# NATIVE AMERICAN YOUTH MENTAL WELLNESS REPORT

## SACRAMENTO COMMUNITY NEEDS AND STRENGTHS REPORT


**WRITTEN BY THE SACRAMENTO CIRCLES OF CARE PROJECT TEAM**

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# To the Evaluation Advisory Committee, Native Youth Ambassadors, and Native Circle Representatives

*This report could not have been completed without your dedication, commitment, and support throughout the process. Your willingness to share your time, energy and ideas in order to improve mental wellness built upon a strong foundation of cultures and traditions, where healthy lifestyles include the balance of mind, body and spirit, creating a restored legacy of well individuals and families, is greatly appreciated. We are humbled by your dedication and generosity and consider it a privilege to work with and for you.*

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The Community Advisory Groups which include the Native Circle Representatives, our Parent Advisory Group, and the Native Youth Ambassadors, our Youth Advisory Group, provided valuable input, feedback and interpretation of the information included in this report.

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- Aetna Better Health of California
- California Consortium of Urban Indian Health (CCUIH)
- California Council of Community Behavioral Health Agencies
- California Department of Human Services
- California Department of Social Services
- California Department of Social Services, Office of Tribal Affairs
- California Indian Manpower Consortium (CIMC)
- California Tribal College (CTC)
- Capital Area Indian Resources (CAIR)
- Colusa Indian Community Council
- Department of Health Care Services
- Each Mind Matters
- El Hogar
- Elk Grove Unified School District
- Health Insurance Advocacy and Counseling Program (HICAP)
- La Familia
- Mental Health Services Oversight and Accountability Commission (MHSOAC)
- Native American Child Abuse Treatment Behavioral Health Youth Program
- NorCal Mental Health America
- Racial & Ethnic Mental Health Disparities Coalition
- River Oak Center for Children
- Sacramento City Unified School District
- Sacramento County Department of Health and Human Services
- Sacramento County Department of Children, Family & Adult Services, Child Protective Services
- Sacramento County Division of Behavioral Health Services
- Sacramento County Office of Education, Project SOARS (Screening, Outreach and Referral Services)
- Sacramento County Public Library
- Sacramento County Unified School District
- Sacramento LGBT Center
- San Juan Unified School District
- Supporting Community Connections, Children's Receiving Home of Sacramento
- Shingle Springs Tribal TANF (Temporary Assistance for Needy Families)
- Social Changery
- Twin Rivers Unified School District
- University of California Davis
- Wilton Rancheria
- WEAVE

Many meaningful themes emerged in the course of collecting information for this report, the strongest of which are presented here:

- Native youth and community value the role of culture and identity in supporting mental wellness.
- Native youth want a space where they can feel safe, have a safe person to talk to and socialize with other Native youth, free from peer pressure, bullying, and family to explore their multiple and still forming identities.
- Schools are a place of risk for Native youth with a curriculum that imparts damage while having limited resources for supporting mental health.
- Stigma around mental health and help seeking behavior has meaningful impact and prevents people from getting support and services.
- Institutional service systems are inadequate to meet the full range of need in this community.
- Lack of cultural humility in working with Native people is a significant challenge in the service system.
- Many Native people turn to their community, culture, traditions, healers and ceremonies to create mental wellness.
- Sexual abuse, particularly commercial sexual trafficking of youth, is extremely high in Sacramento County and disproportionately impacts Native youth.

# EXECUTIVE SUMMARY

This Community Needs & Strengths Assessment details the mental wellness needs, strengths and assets of Native youth and families in Sacramento County. It is a compilation of information and feedback from the community itself, including youth, parents, and elders, as well as professionals from local schools, service providers, and partner organizations. It details the challenges Native youth and families face in staying mentally well as well as the assets that support the development of healthy young people.

The data collection for this report focused on methods that maximized group participation and input in large community meetings as well as small groups. Collection included reviewing community readiness interviews, hosting focus groups, and conducting one-on-one interviews. Data from institutional sources were reviewed and included to further document the depth and extent of the challenges this community faces as well as its assets and resources.

The community expressed the need for supportive services for youth **(FIGURE 1)** that also help the entire family address certain mental health issues that may run in the family. Naming the need to build a holistic support system, there was a particular concern expressed for youth that are living within families facing mental health challenges, distress, and in need of help. Services requested include: a youth/parent (or guardian) group, a parenting group, support for grandparents raising grandchildren and more in-home services.

**FIGURE 1. SPECIFIC SERVICES REQUESTED FOR YOUTH**

1. **Youth Center:** A physical space where Native youth can come together safely and develop their own identities.
2. **Academic/Career Support** for youth.
3. **Skill-Building Activities** for youth.
4. **Community Service Opportunities f**or youth to support elders, single adults, and mothers.
5. **Cultural Classes** for youth include drumming and language.
6. **Talking Circles** for youth to connect and support mental wellness.
7. **Sports, Organized Physical Activities**, and **Native Games** for youth.

The process of creating this report highlights significant community and service system strengths from which to build a system of care that can begin to address the needs noted in this report. At the center of this is the local Native community, which is enormously diverse and has a blend of rich cultural traditions and practitioners to draw upon. This community comes together in a large number of cross-cultural Native traditions which highlights a strong social component that is a source of strength for many Native people. The community also identified the importance of culture and its role in supporting health and wellness. People named a broad range of Native cultural practices as part of their wellness: Dance, Prayer, Smudge, Sweat Lodge, Talking Circle, Bear Dance, Round House, Big Times, Brush Dance, Elders, Ceremony, Traditional Medicine, Healers. A natural accompaniment to both culture and community is the people who embody this culture and share it with others.

These individuals – Native People, Elders, Helpers, Leaders, and Teachers – are the living culture of the community and are the most important strength and resource from which to support building wellness for young people. The other related complement to this, the role of mentorship, is an embedded traditional practice that many Native people engage in naturally. This aspect of teaching, person-to-person, elder-to-youth, is ancestral and essential to the health, wellness, survival and resilience of this community. Another culturally-based strength that emerged as essential to youth wellness is the importance of sports and exercise in developing into a healthy adult.

Another substantial strength of Sacramento County is the wide array of services and spaces that exist to support health, wellness and rebalancing techniques. While these supports are not always perfect, there is an enormous

## KEY RECOMMENDATIONS

This team will continue its planning process for another 2 years, using the information in this report to guide next steps at it shares the information in this report with partners and community and develops a detailed Blueprint for creating improvements in Native youth mental wellness. Immediate take-homes from this report are listed here:

- Identify resources, funding and a physical space for a Native youth center.
- Identify resources and funding to provide culturally competent services to Native youth and families.
- Provide cultural competency training to partners on how to work with Native people, particularly school and mental health partners.
- Develop a Native mental health service providers resource guide to be shared across service organizations.
- Improve ways of identifying Native youth across partner organizations: schools, juvenile justice, and mental health.
- Promote and improve the implementation of the Indian Child Welfare Act.
- Improve identification, outreach and engagement to the highest risk Native youth.
- Address school-based challenges for Native youth.
- Work collaboratively with local service partners to plan ways to address additional challenges highlighted in this report.


*Native Youth Ambassadors Representatives*

service structure that exists in the County. This structure includes an extensive mental health service system that is an engaged partner with this project. Furthermore, there are a significant array of community-based organizations that provide supportive social services including food, clothing, housing, and domestic violence support. Lastly, there is a network of Native and Native-serving agencies that are a first stop for Native people seeking assistance. These organizations prioritize hiring Native people that are particularly attuned to the needs and challenges of this community and provide culturally-based and trauma-informed services.

Highlighted throughout this report are many strengths and resilience factors present in the community and the supporting service system to build upon in creating a more effective care system for Native youth. Despite the identified needs and gaps in services, there is a strong sense of hope in the community that has been emboldened through this planning process. We are optimistic about taking the next steps to continue work with the community and system partners to plan services and community supports addressing some of these challenges.

# INTRODUCTION

*The Community Needs and Strengths Assessment* was conducted as part of the Sacramento Circles of Care project in partnership with the local American Indian community and service system partners. This work is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) in order for the Sacramento Native American Health Center to work with the local community to create a plan for addressing and improving Native American youth wellness. *The Community Needs and Strengths Assessment* is a collection of information that provides insight into the mental wellness needs of Native youth and their families in Sacramento County. Data was reviewed and collected using a community-based participatory research approach, which engages communities as partners and experts in the process. With this model, the community was provided training and education about evaluation methods and supported by the Evaluator to help develop, implement, analyze, interpret and disseminate findings. The project's advisory group members were nominated through a community process at the Circles of Care project's initial kick-off meetings. The Evaluation Advisory Committee led and approved the work contained in this report in collaboration with the Native Circle Representatives and Native Youth Ambassadors as essential partners.

The most important component of this work has been bringing the community together to discuss how to best support the health and wellness of Native youth. The advisory groups have discussed a great sense of skepticism about how long it takes for things to change given that the challenges faced today developed over hundreds of years. Within the community there exists an understanding that solutions to big challenges will only come about through engaged partnership with many constituents present at the table. This assessment and report represent an important step in the path to community wellness, as it centers around the community's youth and provides resources to document the lasting impacts of the colonization on American Indians in planning a transformative way forward.

Honoring their dedication, the partners who have come to the table and participated in this project have done so in a loving and humble way. The depth of information collected and summarized in this report could not have been possible without the passionate support of the project staff, leadership of SNAHC, and the countless contributions from the community and its partners. It is in this spirit that this report has been developed. *The Community Needs and Strengths Assessment* reflects the needs, challenges, strengths, and assets of the Sacramento Native community and service system. This report represents a preliminary point in a larger process that is intended to spur conversation for improvements, as well as questions for deeper investigation. It is presented and shared in the spirit of improvement, growth and transformation. We recognize the commitment and dedication of our system partners and the many challenges they face in supporting the broad and varied population of Sacramento. Their dedication and partnership reflect their commitment to the process. Finally, we recognize the particular vulnerability of Native children and the struggles disproportionately affecting them and their families as we remain committed to working hand-in-hand, nurturing health and wellness for all Native families.

## OVERVIEW OF THE PROJECT AND GOALS OVER THREE YEARS

In 2017, Sacramento Native American Health Center received a 3-year planning grant for the Sacramento Circles of Care project. This project focuses on planning the infrastructure necessary to implement a holistic, comprehensive, coordinated behavioral health system of care for urban American Indian/Alaska Native (AI/AN) children and youth, 0-25, and their families living in Sacramento County. Under this program, SNAHC holds the central role of building collaboration between families, youth, and system partners to addresses the current local need for increased capacity, efficiency, sustainability, and culturally-appropriate behavioral health services. This project brings the Sacramento AI/AN community together to plan and perform an in-depth gap analysis of the systems of care that can impact the mental health and wellness of American Indian children and their families.

### PROGRAM GOALS

- Create a culturally relevant integrative system of care with youth, adults, respected elders, agencies, and providers in Sacramento County by engaging AI/AN Families and Community Members, AI/AN Youth and Multi-Agency Partners.
- Develop a community-based System of Care Blueprint model, for how AI/AN children/ youth Mental Health and Wellness services and supports will be provided in Sacramento County, building off of the Community Needs and Strengths Assessment and the Community Readiness Assessment.
- Actively build a culture of learning among staff and community to support goals of system change by building knowledge of the system of care, family-driven and youth-guided care, and community-based participatory evaluation.
- Increase awareness of child/youth mental health and wellness issues through social marketing by developing and implementing a community-based social marketing and public education plan.

## BRIEF HISTORY OF NATIVE PERSONS IN SACRAMENTO

The history of California tribal communities is a history of resistance and resilience. In discussing the mental wellness of Native people today, it is essential to acknowledge and impart some of the history that lead to this moment. This history is not meant to be comprehensive; it is an effort to convey some of the depth and intensity of what Native American people have lived through and survived. The strength necessary to not only exist, but to thrive, in today's world is enormous. This resilience is, in and of itself, the most noteworthy strength and asset of the Native community.

The Sacramento area includes the ancestral homelands of the Maidu, Miwok, Me-Wuk, Wintun, Wintu, Patwin, and Nisenan Tribes.[1] Tribes lived off the land they inhabited and today they continue to inhabit the foothills, the rivers and deltas, and the central valley of their ancestral homelands. Sacramento Native Tribes had extensive trade networks, political alliances, and led stable lives with rich cultural and social traditions.[2] Within each region tribes were linked by intermarriage as a way to create partnerships and alliances between local tribes. The lives of California Native

communities were forever changed with the arrival of the Spaniards, the Mexican government, the influx of immigrants to the Sacramento region during the Gold Rush, and the systematic oppression by federal and state governments that continues to this day.[3]

The Spanish Missionaries began to systematically colonize California in the mid to late 1700's.[4] California Native Tribes were enslaved into the Mission system and endured physical, mental, and sexual abuses by Spanish priests and armed forces.[4][6] Native Americans living in the Missions were forced into Christianity and violently punished for speaking their Native language and practicing tribal traditions.[7][8] Families were separated and forced to live apart from each other. There were many attempts by California Tribes to escape enslavement, risking torture and death if recaptured.[9] The Spanish priests also brought diseases from Europe that were fatal to California Natives. Due to the unsanitary living conditions California Natives had to endure inside the missions, many became sick and died.[11] By the time the Mexican Republic stripped the missionaries of their power to coerce labor from the Natives in 1836, approximately one third of the Native population of California was dead as a direct result of their actions.[12]

Mexico and the United States were battling for control of California during the early part of the 1800's. For California Native tribes, the fight to exist and maintain ancestral lands continued. In 1824, the Mexican government issued 800 land grants to Mexican citizens.[8] Most, if not all, of the land grants issued were lands that belonged to enslaved Natives.[12] During this time John Sutter, a Swedish immigrant, became a Mexican citizen in order to be granted land by the Mexican government. He acquired about 50,000 acres of land that belonged to local Me-wuk and Maidu people and then enslaved them.[13]

Land grabs and Indian slave hunting parties from Mexico continued to decimate the California Indian population until the American invasion in 1846 and during the Gold Rush starting in 1848.[14] An unprecedented number of colonizers arrived in the region and violence erupted, particularly against Natives who resisted the intrusion of Gold Rushers onto their land.[12] Within two years of the discovery of gold, over two-thirds of the Native population was killed, some 100,000 people.[15]

The Maidu, Miwok and Nisenan tribes suffered greatly at the hands of Sutter and white settlers. In 1848, the Mexican-American War ended and Mexico ceded what are now Arizona, California, Colorado, Nevada, New Mexico, Utah and Wyoming to the United States. California Native communities continued to be pushed off their lands with the discovery of gold at Sutter's Mill. Sutter used violence and intimidation to force local Natives to work and protect his land.[13] He slaughtered men, women, children, and elders if they did not comply with his demands.[16] At the same time, California was becoming a State and began to systematically abolish Native people by creating laws that legalized their murder, kidnapping and enslavement by stripping them of all rights. Natives were denied the right to vote, were not recognized as citizens, and were denied due process. Military sponsored raids on Native villages and forced removal of Natives from their ancestral lands were commonplace.

