Improving Cultural Connectedness Within Native Americans Clients: A Paradigm Shift that Improves Mental Health Outcomes

IMPROVING CULTURAL CONNECTEDNESS WITHIN NATIVE AMERICANS CLIENTS: A PARADIGM SHIFT THAT IMPROVES MENTAL HEALTH OUTCOMES

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PARAGON RECOVERY; CALIFORNIA ASSOCIATION FOR ALCOHOL/DRUG EDUCATORS

AGENDA

- Why are we here and why should you care?
- What made this work necessary?
- What is the Culture is Prevention Program
- Why is Culture such an important aspect of treating Native/Indigenous Peoples
- Cultural Connectedness and how it is measured
- Well-Being and how is it measured
- How do we move from Cultural Expectancy to Cultural Humility?
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### WHY IS IT IMPORTANT TO MOVE FROM CULTURAL COMPETENCY TO CULTURAL HUMILITY?

**Why should you care?**

Strengthening Culture is Healing emotionally, physically, spiritually, and cognitively

The loss of culture has had a strong and negative impact on the health and well-being of Native Americans (resulting in poor mental, emotional, spiritual, and physical health; lowered life satisfaction; and substance abuse). Given this, the degree of reclaimed culture or increased cultural connectedness may be a more important outcome measure than the reduction in frequency of some risky behaviours.

**BARRIERS TO PARADIGM SHIFT**

"Improving Well-being Requires Strategies that Counter Cultural Loss." … “Cultural connectedness predicted positive mental health above and beyond other social determinants of health.” (Snowshoe, 2016)

Although the WHO and UN have recognized and adopted charter changes to support Native/Indigenous knowledge and practices - Government, academia, and western medicine should be cognizant that Indigenous cultures historically manufactured good health. They should try to better understand and promote Indigenous epistemology, community defined evidenced practices and culture and not undermine it.

Support exist for equitable programs to implement not cultural awareness or cultural competence but move toward cultural sensitivity and cultural humility. Instead of asking, What is wrong with communities and what are their barrier to seeking treatment? Start asking, What has historically been healing and healthy within Native/Indigenous communities and how can we support those aspect? Finally, accepting and supporting via financial support and programmatic changes Native American Epistemology and Approaches.

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**Culture is PREVENTION**

Promoting Culture, a social determinant of health, for Native Americans is a must to promote health equity and social justice

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The **CULTURE IS PREVENTION** Project

NATIVE AMERICAN HEALTH CENTER
Serving the community since 1972
Why did the Culture is Prevention Project start?

30 Person Community Advisory Board

SAMHSA funded project (June 2015)

Concerns - SAMHSA required evaluation questions about alcohol/drugs:

1) Were not an appropriate or comprehensive method of evaluating if their programs improved health, resiliency, strength and other outcomes in youth.

2) Were not aligned with traditional Native American strength-based approaches. (i.e., versus risk/deficit-based Western approaches)

3) Some questions were potentially harmful.

Decision Identify or develop program evaluation approaches that were culturally appropriate and aligned with Native ways of evaluating health.

“Indigenizing Approaches to Evaluation”

CALIFORNIA DISPARITIES PROJECT

PHASE I (2016-2021)
EXTENDED DUE TO COVID

PHASE II (2023 – ONGOING)

The California Reducing Disparities Project (CRDP) is a first of its kind initiative intended to demonstrate the effectiveness of Community-Defined Evidence Practices (CDEPs) in reducing mental health disparities for diverse, multicultural communities, and reinforce the infrastructure to deliver these services. The purpose of the Statewide Evaluation (SWE) is to assess the overall effectiveness of the California Reducing Disparities Project (CRDP), identify and implement strategies addressing mental health disparities, and to demonstrate the effectiveness of Community-Defined Evidence Based Practices (CDEPs) in reducing mental health disparities in the five priority populations using Community Based Participatory Research (CBPR) Methods.

Phase I – Statewide Evaluation report was completed June 2, 2023 and is available


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CULTURAL CONNECTED SCALE ADAPTATION

Snowshoe et al., 2015 developed and validated the original CCS.

She employed Native American/First Nations methodologies (talking circles, gatherings, and keepers of knowledge "Elders") to answer three questions:

- What does Culture look like?
- What does Culture feel like?
- What does Culture sound like?

She developed the measure using Indigenous persons living on reservations in Canada.

The measure was the first of its kind developed by Natives for Natives.

