AMERICAN INDIAN HEALTH & SERVICES

COMMUNITY WELLNESS REPORT 2020

AN ASSESSMENT OF THE STRENGTHS & NEEDS OF THE URBAN AMERICAN INDIAN & ALASKA NATIVE COMMUNITIES OF SANTA BARBARA & VENTURA COUNTIES

American Indian Health & Services
Improving the Health of Our Communities

Acknowledgments

This document is the culmination of diligent work of the Santa Barbara, Ventura and surrounding area AIAN community members and their allies. Special contributions by the AIH&S Community Advisory Council and Youth Council members guided and led this work alongside the dedicated staff of AIH&S. This project would not be possible without the broader support of local stakeholders, advocates and community partners. It is with gratitude and thanks to all of these contributors for support and deep commitment to a community-led process for positive change in revitalizing and reimagining the wellness network of our AIAN community.

Prior to commencing this report, it is vital to include the acknowledgment of the traditional keepers of the land, in which American Indian Health & Services is located—the Chumash peoples. It is important to recognize this area's rich history and culture, both past and present, as well as the significance of Native American peoples' place in community health and public Health. The respect for this timeless knowledge of elders and their memories, traditions, and culture of the area is essential, because it has become a place to call home for many people from all over the world.

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Circles of Care Project Goals and Community Wellness Report Goals: Developing a System of Care For Native Youth and Families

In 2017, American Indian Health & Services (AIH&S) was awarded a Circles of Care Grant through the Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the U.S. Department of Health & Human Services. Circles of Care is an infrastructure and planning grant that seeks to increase the capacity and effectiveness of the mental health systems serving AIAN Communities.

The full Circles of Care Project entitled, "Planning and Developing Infrastructure to Improve the Mental Health and Wellness of American Indian and Alaska Native (AIAN) Children, Youth, and Families," which aims to provide Native communities with tools and resources to plan and design a holistic, community-based, coordinated "System of Care" (SOC). In this approach to support mental health and wellness for children, youth and families for the purposes of the Circles of Care grant, the AIH&S has defined the service area using a smaller, core area along the South Coast that stretches from Lompoc in Santa Barbara County to Thousand Oaks in Ventura County where many of the families served at AIH&S reside. (see Figure 1, below).

Project goals are community-driven and defined by participation of youth, adults, community groups, partner agencies, and other stakeholders.

Circles of Care
Project Goals

1

Conducting multiple, diverse assessments on community readiness, unmet mental health needs for children, youth and families, as well as the potential for partnerships, maximization of resources, and solutions that enhance mental health and community wellness.

2

Developing a comprehensive SOC "Blueprint" that includes a plan for addressing unmet needs and gaps in mental health services.

3

Developing a short- and long-term plan for sustainability based on programmatic and service elements identified in the blueprint, to ensure that Native youth and their families benefit from a community-endorsed expansion of services that addresses the most critical needs for mental health and wellness.

American Indian Health & Services Circles of Care Service Area

Community Wellness Report Goals

The purpose of this Community Wellness report is to share the results of the data collected during year one and two of the three-year grant program through a community-based lens. The aim is to educate and inform community partners and stakeholders on the strengths and challenges facing Native youth and families regarding access to mental health and wellness services. This report identifies the existing gaps in the availability and coordination of substance use treatment and recovery, as well as mental health, cultural and community-based wellness services.

The data highlighted in this report supports the development of a system of care that is holistic, community-based and culturally-responsive and designed to meet the mental health wellness needs of AIAN youth and their families. The system of care plan or 'Blueprint', is currently under community review to integrate the identified community strengths and needs for service expansion, which will ultimately create change within the regional health infrastructure that addresses the mental health and wellness of Native children, youth and families in Santa Barbara and Ventura Counties.

AIAN Population Identity Statement ▶▶▶

This document refers to American Indian & Alaska Native (AIAN), Native American, American Indian, Native and Indigenous depending on the data source, community authorship or originating referenced sources. AIAN peoples have diverse identities and complex political histories that make it impossible to classify these communities uniformly. AIAN is the current United States federal designation however, for the purpose of this document, we will be using some of these terms interchangeably and as responsive to community preference where possible. These terms seek to identify Native people originating from what is now known as the United States and their decedents whose ancestry originates from this land.

Executive Summary

This Community Wellness Report examines the health and wellness of the American Indian/Alaska Native (AIAN) communities of Santa Barbara and Ventura counties. The purpose of this report is to identify and prioritize the AIAN mental, emotional, cultural, spiritual and social service needs, as well as strengths that impact the overall wellness of the community. The comprehensive findings and priorities identified in this report create the foundation for the proposed AIAN youth and families system of care.

American Indian Health & Services (AIH&S) serves a diverse population in Santa Barbara and Ventura counties. A patient population of over 500 AIAN patients are served annually with representation from 80 Native nations, tribes, and/or bands.

The AIH&S and California Consortium for Indian Health (CCUIH) acted as the project stewards by coordinating research, assessment, evaluation and meetings with the community. The primary data collection and analysis communicated in this report was conducted with leadership and in partnership with AIAN communities in the service area.