In the 1850's the US government began attempting to make treaties with the California tribes, though these were based on faulty information, poor translations, and a well-earned lack of trust from the Natives. Despite California entering the Union

as a free state, inhumane indentured servitude laws were instituted, further subjecting Indians to slavery and denying them citizenship or the opportunity to address grievances in court. This, consequently, laid the foundation for the establishment of a system of slavery in California which was not abolished until 4 years after the Emancipation Proclamation.[19] By 1900 there were fewer than 16,000 Natives living in California.

Between 1851 and 1852 representatives from Washington were sent to California to establish treaties with Native tribes.[8] The treaties agreed to set aside 7.5 million acres of land for Natives.[8] Eighteen treaties were made with various California tribes, however not all Native California tribes were represented or aware of what the government was trying to do and many did not understand what they were signing or agreeing to because of language barriers.[12 18] Ultimately, the 18 treaties created were not honored or recognized because they were blocked in the United States Senate.[12 19] Lands belonging to California Tribes continued to be taken and Native people continued to be displaced and murdered.

In 1863 more than 400 Maidu, Wailaki, Pit River, Pomo, Concow, Koncow, Pahto from Chico and surrounding Counties were forced to walk 200 miles to Round Valley onto Yuki lands.[20 21] Only 277 Natives survived the relocation to Nome Cult Farm.[22] The Yuki were forced to share their land with other Natives that had different cultural and language practices.[23] These seven tribes were forced to live together and became what is now the Round Valley reservation.[24]

In 1887, California passed the Dawes Act which granted United States citizenship to tribal people and also relinquish communal control of their lands.[25] This law incentivized Native people to disband and separate so they could own land and become US citizens. This allowed the government to dissolve tribal lands and to create land allotments for Natives and non-Natives in an effort to further assimilate tribal communities. Allotment property tax often resulted in the forced sale or seizure of many allotments made to Native people. This land was typically sold to non-Natives.[26]

The process of recognizing the autonomy and rights of California Tribes by the government began with the Supreme Court of California granting citizenship to California Natives in 1917. Since 1921, political activism on the part of California Natives has led to federal action, though this has not been without controversy. The Indian Reorganization Act (IRA) followed and was signed by President Roosevelt in 1934. The IRA set aside sixty-one reservations in California and meant to restore tribal lands, ownership, sovereignty, and self-reliance.[8] The IRA also created a definition of a person as Indian based on three criteria; tribal membership, ancestral descent, and/or blood quantum. Blood quantum began to be widely used as criteria for tribal membership. It originally dates back to the 1890s when settlers began allotting lands in Oklahoma and created rolls to document Natives' names and their blood quantum. Generally, the more European blood, the more civilized, and the more trustworthy a person was considered.

In 1944, reparations were agreed to for the theft of California Indian ancestral land; though this included a deduction of the government's costs of providing services to the reservations they had forced Natives onto against their will. Eventually only $5 million was awarded, or approximately $150 per person. Further legal action by tribes led to a decades long battle with the American government, ultimately leading to a payment that worked out to 47 cents per acre of stolen land. Of

note is the fact that the entirety of these activities occurred outside normal court processes and without constitutional protections.

In late 1952, another issue was brought to the attention of the public. “Twenty-two young Indians, veterans of World War II and Korea, claimed they cannot buy shaving lotion because it contains alcohol. They have formed an Indian Right Organization to fight what they call ‘this new menace to the Indian.’”[27] However, this was not the first time that the problem had been brought to the attention of the government. In 1946, Indians, in a hearing in Eureka, requested that the prohibition against the sale of alcohol to Indians be lifted. In April 1953, Governor Earl Warren signed into law Senate Bill 344, which for the first time in 81 years made it legal for “full blooded Indians” to purchase alcohol.[28]

Termination era policies had devastating effects on the Native people across America. These policies continued Native assimilation efforts, ended government support of tribal communities and most importantly ended Federal recognition and protection of over 100 Tribes nationwide.[29] For California Tribes, it meant the Rancherias would no longer receive support from the Federal government, but State governments could take over assisting tribes.[30] Native Americans were encouraged to leave their reservations and relocate to urban areas for better economic prospects. Sacramento was designated as a relocation site. Men were promised vocational training and most ended up working manual labor for the rail road and the women were domestics. They were promised transitional support upon arrival, which often did not come. Life on the reservation was hard due to limited resources, poverty, and a lack of economic and educational opportunities. Natives from across the United States left their respective reservations and moved to urban areas as part of federal Relocation policies; often this was a one-way bus ticket. Those that stayed in these urban environments searched for employment but experienced discrimination, exploitation, and poverty. Native people with varied cultural practices and traditions found themselves living in large urban centers and cities, far from home and in need of support. Naturally, these people came together and created community, mixing with each other and other racial groups, creating a new urban Indian community. Nearly 100,000 Indians were relocated to California from 1952-1968 as a result of these and other related policies, and as a result it has the highest population of Natives of any State.

By the 1960’s minority groups across the nation were organizing and demanding equal rights and access to opportunities provided to White Americans. In the San Francisco Bay Area, a group of Natives calling themselves, Indians of All Tribes (IAT), organized the occupation and attempted reclamation of Alcatraz Island for Native people.[31] Indians of All Tribes was protesting Federal Termination policies, broken treaties, land grabs, forced relocation, and systematic extermination. After successfully landing on the island in 1969, the Occupation of Alcatraz gained nationwide media coverage and highlighted the diversity of Tribes from across the nation that were working toward the same goals: to have the government acknowledge the atrocities against Native people and work towards reconciliation.[32] The occupation lasted for fourteen months and brought attention to the brutal history Native generations experienced in America. To this day, Native people from all over the continent gather in solidarity for a sunrise ceremony on Unthanksgiving day on Alcatraz Island.

Another important development since the 1960s was the creation of Native American studies departments at major universities in California. In the fall of 1969, Indian students at the University of California at Berkeley, Los Angeles, and Davis and at Sacramento State University demanded that these institutions begin programs and offer courses in Indian culture and history. Today, much valuable information has come from these programs. They have also assisted Indian students by providing them with needed services, and have promoted a better Indian self-image.

The forced assimilation, enslavement, genocide, systemic oppression and removal of Native people from their lands led to the destruction and separation of families and cultural support systems. The experience described here focuses on the Sacramento area, however none of this experience is geographically isolated. Native people from across this continent have had similar experiences – murder, rape, enslavement, stolen lands, disrupted family structures, relocation, long walks, broken promises. In spite of this, Native communities are still here. They are educating younger generations about cultural practices and traditions, and continue to adapt and change to thrive in this America.

Today, the State of California has 109 federally recognized Tribes and 78 more petitioning for recognition. There are close to 100 Rancherias in the State.[33] Under Relocation, over 100,000 reservation Indians resettled in metropolitan areas, including Sacramento. The Sacramento Native community includes tribal people from many different States and regions with unique cultures and histories. There is a distinct cultural richness in the Native population of Sacramento. The continued existence of Native people and the preservation of cultural identity and traditions is, in of itself, a revolutionary act and one that at many times in California and US history had to be maintained in secrecy.

Due to this history, the Native community in the Sacramento area is incredibly diverse. There are many people from tribes that do not historically belong to this land; for some there has been a significant loss of cultural and historical knowledge. The impact of blood quantum as a defining factor for the degree of how “Indian” a person is has been significant. This practice fails to recognize Native practices of adopting others into their tribes and the existence of multiracial children. There are many issues with this form of identification, including that not all Natives were historically accurately recognized and recorded, and some refused to be recorded as a matter of principle. Today, tribes vary on the requirements to be considered a member of the tribe. This is a factor that contributes to variation in sizes of remaining tribes, with some having only a handful of members while the Cherokee Nation claims over 500,000 members. This also has become a factor between Indian people and can contribute to lateral oppression, individual feelings of being “Indian enough”, and challenges around identifying oneself as an Urban Indian. As a counter balance to this, today there are thriving cultural practices of Urban Indians who do not have access to their ancestral lands/community. This includes a wide range of religious and spiritual beliefs that include Christianity as well as tribal practices including Bear Dance, Round House, Sweat Lodge/Inipi, Sundance, Native American Church and a thriving social community include Pow Wows, Big Times and Community Events.

*Native Youth Ambassador meeting*

## METHODOLOGY

The information in this report was collected from the community and reviewed by community advisory boards before being finalized and presented here. Three large community meetings were held in January of 2018 in 3 areas of Sacramento County to maximize community input and participation. Questions from **Figure 2** were proposed on large post-it notes which were placed around the room in 3 'stations' accompanied by at least one staff person. Members were invited to approach each station and share or write their responses. A kick-off meeting was also held in January with Sacramento County Multi-Agency Partners (MAP). A similar process occurred with this group using the questions in Figure 3. A second meeting of the MAP was held in April where the data from the January MAP meeting was reviewed with attendees. The aim of the second MAP meeting was to further develop the ideas and community knowledge gathered in January (**Figure 4**).

**FIGURE 2. COMMUNITY QUESTIONS ON NATIVE YOUTH MENTAL WELLNESS**

**Data Collected at January 2018 Community Kick-Off Meetings (n=109)**

1. What have you observed in the community regarding mental health services (+ and -)?
2. What are the most important things in supporting Native youth mental health and wellness?
3. What should SNAHC focus on regarding Native youth mental health and wellness?

**FIGURE 3. MULTI-AGENCY PARTNER QUESTIONS ON YOUTH WELLNESS SERVICES**

**Data Collected at January 2018 Multi-Agency Partners Meeting (n=55)**

1. In our current youth services delivery model in Sacramento County (schools, mental health, substance abuse, foster care, child protective services, etc.), where are Native children/youth falling through the cracks?
2. What is working well in our youth services delivery model?
3. Is there a collaborative youth mental health system/collective happening in the county? Who are involved?

**FIGURE 4. MULTI-AGENCY PARTNER QUESTIONS ON NATIVE IDENTIFICATION & CARE COORDINATION**

**Data Collected at April 2018 Multi-Agency Partners Meeting (n=23)**

1. How can we improve identification of Native youth?
2. How can we improve coordination of services for Native youth?

**FIGURE 5. YOUTH QUESTIONS ON NATIVE YOUTH MENTAL WELLNESS**

**Data Collected at May 2018 Native Youth Ambassadors Meeting (n=9)**

1. What is most important to improving mental health treatment for Native youth?

**FIGURE 6. ADULT FOCUS GROUP QUESTIONS**

**Data Collected at June 2018 Parent Focus Group (n=25)**

1. Half of all mental illness begins by age 14; three-quarters by age 24. However, it takes young people an average of 6-8 years after the onset of symptoms to reach out & get help. How does that make you feel?
2. What would you say to a young person who confided in you that they were struggling with mental health? What would you tell them to do?
3. "Protective Factors" refers to attributes in communities that help people deal more effectively w/stressful events and lessens risks. What are some protective factors in the Native Community?

In April the Evaluator met with the Native Circle Representatives to get their input on prioritizing the most important challenges identified by the community. In May, the Evaluator met with the Native Youth Ambassadors to gather information from them on what the most important aspects are around improving Native youth mental health and wellness (**Figure 5**) and to prioritize and give perspective on the information that had already been collected. Each youth was given an endless pile of small post-it notes to write down ideas. The group came together and organized the ideas by theme, then voted to prioritize them.

In June, two focus groups were held to gather parent and youth perspective on mental health language and issues (**Figures 6** and **7**). All of the written data collected was reviewed by the team's evaluation staff who identified major themes in the data, both strengths and weaknesses.

A total of 16 interviews were conducted. Eight individuals participated in Community Readiness Interviews for this project that focused on Native youth wellness. For a sister project, eight additional interviews were conducted that focused on suicide and substance abuse prevention with Native youth. The evaluation team listened to these interviews to gather additional perspective on the themes identified in the data and provided quotes from community members that punctuate these themes.

In July, asset data was collected from the Parent, Youth and Multi-Agency Partner Advisory Group. This information was used to further develop the strengths, resources and asset section of the report. All of the major themes identified here have been presented and discussed with these three advisory boards, as well as the Evaluation Advisory Committee who has been instrumental in guiding this report.

## FIGURE 7. YOUTH FOCUS GROUP QUESTIONS

Data Collected at June 2018 Youth Focus Group (n=9)

What would you say to a friend who confided in you that they were struggling with mental health challenges? What would you tell them to do?

What do you think of when you hear the term “mental health”?

How open are your friends/ family/ community when it comes to talking about mental health?

In general, how do you think the Native community feels about mental health? Is there a difference between what elders think versus what young people think?

How can people with mental health challenges be supported?

If you were struggling with mental health challenges, who would you reach out to?

What can we do as a community to help people struggling with mental health challenges?

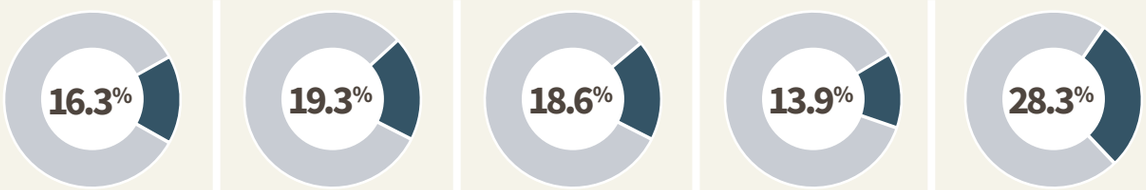
Approximately 1 in 5 adults in the U.S.—43.8 million, or 18.5%—experiences mental illness in a given year. How does that make you feel? Are you surprised?

Take a look at this chart [Figure 8, below]. What do you think? How does that make you feel? Why do you think AI/AN adults have the highest prevalence of mental illness?

Half of all chronic mental illness begins by age 14; three-quarters by age 24. However, it takes young people an average of 6-8 years after the onset of symptoms to reach out and get help. How does that make you feel? Are you surprised?

“Protective factors” refers to attributes (skills, strengths, resources, supports or coping strategies) in individuals, families, communities or the larger society that help people deal more effectively with stressful events and lessen or eliminate risk in families and communities. What are some protective factors in the Native community?

## FIGURE 8. PREVALENCE OF ADULT MENTAL ILLNESS BY RACE (SHARED WITH YOUTH AT FOCUS GROUP)




Hispanic adults living with a mental health condition.

White adults living with a mental health condition.

Black adults living with a mental health condition.

Asian adults living with a mental health condition.

American Indian/ Alaska Native adults living with a mental health condition.

