the AIAN experience warrants attention, especially those who live in urban areas.

Urban AIAN communities continue to experience the impact of boarding schools, relocation, and prohibition of traditional ceremonies and tribal languages (Weaver 2012; Hartman & Gone 2014). Loss in cultural identity is not the only outcome of historical trauma; AIAN have higher rates of substance abuse, clinical depression, posttraumatic stress, domestic violence, and suicide compared to all other races (Gone, 2004). The urban AIAN population experiences significant 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 (Ivanich et al., 2021).

**Mental health disparities of urban AIAN youth**

Urban AIAN communities have unique needs that distinguish them from their rural or reservation counterparts. Qualitative findings from a 2019 study endorsed themes of historical loss, cultural loss, race consciousness (Guenzel, et al. 2019). Specifically, many AIAN youths are culturally isolated from their tribes, and from other AIANs, 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. AIAN youth with little or no cultural connectedness lack cross-cultural protective factors and are at a greater risk of developing behavioral health issues, suicidality, as well as substance abuse and conduct disorders. Poverty, mixed with the lack of cultural resources, contributes to AIAN youth being at particularly high risk for substance abuse and suicide. Linking AIAN 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 illustrate knowledge about the value of CDEPs for AIAN communities by providing data on the impact of culturally based interventions that strengthen Native American cultural identity.

# 6. CDEP Purpose, Description, and implementation

## A. CDEP Purpose

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 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. The CEDP has the following goals:

- Prevention to reduce mental health negative outcomes among people with greater than average risk of mental illness.
- Intervention to reduce mental health 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 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 because of mental illness.

## B. CDEP Description and Implementation Process

The Strengthening Youth and Families Project consisted of 5 different CDEP activities that are implemented year-round throughout the length of the project by IHCSCV staff. The CDEP activities are Traditional Song Class, Traditional Dance Class, San Jose Native Youth Empowerment Group, Cultural Arts Classes, and Mini-Powwows. (The Gathering is part of the CDEP but did not take place during this project.) These activities are listed here, along with how frequently they took place, their length, and the range of the number of participants at each activity over the course of the intervention. This is total participants, not the number included in the evaluation.

| **CDEP Activity** | **Frequency** | **Length** | **Participants** |
|---|---|---|---|
| Traditional Song Class | Weekly | 2 hours | 6-41 |
| Traditional Dance Class | Weekly | 2 hours | 15-61 |
| Native Youth Empowerment Group | Monthly | 2 hours | 5-7 |
| Cultural Arts Class (*Intermittent) | Monthly* | 2 hours | 42-60 |
| Mini Pow Wow | Annually | 1 day | 120 |

The population targeted for these activities was AIAN youth, transitional-aged youth, and adults. These activities were widely attended by many community members. AIAN individuals who were new to these activities were invited to join the evaluation project. A majority (n=12) of CDEP evaluation participants were adults between the age of 18 and 65+ followed by adolescents (n=2) between the age of 12 and 17, and children (n=2) between the age of 8 to 11.

The Gathering of Native Americans (GONA) is an evidence-based culturally grounded approach to address community-identified challenges that center AIAN cultural values, traditions, and spiritual practices. The GONA curriculum follows themes for each day: Belonging, Mastery, Interdependence, and Generosity. These themes are universal amongst AIAN cultures and apply to all activities used in this project. The GONA curriculum is infused into all youth and family programming at IHCSCV. Specifically, GONA principles and themes are incorporated into all CDEP activities. The activities were implemented by experienced staff with AIAN cultural backgrounds and also trained in facilitation of GONA. Although it was not held this phase, 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.

The Traditional Song and Dance Class took place simultaneously weekly on Tuesday evenings from 6:00-8:00 pm. Program participants arrived and checked in with staff members at the Roosevelt Community Center. This activity was open to community members of all ages. 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 6:30 pm, IHCSCV staff then 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 ice breaker 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 7:00 pm, 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. Attendance data collection started in July of 2024, and 35 song and dance classes were completed since then.

San Jose Native Youth Empowerment Group took place monthly on Thursday evenings from 6:00 to 8:00 pm. American Indian and Alaska Native Youth ages 11-17 participated in activities that build and strengthen their cultural identity. On arrival staff welcomed youth that were dropped off by caregivers, and those picked up by staff from their homes. Each group session opens with a prayer followed by a healthy meal. Youth then participate in an icebreaker activity to build a sense of belonging before beginning the main program activities. Dosage data collection began in July 2024, and since that time, 5 San Jose Native Youth Empowerment group meetings were held.

The Cultural Arts Classes offered hand-on activities centered around cultural-specific projects such as basketweaving, star-quilt making, T-dresses, ribbon skirts, and moccasins. IHCSCV contracted skilled cultural arts instructors to lead the classes and offer participants an intertribal perspective. Depending on the project, IHCSCV staff also supported facilitation. Cultural Arts classes were open to community members of all ages, but required advanced registration to ensure materials were available for each person. Cultural Arts classes were 2-hours in length, but each project required a different number of two-hour sessions to complete.

The Mini-Powwows were community-centered that provided Traditional Song and Dance participants with an opportunity to highlight their new skills while wearing full regalia. The events were open to community members of all ages and were held annually in the fall throughout the project period. The Mini-Powwow takes place annually in the Fall of each year of the project period.

## 7. Evaluation Questions

This CRDP study comprised the following evaluation questions:

- In what ways does mental health improve with the 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 is beneficial?

The evaluation questions were unchanged throughout the CDEP study. The original intent of the evaluation was to assess mental health improvements by individual CDEP activity. However, CDEP participants were invited to all CDEP activities, and evaluation data was collected on the totality of their experience. Tracking of individual attendance and dosage data was incomplete, only being collected at the Traditional Song and Dance classes and the San Jose Youth Empowerment Group meetings. The team was unable to consistently collect dosage across all CDEP activities. As a result, for this cohort it was not possible to answer whether higher levels of participation in cultural activities contributed to increased levels of positive mental health.

The primary adaptation that was made to this CDEP is that the Gathering was not conducted.

Data was reviewed and assessed by the research team in collaboration with community members. These individuals still felt strongly that these approaches are impactful and that the evaluation approach failed to fully describe and assess the impact of this programming on program participants.

# 8. Evaluation Design and Methods

## A. Design

The evaluation method for this study was quantitative, and data was collected through surveys. IHCSCV disseminated a combined instrument to all participants comprised of the Statewide Evaluation and local evaluation measures. Surveys were self-administered online (using Microsoft Forms software) and could be completed on their own devices or on tablets provided by IHCSCV. Participants enrolled in the evaluation study provided contact information (email, phone) to enable IHCSCV staff to locate participants for follow-up surveys even if they did not continue attending IHCSCV services or activities. IHCSCV's CDEP received IRB exemption in 2022.

## B. Sampling Methods Evaluation Participants and Recruitment

The evaluation used convenience sampling methods inclusive of all participants in CDEP activities, with an initial enrollment target of 45 survey participants. The primary recruitment population consisted of individuals ages 8 and older who participated in Traditional Song and Dance Class, Youth Program, Cultural Arts Class, and the Mini Pow Wow at IHCSCV during the

CRDP project period. Because many IHCSCV programs encourage family engagement the sampling approach was expanded to include adult participants for this CRDP phase. Supporting the mental health of parents and caregivers is essential to promoting positive mental health in youth, and including adults allowed the evaluation to assess whether CDEP activities foster mental wellness across all age groups.

Eligibility criteria required participants to identify as AIAN, reside in Santa Clara County (SCC), be new to the CDEP prevention services, and be at least 8 years of age. The CDEP activities are culturally specific AIAN programming and this study focused solely on promoting positive mental health outcomes for AIAN in SCC due to the need for appropriate impact of mental health challenges for AIAN in urban areas. Also, this CDEP excluded individuals outside of SCC, due to the agency's service area being limited to the county and the project's emphasis on local community impact.

### Recruitment

For initial recruitment, IHCSCV staff invited new attendees at the events to a welcome dinner in July of 2024. The aim of this dinner was to welcome new attendees to IHCSCV programming and inform them of the many resources available at IHCSCV and then introduce them to the CRDP study. In terms of the CRDP study, IHCSCV used the recruitment script to outline 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 participants whether they were interested in participating in the evaluation. IHCSCV had some individuals complete their baseline survey during the dinner but continued ongoing recruitment at the CDEP activities and other community events until November 2024. Individuals who were interested were asked to provide consent/assent. For those under the age of 18, parental consent and minor assent was obtained. Signed consent/assent was obtained for the local and State-Wide Evaluation (SWE) and all participants were assigned a unique participant ID number to protect the confidentiality of their survey responses. Designated IHCSCV staff conducting recruitment for the CRDP project completed human subjects research training prior to participating in recruitment activities. Respondents were provided with gift card incentives for completing the intake and follow-up surveys. Additionally, three participants wone a raffle that incentivized frequent attendance at CRDP events. The more a participant attended the event, the higher the chance they had to win the raffle. Raffle prize winners were selected in September of 2025. The project implementation team was disappointed in the overall numbers they were able to recruit, and particularly with follow-up challenges. Due to circumstances beyond their control, they were blinded to data processes and often received data feedback on a timeline where they were unable to enact changes. The team felt some recruitment opportunities were missed by their in-house data person.