Culture is Prevention Project - 6 PHASES

**Completed**

Phase 1 – Consensus Generating Workshop (2 day 35 staff & community leaders)

Phase 2 – Scoping Review (Literature Search & Knowledge Synthesis)

Phase 3 – California Adaptation of Snowshoe ‘Cultural Connectedness Scale’ for Multi-Tribal Communities in California

Phase 4 – Testing & Analysis of the new Cultural Connectedness Scale – California (CCS-CA) (107 Tribes Represented, N =344)

Phase 5 – Native Culture, Physical/Mental health and the Predictive Properties of the CCS-CA [Funding – Blue Shield of California Foundation]

**Currently Being Conducted in Phase II CRDP**

Phase 6 – Cultural, Integration, Health, Utilization and Costs in Health Centers

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CULTURAL CONNECTED SCALE-CA

Main Results: Psychometric Testing & Analysis of the CCS-CA

- Snowshoe CCS and the modified CCS-CA
- 29 item instrument - measures culture on three sub-scales: Identity, Traditions & Spirituality
- CCS Developed/tested First Nations/Indigenous youth (N = 318)
- CCS-CA Developed/tested Multi-tribal Native American/Indigenous adults (N = 344)

Very similar results in both studies

NATIVE AMERICAN HEALTH CENTER

Pearson’s Correlations between the CCS-CA and Herth Hope Index

<table>
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<tr>
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<th>CCS-CA Total Score</th>
<th>Traditions</th>
<th>Identity</th>
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*p<0.001
Means, Standard Deviations, and Ranges for the CCS-CA and Herth Hope Index

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<th>Range</th>
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<td>HHI</td>
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<td>16.0 - 48.0</td>
<td>41.78</td>
<td>43.00</td>
<td>4.78</td>
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**CULTURAL CONNECTED SCALE-CA OVERALL**

- **CCS-CA is valid and reliable** (e.g., CFI = .913, Cronbach’s Alpha of .941 for CCS-CA and adequate factor loads for all items). (except 2 items which including them or not did not change the Alpha or other analysis)

- **CCS-CA total scores and individual sub-scale scores demonstrated statistically significant positive correlation with measures of mental health/well-being.** \( p < 0.001 \)

- **Two large sample studies in two countries with similar results.**

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Masotti et al., 2023

**Correlation and Effect Size**

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<th>Table 5</th>
<th>Bivariate correlations combined step one and step two</th>
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<td>1. Cultural Connectedness Scale (CCS-CA)</td>
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<td>2. Herth Hope Index (modified) (mHHI)</td>
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<td>3. Satisfaction With Life Scale (SWLS)</td>
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<td>4. Center Epidemiology Study Depression (CES-D)</td>
<td>-.23^a</td>
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<tr>
<td>5. HRQOL No. Good Health Days</td>
<td>.13^b</td>
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</table>

^a Correlation is significant at <.01  
^b Correlation is significant at <.001

**CONSIDERING CULTURE IS IMPORTANT TO NATIVE/INDIGENOUS PEOPLES**

- Lalonde and Chandler (1998) found that in tribes where cultural reclamation and practice was being undertaken by the tribe and tribal members, there was an 800 percent decrease in suicide and that those tribes had significantly lower suicide than the national average.

- Social Support must be meaningful to the individual and with recent research showing that when compared to other races, ethnicities, and cultures, Native youth spend approximately three times the amount of time doing familial support activities.

- The CRDP state-wide Evaluation has found that Community Defined Evidence Practices and Culturally informed preventions and interventions have the most significant positive effect.

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To continue to track and assess programs we needed an evaluation tool.

- We followed the same principle and guidelines for the instrument development.
- It had to be developed with the community (CBPR).
- It had to be based upon and from a Native perspective.
- It has to be useful to the community.

We are currently collecting data on Phase II of developing a Well-being measure.

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**RECOVERY CAPITAL AND WELL-BEING (CANO ET AL., 2017)**
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NATIVE AMERICAN WELL-BEING SCALE (DENNEM ET AL.)

- Existing constructs and measurement instruments do not essentially capture well-being from Native American epistemologies.
- Development of a new scale:
  - Developed themes based on a nominal groups design (Identity/Becoming; Spirituality/Being; Tradition/Belonging; Positive Emotions/Life Satisfaction)
  - Drafted a 29-item measure with input from community stakeholders
  - Still in data collection; preliminary results following