## FIGURE 9. SUMMARY OF DATA COLLECTION, NUMBER OF PARTICIPANTS & REVIEW PROCESS

| YEAR 1 • QUARTER 2 | | | | YEAR 1 • QUARTER 3 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1/10/18 | 1/17/18 | 1/24/18 | 1/19/18 | 4/11/18 | 4/27/18 | 5/01/18 | 5/03-05/16/18 | 5/06/18 | 5/16/18 | 5/30/18 | 6/06/18 | 06/11/18 | 06/14/18 |
| COMMUNITY MEETING 1 | COMMUNITY MEETING 2 | COMMUNITY MEETING 3 3 | MULTI-AGENCY MEETING 1 | NATIVE CIRCLE REPRESENTATIVES | MULTI-AGENCY MEETING 2 | EVALUATION ADVISORY COMMITEE MEETING 1 | COMMUNITY READINESS INTERVIEWS | NATIVE YOUTH AMBASSADORS | EVALUATION ADVISORY COMMITEE MEETING 2 | EVALUATION ADVISORY COMMITEE MEETING 3 | EVALUATION ADVISORY COMMITEE MEETING 4 | YOUTH FOCUS GROUP | PARENT FOCUS GROUP |
| 19 | 45 | 45 | 55 | 8 | 23 | 8 | 16 | 9 | 8 | 8 | 8 | 9 | 25 |
| Kick-off meetings. Collected data on current system's strengths and challenges | | | | Input on kick off data; issue prioritization. | Input on 1/19/18 MAP data. Data collection | Kick-off meeting | Youth wellness and suicide assessment | Input on kick off data; issue prioritization. | Review timeline, report structure. Ethics training. | Discuss survey approach | Review timeline & raw data | Ideas, thoughts & beliefs about mental health | Protective factors & mental health communication |

| YEAR 1 • QUARTER 4 | | | | | | | | YEAR 2 • QUARTER 1 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 7/12/18 | 7/20-07/22/18 | 7/11/18 | 8/10/18 | 8/14/18 | 9/10/18 | 9/12/18 | 9/26/18 | 10/15/18 | 11/5/18 | 12/15/18 |
| EVALUATION ADVISORY COMMITEE MEETING 5 | YOUTH GONA | NATIVE CIRCLE REPRESENTATIVES | MULTI-AGENCY MEETING 3 | EVALUATION ADVISORY COMMITEE MEETING 6 | NATIVE YOUTH AMBASSADORS | NATIVE CIRCLE REPRESENTATIVES | EVALUATION ADVISORY COMMITEE MEETING 7 | EVALUATION ADVISORY COMMITEE MEETING 8 | EVALUATION ADVISORY COMMITEE MEETING 9 | HOLIDAY GATHERING OF ALL 3 ADVISORY GROUPS |
| 5 | 26 | 8 | 19 | 8 | 9 | 8 | 8 | 5 | 5 | 100 |
| Review Needs Section | Asset Data Collected | Asset Data Collected | Asset Data Collected | Review Needs Strengths & Assets | Provide input on major themes of needs, strengths & assets | | Review Strengths & Assets | Approve CNS for dissemination | Plan next steps for EAC (training, adding new members, sharing information out) | Acknowledgement of contributions and results of work |

- GENERAL COMMUNITY RESOURCE OR GROUP OR ALL ADVISORY GROUPS
- SACRAMENTO COUNTY SYSTEM PARTNERS
- PARENT ADVISORY GROUP
- EVALUATION ADVISORY GROUP
- YOUTH ADVISORY GROUP

For Community Readiness Assessment (CRA) results, please see a report titled **"Sacramento Circles of Care Community Readiness Assessment and Social Marketing Plan"**

## SACRAMENTO COUNTY: FACTS & FIGURES

| | |
|---|---|
| **POPULATION** | 1,488,300 |
| **MEDIAN AGE** | 35.7 |
| **MALE** | 722,955 (48.6%) |
| **FEMALE** | 765,345 (51.4%) |
| **PER CAPITA** | $23,508 (2013) |
| **IMPORTANCE** | Capitol of California |
| **SIZE** | 6th largest city in California, 50th in the Nation. |
| **LOCATION** | In the center of the State, 90 miles East of San Francisco and 86 miles West of Lake Tahoe. |
| **LAND AREA AND USE** | 97 square miles, 25 feet elevation, significant agricultural uses, it is marketed as a "farm-to-fork" capital due to its numerous restaurants offering foods grown and raised in the region. |
| **WATER** | Located at the confluence of the American River and Sacramento River, it is a hub of river transportation and major deep-water port connected to the Pacific Ocean. |
| **HISTORY** | Hub of the gold rush and gold mining, terminus of the first railroad in 1856 and western terminus of the Pony Express in 1860. |
| **LESBIAN, GAY, BISEXUAL, TRANSGENDER** | At 10%, one of highest LGBT populations per capita, 3rd in California and 7th in nation. |

| | |
|---|---|
| **NUMBER OF TRIBAL NATIONS REPRESENTED** | 47<br>*Source: 2012-2016 American Community Survey 5-Year Estimates*<br>*This source of data is well documented as undercounting Native people* |

## HOW MANY NATIVE PEOPLE ARE THERE ANYWAY?

| | | | |
|---|---|---|---|
| **AI/AN ALONE** | 11,133 or 0.8% | | |
| **2 OR MORE RACES (ANY):** | 108,646 or 7.3% | | |
| **AI/AN & ANY OTHER RACE:** | 33,725 or 2.3% | | |
| **AI/AN & WHITE:** | 12,966 or 0.9% | **AI/AN & HISPANIC:** | 7,529 or 0.05%<br>*Source: 2012-2016 American Community Survey 5-Year Estimates* |
| **AI/AN & BLACK:** | 2,156 or 0.01% | | |

| | |
|---|---|
| **SACRAMENTO COUNTY'S NATIVE YOUTH POPULATION ESTIMATE** | The total youth population of Sacramento County is over half a million people (501,436). Depending on the racial definition used ("AI/AN Alone" or "AI/AN Alone or In Combination with One or More Races") the estimated Native youth population makes up somewhere between 4,011 and 11,533 individuals (or 0.3% to 0.8%). |

**FIGURE 10. SACRAMENTO COUNTY'S YOUTH POPULATION**

| | Number | Percent |
|---|---|---|
| Population under 5 | 99,866 | 6.7% |
| Population 5-9 | 100,822 | 6.8% |
| Population 10-14 | 100,508 | 6.8% |
| Population 15-19 | 96,125 | 6.5% |
| Population 20-25 | 104,115 | 7.0% |
| Total Sacramento Youth Population 0-25: | 501,436 | 33.7% |
| Estimated AI/AN Alone Youth Population (0.8%) | 4,011 | 0.3% |
| Estimated AI/AN Alone or in Combination with One or More Races (2.3%) | 11,533 | 0.8% |

*Source: 2012-2016 American Community Survey 5-Year Estimates*

**EDUCATION**

- Central to several local universities: University of California Davis, California State University Sacramento, University of the Pacific and Los Rios Community College District.
- 14 Unified School Districts in the County. Elk Grove, San Juan, Sacramento Unified, and Twin Rivers have the largest numbers of Native students. Native American students have some of the lowest graduation rates.
- Data does not include private school, charter school or home-schooled youth.

## NATIVE POPULATION OF ALL SACRAMENTO COUNTY PUBLIC SCHOOL DISTRICTS

**FIGURE 11. POPULATION FOR ALL SACRAMENTO COUNTY PUBLIC SCHOOL DISTRICTS**

| | Total | AI/ AN | | 2 or More Races | |
|---|---|---|---|---|---|
| Arcohe (K-8) | 451 | 1% | 5 | 5% | 21 |
| Center (K-12) | 4,477 | 1% | 39 | 6% | 275 |
| Elk Grove (K-12) | 63,061 | 0.60% | 401 | 9% | 5,656 |
| Elverta (K-12) | 288 | 2% | 6 | 9% | 25 |
| Folsom Cordova (K-12) | 20,312 | 0.40% | 84 | 6% | 1,237 |
| Galt (K-8) | 3,616 | 0.30% | 11 | 2% | 66 |
| Galt High (9-12) | 2,191 | 0.30% | 7 | 5% | 103 |
| Natomas (K-12) | 14,631 | 0.60% | 92 | 8% | 1,180 |
| River Delta (K-12) | 2,350 | 0.60% | 14 | 5% | 113 |
| Robla (K-6) | 2,284 | 1% | 26 | 3% | 64 |
| Sac City (K-12) | 46,815 | 0.60% | 275 | 6% | 3,013 |
| San Juan (K-12) | 49,255 | 1% | 459 | 4% | 2,115 |
| Twin Rivers (K-12) | 31,979 | 0.80% | 241 | 4% | 1,277 |
| Sac County Office of Edu (K-12) | 2,214 | 2% | 36 | 4% | 93 |
| **TOTAL OF ALL COUNTY SCHOOL DISTRICTS** | **244,394** | **0.70%** | **1,697** | **6%** | **15,238** |

| FIGURE 12. SACRAMENTO COUNTY'S HIGH SCHOOL GRADUATION RATES BY RACE/ETHNICITY | | | | |
|---|---|---|---|---|
| **Source: www.kidsdata.org** | **California** | | **Sacramento County** | |
| **RATE** | # | % | # | % |
| African American | 23,728 | 70.8 | 1,834 | 70.4 |
| AI/AN | 2,467 | 73.1 | 144 | 78.7 |
| Asian American | 40,843 | 92.6 | 2,379 | 90.9 |
| Filipino | 13,455 | 93 | 530 | 93.8 |
| Hispanic/Latino | 195,963 | 78.5 | 3,796 | 75.6 |
| Native Hawaiian/Pacific Islander | 2,299 | 82.2 | 239 | 86 |
| White | 113,367 | 88 | 5,290 | 84.8 |
| More than one race | 8,974 | 86 | 440 | 77.2 |

**JUVENILE JUSTICE:**

- Native Americans are twice as likely to report being the victim of a violent crime.
- American Indian youth are overrepresented in juvenile facilities. Excluding youth held in Reservation Facilities, American Indians make up 3% of girls and 1.5% of boys in juvenile facilities, despite comprising less than 1% of all youth nationally.
- There are more than 80 Reservation Facilities. https://www.prisonpolicy.org/reports/youth2018.html

## CHILD WELFARE INDICATORS:

When compared with all youth in the County and all Native youth in the State, Native youth in Sacramento County are experiencing higher rates of child abuse/neglect, higher participation in the foster care system, higher gang membership, more dating violence, higher rates of depression, and poorer overall indicators of health (see **Figure 18**).

**FIGURE 13. CHILD WELFARE DATA**

| Source www.kidsdata.org | | Population - All | | Native Americans | |
|---|---|---|---|---|---|
| INDICATOR | YEAR | Sacramento | California | Sacramento | California |
| Child Population (0-17) | 2016 | 358,835 | 9,118,201 | 1,542 | 34,215 |
| % of Children in Households Headed by Single Mothers | 2010-2014 | 21.6 | 18.7 | - | 27.1 |
| % of Children Living in Poverty (0-17) | 2014 | 24.0 | 22.7 | - | 29.3 |
| % Health Insurance Coverage (0-17) | 2015 | 97.7 | 96.7 | - | 92.2 |
| Reports of Child Abuse/Neglect (0-17): Rate/1,000 | 2015 | 57.3 | 55.0 | 133.4 | 115.3 |
| Substantiated Cases of Child Abuse/Neglect (0-17): Rate/1,000 | 2015 | 11.4 | 8.2 | 40.4 | 21.9 |
| Children in Foster Care (0-20): Rate/1,000 | 2015 | 6.8 | 5.8 | 32.7 | 21.4 |
| Gang Membership: Rate/1,000 | 2011-2013 | 7.6 | 7.9 | 16.4 | 10.2 |
| Experience Dating Violence: Rate/1,000 | 2011-2013 | 4.8 | 5.3 | 9.2 | 8.1 |
| 7th Graders Bullied Past Year: Rate/1,000 | 2011-2013 | 40.9 | 39.4 | 37.8 | 38.7 |
| 7th Graders Overweight or Obese: Rate/1,000 | 2015 | 35.4 | 38.5 | 45.3 | 44.8 |
| 9th Graders With Feelings of Depression: Rate/1,000 | 2011-2013 | 30.5 | 30.7 | 31.6 | 27.9 |

## SNAHC NATIVE YOUTH DEPRESSION & SUICIDE DATA

- Sacramento Native American Health Center screen patients for depression and suicide, if they present with mental health needs.
- 30% of all Native patients screened indicated that they were suicidal.
- 60% of youth under 18 were suffering from moderate to severe depression; 2.6% were suicidal.
- 49% of youths 18-25 were suffering from moderate to severe depression; 9.4% were suicidal.
- More than 10% of Native patients screened for depression were under 25.

## SUBSTANCE ABUSE IN YOUTH IN SACRAMENTO COUNTY

- Native youth in Sacramento County have higher rates of substance abuse than all other races.
- In the 2015-16 school year, Native youth had significantly higher rates of feeling sad or hopeless in the last 12 months than all other races (35.1% compared to 30.5%). Since then, these rates have fallen for all races and there is no longer a significant difference in the rates by race, which may indicate some progress is being made in this area.

**FIGURE 14. CALIFORNIA HEALTH KIDS SURVEY, 2015-2016, SUBSTANCE USE**

| | Native Americans | | All Other Races | |
|---|---|---|---|---|
| **INDICATOR** | **#** | **%** | **#** | **%** |
| Alcohol Use, Lifetime | 202 | 30.1 | 3368 | 24.1 |
| Alcohol Use, Past 30 Days | 110 | 16.5 | 1703 | 12.2 |
| Marijuana Use, Lifetime | 160 | 23.9 | 2315 | 16.6 |
| Marijuana Use, Past 30 Days | 85 | 12.7 | 12456 | 8.9 |
| Cocaine Use, Lifetime | 4512 | 9.5 | 362 | 3.8 |
| Felt Sad/Hopeless, Last 12 Months | 1285 | 29.3 | 3790 | 27.9 |

# COMMUNITY STRENGTHS

## OVERVIEW OF THE PROJECT AND GOALS OVER THREE YEARS

Sacramento County, and specifically the Native American community within the County, have significant strengths and resources that are important to the promotion, maintenance, and healing of mental health and wellness.

With three separate meetings in July 2018, SNAHC engaged youth, parents, community members, and multi-agency partners and providers to collect information on community assets: Cultural, Spaces/Places, People, and Healthy Activities. To inform the development of a Resource Guide, in-depth Information was collected from multi-agency partners on: Native Organizations, Mental Health Providers, General Support Services, and Helpers in the Community. All information presented here came directly from community members and service partners.

## SUMMARY OF ASSETS AND RESOURCES

**COMMUNITY:** Many people identified the broader Native community as a source of strength and a resource to help address mental health issues. Having a broader network of people who have similar backgrounds and life experiences is important for connection, health, and wellness.