Table 1 describes age groups and survey completion across both time points. At intake, 31 participants completed a survey: 23% (n=7) were ages 8-11, and 77% (n=24) were ages 12 and older. Fifty-two percent (n=16) completed both the intake and follow-up surveys. The remaining 48% (n=15) were lost to follow up despite multiple outreach attempts by email, text, and phone calls. Specific reasons for this attrition cannot be determined from this data.

A subset of 16 participants completed both the intake and follow-up surveys, allowing us to examine changes over time. This subset includes 16 respondents -2 youth aged 8-11 and 14 participants aged 12 and older, drawn from the full sample of 31 participants. These 16 individuals are the only participants for whom change can be assessed over time in mental health, cultural connectedness, substance use, and other key measures.

Demographic characteristics for the 31 respondents who completed a survey at intake along with the subset of participants included in the statistical analysis are presented in Table 2. Overall, most respondents were 18+ years at intake with 23% aged 18-29. It is important to note that historically, the CDEP has aimed to recruit youth aged 12-17, but during this phase the CRDP study was opened to adults. With that said, only 10 responses (32%) were aged 8-17 with three being aged 12-17. Women/girls represented 84% of the sample size, and an overwhelming majority identified as straight/heterosexual (94%). Most participants identified as American Indian/Alaskan Native (58%), with 23% identified as Latino/Hispanic/Spanish, 13% identifying as multi-racial.

Table 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.

## C. Evaluation Measures and Data Collection Procedures

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

The surveys assessed both the SWE Core Measures and a series of local evaluation items chosen to reflect the areas that IHCSCV 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 participants 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 IHCSCV services utilized by each youth participant were tracked by IHCSCV 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 (Microsoft Forms) 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 confidentiality, data in their raw form were not shared with project staff at IHCSCV, 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. 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 **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 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 IHCSCV, the 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); a slightly

modified version was utilized 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. 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."

## D. Fidelity and Flexibility

The Strengthening Youth and Families Project CDEP activities were documented by IHCSCV staff using weekly planning and summary sheets to ensure consistent delivery of programs across sessions. CDEP staff checked-in with participants during the 6-month follow-up surveys and gathered additional feedback on participants' experience. CDEP staff reviewed the feedback and made changes to programming suggested by survey participants. 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 ensured cultural relevance while allowing participants to tailor activities to their interests and needs.

The Strengthening Youth and Families Project CDEP activities intended to include The Gathering which follows the Gathering of Native Americans (GONA) curriculum and fidelity tool. It was not implemented during this period. Staff have completed GONA Training of Facilitators and applied their training to each of the CDEP activities. CDEP staff adapted activities to follow the GONA flow and components, teaching about Belonging, Mastery, Interdependence, and Generosity in

that order. Using the structure of the GONA curriculum as the basis for activities provided a structure for maintaining fidelity within activity.

Formal fidelity testing did not take place. However, the lead staff were trained in facilitators who organized the activities and ensured all aspects of the curriculum were addressed in the design of activities. Key components of the curriculum were delivered as designed. GONA is particularly beneficial as it is designed to allow for flexibility and adaptability so that it is culturally relevant, with local adaptation, to any Native community. The program demonstrated improvements in cultural connectedness and mental health among participants in CDEP activities.

### E. Data Analysis

Results are presented 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., scale scores or counts) are provided. Most of this report focuses on data collected from the 44% (n=16) of respondents who were aged 12 or older and who completed both a baseline and follow-up survey.

Depending on the variable type, paired-sample t-tests were used for continuous outcomes and Fisher's Exact Tests were used for categorical outcomes given the small sample size. Correlation analyses were conducted to examine the relationship between participants' pre- and post-intervention mean scores on the validated scales (GSE, MEIM, and ARS). Regression analyses were not performed because the small sample size limited statistical power and did not meet the assumptions required for multivariable modeling. Although none of the correlations were statistically significant, the observed relationships were in the expected direction.

## 9. Results

### A. Quantitative Data Findings

#### *Service Dosage*

Service dosage was collected to address the evaluation question: Do higher levels of participation in cultural activities result in more positive levels of mental health? Service dosage is typically described as amount, frequency, duration and delivery method. For this study, attendance and frequency was collected, with duration being inferred from attendance and delivery method being a group setting. These activities are much smaller groups where it is simpler to collect dosage data for CRDP activities. Due to the volume of attendees at the other CRDP activities, dosage data was not collected at Cultural Arts and the Mini Powwow. Lastly, there was no Gathering during this iteration of CRDP.  Out of the 16 respondents with both a baseline and a follow-up survey, attendance ranged from two activities to 25 activities. The average attendance

was 12 activities for those with both a baseline and a follow-up, while the average was one for those who did not. The analysis of attendance data as it pertains to improved outcomes will be discussed in the overall presentation of the findings section of this report.

## Survey Findings

### *Cultural Connectedness*

Four questions from the SWE Core Measures Survey assessed cultural connectedness. The analysis of these measures is reflective of fourteen respondents aged 12+. As shown in Figures 1-4, cultural connectedness remained high from baseline to follow-up. Specifically, 100% of respondents agreed and strongly agreed that their culture gives them strength, their culture is important to them, and their culture helps them feel good about who they are. There was an increase in respondents' connection to the spiritual/religious traditions of the culture they were raised in from 79% to 86% from baseline to follow-up, respectively.

Respondents also reported on their connection to culture using a modified version of the MEIM that focused specifically on their American Indian/Alaskan Native heritage. There was strong agreement from baseline to follow-up for all responses options, but follow-up did see slight declines in several response options as noted in Table 4. However, many responses to the MEIM saw no change from baseline to follow-up. Specifically, 93% of respondents at both timepoints stated that 1) they have spent time trying to find out more about my American Indian/Alaskan Native heritage, such as its history, traditions, and customs, 2) they are happy that I am a member of the American Indian/Alaskan Native heritage I belong to, and 3) they have a strong sense of belonging to my American Indian/Alaskan Native heritage. Lastly, 86% reported that in order to learn more about my ethnic background, they have often talked to other people about my American Indian/ Alaskan Native heritage. These decreases are further supported by the baseline values (mean=54.21, SD=5.16) and follow-up values (mean=52.00, SD=12.75), but these decreases were not statistically significant (p-value=0.56). These results can be seen in Table 5.

### *Social Connectedness*

Respondents reported on social connectedness. The analysis of these measures is reflective of fourteen respondents aged 12+. Table 6 saw these outcomes decrease from baseline to follow-up with the exception of one response option "I feel I participate when I'm with people or in groups" at 86% for baseline and follow-up. All other responses had significant decreases, specifically, the biggest decrease was for the response option of "I have a sense of brotherhood/sisterhood with my friends, which decreased from 100% to 64%. As part of the analysis, each social connectedness scale was scored and calculated the average scores of all respondents from pre and follow-up. The baseline average was 25.79 and the follow-up average was 22.64. Although these measures saw significant decreases, the decreases were not statistically significant (p-value=0.19). This is illustrated in Table 7.

### *General Self-Efficacy*

Respondents reported on GSE. The analysis of these measures is reflective of fourteen respondents aged 12+. Figures 5-14 saw these outcomes increase from baseline to follow-up. Specifically, significant increases were illustrated in the response option "I can usually handle whatever comes my way" with an increase of 29 percentage points, with 43% stating that this statement is exactly true at baseline and 71% at follow-up. Also, the statement "If I am in trouble, I can usually think of a solution," "When I am confronted with a problem, I can usually find several solutions," and "I can remain calm when facing difficulties because I can rely on my coping abilities" had an increase of 43 percentage points with 79% stating the statement is exactly true at follow-up while 36% stated it was exactly true at baseline. The mean score of the baseline was 32.86 and the follow-up mean score was 34.43. Figure 8 shows that, although these measures saw increases, there was no statistical significance (p-value=0.51).

### *Perception of Substance Use Risk*

Questions about perception about substance use risk were asked of respondents (n=2) aged 12-17. These results are shown in Tables 9-14. Baseline results showed high levels of perception of risks of substance use. The first set of questions assessed the respondent's own perception of risk. Baseline results illustrated that 100% of respondents reported a great risk if someone has five or more drinks of alcohol once or twice a week, smokes one or more packs of cigarettes a day, and uses prescription drugs not prescribed to them. This decreased to 50% as one response declined to answer on the follow-up. In terms of parental perception of risk, 100% of respondents stated that their parents would feel like it is "very wrong" to conduct any of these activities. This remained unchanged in follow-up results. Lastly, in terms of the approval from their peers, 100% stated that their peer would find it wrong to have one or two drinks of alcohol nearly every day and use prescription drugs not prescribed to you. There was less perception of peer risk in terms of smoking tobacco or marijuana; 50% stated that their peers would find it "a little wrong." Follow-up results varied in that 50% of respondents stated that their peers would find the usage "very wrong" (a response that was not given in the presets), while 50% of respondents on the follow-up stated that their peers were find smoking marijuana "not wrong at all." No test of significance was conducted due to small sample.