PRELIMINARY FINDINGS – 6 ITEM SCALE

- 6 questions based on two domains from factors:
  - Internal (a = .90)
    - I have a connection to an inner strength
    - I feel satisfied with my life overall
    - I have a positive outlook toward life
  - External (a = .80)
    - People from my community are an important source of support
    - I know my community is there for me when I need them
    - In the past 30 days I have spent time trying to find out more about being Native American
  - Single factor: $\chi^2 (9) = 12.09, p = .209$, RMSEA = 0.080, RMSR = 0.056, CFI = 0.954, TLI = 0.923
  - Correlated two factor: $\chi^2 (8) = 8.72, p = .366$, RMSEA = 0.041, RMSR = 0.044, CFI = 0.989, TLI = 0.980
  - Chi-Square model comparison: p = .087
  - EGA result: single factor
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COMPARED TO TEMPORAL SATISFACTION WITH LIFE, SUBJECTIVE HAPPINESS AND CESD-10

<table>
<thead>
<tr>
<th>Measure</th>
<th>Correlation</th>
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<tbody>
<tr>
<td>TSWL (TS)</td>
<td>R = 0.67</td>
</tr>
<tr>
<td>SHS (H)</td>
<td>R = 0.39</td>
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<tr>
<td>CESD-10 (E)</td>
<td>R = -0.35</td>
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</tbody>
</table>

CULTURAL IDENTITY DIFFERENCES

INTERNAL RESOURCES
- HIGH: M = 4.21
- LOW: M = 3.69
- T (150) = 4.16; P < .001, D = 0.77

EXTERNAL RESOURCES
- HIGH: 4.13
- LOW: 3.59
- T (150) = 3.73; P < .001, D = 0.69

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CULTURAL COMPETENCY

- Question(s) -
- What do you know about Native Culture?
- What were you taught to expect when treating Native/Indigenous persons?
- What were you taught about Natives and their relationship with Substances of Abuse?

Current Model of Native and their Identity as Predictor of unhealthy behaviors

- Native Identity is Perceived as a Risk Factor for Poor Health
- Ineffective Western Measurement tools and Interventions
- Prescriptive Stereotypes
- Learned Helplessness
- External Loss of Control
- Unhealthy Behaviors

Colonization → Historical Trauma → Native Health Disparities

Peters and Peterson, 2019
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VIOLATIONS OF CULTURAL EXPECTANCY

- Religious practices
- Cultural norms (e.g., eye contact)
- Epistemologies
- Individualism VS collectivism
- 82 percent of a sample of 339 Native individuals in the SF Bay area reported being made feel misunderstood, not listened to, and blatantly discriminated against.
- 46.7 percent said they would not go back for treatment because of the way they were treated.
- 52 Percent would like to have access to Native Practices and Native Healers.

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MOVE TO CULTURAL HUMILITY

EXAMPLES FROM CLINICAL PRACTICE

- Motivational Interviewing in its original form was iatrogenic for Native people. It was modified and has its own design when working with native communities. (See Liz D’Amico and DL Dickersons work for Youth and Walker et al., 2023 for adult)
- Asking questions that engage the client and not enrage or distance them. (e.g., Would you mind teaching me about how things are done from a Native or Indigenous perspective? Would you like to maybe implement some of your own spiritual practices into your treatment plan such as burning medicines?)
- Instead of asking if they feel lonely or alone. Ask them if it is difficult to be this disconnected from their family and community?
- Before each session with a Native individual take some time to rearrange your thoughts so as to disengage from your usual ways of engaging and be mindful of this when it occurs.
- Do not rely on self-reports of Satisfaction With Life alone. The principle that and individual can be satisfied while still dealing with serious issues is quite common in Native Communities.
  - "Being cured is not always possible, but one can heal allowing that person to accept their life as it is." Sometimes this acceptance is premature and doesn’t allow for complete healing.
  - Leading to non Natives to believe that Natives have a problem with helplessness or hopelessness.
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References


QUESTIONS AND DISCUSSION

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BONUS SLIDES

1. Pilot testing results with at risk persons (12 – 24 Years old)

2. The CCS-CA with list of items

PRELIMINARY RESULTS – SF Study

58 Native American Youth in a 2-day cultural intervention
(12-24 years, Ave = 16)

MEASURES:
1) CCS-CA
2) ‘At-risk’ behaviors for alcohol or prescription drug use – Red Vision Questionnaire

Ave CCS-CA score all 58 youth = 104.6

- Alcohol Use past 30 days: Ave CCS-CA = 91.6 (n=7 < 21 yrs)
- Inappropriate Prescription Drug Use: Ave CCS-CA = 94.1 (n=5)

- NO Alcohol past 30 days: Ave CCS-CA = 106.2
- No Inappropriate Prescription Drug Use: Ave CCS-CA = 106

[Small sample size. F test and T test results had p values > .05. Can’t say results were statistically significant]

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