**CULTURE:** Individuals identified their Native culture as a source of healing and guidance during difficult times. In particular, community members identified spiritual leaders, Native people, ceremony, and sweat lodge/Inipi as important factors in supporting healing and mental health.

*"Culture is prevention."*

– ALL QUOTES USED IN THIS DOCUMENT ARE FROM NATIVE AMERICAN COMMUNITY MEMBERS

**MENTORSHIP:** A factor strongly linked with both culture and community, and also identified as a need for youth, mentorship is an important factor in linking young people to information, knowledge and resources to help promote their growth and development into healthy adults.

**NATIVE AGENCIES:** Community members and agency partners reference the importance of having Native-serving agencies that hire staff that are from the Native community and have training and experience providing services to the Native population. These organizations tend to place a higher value on collaboration and coordination for the benefit of the people they serve. The Fatherhood is Sacred/Motherhood is Sacred group was identified as particularly beneficial for Native parents.

**SPORTS:** The importance of physical activity and sports and their role in both Native cultural identity and their impact on mental health has been a strong theme. Native people are avid sports enthusiasts. In addition, youth named exercise in general as very important to maintaining mental wellness.

**COUNTY, PARTNER & COMMUNITY RESOURCES:** Sacramento County has significant infrastructure and resources. The importance of the availability of mental health services, mental health hospitals, welfare services, and many other specific

organizations were highlighted as significant strengths and benefit.

**AWARENESS OF MENTAL HEALTH ISSUES:** There has been broad acknowledgement of the prevalence of mental health issues by the Native community at large, focus group participants, and the advisory board members. Individuals have been very open about discussing where issues exist. While there are also challenges in this area, mostly pertaining to stigma surrounding mental health issues and a lack of knowledge of what to do when a loved one is experiencing a mental health crisis, it is clear that there is some level of openness and willingness to engage in solutions to mental health challenges and the need to promote broader acceptance, identification, prevention and treatment of issues.

*"It's real and must be talked about to bring awareness."*

*"If we knew about this we would probably be doing more."*

**WILLINGNESS TO LISTEN TO YOUTH:** Community members understand the need to listen to young people when they come forward with problems. They are open to hearing them out and understand the need to link them with culture, ceremony, elders, mentors and mental health services so they can get the help they need.

*"I would ask if they are safe. I would be a listening ear and a shoulder to lean on. I would also tell them to smudge (clean) their energy and consider talking to a professional therapist. Other than that, I'll show complete love and respect. No judgment."*

*"People are waking up to these topics that affect our community. I see positive changes in the future."*

**FIGURE 15: STRENGTHS AS IDENTIFIED BY THE COMMUNITY**

| | |
|---|---|
| **ALL** | • Mentorship<br>• Safe Space<br>• Identity Development<br>• Trained Staff<br>• Cultural Competence<br>• Skill Building<br>• Support in Transition to Adulthood<br>• Awareness of Issues |
| **ADULTS** | • Identity = Culture/History<br>• Ceremony<br>• Family Services & Support |
| **YOUTH** | • Identity = Self/Social Development<br>• Music/Modern Culture |

## ASSET MAPPING

Asset Mapping was conducted in July 2018 in 3 separate sessions. The first was with 27 youth at the Gathering of Native Americans, followed by a meeting with 7 community members at the Native Circle Representatives Meeting (Parent Advisory), and with a meeting of 25 partners organizations at the Multi-Agency Meeting. This data is presented here, primarily using word clouds. All word clouds in the asset mapping portion of this report reflect the responses of the community. The larger an item is in the word cloud, the more times it was named. With each Figure presented, the source of the information was named. Participants were asked a general open-ended question which is noted under each section heading.

### CULTURAL RESOURCES THAT PROMOTE MENTAL WELLNESS

**QUESTION ASKED:** What are the cultural resources in your community that promote mental wellness and overall well-being? Data collected from youth and families

**FIGURE 16. CULTURAL RESOURCES**

**FIGURE 17. TYPES OF PEOPLE**

| |
|---|
| **ME, MYSELF & I** |
| **FAMILY:** MOM, GRANDMA, SISTER, CHILDREN |
| **COMMUNITY:** US, SIGNIFICANT OTHER, FRIEND, SPONSOR, DANCE CAPTAIN, SINGERS, LITTLE SNAHCS |
| **SPIRITUAL:** CREATOR, ANCESTORS, PEOPLE WHO HAVE PASSED, HEALERS, SPIRITUAL LEADERS |
| **HEALTH:** SOCIAL WORKERS, DOCTORS, COUNSELORS |
| **INDIVIDUALS:** SEE WORLD CLOUD |

**data in **Figure 17 (above)** is not presented in any particular order*

**FIGURE 18. PEOPLE ASSETS**


## PEOPLE THAT PROMOTE WELLNESS

**QUESTION ASKED:** Who are the people in your community that promote mental wellness and overall well-being? Data collected from youth and families.

**Figure 17** describes general types of people who are important in promoting wellness. The second names key individuals, which those who were mentioned more times showing up larger in the word cloud.

Many individuals were identified as having an important role in promoting mental health and well-being in the Native community (see **Figure 18**). All of these individuals are Native community members who bring a significant cultural influence to supporting other community members. These are key individuals who in their embodiment hold knowledge and information that is important for this project as it moves forwards.

Some of the roles the individuals named include:

- Youth Leaders - Aiyanna, Isa, Pablo Ruiz, David, Merissa, Cece, Annie, Paco, Cienna, Araya, Alena, Harry
- Principle of United Auburn Indian School and GONA facilitator - MJ, Mikela Jones
- Cultural and Miwok Language Advisor - Carlos Geisdorff
- Sacramento City Indian Education Coordinator - Christina Prairie-Chicken
- Community Elder - Mama Bear
- Addiction Counselor and Community Elder - Albert Titman
- Community Elder, Spiritual leader and Dance Captain – Razz
- Community Elder and Community Advocate - Alex
- Founder of the Native Dads Network and Addiction Counselor – Mike
- SNAHC Board Member - Crystal Blue

## PLACES AND SPACES THAT PROMOTE MENTAL WELLNESS

**QUESTION ASKED:** What are the places and spaces in your community that promote mental wellness and overall well-being? Data collected from youth and families (see **Figure 19**).

Community members named a broad range of spaces and places as important in promoting mental wellness. These include natural spaces, culturally-rooted space, community organizations and spaces, and also private locations.

**FIGURE 19. PLACES AND SPACES**


**SNAHC**
Sacramento Native American Health Center

**SSTF**
Shingle Springs Tribal TANF

**GONA**
Gathering of Native Americans

**AISI**
American Indian Summer Institute

*Sacramento Republic (Professional Soccer Team) Native American Heritage Night*

## HEALTHY ACTIVITIES THAT PROMOTE MENTAL WELLNESS

**QUESTION ASKED:** What are the activities in your community that promote mental wellness and overall well-being? Data collected from youth and multi-agency partners (see **Figure 20**).

**FIGURE 20. HEALTH ACTIVITIES**

## RESOURCES THAT PROMOTE MENTAL WELLNESS

**QUESTION ASKED:** What are the resources in your community that promote mental wellness and overall well-being? Data collected from youth, families, and multi-agency partners.

The resources on this list were simply named and have not be reviewed or vetted for efficacy or capacity to work with Native people (see **Figure 21**).

### NATIVE POPULATION OF ALL SACRAMENTO COUNTY PUBLIC SCHOOL DISTRICTS

**FIGURE 21. SERVICES IN SACRAMENTO COUNTY**

| | |
|---|---|
| **NATIVE HEALTH** | |
| Chapa De Health Clinic | Medical, Dental, Behavioral Health Care |
| Northern Valley Indian Health Clinic | Medical, Dental, Behavioral Health Care |
| Sacramento Native American Health Center (SNAHC) | Medical, Dental, Behavioral Health Care |
| Shingle Springs Health and Wellness | Medical, Dental, Behavioral Health Care |
| **NATIVE EDUCATION & CULTURE** | |
| 5th Direction | Talking circle, protective factors supports, sports. |
| California Indian Man Power Consortium (CIMC) | Job assistance, Advocacy, Elder programs, Youth Programs, Small Business education training |
| California Rural Indian Health Board (CRIHB) | Advocacy and Training |
| Elk Grove Indian Education | Student engagement |
| Inter Tribal Council of California (ITCC) | Domestic violence prevention, childcare. |
| Native Dads Network | Advocacy and Training, Community events |
| Native Education Raising Dedicated Students (NERDS) | positive peer-to-peer mentoring, raising funds for education, cultural support services, scholarship and intern opportunities |
| Shingle Springs Tribal TANF (SSTTP) | TANF, employment education, wellness, culture |
| San Juan School district Indian Education | Student engagement |
| Sacramento City School District Indian Education | Student engagement |
| Sol Collective | Provide artistic, cultural, and educational programming, promote social justice, and empower youth of color, marginalized, and underserved communities through art, activism, music, and media |

| FIGURE 21. SERVICES IN SACRAMENTO COUNTY (...CONTINUED) | |
|---|---|
| **NATIVE ORGANIZATIONS** | |
| Indian Heritage Center Foundation | Supports special events, outreach and education |
| United Auburn Indian Community | Preserving Culture, and enriching the community through economic development and education services |
| Ione Band Of Miwok Indians | Tribal Organization |
| Wilton, Buena Vista, Ione band | Tribal Organization |
| Yocha Dehe Wintun Nation | Tribal Organization, Culture preservation, Advocacy |
| **NATIVE-FOCUSED ADVOCACY ORGANIZATIONS** | |
| Sacramento Native Caucus | Works to increase educational, economic, and social opportunities while preserving cultural heritage of the state's minority populations |
| California Consortium of Urban Indian Health (CCUIH) | Urban Indian Advocacy. Centralized management of community health organizing, training and technical assistance, public education, and policy advocacy |
| California Indian Legal Services (CILS) | Legal Advocacy, protection of burial remains, sovereignty, freedom of expression, school discrimination |

| FIGURE 21. SERVICE PROVIDING ORGANIZATIONS | |
|---|---|
| **HEALTH** | **SERVICES** |
| Sacramento Community Support Team (County Dept of Human Services) | Referral and Intervention |
| Consumer Self Help (Non-Profit) | Mental Health Support Groups |
| Covered California (State) | Medical & Dental Insurance |
| Alcoholics/Narcotics Anonymous (Non-Profit) | Peer Support Addiction Groups |
| Quality Child Care Collaborative (Non-Profit) | They promote the education and social welfare of children and families and to advocate on their behalf. Programs include resource and referral services for families seeking child care, child care subsidies for qualifying families, recruitment and professional development of the child care workforce, and family education and support |
| HEARTS for Kids | HEARTS for Kids ia a multi-disciplinary early intervention program that provides in-home services to foster children to support their social and emotional development |

| FIGURE 21. SERVICE PROVIDING ORGANIZATIONS (...CONTINUED) | |
|---|---|
| Sacramento Children's Home (Non-Profit) | Family Resources, Crisis Nursery, Counseling Center, Residential Program, Transition Age Program, Wraparound Program, Educational Program, eVIBE (This program helps the kids with social issues and helps kids build strong relationships with their parents and other kids. It teach kids "social skills, violence prevention, and conflict management") |
| Sac EDAPT (Early Diagnosis and Preventative Treatment Clinic) (Funded through MHSA/Prop 63 - See Full Service Partnership for more details) | A unique collaboration between UC Davis Department of Psychiatry and Sacramento County Mental Health to provide state-of-the-art care to transition-age youth who are experiencing the earliest stages of psychosis (Comprehensive Psychiatric Assessment, Medication and Case Management, Individual Psychoeducation and Support Groups, Multi-family Psychoeducation and Support Groups, Supported Education and Employment, and Peer and Family Advocate Support |
| Mobile Crisis Response Teams- includes the Children's Crisis Stabilization Unit (4 in total; City wide, South Patrol, North Patrol, Citrus Heights/Folsom) (County Dept of Human Services) | The Minor Emergency Response Team is a crisis intervention and stabilization unit for children and youth ages 0-18 years who are experiencing a psychiatric emergency. Youth can be seen at the MERT unit located within the Sacramento County Mental Health Treatment, 7 days per week, 365 days per year, between the hours of 10 a.m. and 7 p.m |
| Saint Johns Program for Real Change (Non-Profit) | Mental Health Services (individual, group, family) for children and mother's in crisis, supportive services (housing, transportation, education), career placement center, on-the-job training, respite center |
| A Church for All (Non-Profit) | The Ripple Effect Mental Health Respite Center |
| Transcultural Wellness Center (Non-Profit) | The TWC is an outpatient mental health service program designed to provide a full range of coordinated therapeutic and support services for all ages, including children, transitional age youth, and older adults, with a special emphasis on the Asian and Pacific Islander language and cultural groups in Sacramento County. |
| Sacramento County Access Team (County Dept of Human Services) | Access to Mental Health Services |
| **LEGAL /ADVOCACY** | **SERVICES** |
| Black Child Legacy Campaign | Advocacy and services around African American Child death |
| Social Worker, Native American Liaison (by special request) | Native family preservation in support of Indian Child Welfare Act |
| Each Mind Matters | Advocacy and information around Mental Health |
| Native American Special Skills Social Worker (County Dept of Human Services) | Provides services to Native Amerian children within the CPS system, if specifically requested by the family |
| Legal Service California (Non-Profit) | Free and pro bono legal advice |
| Mental Health America (Non-Profit) | Mental Health Advocacy |

| FIGURE 21. SERVICE PROVIDING ORGANIZATIONS (...CONTINUED) | |
|---|---|
| Mexican Consulate | Counseling and immigration support |
| Omni Youth (Non-Profit) | Develop youth leaders and engage the community to prevent youth alcohol and marijuana use |
| Terra Nova (Non-Profit) | Terra Nova's clinical staff often use evidence-based practices (EBPs) to provide services to the children entrusted to us. Terra Nova staff use EBPs such as Parent-Child Interaction Therapy (PCIT) Dialectical Behavior Therapy (DBT), and Trauma Focused Cognitive Behavioral Therapy (TF-CBT). They do individual and family counseling, in addition to educational classes |
| Terkensha Associates (Non-Profit) | Individual Therapy, Group Therapy, School Based Services, Psychiatric and Medication Services, 24 Hour Crisis Intervention (people are referred here via ACCESS team) |
| Sacramento Area Congregations Together (ACT) (Non-Profit) | A multi-racial, multi-faith organization advocating a transformation of our community rooted in our shared faith value |
| **FOOD** | **SERVICES** |
| Loves and Fishes (Non-Profit) | Homeless services, advocacy, hot meals |
| River City Food Bank (Non-Profit) | Emergency food, based on income |
| Sacramento Food Bank (Non-Profit) | Food, community distribution, refugee assistance and support |
| St. Vincent de Paul (Non-Profit) | Food, clothing, direct financial assistance for rent, utilities, transportation, beds and furniture |
| **SHELTER / HOUSING** | **SERVICES** |
| Bringing Families Home Program (County Dept of Human Services) | Housing support for homeless children |
| Community for Peace (Non-Profit) | Domestic support services, respite, counseling services, emergency shelter, legal services, training |
| Family Support Rapid Rehousing (County Dept of Human Services) | Housing support |
| Family Support Rapid Rehousing (County Dept of Human Services) | Housing support |
| Guest House (El Hogar) (Non-Profit) | Emergency shelter, Full-Service Partnership |