### *Mental Health & Wellness*

Respondents were asked a series of questions regarding their mental health and wellness. Figures 15-18 illustrated these findings for respondents aged 12+. First, they were asked to report their mental health symptoms in the past 30 days. When asked whether they felt nervous, hopeless, or restless or fidgety, there was an increase in the percentage of respondents that reported "none of the time" and "a little of the time." For this section, percentages will be reflective of the sum of these two responses. The frequency of feelings of hopelessness saw positive changes as more respondents (79% at baseline to 93% on the follow-

up) stated little to no frequency of hopelessness. Also, more respondents reported less frequency of feelings of nervousness which increased from 43% to 57%. Feelings of depression were low amongst respondents at baseline and follow-up as 86% of respondents reported little to no feelings of depression on the baseline and 93% reported little to no feelings on the follow-up. Lastly, more respondents reported less frequency in feelings of worthlessness with 86% at baseline and 93% at follow-up. These results are positive findings that the mental health of the respondents improved from baseline and follow-up; however, these findings were not statistically significant (p-value=0.26). These results can be found in Table 14. IHCSCV CDEP activities yielded positive growth in knowledge about mental health and suicide prevention. Additionally, 65% of respondents aged 12+ stated they are more knowledgeable about stigma and mental illness, 72% are more knowledgeable about suicide prevention, and 79% indicted that they are more knowledgeable about the early signs of mental illness.

As previously mentioned, the Adolescent Resilience Scale (Table 15) aims to measure one's ability to succeed despite adversity. There are three factors: novelty seeking, emotional regulation, and positive future orientation. Only respondents aged 12-17 were asked these questions, and these findings are reflective of the two respondents of that age group. The total mean score at baseline was 70.00 and it increased to 72.00 at follow-up. Findings on the subscales remained relatively unchanged as future orientation was 24.5 at both timepoints, emotional regulation slightly increased from 29.5 to 30.5, and novelty slightly increased from 16.0 to 17.0. There was no statistical significance as the total score had a p-value of 0.30.

In terms of children aged 8-11, one hundred percent of parent respondents agreed that their child is more knowledgeable about stigma and mental illness. Furthermore, 100% of parent respondents agreed or strongly agreed that their child is more knowledgeable about how discrimination can affect their mental health. These findings are in Tables 16-20.

### *Experience with Services at IHCSCV*

There was very high satisfaction with IHCSCV services amongst all respondents. These findings can be seen in Tables 16-20. For respondents 8-11, there was 100% agreement (both agree and strongly agree) across all response options. Specifically, parents reported that they are overall satisfied with the services their child received, they felt their child had someone to talk to when they were troubled, and the services their child and/or family received were right for them. Respondents aged 12-17 expressed no disagreement with any of the satisfaction responses. Of note, 100% of respondents agreed that they are overall satisfied with the services they received, the services they received were right for them, the staff respected their religious beliefs, staff spoke to them in the way they understood, and staff were sensitive to their cultural/ethnic background. Respondents 18+ reported no disagreement with any satisfaction response options, but two respondents did express neutrality with the statements "when I first called or

came here, it was easy to talk to the staff" and "My symptoms/problems are not bothering me as much." At least one respondent indicated not applicable for the response options "I like the services that I received here," "Services were available at times that were good for me," and "Staff are willing to be flexible and provide alternative approaches or services to meet my needs." With that said, there was high satisfaction with IHCSCV services with adult respondents. Ninety-two percent agreed that they were overall satisfied with the services they received, services were available at good times, and that staff were easy to talk to when they first called. Respondents also endorsed the cultural responsiveness and inclusivity of the staff. One hundred percent of respondents stated that the staff was respectful of their race/ethnicity, the staff respected their religious beliefs, and the staff respected their gender identity and sexual orientation.

## B. Qualitative Data Findings

This CRDP study did not use a qualitative evaluation method, therefore there are no qualitative results to report. The research team did discuss and review findings with the staff and community members who were able to share some perspective on the findings. This information has been integrated below.

## C. Synthesis of Findings

As previously mentioned, IHCSCV employed a quantitative evaluation method through survey administration with no qualitative data. Although the findings had no statistical significance, the data showed positive improvements from CRDP activities. First, there was high satisfaction with IHCSCV services, and staff were received well by survey respondents. Data showed that IHCSCV maintained accessibility and inclusivity of race, religion, and language. There was also an increase in the knowledge of suicide prevention, mental illness and stigma, and the early signs of mental illness.

There was fluctuation in some other data points as social connectedness saw a decrease from baseline to follow-up.

The highest score possible on the GSE is 40 and participant responses had a mean score of 32.86 at baseline and 34.43 at follow-up. This data shows that respondents had generally high self-efficacy at baseline and slightly increased at follow-up.

The total mean score on the ARS slightly increased as well, indicating an overall increase in resiliency for adolescent respondents.

The MEIM was the only scale that saw a decrease in mean scores. This scale is meant to measure their sense of ethnic identity and sense of belonging.

## D. Overall Presentation of Findings

The evaluation questions for this study were:

- In what ways does mental health improve with the 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 is beneficial?

This evaluation aimed to answer all the evaluation questions, but there were some limitations with the data collection. In terms of the first four evaluation questions, the data collected was based on participants' overall experience with the CDEP activities and they did not ask specific questions about each CDEP activity. With that said, while the data cannot state whether individual CEDP activities improve mental health, it is possible to illustrate the collective impact of improvements of mental health from the program findings. As previously stated, there were improvements, albeit not statistically significant, in mental health amongst participants. Participants reported an increase in the percentage answering "none of the time" and "a little of the time" when asked whether they felt nervous, hopeless, or restless or fidgety.

The goal of the Strengthening Youth and Families Project was to prevent 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 small sample size and low follow-up rate, it is hard to interpret the small changes that are seen in the data. While social connectedness scores worsened for some respondents 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.

As previously stated, there were limitations to dosage data collection. Dosage data is not reflective of all CDEP activities therefore it is not possible to ascertain whether overall dosage or even attendance at CDEP activities had an impact on mental health. However, individuals who had a baseline and a follow-up survey had a higher average or dosage than those that didn't. With that said, those that attended more activities were more likely to complete a follow-up survey. T-test and chi-squared tests of dosage data were run with all the survey measures and there was no statistical significance.

During this iteration of the CRDP, there were no adaptations that were made to the program, so the evaluation question: What adaptations are made to the program? is not answered in this evaluation.

The evaluation question: Do participants perceive that participation in cultural activities is beneficial? is answered in this evaluation as the previous section illustrated that there was strong agreement amongst respondents that they had positive experiences with staff and services at IHCSCV. This shows that these CDEP activities are needed and wanted by the AIAN community of Santa Clara County.

# 10. Discussion and Conclusion

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, and mental health and wellness. In terms of substance use, data from the tiny sample of youth indicated small changes in the perceived risk of harm of substances generally decreased between baseline and follow-ups. It is important to note that there were only two respondents who were asked questions about perception of harm and one respondent declined to answer most responses during the follow-up. This data is far from conclusive. This could still be an area to focus intervention and education efforts and help youth understand the risks of substance use.

Mental health outcomes improved slightly as respondents reported less frequency of hopelessness, fidgeting, and nervousness. Additionally, there was minimal depression reported with 86% of respondents indicating little to no feelings of depression, with even higher numbers of respondents at 94% reporting little to no feelings of depression. Only two respondents answered the ARS. The total mean score at baseline was 70.00 and it increased to 72.00 at follow-up. Findings on the subscales remained relatively unchanged as future orientation was 24.5 at both timepoints, emotional regulation slightly increased from 29.5 to 30.5, and novelty slightly increased from 16.0 to 17.0.

The main limitation is that the Strengthening Youth and Families Project evaluation had a small sample size to determine if the outcomes are true findings. The small sample size is due in part to convenience sampling and recruiting participants that participated in any of the CDEP activities at least once. For this round of the CDEP the goal was to recruit a group of new AIAN participants who had not been part of any previous activities or study. This created some challenges. First, the sample was expanded to include preveGntion work for adults in addition to youth. The IHC team has a lot of experience working with youth in this capacity and less with adults. Recruitment and data collection was not the same for adults, which was the primary group enrolled in this study. Second, it is important to note that data collection started in July 2024 and ended in May 2025. Many marginalized communities have reported feeling unsafe and targeted by the policies implemented by the new administration. The IHC clinic itself experienced a sharp and notable decline in attendance across all services. While there is no data in this study that gives specific reasons underlying participants' responses, it is reasonable to consider that broader contextual factors such as the political climate could influence participants' sense of cultural pride and identity, attendance, and willingness/ability to participate in research.

For this study, a different recruiting strategy was employed: having a recruitment dinner for new attendees at Song & Dance in July of 2024. After which, recruitment occurred on an ongoing basis until November 2024 through social media, emails, and in-person. Due to operational issues, there was not enough in-person recruitment at specific events.

Finally, there was a relatively low follow-up rate as less than half of respondents completed a baseline and a follow-up, thus limiting ability to match participant data across both timepoints.

With these findings IHCSCV offers the following recommendations. First, the CDEP activities are needed and wanted by the AIAN community of Santa Clara County and further investment is needed in sustaining programs like this to meet the needs of the community. Second, the findings are consistent with messaging heard from AIAN communities and support further research and inquiry into culturally based approaches to mental health prevention and promotion. Third, engage in-person recruitment approaches more strongly and spend more time directly engaged with the community and participants around evaluation. Fourth, develop a qualitative follow-up study to review and more deeply understand how these various CDEP components and the CDEP overall impact mental health prevention and promotion.