Report Methodology

Primary and secondary data collection were utilized to assess individual and community well-being. To guide this assessment, a process of multi-year data collection and analysis of qualitative and quantitative variables were developed.

The AIH&S staff and evaluation team collaborated with community members in the review, development and adaptation of several research tools. Specific methods used to gather data included: surveys, focus groups, key informant interviews, community forums and evaluation workgroups. Data was also collected via a thematic youth photovoice project. Qualitative data included surveys from (n134) of AIAN people living in Santa Barbara and Ventura Counties, (n10) key informant interviews with community stakeholders, youth (n6) and adult focus group participants (n9).

The secondary data presented in this report represent wellness indicators from publicly available county, state and federal data sets. The data include population-level measures that are known to impact multiple domains of health and community wellness, such as morbidity and mortality, as well as social, economic and education factors.

The primary and secondary data were analyzed to identify and prioritize needs across multiple domains of wellness in the community. Using Community Based Participatory Research (CBPR), twelve priority areas were identified that would address the inequities and needs of the AIAN populations in Santa Barbara and Ventura Counties.

Summary of Secondary Data

The secondary data included in this report highlight AIAN epidemiology and disparities in the following domains:

- State, county-level and local AIAN population data
- Education attainment
- Youth mental health outcomes
- Rates of bullying and harassment
- Rates of substance use
- Involvement in carceral systems
- Youth gang membership
- Rates of disability
- Youth physical fitness
- Youth involvement in social service and foster systems
- Childhood trauma
- Health insurance access

In a number of domains, including mental health outcomes, racial health disparities are identified between AIAN and non-Hispanic white survey respondents. For example, AIAN students experience higher rates of depression-related feelings and suicidal ideation, as compared to non-Hispanic white respondents.

In identifying the AIAN population in Santa Barbara and Ventura counties, 26,106 (2.02%) individuals identify as AIAN alone or in combination with one or more races (US Census Bureau, 2018) and of those, approximately 40% of the population consists of AIAN people who are under the age of 24.

Summary of Primary Data

Community Assets and Strengths

Over two years, the AIH&S Community Advisory Council (CAC) developed a formal definition of community assets and sub-domains. These community assets and strengths were identified with multiple primary data collection modalities. AIH&S conducted Community Asset Mapping (CAM) which leveraged existing knowledge of community resources. The results are presented in the following categories within this report: individuals, activities, values, cultural wisdom, places, events, groups, programs and services, organizations, funders, media, and information.

Community Wellness Needs Data

The wellness needs of the community are identified using a Medicine Wheel that includes multiple community-defined domains of health. Each category includes a community definition of the domain, quantitative health and service-delivery indicators, as well as qualitative themes identified from the primary data. The report utilizes these domains to identify the wellness needs in the following areas:

1. Spiritual health and traditional healing
2. Mental health and substance use
3. Emotional health
4. Physical and environmental health

Notably, in the domain of emotional health, 96% of respondents reported that if community activities were offered on a regular basis, they would attend. Community readiness for a System of Care was assessed based on the community's current perspectives regarding native youth wellness. A social marketing plan was developed by the community to address the need to raise awareness and community readiness levels in the domains of Community Efforts, Knowledge about the Issue, and Resources Related to the 'Issue' (Native youth wellness). (Appendix B & C).

Discussion

The Discussion and Future Directions section of this report utilizes a social determinants of health framework to synthesize the primary and secondary data, examining the multitude of individual, community, structural risk and protective factors that impact the wellness of AIANs in Santa Barbara and Ventura Counties. The risk and protective factors identified through the primary analysis are reviewed in a socio-cultural-historical context.

All primary and secondary data was utilized to account and assess the multidimensional and complex wellness needs of the AIAN community. However, there remains a lack of quality data for the AIAN population in Santa Barbara and Ventura counties, especially around including AIAN populations in data collection for different federal, state, and local governmental agencies, as well as the lack of consistency in those defined as AIAN populations. In addition, with respect to health and social service systems in the counties, the largest need identified is improvement of cross-service system integration with traditional health services and coordination of care.

Summary & Recommendations

This report details the unique needs of the overall wellness in health, social services and settings of the AIAN youth and families in Santa Barbara and Ventura Counties. It provides an overall health and social examination of the strengths, assets and needs of the community members living in these areas, outlining health disparities experienced by the AIAN community. This report is an integral component in the process of building a comprehensive, accessible and culturally centered System of Care. Furthermore, the results of this report reflect the AIAN community's readiness for a community-led model of community wellness and System of Care that addresses the health and social service disparities within the population.

The following are the priorities/service system recommendations identified by the community in order to create a viable System of Care for AIAN youth and families:

1. Increase coordination of wellness resources and services for AIAN youth and families across Santa Barbara & Ventura Counties.
2. Engage stakeholders, community partners and local agencies in addressing the needs of the AIAN community.
3. Increase youth services and programming to address wellness needs.
4. Address stigma related to mental health and wellness services for youth, families and elders.
5. Workforce and economic development.
6. Address housing resources and economic development programming and services for Native families.
7. Develop resources and programming for Native youth in the foster care system.
8. Develop a resource guide for AIAN youth and families with services in Santa Barbara and Ventura Counties as well as national wellness resources and help-lines.
9. Increase access and utilization of culturally centered recovery resources.
10. Develop training for providers in Santa Barbara and Ventura counties on cultural humility/ sensitivity and best practices for working with Native families.
11. Engage local tribal partnerships to coordinate activities and services delivery strategies for youth and families.
12. Increase the availability of culturally centered programs and services for youth and families.