| FIGURE 21. SERVICE PROVIDING ORGANIZATIONS (...CONTINUED) | |
|---|---|
| Mutual Housing California (Non-Profit) | develops, operates and advocates for sustainable housing |
| ReMarcAble Enterprise (Non-Profit) | Room and Board for men and women |
| Sacramento Steps Forward (Non-Profit) | Homeless Emergency Assistance and rapid Transition to Housing |
| St. Francis Women/Family Shelter (Non-Profit) | Emergency shelter |
| Transitional Foster Care for Youth | Advocacy for transitional youth in foster care |
| Union Gospel Mission (Non-Profit) | Emergency shelter for men in recovery |
| Volunteers of America (VOA) (Non-Profit) | Eviction prevention, emergency services, transitional housing and permanent affordable housing |
| Wind Youth Services (Non-Profit) | Street Outreach, Drop-In Center, Housing Programs, Emergency Youth Shelter |
| **OTHER RESOURCES** | **SERVICES** |
| Cal Works Wellness Team (County Dept of Human Services) | Welfare services for parents of young children |
| "Friends for Survival (Non-Profit)" | Suicide Bereavement; a national non-profit bereavement outreach organization available to those who are grieving a suicide death of family or friends. Also to professionals who work with those who are grieving a suicide tragedy |
| Juvenile Justice Diversion and Treatment Program (County Dept of Human Services) | JJDTP is a Full Service Partnership for probation-connected youth and their families, designed to enable youth with a Serious Emotional Disturbance and current involvement in the juvenile justice system to remain in their homes, schools and communities by providing a comprehensive array of mental health services and supports. Youth are referred between the ages of 13 and 17 years and may participate up to age 26. Goals include stabilizing placements, reduce homelessness, support academic participation, increase vocational or employment opportunities, reduce psychiatric hospitalizations and detention or incarceration. |
| LGBTQI Center (Non-Profit) | Support groups and services for this population- includes drop-in center, support groups, and youth events (all youth focused) |
| Mental Health Services Act, Full Service Partnership (FSP) (State) | State tax provides mental health services to underserved populations with goal of filling gap in existing services. The FSP provides on-call 24-hour services to the highest risk individuals. |
| North Sacramento Family Resource Center (FRC) (Non-Profit) | Home Visitation, School Readiness, Parent Workshops, Crisis Intervention, Group Activates, Full Service Partnership |

| FIGURE 21. SERVICE PROVIDING ORGANIZATIONS (...CONTINUED) | |
|---|---|
| Paradise Oaks (Non-Profit) | Paradise Oaks Foster Family Agency provides treatment foster care. The agency is designed to accept boys and girls between the ages of 0-17. Boys and girls are thoroughly screened to determine appropriateness for placement in a Certified Foster Family Home through a review of educational, social, psychological, and psychiatric records. Those identified as appropriate for Foster Family placement need a caring and loving home in which the foster children can grow and develop. |
| PRIDE Industries (Non-Profit) | Vocational Rehabilitation & Training, Employment Choice, Transition Services, Independent Living, Youth Services |
| Salvation Army (Non-Profit) | Food boxes, Rental assistance, Utility bill assistance, Back to school uniforms, backpacks, Emergency lodging/Shelter, work force development |
| School District Liaison for Homeless Families and Youth (County Dept of Human Services) | Supports the enrollment, attendence and achievement of homeless students to ensure they receive equal access to educational opportunities. Services include: school enrollment, attendence support, records retrieval, school and hygiene supplies, health/ immunization referrals, shelter/housing referrals, and education support (this is a result of the McKinney-Vento Homeless Assistance Act) |
| Stanford Youth Solutions (Non-Profit) | After-school groups (These groups assist children in developing important interpersonal skills necessary for success in their homes, schools, and communities), Supportve services to schools (attendence and behavioral issues), adovates for parents, and they have a teen center |
| Suicide Helpline | Suicide Support |
| Transforming Lives, Cultivating Success (TLC) (Non-Profit) | Mental Health Crisis Respite Center, Case Management, Psychiatry, Advocacy and Referral, Employment support, Recovery support, Drop In Clubhouse,<br>Full Service Partnership |
| United Cerebral Palsy Association of Sacramento and Northern California (Non-Profit) | Respite Care, Adult Day Care, Transportation for people with disabilities |
| WEAVE (Non-Profit) | Support Groups & Grief |
| **HOSPITAL** | **SERVICES** |
| Folsom Sierra Wellness Clinic (Non-Profit) | The Folsom Sierra Wellness Clinic provides mental health treatment for adults and adolescents in the Folsom, California area. Folsom offers partial hospitalization program, dual diagnosis hospitalization program and intensive outpatient program for adults. For adolescents, ages 13-17, the clinic offers an after school based intensive outpatient program. |
| Heritage Oak Behavioral Hospital (Non-Profit, FSP) | Heritage Oaks Hospital is a psychiatric hospital that provides treatment to teens, adults, and senior adults struggling with mental illness or addiction issues. They offer inpatient and outpatient care at our main location in northern Sacramento and deliver outpatient services in West Sacramento and Roseville. |
| Kaiser Permanente (Private) | Mental Health Services, including a 24/7 hotline, in Sacramento. Wellness coaching, support groups, therepy, medication assistance. |

| FIGURE 21. SERVICE PROVIDING ORGANIZATIONS (...CONTINUED) | |
|---|---|
| Mercy General Medical Hospital (Private) | Mercy Medical Center's Behavioral Health Services have been meeting the behavioral health needs of the community since 1958 and are staffed by caring, qualified health professionals, including psychiatrists, psychiatric nurse practitioners, licensed clinical social workers, licensed mental health counselors, registered nurses, licensed creative arts therapist, activities therapists and behavioral health aides. |
| River City Recovery | River City Recovery Center is a comprehensive residential treatment program which addresses all aspects of the disease of alcoholism and drug addiction. They offer a highly structured program of education and counseling. Residents receive an intensive education on the physical, psychological, social and spiritual effects of alcoholism and chemical dependency. They developed a thorough curriculum that includes the medical implications of substance abuse, emotional and spiritual recovery, relapse prevention, anger management, family aspects and goal setting. Residents receive both group and individual counseling, wherein we employ selected elements of cognitive behavior therapy. Personnel onsite 24-hours a day. |
| Sierra Vista Hospital (Non-Profit, FSP) | Located in Sacramento, California, Sierra Vista Hospital is a behavioral health facility and a center of support for adult and adolescent patients and their families. They offer clinical expertise to those suffering from behavioral health disorders or dual diagnosis. Sierra Vista, is a private 171-bed facility is home to a clinical team of licensed professionals committed to providing the highest quality care. They also provide inpatient alcohol detox and outpatient chemical dependency services. |
| Sutter Health | Their Behavioral Health Department features" Addiction Treatment, BH Care for Seniors, Outpatient services, Child and Adolescent BH, Eating Disorder Treatment, Electroconvulsive Treatment, Inpatient Psych Services, Interventional Psych, Partial Hospitalization and Intensive Outpatient Care. |
| The Child and Adolescent Psychiatric Services (CAPS) Clinic | provides psychiatric assessment, medication support, psychological testing and mental health services to children and youth. Medication focused case management services are<br>also provided. |
| UC Davis Medical Center | The Department of Psychiatry and Behavioral Sciences at UC Davis provides clinical services at a number of locations throughout the greater Sacramento area. Faculty and residents also provide services at three County of Sacramento regional clinics, a cross-cultural outpatient clinic, and a homeless mentally ill clinic. The Department has a child and adolescent psychiatry division, a forensic psychiatry division, and a clinical neuroscience division. The Department has four accredited residency programs: general psychiatry, child and adolescent psychiatry, family medicine/ psychiatry, and internal medicine/psychiatry. It also supports fellowships in forensic psychiatry and psychosomatic medicine. |
| **FEDERALLY-QUALIFIED HEALTH CENTERS** | **SERVICES** |
| Peach Tree | Medical, Dental, Vision |
| Planned Parenthood | Abortion Services, Birth Control, General Health care, HIV services, LGBT Services, Men's Health, Patient Education, STD Testing, women services |
| Well Space Health | Child, Adult primary care, Dental, women health, Prenatal, counseling & Prevention |
| Sacramento Native American Health Center (SNAHC) | Medical, Dental, Behavioral Health Care |

**FIGURE 21. HEALTH CLINICS & HOSPITALS**

| EMERGENCY | SERVICES |
|---|---|
| Sacramento Crisis Nursery (County Dept of Human Services) | Emergency Crisis child care for children under 5 years old |
| Sacramento County Mental Health Treatment Center (County Dept of Human Services) | Psychiatric Health Facility and Intake Stabilization Unit |
| Urgent Care Clinic-Sacramento County Mental Health (Non-Profit, FSP) | Peer support, psychiatric medication evaluation, crisis intervention and counseling, referral and linkage |
| **MENTAL HEALTH PROVIDERS** | **SERVICES** |
| Stars Behavioral Health Group, Capital Star (Non-Profit, FSP) | "They offer a Full Service Partnership (FSP) program for young adults ages 16-25 that provides mental health services and supports young people's independence. Treatment includes involving Transition Age Youth (TAY) in their own futures planning related to employment, education, living situations, and more. The youth learn skills like budgeting and meal preparation, and most importantly, they will also develop their own personal toolkit with coping techniques. Services include: Individual and Family Counseling,Psychiatric Care,Medication Management,Crisis Intervention Services,Housing,Education,& Vocational Support,Independent Living Skills Development,Peer support,and After-School Groups/Activities. Capital Star Community Services provides these services 24/7, including needs assessment, crisis intervention, harm reduction education, linkage and referral to needed resources and support. The center also includes a TAY Hot Spot where young people can come for vocational support, educational support, parenting skills workshops, housing referrals, mental health services, and more." |
| El Hogar | Personal Growth Associates (PGA) provides behavioral health counseling and psychiatric services to individuals of all ages experiencing mental health challenges; El Hogar operates one of four "Regional Support Teams" (RST) for adults living in the greater Sacramento area. El Hogar's RST helps consumers work through the addiction and/or mental health challenges that get in the way of daily living; The Guest House Homeless Clinic Offers outpatient medication and mental health support services to adults experiencing homelessness and struggling with mental health challenges. |
| Gender Health Center (Non-Profit) | Gender Health Center is a non-profit organization meeting the counseling needs of the whole community in Sacramento and the surrounding areas by making our services accessible to the most underserved communities, including the LGBTQQI community and focusing on the "T" or transgender. They provide excellent counseling/therapy services to anyone who expresses the need as well as anyone who self identifies or is perceived to be gender variant. Their services embrace the psychological well-being and self-fulfillment of individuals coming out and/or beginning or in the transition process in a safe, supportive and welcoming environment. Services include: counseling, advocay, respite, hormone prescription clinic, and name and gender change assistance. |

| FIGURE 21. HEALTH CLINICS & HOSPITALS (...CONTINUED) | |
|---|---|
| La Familia (Non-Profit) | Birth & Beyond – Nurturing Parenting Program (NPP), Project Reach (Positive alternatives, counseling and support services for youth ages 10-21 who are at risk of dropping out of school, or are pre-gang and/or gang affiliated), Mental Health Services (Children and youth, ages 0-21, residing in Sacramento County, Sessions can be held at home, school sites, La Familia office, or various locations as requested by families. Medi-Cal insurance only. Parent Youth advocate are available to assist families with support & resources), Crisis Intervention Specialist, Child Development Groups, Club Excel (Recreational activities, arts and crafts, youth leadership development, GED preparation and workshops for youth), Project Youth Voice (Project Youth Voice provides youth leadership training, community workshops on violence prevention, and education on other health related issues), Karate, Community Collaborative Charter School, Counseling, Redirective and Supportive Services ( At-risk children and youth, ages 10-21; Counseling and support services through support sessions at home, school, or the La Familia office). |
| My Sister's House (Non-Profit) | 24-hour helpline, shelter program, counseling, parent education, legal support for immigration and domestic violence |
| National Alliance on Mental Illness (NAMI) (Non-Profit) | Peer support groups, education programs, advocacy in mental health, helpline, mental illness awareness |
| River Oak Center For Children (Non-Profit, FSP) | Children's Mental Health provider |
| "Terkensha (Non-Profit, FSP)" | Children's Mental Health provider |
| Turning Point (Non-Profit, FSP) | Children's Mental Health provider |
| Sacramento Mental Health Access Team | Crisis intervention, mental health assessments, therepy and/or rehabilittaion services, intensive home-based services, skills building and support groups, case management, intensive care coordination, linkage to community resources, medication support, Services for Youth with coexisting Mental Health and Alcohol/Substance Abuse Disorders. |
| Another Choice Another Chance (Non-Profit) | "Children's General & Specialized Mental Health Services. Individual and group counseling, Trauma Counseling, Mental Health Therapy, Intensive Outpatient, Partial Hospitalization, Residential Programs" |
| Sierra Forever Families (Non-Profit) | Children's General & Specialized Mental Health Services- specializes in foster adoption. Sierra Forever Families provides a full range of programs and services to support each family and child. From the first contact through to post-adoption, Sierra is there at every stage of the lifelong journey |
| Visiona Unlimited Inc. (Non-Profit) | Children's General & Specialized Mental Health Services-Visions Unlimited's Regional Support Team (RST) provides outpatient recovery-based and culturally appropriate specialty mental health treatment and support services for adults (ages 18 +) struggling with severe and persistent mental illness. They also do Early Periodic Screening, Diagnosis, and Treatment Program |

| FIG 21. INDIVIDUALS | |
|---|---|
| **PEOPLE** | **ROLE** |
| Albert Titman | Elder, Traditional & Cultural Teacher, Spiritual Advisor |
| Alexanderia Russell | Elder, Mentor, serves on the Native American Caucus in Sacramento |
| Athalia Chambers | Sacramento Native Caucus and Cobell UC Davis Scholarship application reader |
| Calvin Hedreck | Does Youth Programming throughout the state of California, works to change school curriculum-particuraly the mission project- throughout CA, provides leadership skills to Native youth and does cultural competency training to Native serving orgs, Program Director of The 5th Direction |
| Claire Brown | Outreach Coordinator at Acadia Health Care |
| Dr. Alok Banga | Psychiatry & neurology - child & adolescent psychiatry |
| Dr. Jefferey Applebomb | Psychiatry |
| Dr. Katherine Elliot | Researcher |
| Dr. Robin Zasio | Psychologist in Sacramento, CA. She specializes Cognitive Behavioral Therapy and Exposure and Response Prevention techniques |
| Jesse Archer | Youth program manger at LGBT Community Center |
| Martha Sinclair | Program Director at El Hogar Community Services Inc, Sierra Elder Wellness Program |
| Mary Nakamura | Cultural Competence & Ethnic Services / Workforce Education & Training Health Program Manager |
| Mary Thompson | Spirirual leader, elder, traditional and cultural teacher |
| Mike Duncan | Traditional and Cultural Teacher, Executive Director of Native Dads Network |
| Rachel Guerrero | Ms. Guerrero is a nationally recognized leader in the field of mental health and cultural competence. She has held several positions around the state including working for a county, Department of Social Services and in child welfare services, juvenile justice, and as an out-patient mental health service provider where she worked for ten years as a child family therapist |
| Rice Wheeler | Unknown |
| Dr. Parikh | Unknown |
| Nathan Desyrs | Unknown |
| Cynthia Folz | Unknown |
| Erin Barret | Unknown |

# NEEDS ASSESSMENT: CROSS-CUTTING ISSUES

In identifying, addressing, and treating mental health issues and improving mental wellness for Native youth in Sacramento County, multiple issues were stressed as being essential. This report provides information collected from the community, including over 100 community members (youth, family, elders), representatives from over 65 service partner agencies, and guidance from the project's 25 youth and community advisory board members. Cross-cutting issues that apply to all aspects of this initiative include the need for **safety,** and the importance of **culture** and **identity.** Additionally, and related to these other issues, is the need for culturally appropriate services.