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# 12. Appendix A

Table 1 IHCSCV Completed Surveys

| | N | % |
|---|---|---|
| **Total Respondents** | **31** | **100** |
| Ages 8-11 | 7 | 22.6% |
| Ages 12+ | 24 | 77.4% |
| **Intake Only** | | |
| Ages 8-11 | 5 | 16.1% |
| Ages 12+ | 6 | 19.4% |
| **Intake and Follow-up** | | |
| Ages 8-11 | 2 | 6.5% |
| Ages 12+ | 14 | 45.2% |

Table 2 Respondent Characteristics

| | % (n) | |
|---|---|---|
| | Overall Sample | Longitudinal 12+ (n=14) |
| **Age** | | |
| Between 8 and 11 years of age | 22.6 (7) | - |
| Between 12 and 17 years of age | 9.7 (3) | 14.3 (2) |
| Between 18 and 29 years of age | 22.6 (7) | 28.6 (4) |
| Between 30 and 39 years of age | 16.1 (5) | 28.6 (4) |
| Between 40 and 44 years of age | 6.5 (2) | 7.1 (1) |
| Between 45 and 49 years of age | 3.2 (1) | - |
| Between 50 and 64 years of age | 12.9 (4) | 14.3 (2) |
| 65 or older years of age | 6.5 (2) | 7.1 (1) |
| **Gender** | | |
| Woman/Female | 83.9 (26) | 78.6 (11) |
| Man/Male | 16.1 (5) | 21.4 (3) |
| **Sexual Orientation** | | |
| Straight/Heterosexual | 93.5 (29) | 85.7 (12) |
| Bisexual | 6.5 (2) | 14.3 (2) |
| **Race/Ethnicity** | | |
| American Indian or Alaska Native | 58.1 (18) | 64.3 (9) |
| Black or African American | 3.2 (1) | - |

| | | |
|---|---|---|
| Latino, Hispanic, or Spanish | 22.6 (7) | 14.3 (2) |
| Multi-Racial | 12.9 (4) | 21.4 (3) |
| Native Hawaiian or Other Pacific Islander | 3.2 (1) | - |

Table 3 Tribal Affiliation (Categories not mutually exclusive)

| | % (n) |
|---|---|
| Navajo | 6.5 (2) |
| Juaneño | 6.5 (2) |
| Apache | 6.5 (2) |
| Yaqui, Apache, Pueblo, Mexica | 3.2 (1) |
| Apache, Yaqui, Pima, San Luiseño Saboba | 3.2 (1) |
| Chumash | 6.5 (2) |
| Choctaw | 3.2 (1) |
| Little Shell Chippewa of Montana | 3.2 (1) |
| Omaha, Ponca, Pomo | 3.2 (1) |
| Apache, Mexican, Yaqui, Pueblo | 3.2 (1) |
| Mexica | 3.2 (1) |
| San Carlos Apache | 3.2 (1) |
| Yaqui | 3.2 (1) |
| Tohono O’ Odham | 9.7 (3) |
| Chickasaw | 3.2 (1) |
| Chumash/Aztec | 3.2 (1) |
| Decline to Answer | 9.7(3) |
| Don't know | 12.9 (4) |
| None | 3.2 (1) |
| Not Applicable | 3.2 (1) |

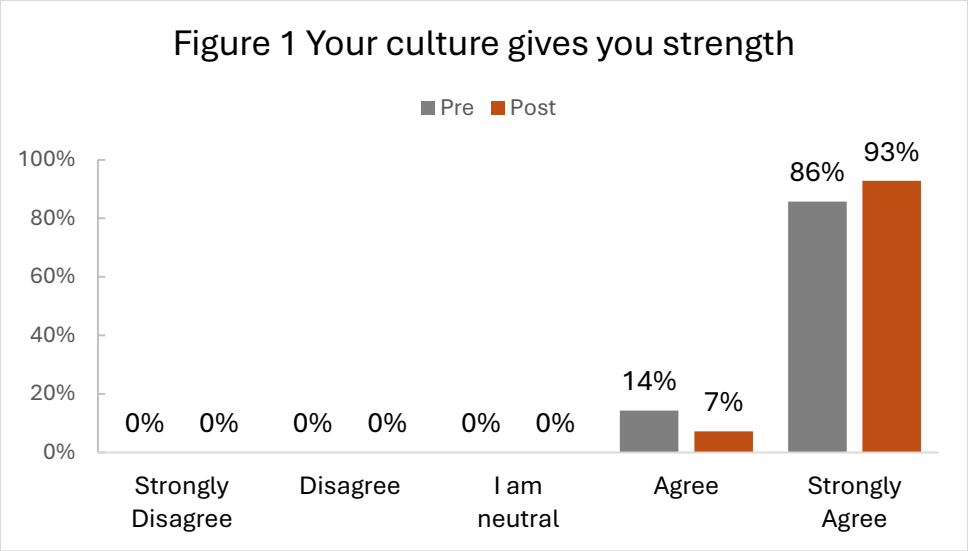


Figure 1 Your culture gives you strength
Pre
Post
100%
80%
60%
40%
20%
0%
0%
0%
0%
0%
0%
0%
14%
7%
86%
93%
Strongly Disagree
Disagree
I am neutral
Agree
Strongly Agree

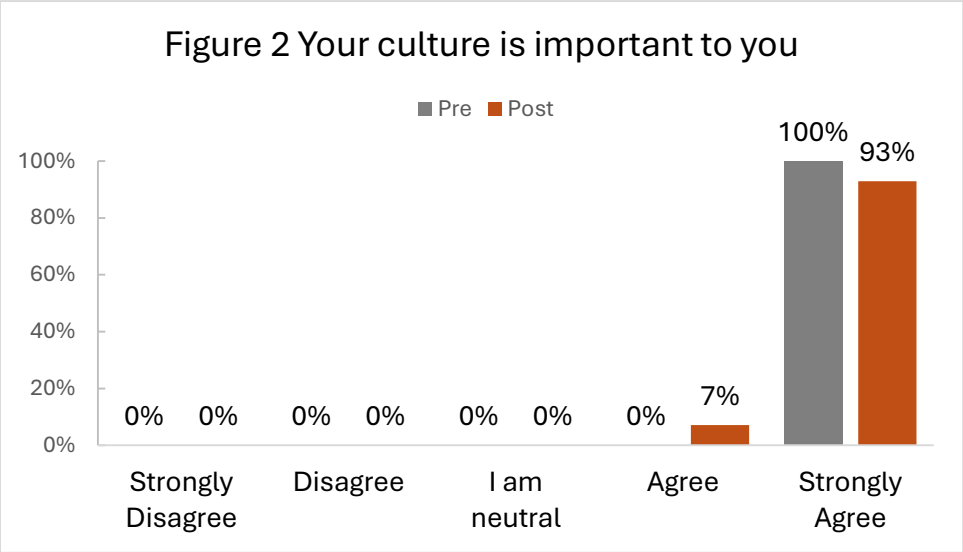


Figure 2 Your culture is important to you
Pre
Post
100%
80%
60%
40%
20%
0%
0%
0%
0%
0%
0%
0%
7%
100%
93%
Strongly Disagree
Disagree
I am neutral
Agree
Strongly Agree

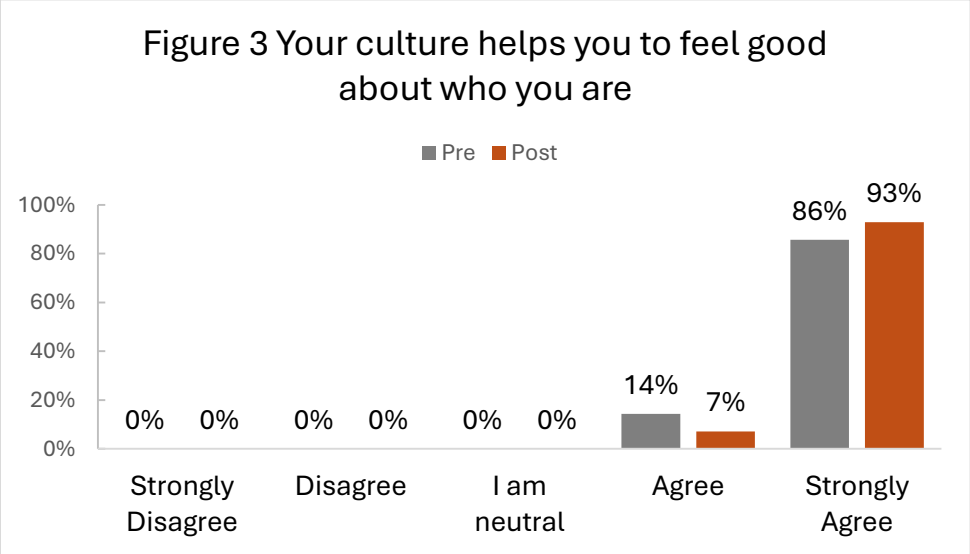
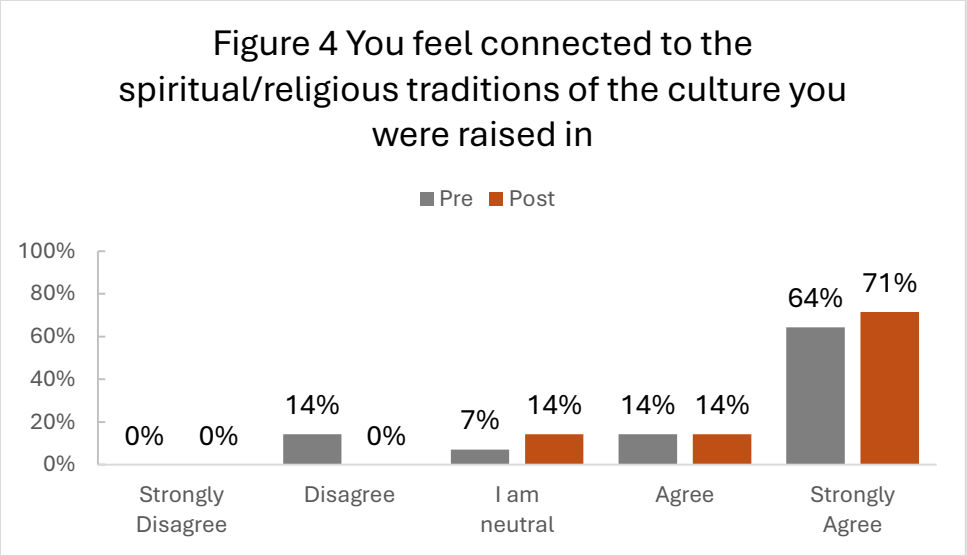