**SAFETY:** Everyone, particularly youth, stressed the need for safe spaces and that "kids need to feel comfortable." Having a place to explore their identity and get support that is free from stigma and the judgement of peers, parents, and others topped the list. Youth stressed the importance of connecting with other youth, finding a place where they can be heard and the general need for trauma-informed care.

*"Ceremonies and community gatherings are protective factors."*

*"The stigma is real and needs to be removed because they should not feel ashamed."*

**CULTURE:** The importance of culture and the need to connect youth to culture, spirituality, tradition, and language was emphasized broadly. Parents and elders felt it essential that youth know their history. Youth were much more focused on safety, engaging the family for support, and the opportunity to explore mainstream youth culture and their own identities; however, they did emphasize the need to have trained professionals who understand and are able to work with Native people. Families encouraged the use of ceremony as a healing factor. Finally, the need for mentorship and development of youth is another strong theme with a cultural basis.

*"Connect mental health and wellness to ceremony, bring it to the community, go to them."*

*"If I were to create services to meaningfully impact and improve Native youth mental health and wellness I would make a youth center where you can be yourself, start over, there's no bullying, it's independent, and you can hang out with other youth and learn about culture."*

*"Let [youth] develop the culture because they are the ones who will be taking it. Hip hop speaks to their lives like ceremony doesn't... Songs tell stories."*

**IDENTITY:** Identity and Identification are also significant issues. This was a hot button issue with a broad range of perspectives. Intersecting identities are a significant part of the Native experience in Sacramento County. Parts of the county are rural, including the ancestral homelands of multiple tribes, while other parts are urban and a former relocation center, providing a home to indigenous people from across the nation and other countries. In addition to ancestral identity and relocation, there are many Native people from tribes that were terminated by the US government and carry no American Indian political status today. Others have been disenrolled from their tribes for various reasons, typically related to control of resources. Finally, and not without significant consequence, is the matter of being mixed race. This is a huge issue for Native people as both inter-tribal and inter-racial mixing are quite common. This will be revisited under data.

*"Address historical and intergenerational trauma."*

*"…Focus on knowing where you come from: roots, history, and ancestry."*

*"[There is] a tendency to lump all Native youth under one umbrella and not recognize the different culture of each youth."*

*"We are not in this box delineated by membership, but grants sometimes require that."*

It should be noted that identity is a very broad topic with a lot of varying opinions. People stated that there was a strong sense of "not being Indian enough" for some members of the community, and others felt that lateral oppression was overwhelming. There is an intense feeling that the impact of historical and intergenerational trauma is alive and well in the community and is propagated by how Native people interact with one another. In discussion of identity youth again did not share the same perspectives as parents and elders. This disagreement aligns with social development and the process of individual identity development. Parents were more likely to emphasize the importance of knowing one's own culture, traditions, and history. Youth felt the most important thing was to have a safe place to explore one's identity and identities, whatever that might be and wherever it might take them.

*"More Indian than YOU!"*

*"Less racism against our own race - let [people] know they belong in the community."*

**CULTURAL COMPETENCE:** A common theme was the need for culturally competent services and service providers to work with the Native community. There is a lack of professionals trained to work with the Native community or coming from it. In particular, the community cites a lack of knowledge around the Indian Child Welfare Act (ICWA) and how to apply it, as well as a general misunderstanding of what cultural competence is. For example, stating "I don't see color" as a

response to racially-unique challenges dismisses the discussion rather than working to address the issues.

*"The ones, services, that exist are very general."*

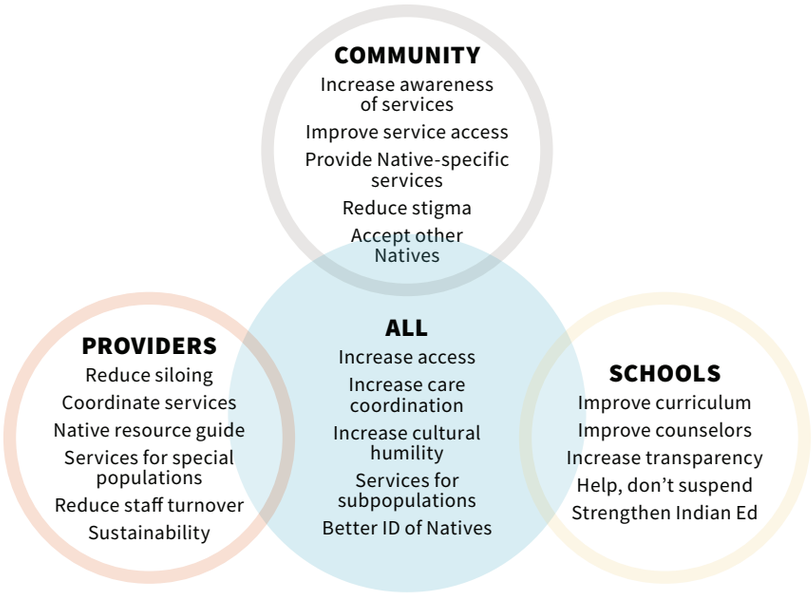
*"Services don't have culture appropriateness."*

# NEEDS ASSESSMENT: SPECIFIC ISSUES

## SYSTEM CHALLENGES

**SYSTEM:** Both community members and system partners provided insight into the challenges that exist in accessing services. Notably, system partners reported: the system they work in is dysfunctional, there is a tendency to focus on one's own work area with little collaboration, and

**FIGURE 22: SUMMARY OF NEEDS AS IDENTIFIED BY SACRAMENTO COMMUNITY AND PROVIDERS**



there is a need for improved care coordination services. Another prevalent theme was the lack of culturally-competent workforce to treating Native people. Community members reported the following factors were challenges to utilizing services:

1. **ACCESS**
   - Not enough services
   - Wait times can be too long
   - It is unclear how to access services
   - There is a need for transportation; services are located far from people's homes
   - Childcare is needed to engage services
   - There can be a lack of continuity of care because of service limitation
   - There aren't enough services for special groups: homeless youth; special needs/ disabilities
   - Lack of sustainability; difficult to retain crisis workers due to high turnover

2. **CARE COORDINATION** - It is difficult to navigate the system

3. **CULTURAL COMPETENCY**
   - Services are too general for Native people
   - There isn't sufficient training on how to work with Native people
   - Indian Child Welfare Act (ICWA) is not being implemented correctly
   - There is a need for complementary/ alternative health services

*"If Natives are mixed, they do not get the opportunity to be counted, funded, or targeted for programs that address their culture or get services for their culture. Multicultural issues are not addressed and they are forced to identify as 'one.'*

**DATA:** An overwhelming issue is the lack of good data on Native people and the fundamental reason for this is low quality identification. A lack of systematic approaches to identifying and collecting race data in general, and on Native people in particular, is responsible for this poor source of data. Every system has a different approach, some using a 3rd party system where a provider simply looks at the individual to be identified and then assumes that person's race. Some systems allow individuals to self-identify, while others require Native people provide proof of tribal enrollment. The most significant issue is that many systems, including county mental health, do not allow individuals to self-identify as more than one race (MTOR). Those who do identify as MTOR are asked to check one box to signify such, meaning that no finer data is collected on the specific races of these people. Often the MTOR (sometimes called 'Other') includes Native people of more than one race. It is possible that Native individuals of MOTR could be of higher risk when it comes to mental health issues, due to the challenge of not knowing where or which racial group they are accepted by, and that identifying

these people should be a high priority. The lack of good systems for collecting race data on Native people reinforces the myth that Native people no longer exist and compounds feelings of invisibility. The lack of specialized processes to collect this data by existing systems demonstrates a lack of political will to address the needs of this population.

**RESOURCE GUIDE:** There needs to be a central resource for individuals working with Native youth and their families. There are pockets of expertise in working with Native people but not a strong centralized place for updating this information or resources for maintaining it.

## NATIVE YOUTH AND FAMILY SERVICE NEEDS

There was a lot of feedback about the overall need for services for both youth themselves as well as for their families.

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*"Empowerment."*

*"The most important thing is having someone to talk to."*

---

Specific service supports that were requested by the community include:

- Youth Center
- Academic/Career Support
- Skill-Building Activities
- Community Service – elders, single adults, mothers
- Cultural Classes – drum, language
- Talking Circles – non-hierarchical sharing space
- Sports/Physical Activity – organized Native games

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*"A safe haven for youth."*

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**YOUTH SERVICES:** There was overwhelming feedback about the need for youth to have: a safe space; a place to create and develop peer-to-peer relationships with other Native youth; and the need for role models and mentors. Further, the need for young people to have general guidance and support transitioning to adulthood, in an environment that supports development of positive self-esteem and helps young people find their passion was strongly emphasized. Youth particularly stated the desire for a safe space, a place to meet other Native youth, and have Talking Circles. However, they were less insistent than older community members that these services must have Native history and culture as their main focus. Rather, the emphasis was on having a safe place to explore and develop one's own personal identity, as a Native person but also as a Sacramento youth.

---

*"Validate their experiences."*

---

**FAMILY/PARENT SERVICES:** The need for supportive services for the entire family was another important theme. Families expressed that mental health issues often run in the family and that there is a strong need to build a transgenerational support system. There was a particular concern expressed for youth that are living within dysfunctional families and in need of help. Services requested include: a youth/parent (or guardian) group, a parenting group, support for grandparents raising grandchildren and more in-home services.

*"It's important for parents to be involved with the child and young adult to keep them involved in our culture and community... This world we live in now conflicts with traditional Native values because we spend so much time away from families."*

*"…supporting adult family members is also important, also supporting the full additional family members that may not understand how the functioning of mentally challenged adults/parents and/or children so no one is stigmatized from lack of knowledge or awareness on onset of teenage or adult psychosis, for example."*

## AWARENESS AND SOCIAL STIGMA CHALLENGES

**AWARENESS OF SERVICES:** Community members overwhelmingly report the need to increase awareness of the availability and type of mental health services available. They recommend more health fairs, more advertisement and more informational pamphlets.

*"Community needs more awareness of services available and more connections between different agencies so people can share knowledge and services available as well as events."*

**EARLY INTERVENTION AND COORDINATION:** It is important to identify youth that need support early, so that they don't suffer and fall through the cracks. The community is aware of mental health hardships and that some youth need a lot of help. Having resources available to help earlier in the onset of issues would be highly beneficial. Related to the necessity of early intervention is the need for better coordination and continuity of services once people struggling with mental health issues have been identified.

*"There are no culturally appropriate treatment centers for youth mental health."*

*"There is no referral system to a Native resource."*

**STIGMA:** Many community members noted there is stigma associated with receiving mental health services, having mental illness, or going to the part of the clinic that provides these services.

Further nuanced, there was a sense of normalcy around mental health challenges; seeking treatment is unnecessary because the conditions are so common. Intergenerational factors also contribute to stigma challenges – older people can have a 'tough it out' approach or a different perspective on how to address such issues based on their life experience, while younger people may feel that issues should or can be addressed by talking to safe people in their lives. Factors related to lateral oppression also emerged here: some people do not feel "Indian enough" to be welcomed into Native-specific wellness services provided in the community.

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*"It took me 40 years to be treated. I would not admit my problem due to Native Stigma."*

*"Kids don't know how to reach out, because if they do, it is looked down upon."*

*"You're not supposed to talk about those things in society."*

*"Everyone wants to be normal, whatever that is.*

---

**TRUST:** Another factor related to stigma emerged: distrust of institutional systems and individuals trained to provide services. There is a clear legacy of historical trauma, which used institutions to oppress and destroy Native people. This trauma began at the start of colonization, is clear during the boarding school era, and continues with recent events including the ongoing assaults on Tribal and Indian sovereignty. Many mental health staff, while good-intentioned and well-trained, can be too academic to relate to the community. Paraprofessional or lay workers who are from the Native community are appealing to community members and are highly sought after, especially when they can provide cultural context and education with their service provision. Some project participants suggested integrating mental health staff into the youth/prevention programming to build familiarity and knowledge of the workers themselves. When these staff have trusting relationships with young people, the youth are more comfortable coming forward when challenges arise.

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*"Start with building strong relationships with the youth so they feel comfortable talking about their mental health."*

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## EDUCATION SYSTEM CHALLENGES

**CURRICULUM:** Schools emerged as a significant source of risk for Native children and youth, primarily due to racist tropes that still litter the curriculum. The information taught is damaging to Native children and reinforces negative stereotypes. Some noteworthy examples include: The California Mission Project, settler perspectives on the Gold Rush, and a general mishandling of oppressive holidays like Thanksgiving and Columbus Day.

**COUNSELORS:** Youth were particularly focused on the role of the school counselor, stating that they are generally guidance counselors who aren't familiar with Native culture, lacking cultural competence to work with Native youth. They further cited that it would help enormously to have Licensed counselors (LCSW or LMFT) in the schools as they are more equipped to handle the complex problems that youth face. The community cited the importance of engaging high-risk youth and making a focused effort to help them. Some felt that school counselors often exacerbate problems as they don't understand the youth coming to them and can unintentionally reinforce distrust and feelings of isolation.

*"It feels like you are being interrogated."*

*"Need more service providers involved in the community and not just there for a paycheck."*

**LACK OF TRANSPARENCY:** Within the community, there is a general lack of knowledge about what occurs inside of the school. Parents expressed that they don't know what is going on in the schools or how to get information, especially when their children aren't forthcoming.

**SUSPENSIONS:** There was feedback that the school system errs towards discipline when these youth are often facing incredibly complex issues that require help. Often willfully defiant young people need help and support, not punishment which can reinforce negative behavior.

*"Kids are labeled in schools as 'bad kids' and are being suspended instead of linked to services that can help."*

**INDIAN EDUCATION SYSTEM:** Families reported very different structures within the Indian Education programs in each district. They operate with differing degrees of openness and functionality. They also don't exist in all schools. Parents felt the operations of these programs could be adapted and adjusted to be more supportive to Native youth.

# GLOSSARY

**AMERICAN INDIAN POLITICAL STATUS:** Recognition of the Native American tribes as sovereign nations, free from regulation by the states, but not exempt from legislation by Congress. The unique relationship between the tribes and the government arises from the colonial history of claiming indigenous lands, without which the United States could not exist as it does today, and ousting the occupants to make way for the colonizers. Tribes do not have full sovereignty as independent nations, but they are generally seen to have full inter- and intra-tribal sovereignty. The degree of Native sovereignty has swung back and forth with various court cases and Congressional decisions. This flip flopping, Native sense that treaties are not being honored, uncertainty about the continuation of their political status, and the repeated interference in Tribal governance and affairs by the federal government continue to be a point of contention and are an aspect of historical and ongoing trauma for Native people.

**ANCESTRAL:** Relating to the "ancient" or "original." Often used in reference to land, but it may also reference cultural and spiritual holdings and values

**ASSIMILATION:** The attempt by the American government and people to transform Native people and cultures into European people and cultures. This process has seen several waves of different attempts and have been heavily resisted by Native persons. US assimilation policy included the banning of traditional religious ceremonies, the forced immersion of Native children into European culture at Native American boarding schools, and various policies designed to take Native lands and disrupt reservations. It is one aspect of historical trauma and in many ways this pressure continues today.

**BLOOD QUANTUM:** Used to define bloodlines related to Native ancestry. A measure of the percentage of a person's ancestors who were full-blood Native Americans. Different tribes require different blood quantum's to be eligible for membership or citizenship.

**DISENROLLMENT:** Removal of an individual's citizenship or status within a tribe, by the tribe itself. Typically done for economic or social reasons, or because the individual does not contain enough Native ancestry to be considered a member of the tribe. Often decried as a form of lateral oppression and ongoing and historical trauma, those who are disenrolled are at higher risk for identity crises, depression, suicide, and other poor mental and physical health outcomes.

**HISTORICAL TRAUMA:** The cumulative emotional and psychological wounding to an individual, generation, or culture due to a traumatic experience or event. The deaths of an estimated 90% of Native Americans and subsequent loss of their lands and in many cases, families, language, and culture has left a deep scar upon the Native people. This has been continued through American policies which has treated Natives as "less than" and continued to take advantage wherever possible. Relocation, termination, and assimilation are all aspects of historical trauma, as are the histories of the genocide and enslavement of the Native people who survived the first wave of colonization. Historical trauma can lead to the erosion of family and social structures, and higher rates of mental illness and substance abuse in the affected communities.

**INTERGENERATIONAL TRAUMA:** Untreated trauma in a parent which is transmitted to the next generation, and may continue for generations beyond that. Here, the original trauma for most families can be traced back to the original colonization contacts- whether through the deaths of the tribe, relocation and loss of ancestral lands, loss of the culture and language, or more intimate losses of close family or friends or the witnessing of violence. Parents may display signs of hypervigilance, lack of affection, or substance abuse disorders, among other symptoms, all of which constitute trauma upon a child living in their care. The child may then carry this untreated trauma onto their children as well. The Native situation includes not one, but many disparate traumatic instances spread over several hundred years, allowing many opportunities for intergenerational trauma to start. Beyond the social dynamics, new genetics research is also showing that trauma creates epigenetic markers which may carry on as many as 3 generations and whose effects on subsequent generations are not yet fully understood.

**LATERAL OPPRESSION:** Violence or oppression towards one's own peers within a marginalized social group as a result of the oppression common to the group as a whole. An example would be the practice of disenrolling Native persons from a tribe for not being "Native enough" so that the remaining tribal members may have more resources.

**LAY WORKER:** A health worker who performs functions related to healthcare delivery and is trained within the context of intervention, but is not formally trained or certified. Often their work based on "lived experiences" (such as in the case of recovering drug addicts working as substance abuse counselors).

**PARAPROFESSIONAL:** Health workers with some training and certification who assist in a particular profession without the same level of credentials as professional employees. They often perform minor medical tasks (such as first aid) and health education and counseling activities.

**RELOCATION:** Forced migration of Native persons and tribes in the 19th century as a result of colonization, theft of land, and the Indian Removal Act of 1830. One aspect of historical trauma.

**TRAUMA-INFORMED CARE:** An organizational structure and treatment framework approach to engaging persons with a history of trauma, which acknowledges the role trauma has played in their lives. It is based on 5 foundational principles: 1. Safety 2. Transparency and Trustworthiness 3. Choice (honoring an individual's dignity) 4. Collaboration and Mutuality (partnership and shared decision making) 5. Empowerment

**TERMINATION:** US policy from the mid 1940's-mid 1960's in which the US government ended its recognition of the sovereignty of tribes, trusteeship over reservations, and the exclusion of Native persons from state laws, including the end of their exception from paying taxes. This was done with the intention of forcing assimilation, reducing Native dependence on a corrupt bureaucracy, cutting the cost to the government of providing these services, and ultimately to grant Native persons all the rights and privileges of citizenship. It clashed greatly with the Native American's desire to preserve their identities and to be self-determinate, as reflected in the rise in Native political activism at the time. Although many tribes that were terminated in this era have regained federal recognition through lengthy court battles, not all have. One aspect of historical and ongoing trauma.

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# SACRAMENTO CIRCLES OF CARE

## COMMUNITY READINESS ASSESSMENT AND SOCIAL MARKETING PLAN

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# PURPOSE

The purpose of the Community Readiness Assessment (CRA) is to aid the Sacramento Circles of Care Project in developing a children's mental health blueprint in Sacramento County. Conducting a CRA is key to initiating community change. The Sacramento Circles of Care Project engaged eight community members to analyze **1) mental health, 2) behavioral health, and 3) wellness in Sacramento County.**

1. **Mental health** is defined as a state of well-being in which the individual is aware of his or her own potential; they have the ability to cope with the daily stresses of life and can work productively; they are able to contribute to the community (World Health Organization, 2014).

2. **Behavioral health** is somewhat different in that it honors the interaction between both substance use and mental health; it recognizes the interaction between mental and emotional health; and finally, it includes preventable chronic health conditions (Indian Health Service, 2012).

3. **Wellness** refers to the presence of balance and the ability to take care of the physical, emotional, mental, and spiritual needs of individuals and families. The ability to achieve wellness includes the development and integration of programs, supports, and systems (both formal and informal); and the ability to promote positive mental health, prevent substance use and abuse, improve physical health, strengthen the spiritual and cultural connections, and address both environmental and social factors (Hodge & Nandy, 2011).

Mental health and behavioral health are often perceived to be interchangeable, however for this initiative they are definitively distinctive. The CRA helped the Sacramento Circles of Care Project to develop an effective, culturally-appropriate and community specific strategic plan for our Circles of Care blueprint. All too often in Indian Country, pathways of change are imposed onto communities, rather than change coming from within the communities themselves. The CRA Model allows communities to define issues and strategies in their own context to creating systemic change in Sacramento community.

# METHODOLOGY

The Sacramento Circles of Care Project used an adapted Community Readiness Model (CRM) for Circles of Care. The CRM is approved by the funder, SAMHSA for community change. This model integrates a community's culture, resources and level of readiness to address youth wellness in Native communities. The CRM encourages community investment in Native youth wellness and community awareness.

The CRM process has 5 components: 1) Define "Community" 2) Conduct Key Respondent Interviews 3) Score to determine Readiness Level 4) Develop Strategies/Conduct Workshops 5) Community Change. In April of 2018, we first defined the target community, which are Native community members residing in Sacramento County or system partners who work in the mental health system. Our goal was to cast a wide net to capture as many experiences and perspectives as possible. Some of the interviewees were nominated by the Native community earlier in the year. From May to June of 2018, four Youth Initiatives team members conducted eight interviews. We interviewed:

1. 1 Native Youth
2. 1 Mental Health Professional (LCSW)
3. 1 Education Professional (Professor at American River College)
4. 1 Native Community Leader/Spiritual Leader
5. 1 member from our local tribal government (Wilton Rancheria)
6. 1 Medical Provider
7. 1 County Mental Health Division Manager
8. 1 Native Community Member/Parent

All interviews took place at the Sacramento Native American Health Center, where we allotted two hours per interview. The project team asked a total of 27 questions which covered five dimensions: 1) Community Knowledge 2) Leadership 3) Community Climate 4) Knowledge about the Problem 5) Resources for Prevention Efforts. These five dimensions of readiness are key factors that influence the community's preparedness to address youth wellness. Some interviews lasted 30 minutes, while others lasted the entire two hours. In each interview, there were two interviewers. Interviewers switched off asking questions, while the other one would take notes. All interviews were recorded for the purpose of the scorers being able to go back and listen so they could score the interviews adequately. Each interviewee signed an informed consent form before the interview began, and we also provided each interviewee a $20 gift card as an

incentive. Each interviewer stressed that if at any time the interviewee felt uncomfortable, they could stop the interview process. We understood that some of the questions could be a trigger for some, so we coordinated with our Behavioral Health staff to make sure a licensed therapist was on site in case they were needed.

After all eight of the interviews were completed, the two team members who did not participate in the interviewing scored the interviews. Prior to the start of the scoring, the Program Manager conducted training with the scorers to teach them the CRM scoring methods. The scorers worked independently, each listening to the interview in its entirety before scoring the dimensions. They then read the anchored rating statements where they went through each dimension, listened to the interview a second time and took notes to accurately score each dimension. When each scorer was finished scoring the eight interviews, they then came together to compare scores. During this part of the process, the two scorers discussed their individual scores and then agreed on a single score. After they scored each dimension, they would add up the scores to find the total for each dimension. This allowed us to see which dimensions had the lowest scores, which

**FIGURE 1: STAGES OF COMMUNITY AWARENESS**

| | |
|---|---|
| 1 | NO AWARENESS |
| 2 | DENIAL/ RESISTANCE |
| 3 | VAGUE AWARENESS |
| 4 | PREPLANNING |
| 5 | PREPARATION |
| 6 | INITIATION |
| 7 | STABILIZATION |
| 8 | CONFIRMATION/ EXPANSION |
| 9 | HIGH LEVEL OF COMMUNITY OWNERSHIP |

**FIGURE 2: STAGE DESCRIPTION**

| STAGE | DESCRIPTION |
|---|---|
| **NO AWARENESS** | Youth wellness is not generally recognized by the community leaders as an issue (or it may truly not be an issue.) |
| **DENIAL/ RESISTANCE** | At least some community members recognize that youth wellness is a concern but there is little recognition that it might be occurring locally. |
| **VAGUE AWARENESS** | Most feel that there is local concern but there is no immediate motivation to do anything about it. |
| **PREPLANNING** | There is clear recognition that something must be done and there may even be a group addressing it. However, efforts are not focused or detailed. |
| **PREPARATION** | Active leaders begin planning in earnest. Community offers modest support of efforts. |
| **INITIATION** | Enough information is available to justify efforts. Activities are underway. |
| **STABILIZATION** | Activities are supported by administrators or community decision makers. Staff are trained and experienced. |
| **CONFIRMATION/ EXPANSION** | Efforts are in place. Community members feel comfortable using services and they support expansions. Local data regularly obtained. |
| **HIGH LEVEL OF COMMUNITY OWNERSHIP** | Detailed and sophisticated knowledge exists about youth wellness prevalance and consequences. Model is applied to other issues. |

dictated what areas we should focus our energy on. Please see **Figure 1** and **Figure 2** for full details of the Stages of Community Readiness.

Once we had the scores for all the dimensions, the Youth Initiatives team presented the scores to the Youth Advisory Board and the Community Advisory Board in August. Each advisory board received a PowerPoint presentation which led to a conversation about the scores. Both advisory groups approved the scores, and also approved the dimensions that we would focus our energy on in year two.

# RESULTS

## **DIMENSION A:** EXISTING COMMUNITY EFFORTS

To what extent are there efforts, programs, and policies that address youth wellness?

**SCORE: 4**

**STAGE OF READINESS- PRE PLANNING:** There is clear recognition that something must be done and there may even be a group addressing it. However, efforts are not focused or detailed.

**GOAL: RAISE AWARENESS WITH CONCRETE IDEAS**

**STRATEGIES FOR INTERVENTIONS:**

- Introduce information about youth wellness through presentations and media. Focus on reducing stigma and raising general awareness.
- Visit and invest community leaders in the cause.
- Review existing efforts in community (curriculum, programs, activities, etc.) to determine who the target populations are and consider the degree of success of the efforts.
- Conduct local focus groups to discuss youth wellness and related issues and develop some basic strategies.
- Increase media exposure through radio and television public service announcements.

## **DIMENSION B:** COMMUNITY KNOWLEDGE ABOUT THE EFFORTS

To what extent do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?

**SCORE: 3**

**STAGE OF READINESS- VAGUE AWARENESS:** Most feel that there is local concern but there is no immediate motivation to do anything.

**GOAL: RAISE AWARENESS THAT THE COMMUNITY CAN DO SOMETHING**

**STRATEGIES FOR INTERVENTIONS:**

- Get on the agendas and present information on youth wellness at local community events and to unrelated community groups.
- Post flyers, posters, and billboards.
- Begin to initiate your own community health events (pot lucks, potlatches, etc.) and use those opportunities to also present information on youth wellness.
- Conduct informal local surveys and interviews with community people by phone or door-to-door about attitudes and perceptions related to youth wellness.
- Publish newspaper editorials and human interest articles with general information and local implications.

## **DIMENSION C:** LEADERSHIP

To what extent are appointed leaders and influential community members supportive of youth wellness?

**SCORE: 4**

**STAGE OF READINESS- PRE PLANNING:** There is clear recognition that something must be done and there may even be a group addressing it. However, efforts are not focused or detailed.

**GOAL: RAISE AWARENESS WITH CONCRETE IDEAS**

**STRATEGIES FOR INTERVENTIONS:**

- Introduce information about youth wellness through presentations and media. Focus on reducing stigma and raising general awareness.
- Visit and invest community leaders in the cause.
- Review existing efforts in community (curriculum, programs, activities, etc.) to determine who the target populations are and consider the degree of success of the efforts.
- Conduct local focus groups to discuss youth wellness and related issues and develop some basic strategies.
- Increase media exposure through radio and television public service announcements.