Figure 3 Your culture helps you to feel good about who you are
Pre
Post
100%
80%
60%
40%
20%
0%
0%
0%
0%
0%
0%
0%
14%
7%
86%
93%
Strongly Disagree
Disagree
I am neutral
Agree
Strongly Agree




| Table 4: Multi-Ethnic Identity Measure (MEIM) | Pre Strongly Agree/ Agree (%) | Post Strongly Agree/ Agree (%) | Change |
|---|---|---|---|
| I have spent time trying to find out more about my American Indian/Alaskan Native heritage, such as its history, traditions, and customs. | 93% | 93% | 0% |
| I am active in organizations or social groups that include mostly members of my American Indian/Alaskan Native heritage. | 100% | 86% | -14% |
| I have a clear sense of my American Indian/Alaskan Native heritage background and what it means for me. | 71% | 93% | 21% |
| I think a lot about how my life will be affected by my American Indian/Alaskan Native heritage membership. | 86% | 71% | -14% |
| I am happy that I am a member of the American Indian/Alaskan Native heritage I belong to. | 93% | 93% | 0% |
| I have a strong sense of belonging to my American Indian/Alaskan Native heritage. | 93% | 93% | 0% |
| I understand pretty well what my American Indian/Alaskan Native heritage membership means to me. | 86% | 79% | -7% |
| In order to learn more about my ethnic background, I have often talked to other people about my American Indian/ Alaskan Native heritage. | 86% | 86% | 0% |
| I have a lot of pride in my American Indian/Alaskan Native heritage. | 100% | 93% | -7% |

| Table 4: Multi-Ethnic Identity Measure (MEIM) | Pre Strongly Agree/ Agree (%) | Post Strongly Agree/ Agree (%) | Change |
|---|---|---|---|
| I participate in cultural practices of my American Indian/Alaskan Native heritage, such as special food, music, or customs. | 100% | 79% | -21% |
| I feel a strong attachment towards my American Indian/Alaskan Native heritage. | 100% | 93% | -7% |
| I feel good about my cultural or American Indian/Alaskan Native background. | 100% | 93% | -7% |

Table 5: MEIM

| Time-Point | Mean | SD | t-statistic | p-value |
|---|---|---|---|---|
| Pre | 54.21 | 5.16 | 0.60 | 0.56 |
| Post | 52.00 | 12.75 | | |

| Table 6: Social Connectedness | Pre Strongly Agree/ Agree (%) | Post Strongly Agree/ Agree (%) | Change |
|---|---|---|---|
| I feel connected to the people around me. | 86% | 79% | -7% |
| When I'm around people I know, I feel I really belong. | 86% | 64% | -21% |
| I feel a sense of togetherness with my peers. | 100% | 71% | -29% |
| I feel I can relate to many different people. | 86% | 64% | -21% |
| I have a sense of brotherhood/sisterhood with my friends. | 100% | 64% | -36% |
| I feel I participate when I'm with people or in groups. | 86% | 86% | 0% |

| Table 7: Social Connectedness | N | Mean Score | Score SD | t-stat | p-value |
|---|---|---|---|---|---|
| Pre | 14 | 25.79 | 3.21 | 1.40 | 0.19 |
| Post | 14 | 22.64 | 7.97 | | |

Figure 5 I can always manage to solve difficult problems if I try hard enough.

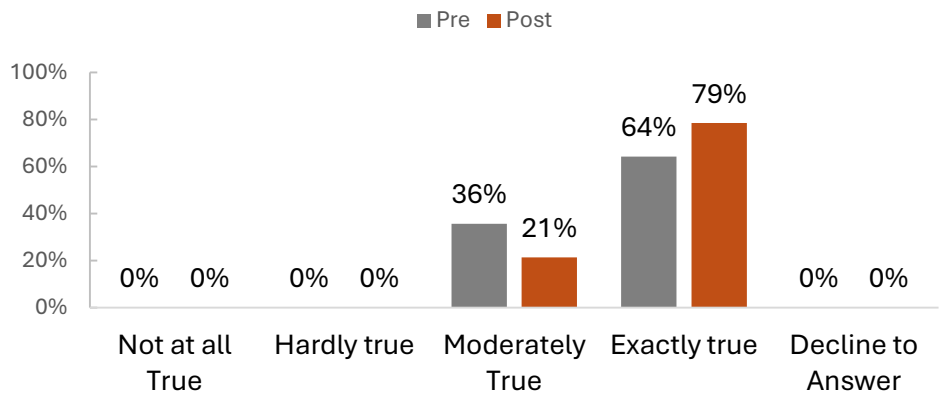



Figure 6 If someone opposes me, I can find the means and ways to get what I want.

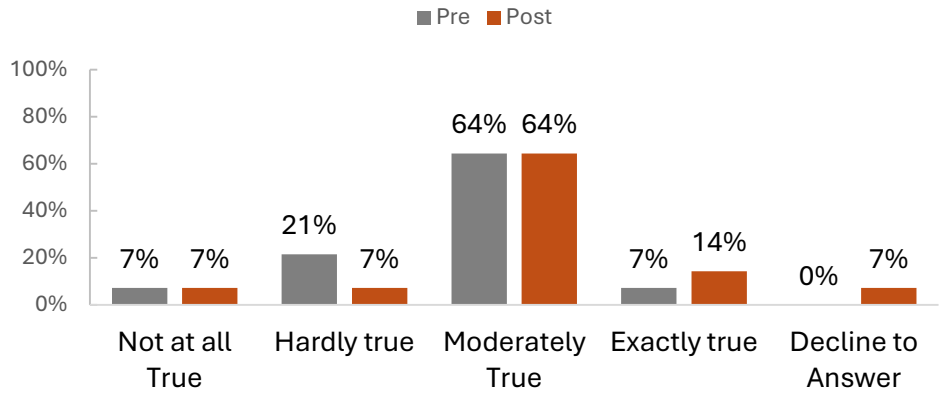



Figure 7 It is easy for me to stick to my aims and accomplish my goals.

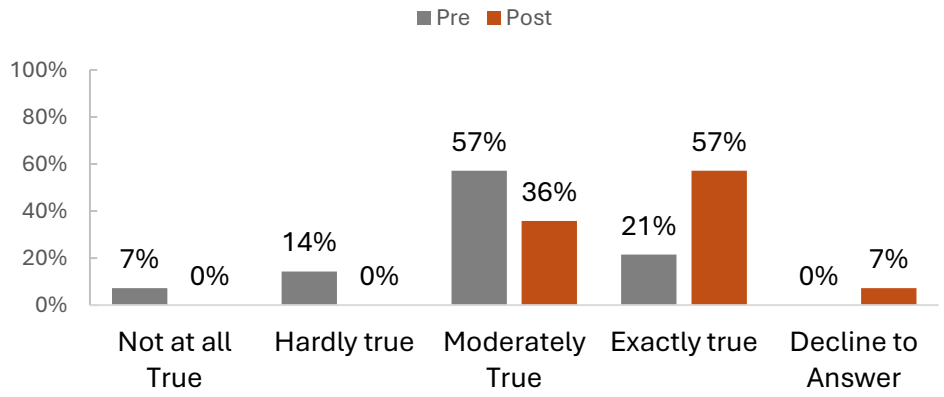


Figure 8 I am confident that I could deal efficiently with unexpected events.

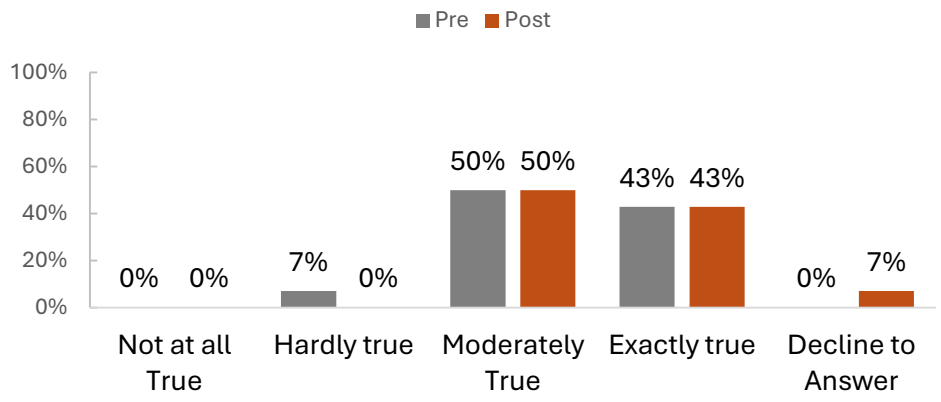



Figure 9 Thanks to my resourcefulness, I know how to handle unforeseen situations.