## **DIMENSION D:** COMMUNITY CLIMATE

What is the prevailing attitude of the community toward youth wellness? Is it one of helplessness or one of responsibility and empowerment?

**SCORE: 4**

**STAGE OF READINESS- PRE PLANNING:** There is clear recognition that something must be done and there may even be a group addressing it. However, efforts are not focused or detailed.

**GOAL: RAISE AWARENESS WITH CONCRETE IDEAS**

**STRATEGIES FOR INTERVENTIONS:**

- Introduce information about youth wellness through presentations and media. Focus on reducing stigma and raising general awareness.
- Visit and invest community leaders in the cause.
- Review existing efforts in community (curriculum, programs, activities, etc.) to determine who the target populations are and consider the degree of success of the efforts.
- Conduct local focus groups to discuss youth wellness and related issues and develop some basic strategies.
- Increase media exposure through radio and television public service announcements.

## **DIMENSION E:** COMMUNITY KNOWLEDGE ABOUT THE ISSUE

To what extent do community members know about or have access to information on youth wellness, and understand how it impacts your community?

**SCORE: 2**

**STAGE OF READINESS: DENIAL/ RESISTANCE-** At least some community members recognize that Native children's mental health is a concern but there is little recognition that it might be occurring locally.

**GOAL: RAISE AWARENESS THAT THE PROBLEM OR ISSUE EXISTS IN THIS COMMUNITY**

**STRATEGIES FOR INTERVENTIONS:**

- Continue one-on-one visits and encourage those you've talked with to assist.
- Approach and engage local educational/ health outreach programs to assist in the effort with flyers, posters, or brochures.
- Begin to point out media articles that describe local statistics and available youth wellness or intervention services.
- Prepare and submit articles on youth wellness for tribal newsletters, church bulletins, local newsletters, club newsletters, etc.
- Present information to local related community groups.

## **DIMENSION F:** RESOURCES RELATED TO THE ISSUE

To what extent are local resources – people, time, money, space, etc. – available to support efforts?

**SCORE: 2**

**STAGE OF READINESS: DENIAL/ RESISTANCE-** At least some community members recognize that Native children's mental health is a concern but there is little recognition that it might be occurring locally.

**GOAL: RAISE AWARENESS THAT THE PROBLEM OR ISSUE EXISTS IN THIS COMMUNITY**

**STRATEGIES FOR INTERVENTIONS:**

- Continue one-on-one visits and encourage those you've talked with to assist.
- Approach and engage local educational/ health outreach programs to assist in the effort with flyers, posters, or brochures.
- Begin to point out media articles that describe local statistics and available youth wellness or intervention services.
- Prepare and submit articles on youth wellness for tribal newsletters, church bulletins, local newsletters, club newsletters, etc.
- Present information to local related community groups.

## COMMUNITY CHANGE ANALYSIS

Interventions introduced in a community must be consistent with the awareness of the problem and the level of readiness for change present among residents of that community. As you can see above, **Dimensions E** and **F** have the lowest scores, and will be used as a guide to help the project navigate the complex process of system and community change. The Sacramento COC team presented the readiness scores to the community and youth advisory groups. From this conversation, the advisory groups advised the project focus on **Dimension B** in addition to **Dimensions E** and **F**. The community advisory stated that these three dimensions complement each other very well, and that they would like to move forward with working on the three dimensions. Moreover, they agreed that these three dimensions and their scores accurately reflect the current state of the Sacramento Native community.

**Dimension B** focuses on the amount of knowledge that the Sacramento Native community has about prevention efforts in regards to youth wellness. Overall, the eight interviewers shared there is not much in terms of prevention that is happening in Sacramento County for Native youth, with the exception of our Circles of Care grant. People stated that there is nothing systematic, programs come and go, haven't been very sustainable, and organizations often work in silos which hurts the overall cause of helping Native youth.

While many providers believed that youth wellness is a huge priority in Sacramento County, many community members did not feel like it was a top priority. Moreover, most community members that were interviewed stated that they did not know how to go about accessing services and that the system is very hard to navigate. Often times Native community members will reach out to Native leaders in their community and ask for help and direction because they do not know where else they can go, resulting in large disconnect between the community and system partners. The system partners could list numerous available services, while community members could not.

**Dimension E** focuses on to what extent community members know about or have access to information on Native youth wellness. A majority of the community members who were interviewed, including youth, stated that printed materials, billboards, and well known telephone hotline numbers were the main avenues of information gathering. The biggest critiques were that there is no direct intervention, not nearly enough information available, and most resources are not strength based and offer very few solutions. Community members also had no awareness about local data that exists, or how to access that data. Similar to the responses for **Dimension B**, there is a disconnect between system partners and the community. Service providers knew how to access this information, while community members did not.

**Dimension F** focuses on resources that are related to Native youth wellness, specifically to what extent local resources are available to support efforts. One community member

mentioned that many organizations have gotten away from providing gathering and meeting space for Native people. Collectively, the community believes a focus on providing gathering and meetings spaces for community gatherings is needed for Native youth wellness.

Following the CRA scores discussion, the advisory board members participated in an asset mapping activity. The Sacramento COC team printed out maps of Sacramento County, and asked individuals the following questions:

1. What are the resources in your community that promote metal wellness and overall well-being?
2. Where can you go in the community if you want information and/or resources about suicide prevention?
3. If you, or someone you know, were experiencing a mental health crisis, where would you go?

After individuals filled out resources on their individual maps, the project team executed a group activity requesting advisory members to identify places, spaces, people, and cultural resources. Lastly, the group was asked to take a step back, and see what was missing from the individual maps. This led to a very fruitful conversation about what our community is lacking in regards to resources. To see full findings of the asset mapping activity, please refer to the Community Needs and Strengths Report.

# NEXT STEPS

Moving forward the Sacramento Circles of Care team will use **Dimension B, E,** & **F** to develop a Social Marketing Plan. The Social Marketing Plan will focus on three audiences: Youth and Young Adults, Parents and Family Members, and Providers and Community Partners. Please see Social Marketing Plan for a comprehensive plan for influencing social change.

# CIRCLES OF CARE SOCIAL MARKETING PLAN OUTLINE

## APPROACH

The approach of this social marketing plan is centered on preliminary findings from the "Native American Youth Mental Wellness Report: Sacramento Community Needs and Strengths Report" detailing the mental wellness needs, strengths and assets of Native youth and families in Sacramento County involving the mental health system that serves them.

The plan is also informed by the PEI Spectrum of Prevention model that simultaneously seeks to: (1) strengthen individual knowledge and skills, (2) promote community education, (3) educate providers, (4) foster coalitions and networks, (5) change organizational practices, and (6) influence policy and legislation. Activities at each of these levels support and reinforce each other and promote overall community health and wellness.

## GOALS

Based on findings from the Community Needs and Strengths Report and the Community Readiness Assessment, the recommended social marketing approach is two-fold:

**YEAR 2 -** Increase mental health education and awareness

**YEAR 3 -** Increase help seeking behaviors

## TARGET AUDIENCE/S

Youth and young adults will be the primary audience of the campaign, with parents, family members, community partners and providers each being reached through additional targeted strategies.

## SOCIAL MARKETING EVALUATION:

In order to evaluate the effectiveness of the Social Marketing plan, we will utilize a combination of penetration and engagement measures as well as qualitative feedback.

Penetration measures will help us track how many people we have reached with our messages. To get a comprehensive understanding of how many people have been reached we will monitor the following metrics:

- # of website visits/downloads
- # of engagements on social media
- # of collateral materials disseminated

Additionally, we will track engagement through the number of youth engaged directly in campaign activities, such as Directing Change participants.

Since these numbers are easily accessible (especially web visits and social media), we will be able to monitor and adjust our outreach efforts in real-time to increase our reach based upon how youth are responding and engaging.

The program will conduct a Community Readiness Assessment (CRA) early in Year 3 and assess overall scores and specific information provided by participants. This information will be used as a point of comparison to information collected during the Year 1 CRA. This information will be reviewed by the Evaluation Advisory Committee, reviewed for content, quality and integrity, and reported back to the community via Town Hall Meeting and/or the Advisory Groups. Since the primary needs identified in the Year 1 CRA was around stigma and awareness of mental health wellness, a Year 3 CRA will provide meaningful information to the Social Marketing efforts and messaging and whether or not we should shift messaging and if there has been an impact of preliminary efforts in this area.

Qualitative data will be collected by direct engagement with our Multi-Agency Partners. This will be done at a regularly scheduled meeting at the end of Year 2, where the Social Marketing team can get information on the reach and impact of this program and its messaging within the service system. Adjustments can then be made if additional efforts are needed to get these partners engaged with planning efforts.

Focus groups will also be conducting early in Year 3 with the youth and families to gauge the impact and reach of our messages. Adjustments may be made to messaging approaches depending on the results of these focus groups. The information will also be used to assess personal impact on sense of acceptance of mental health challenges, stigma, and overall awareness.

In addition to tracking how many people are being reached and are choosing to engage with our campaign, we will create opportunities for qualitative feedback to measure the impact of the social marketing campaign. For example, youth and parents will have a clearly defined opportunity at events to offer feedback in written or verbal formats at events and generally regarding programming and messaging. This feedback will be collected and analyzed to identify areas of strength and areas to improve our campaign. Key points of feedback will be included in the final grant report.

## MESSAGING AND OUTREACH STRATEGIES

Messaging and Outreach Strategies are explored in-depth in **Figure 5**.

**FIGURE 5: MESSAGING AND OUTREACH STRATEGIES**

| | WHO IS YOUR AUDIENCE? | | |
|---|---|---|---|
| | **YOUTH & YOUNG ADULTS** | **PARENTS & FAMILY MEMBERS** | **PROVIDERS & COMMUNITY PARTNERS** |
| **WHAT DO YOU WANT THE AUDIENCE TO DO?** | • Increase awareness and education surrounding mental health and increase help-seeking behaviors<br>• Feel more connected to their community | • Increase education on how to advocate and support for their children and themselves<br>• Find more resources on mental health | • Improve cultural sensitivity when working with Native individuals<br>• Learn more about community strengths and needs regarding mental health, such as family driven care |
| **WHAT ARE THE MESSAGES?** | • Social support (i.e. "how to help a friend")<br>• Building resilience and taking a trauma-informed approach<br>• Consider culture's role as a preventative measure and as a source of healing<br>• Positive and strength-based<br>• Avoid telling youth they are "at risk"<br>• Focus on messages of hope and what youth can do to support their community | • Their community is resilient and strong<br>• Social support is vital to maintaining mental health amongst the youth and young adult population<br>• Resources ARE available to help | • Needs of the Native youth community regarding mental health are unique<br>• All care must be provided through a lens of cultural responsiveness and family-driven decision making |
| **WHICH CHANNELS WILL YOU USE?** | • Custom microsite or SNAHC subpage for the campaign<br>• Marketing materials and collateral<br>• Social media outreach, primarily via Instagram (paid and organic)<br>• In-person outreach events | • The microsite will contain a specific section targeted towards parents and family members<br>• In-person parent education and support meetings held simultaneously with youth events | • The microsite will contain a provider/partner section<br>• In-person outreach and community building<br>• A webinar will be created and publicized |
| **HOW WILL EACH CHANNEL BE USED?** | • The microsite will contain the bulk of reference and education material<br>• Social media will provide accessible/shareable content and direct to the website<br>• In-person events will focus on awareness and education (along with community-building)<br>• Handouts and collateral will provide digestible information and refer to the website for more detail | • The microsite will contain education material and resources<br>• In-person events will allow parents to communicate with SNAHC team members and learn more | • The microsite will contain reference and education material<br>• Printed materials and collateral will be distributed to encourage website visits |

## FIGURE 5: MESSAGING AND OUTREACH STRATEGIES (CONT.)

| | WHO IS YOUR AUDIENCE? | | |
|---|---|---|---|
| | **YOUTH & YOUNG ADULTS** | **PARENTS & FAMILY MEMBERS** | **PROVIDERS & COMMUNITY PARTNERS** |
| **CRM DIMENSION** | DIMENSION B, E, F | DIMENSION B, E, F | DIMENSION E, F |
| **WHAT ACTIVITIES WILL SUPPORT THIS?** | • Work with youth on the type of material they would like to share, increasing likelihood that recipients will be driven to the campaign microsite and Instagram<br>• Participate in the Directing Change Program and Film Contest<br>• Work with youth to create a youth-focused social media team to collaborate with SNAHC communications staff<br>• Mental Health trainings for youth so they feel equipped to respond to peers. | • Mental Health trainings for parents and caregivers so they feel equipped to respond to a child in distress<br>• Parent/Community advisory will approve microsites for family appropriate messaging | • Disseminate the Community Needs and Strengths report through the community, aiming to build partner and community engagement |
| **WHAT EVENTS WILL SUPPORT THIS?** | • Regular social events planned by and targeted at youth, such as a monthly teen night / dance party<br>• Host a youth video screening for the community<br>• Explore intergenerational activities for youth and elders to participate in<br>• Plan and execute a Year 3 Youth Mental Health Conference | • Have a parent meeting at nearby Starbucks while youth meetings and/or teen night happens<br>• Parent specific outreach and programming at a Children's mental health awareness event, such as a resource fair | • Provide training on culturally responsive care via webinar |
| **WHAT MATERIALS WILL SUPPORT THIS?** | • Collateral/outreach materials will be developed, made by and for Sacramento Native youth (i.e. bracelets, "help a friend" cards, stickers, patches, etc.)<br>• Materials should drive them to the campaign microsite and Instagram where they can access resources and "intervention" messaging | • Develop a trauma-informed piece for families (made in partnership with Each Mind Matters) and consider including a section on how to advocate for "your kids and yourself"<br>• Create a parent-specific section of the campaign microsite | • Create a short marketing piece with summary about the Needs and Strengths report to direct providers/partners to download it online<br>• Create a provider/partner section of the campaign microsite and include recordings of the webinar, including a resource guide of Native organizations and services |
| **WHAT IS THE START AND ENDING DATE?** | START YR 2, Q2<br>END YR 3, Q4 | START YR 2, Q3<br>END YR 3, Q4 | START YR 2, Q4<br>END YR 3, Q4 |

**KEY:**

**DIMENSION B** COMMUNITY KNOWLEDGE ABOUT THE EFFORTS: To what extent do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?

**DIMENSION E** COMMUNITY KNOWLEDGE ABOUT THE ISSUE: To what extent do community members know about or have access to information on YOUTH WELLNESS, and understand how it impacts your community?

**DIMENSION F** RESOURCES RELATED TO THE ISSUE: To what extent are local resources – people, time, money, space, etc. – available to support efforts?

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