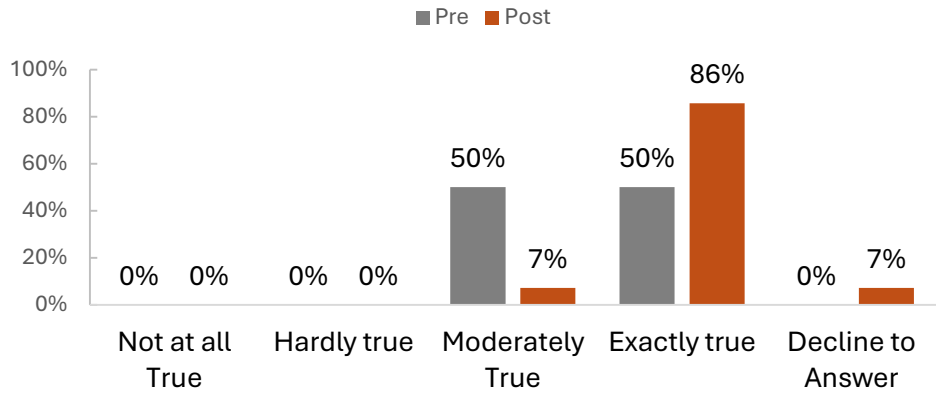



Figure 10 I can solve most problems if I invest the necessary effort.

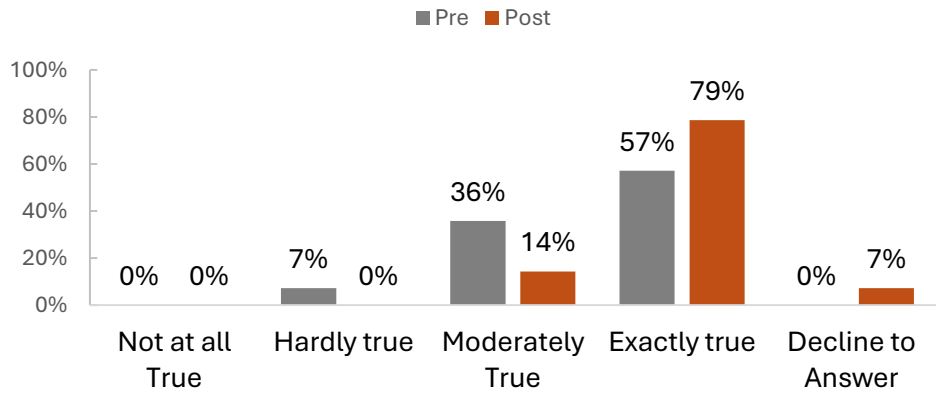


Figure 11 I can remain calm when facing difficulties because I can rely on my coping abilities.

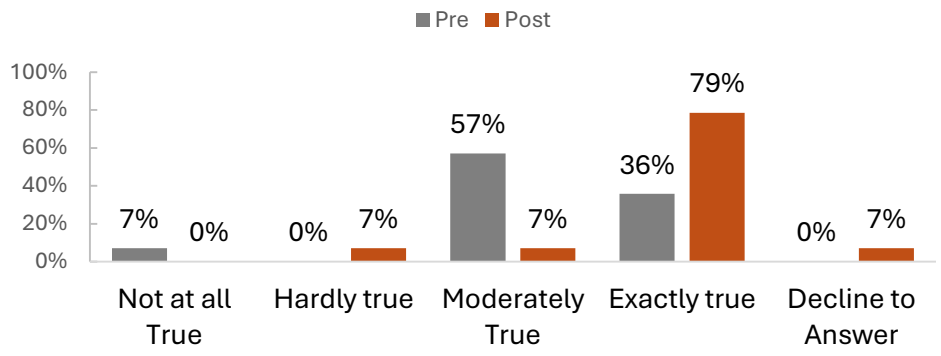



Figure 12 When I am confronted with a problem, I can usually find several solutions.

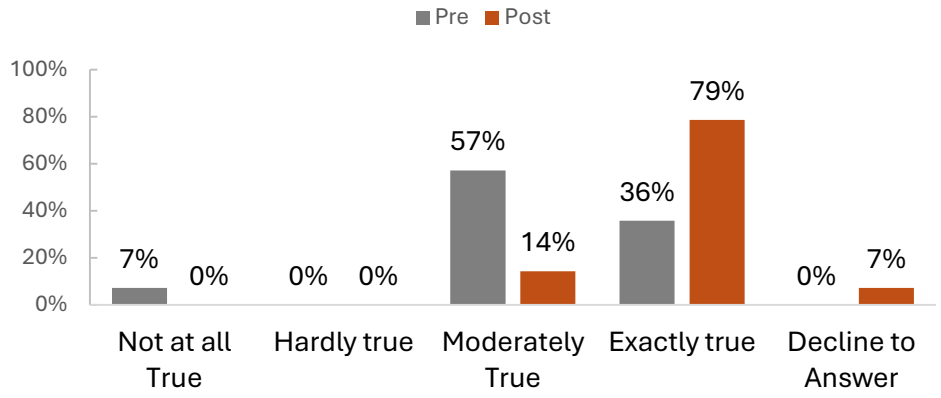


Figure 13 If I am in trouble, I can usually think of a solution.

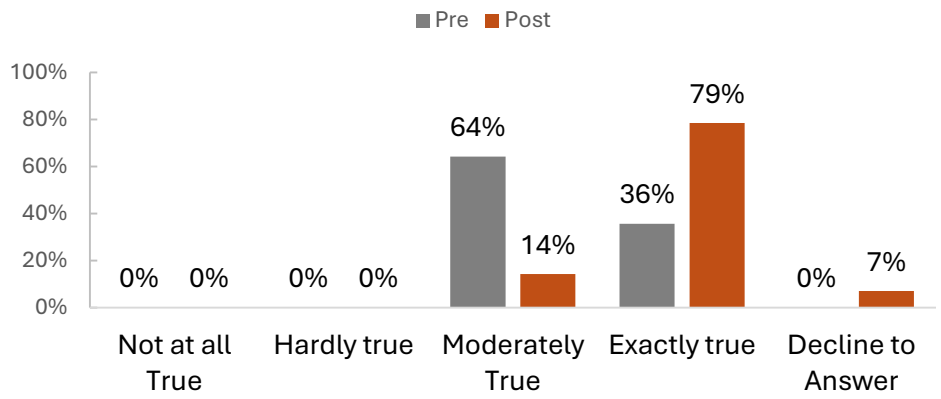
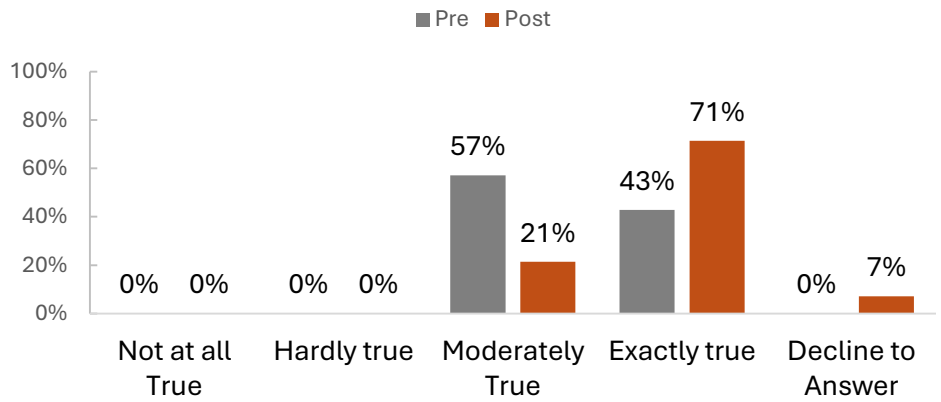



Figure 14 I can usually handle whatever comes my way.




| Table 8: General Self-Efficacy | Mean | SD | t-statistic | p-value |
|---|---|---|---|---|
| Pre | 32.86 | 4.17 | 0.68 | 0.51 |
| Post | 14 | 34.43 | | |

| Table 9 Pre: How much do you think people risk harming themselves physically or in other ways if they... | | | | | |
|---|---|---|---|---|---|
| Statements | Decline to answer | No risk | Slight risk | Moderate risk | Great risk |
| Have five or more drinks of alcohol once or twice a week? | 0% | 0% | 0% | 0% | 100% |

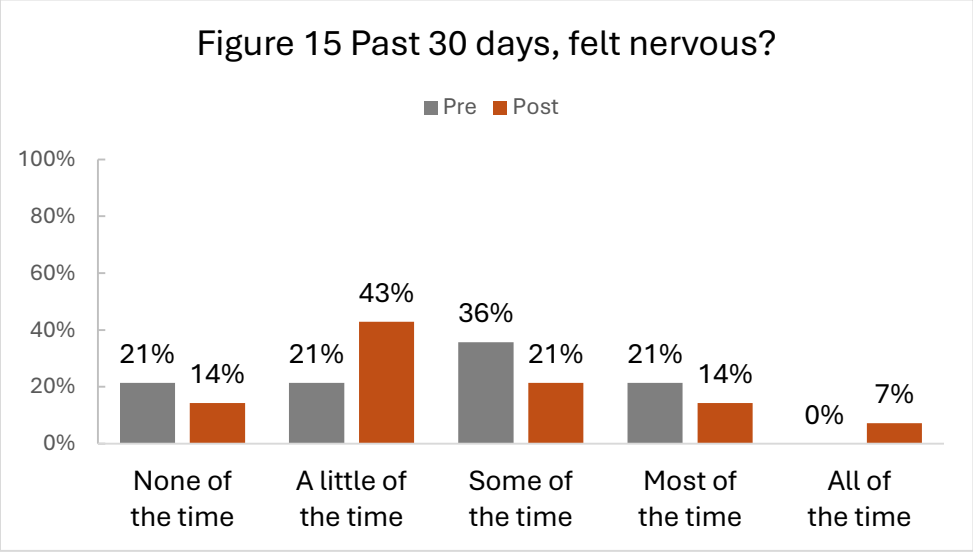
| Table 9 Pre: How much do you think people risk harming themselves physically or in other ways if they... | | | | | |
|---|---|---|---|---|---|
| Statements | Decline to answer | No risk | Slight risk | Moderate risk | Great risk |
| Smoke one or more packs of cigarettes a day? | 0% | 0% | 0% | 0% | 100% |
| Smoke marijuana once or twice a week? | 0% | 0% | 0% | 100% | 0% |
| Use prescription drugs not prescribed to them? | 0% | 0% | 0% | 0% | 100% |

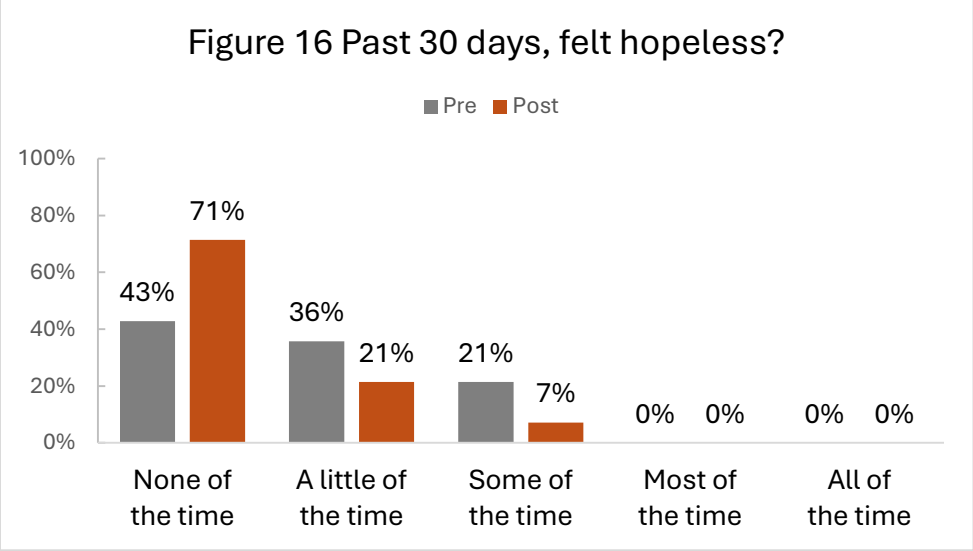
| Table 10 Post: How much do you think people risk harming themselves physically or in other ways if they... | | | | | |
|---|---|---|---|---|---|
| Statements | Decline to answer | No risk | Slight risk | Moderate risk | Great risk |
| Have five or more drinks of alcohol once or twice a week? | 50% | 0% | 0% | 0% | 50% |
| Smoke one or more packs of cigarettes a day? | 50% | 0% | 0% | 0% | 50% |
| Smoke marijuana once or twice a week? | 50% | 0% | 0% | 0% | 50% |
| Use prescription drugs not prescribed to them? | 50% | 0% | 0% | 0% | 50% |

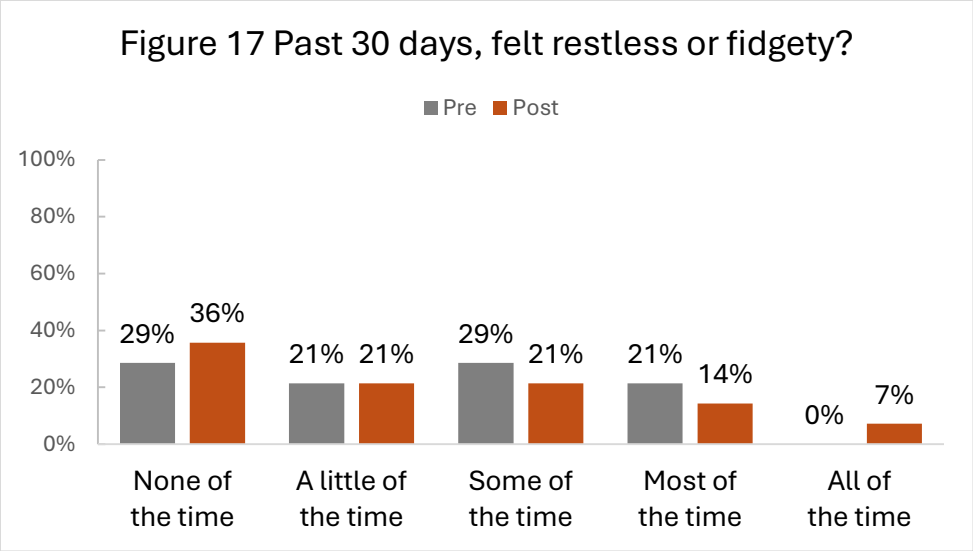
| Table 11 Pre: How wrong would your parents feel it would be for your to... | | | | |
|---|---|---|---|---|
| Statements | Not at all wrong | A little wrong | Wrong | Very Wrong |
| Have one or two drinks of alcohol nearly every day? | 0% | 0% | 0% | 100% |
| Smoke tobacco? | 0% | 0% | 0% | 100% |
| Smoke marijuana? | 0% | 0% | 0% | 100% |
| Use prescription drugs not prescribed to you? | 0% | 0% | 0% | 100% |

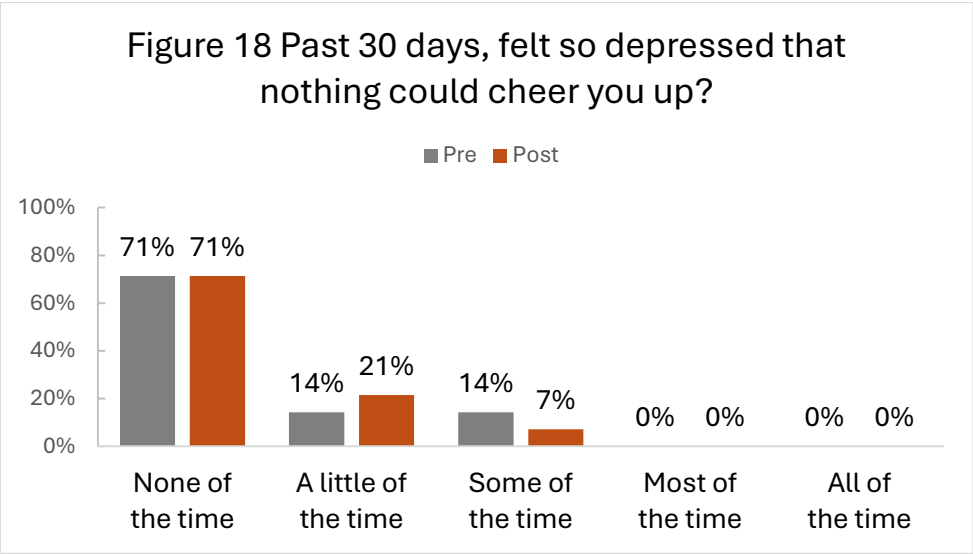
| Table 12 Post: How wrong would your parents feel it would be for your to... | | | | |
|---|---|---|---|---|
| | Not at all wrong | A little wrong | Wrong | Very Wrong |
| Have one or two drinks of alcohol nearly every day? | 0% | 0% | 0% | 100% |
| Smoke tobacco? | 0% | 0% | 0% | 100% |
| Smoke marijuana? | 0% | 0% | 0% | 100% |
| Use prescription drugs not prescribed to you? | 0% | 0% | 0% | 100% |

| Table 13 Pre: How wrong would your friends feel it would be for you to… | Not at all wrong | A little wrong | Wrong | Very Wrong |
|---|---|---|---|---|
| Have one or two drinks of alcohol nearly every day? | 0% | 0% | 100% | 0% |
| Smoke tobacco? | 0% | 50% | 50% | 0% |
| Smoke marijuana? | 0% | 50% | 50% | 0% |
| Use prescription drugs not prescribed to you? | 0% | 0% | 100% | 0% |






| Table 14 | N | Mean Score | Score SD | t-stat | p-value |
|---|---|---|---|---|---|
| Pre | 14 | 12.5 | 4.52 | 1.17 | 0.26 |
| Post | 14 | 11.07 | 3.71 | | |

| Table 14 Post: How wrong would your friends feel it would be for you to... | Not at all wrong | A little wrong | Wrong | Very Wrong |
|---|---|---|---|---|
| Have one or two drinks of alcohol nearly every day? | 0% | 0% | 50% | 50% |
| Smoke tobacco? | 50% | 0% | 0% | 50% |
| Smoke marijuana? | 50% | 0% | 0% | 50% |
| Use prescription drugs not prescribed to you? | 0% | 0% | 50% | 50% |

| Table 15 | **Pre Mean Score** | **Pre Score SD** | **Post Mean Score** | **Post Mean SD** |
|---|---|---|---|---|
| **Adolescent Resiliency Scale** | 70.00 | 2.83 | 72.00 | 4.24 |
| Subscales | | | | |
| Future Orientation | 24.5 | 0.71 | 24.5 | 0.71 |
| Emotional Regulation | 29.5 | 0.71 | 30.5 | 0.71 |
| Novelty | 16.0 | 1.41 | 17.00 | 2.82 |

**Table 16 Experiences among Longitudinal Respondents ages 8-11**

| Statements | 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) | 0% (n=0) | 50% (n=1) | 50% (n=1) | 0% (n=0) |
| I felt my child had someone to talk to when they were troubled. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 50% (n=1) | 50% (n=1) | 0% (n=0) |
| The services my child and/or family received were right for us. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 50% (n=1) | 50% (n=1) | 0% (n=0) |
| Services were available at times that were convenient for us. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 50% (n=1) | 50% (n=1) | 0% (n=0) |
| Staff respected my family's religious/spiritual beliefs. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 50% (n=1) | 50% (n=1) | 0% (n=0) |
| Staff spoke with me in a way that I understood. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 50% (n=1) | 50% (n=1) | 0% (n=0) |
| Staff were sensitive to my cultural/ethnic background. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 50% (n=1) | 50% (n=1) | 0% (n=0) |

**Table 17 Experiences among Longitudinal Adolescent Respondents 12-17**

| Statements | Strongly Disagree | Disagree | Undecided | Agree | Strongly Agree | Not applicable |
|---|---|---|---|---|---|---|
| Overall, I am satisfied with the services I received. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 50% (n=1) | 50% (n=1) | 0% (n=0) |
| I felt I had someone to talk to when I was troubled. | 0% (n=0) | 0% (n=0) | 50% (n=1) | 0% (n=0) | 50% (n=1) | 0% (n=0) |
| I received services that were right for me. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 50% (n=1) | 50% (n=1) | 0% (n=0) |
| Services were available at times that were convenient for me. | 0% (n=0) | 0% (n=0) | 50% (n=1) | 0% (n=0) | 50% (n=1) | 0% (n=0) |
| I got the help I wanted. | 0% (n=0) | 0% (n=0) | 50% (n=1) | 0% (n=0) | 50% (n=1) | 0% (n=0) |
| Staff respected my religious/spiritual beliefs. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 50% (n=1) | 50% (n=1) | 0% (n=0) |
| Staff spoke with me in a way that I understood. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 50% (n=1) | 50% (n=1) | 0% (n=0) |
| Staff were sensitive to my cultural/ethnic background. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 50% (n=1) | 50% (n=1) | 0% (n=0) |
| I am better at handling daily life. | 0% (n=0) | 0% (n=0) | 50% (n=1) | 0% (n=0) | 50% (n=1) | 0% (n=0) |
| I am better able to do things I want to do. | 0% (n=0) | 0% (n=0) | 50% (n=1) | 0% (n=0) | 50% (n=1) | 0% (n=0) |
| I know people who will listen and understand me when I need to talk. | 0% (n=0) | 0% (n=0) | 50% (n=1) | 0% (n=0) | 50% (n=1) | 0% (n=0) |

**Table 18 Experiences among Longitudinal Adult 18+**

| Statements | Strongly Disagree | Disagree | I am neutral | Agree | Strongly Agree | Undecided | Not applicable |
|---|---|---|---|---|---|---|---|
| I like the services that I received here. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 17% (n=2) | 75% (n=9) | 0% (n=0) | 8% (n=1) |
| I would recommend this agency to a friend or family member. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 25% (n=3) | 75% (n=9) | 0% (n=0) | 0% (n=0) |
| Services were available at times that were good for me. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 25% (n=3) | 67% (n=8) | 0% (n=0) | 8% (n=1) |
| When I first called or came here, it was easy to talk to the staff. | 0% (n=0) | 0% (n=0) | 8% (n=1) | 17% (n=2) | 75% (n=9) | 0% (n=0) | 0% (n=0) |
| The staff here respect my race and/or ethnicity. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 8% (n=1) | 92% (n=11) | 0% (n=0) | 0% (n=0) |
| The staff here respect my religious and/or spiritual beliefs. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 17% (n=2) | 83% (n=10) | 0% (n=0) | 0% (n=0) |
| The staff here respect my gender identity and/or sexual orientation. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 17% (n=2) | 83% (n=10) | 0% (n=0) | 0% (n=0) |
| Staff are willing to be flexible and provide alternative approaches or services to meet my needs. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 17% (n=2) | 75% (n=9) | 0% (n=0) | 8% (n=1) |
| The people who work here respect my cultural beliefs, remedies and healing practices. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 17% (n=2) | 83% (n=10) | 0% (n=0) | 0% (n=0) |
| I deal more effectively with my daily problems. | 0% (n=0) | 0% (n=0) | 25% (n=3) | 25% (n=3) | 33% (n=4) | 0% (n=0) | 0% (n=0) |
| My symptoms/problems are not bothering me as much. | 0% (n=0) | 0% (n=0) | 8% (n=1) | 25% (n=3) | 42% (n=5) | 0% (n=0) | 0% (n=0) |

**Table 19 Services Impact among Longitudinal Respondents 12+**

| Statements | Strongly Disagree | Disagree | Undecided | Agree | Strongly Agree | I am neutral | Not Applicable |
|---|---|---|---|---|---|---|---|
| I am more knowledgeable about historical trauma as it relates to my AIAN history. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 36% (n=5) | 43% (n=6) | 7% (n=1) | 14% (n=2) |
| I am more knowledgeable about suicide prevention. | 0% (n=0) | 0% (n=0) | 7% (n=1) | 43% (n=6) | 29% (n=4) | 14% (n=2) | 7% (n=1) |
| I am more knowledgeable about stigma and mental illness. | 0% (n=0) | 0% (n=0) | 7% (n=1) | 36% (n=5) | 29% (n=4) | 21% (n=3) | 7% (n=1) |
| I am more knowledgeable about how discrimination can affect my mental health. | 0% (n=0) | 0% (n=0) | 7% (n=1) | 36% (n=5) | 36% (n=5) | 14% (n=2) | 7% (n=1) |
| I am more knowledgeable about the early signs of mental illness. | 0% (n=0) | 0% (n=0) | 7% (n=1) | 36% (n=5) | 43% (n=6) | 7% (n=1) | 7% (n=1) |

**Table 20 Longitudinal**
**Respondents Ages 8-11**

| Statements | Strongly Disagree | Disagree | Undecided | Agree | Strongly Agree | Not Applicable |
|---|---|---|---|---|---|---|
| My child is better at handling daily life. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 100% (n=2) | 0% (n=0) | 0% (n=0) |
| My child is better able to do things they want to do. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 100% (n=2) | 0% (n=0) | 0% (n=0) |
| I know people who will listen and understand me when I need to talk. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 50% (n=1) | 50% (n=1) | 0% (n=0) |
| My child is more knowledgeable about historical traumas as it relates to our AIAN history. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 50% (n=1) | 50% (n=1) | 0% (n=0) |
| My child is more knowledge about suicide prevention. | 0% (n=0) | 0% (n=0) | 50% (n=1) | 0% (n=0) | 0% (n=0) | 50% (n=1) |
| My child is more knowledgeable about stigma and mental illness. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 100% (n=2) | 0% (n=0) | 0% (n=0) |
| My child is more knowledgeable about how discrimination can affect their mental health. | 0% (n=0) | 0% (n=0) | 0% (n=0) | 50% (n=1) | 50% (n=1) | 0% (n=0) |
| My child is more knowledgeable about the early signs of mental illness. | 0% (n=0) | 0% (n=0) | 100% (n=2) | 0% (n=0) | 0% (n=0) | 0% (n=0) |

**Table 21 IHCSCV Results for SWE Analysis (n restricted to participants aged 12+ who completed**

| Measure Name | Modified | Pre N | Pre Mean Score | Pre Score SD | Post N | Post Mean Score | Post Mean SD | Correlation between Pre and Post Mean score (r) | Cohort | Age Group |
|---|---|---|---|---|---|---|---|---|---|---|
| General Self-Efficacy (GSE) | N | 14 | 32.86 | 4.17 | 14 | 34.43 | 9.35 | 0.37 | N/A | 12+ |
| Multi-group Ethnic Identity Measure (MEIM) | Y | 14 | 54.21 | 5.16 | 14 | 52.00 | 12.75 | - 0.02 | N/A | 12+ |
| Adolescent Resilience Scale* | N | 2 | 70.00 | 2.83 | 2 | 72.00 | 4.24 | - | N/A | Adolescent (12-17) |

**too few values to calculate correlation coefficient.*