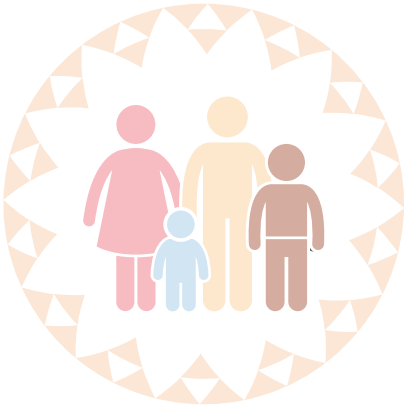
The AIH&S Community Wellness Report ultimately provides an assessment and the beginnings of a roadmap to guide the AIAN community, decision makers, funders, and stakeholders in implementing a System of Care to address community health and wellness. This report also serves as documentation of a community-based participatory model in completing a strength based needs assessment of a community experiencing high rates of health disparities and social inequity. Overall, the report is an example of a successful, collaborative process with the goal of improved community wellness for AIAN people in Santa Barbara and Ventura Counties.

CIRCLES
OF CARE
COMMUNITY
STRENGTH
LINES
IN SOUR
FAMILIES
TRADITIONS

Report Methodology

Data Sources

Data collection utilized primary and secondary (archival) sources. These data form the foundation for understanding a local **System of Care for Native youth and families.**



Introduction to Community Based Evaluation Design

The primary data and information in this report was collected using a Community Based Participatory Research (CBPR) process that engaged community members as co-researchers with the shared goal of building community wellness and health system change. The research was guided by AIAN community members that formed several workgroups including:

- Community Advisory Council (CAC)
- Youth Advisory Council (YAC)
- AIH&S Circles of Care Project Staff
- Evaluation Team

Community members were engaged in the entirety of the community-based evaluation design: forming the research question, participant recruitment, informed consent procedures, co-facilitation of focus groups, design of survey questions, interpretation of results, and dissemination of results.

Data was collected through a mixed methods approach. Survey data collection occurred at several Native community wellness events, community forums, and the 2018 Intro to Gathering of Native Americans (GONA) and 2019 Youth GONA. Focus groups were conducted separately for youth and adults, and key informant interviews with community members, healthcare providers and stakeholders with knowledge of services and programs available to the AIAN community were completed.

Our Community Based Evaluation Process Consisted Of 4 Primary Goals:

1. Organize research activities with community guiding the process
2. Support a data collection process that honors & builds on the strengths within the community.
3. Analyze and interpret data with an emphasis on evaluation methods education and capacity building.
4. Create data 'feedback loops' which continuously engaged community in creating data driven solutions, recommendations and strategies to improve wellness for Native youth & families.

Primary Data Collection Sources

In using a community-based participatory research methodology, the following data collection sources were utilized.

Community Survey: Survey tools developed through a CBPR process with the intent of analyzing local trends and statewide comparatives.

Focus Groups: (Talking Circles) in order to learn about the health needs and solutions from community members.

Key Informant Interviews: Interviews with key stakeholders including members of the Community Advisory Council, local healthcare providers, leaders of cultural services, Native agencies, and identified community champions.

Stakeholder Surveys: Online and paper surveys distributed during the data collection to identified stakeholders.

Community Forums

Evaluation Workgroups: Evaluation Team & Community Advisory Council members

Community Advisory Council Meetings: Monthly from Jan — Dec 2018

Youth Advisory Council Meetings: Monthly from May 2018 — June 2019

Youth Photovoice Project 2018

Gathering of Native Americans 2018 & 2019

Secondary Data Sources

Publicly available data regarding AIAN health and wellness using County, State and Federal sources were gathered to better understand the current services System of Santa Barbara and Ventura counties including:

- ***US Census 2015-17***
- ***California Department of Education: Healthy Kids Survey (2013-2015)***
- ***UIHI Community Health Profile***
- ***KidsData.Org***
- ***CA Department of Social Services***
- ***Bureau of Labor Statistics (2015-2017)***
- ***California Tribal Behavioral Risk Factor Community Survey (CTBRFCS) 2015***
- ***SAMHSA NSDUH Data Report 2014-2016***
- ***Center on Juvenile and Criminal Justice 2016***
- ***DOJ CA 2014***
- ***CDC***
- ***Uniform Crime Reports FBI 2017***
- ***US Center for Health Statistics, Death Certificates, 2010-2014***

Data Collection Methods

Developing and Using Research Tools

AIH&S staff and the evaluation team collaborated with community members in the review, development and adaptation of several research tools, to the completion of evaluating Native youth and family wellness.

Community Health Needs Assessment Survey

The questions assessed: access and availability of resources for mental, emotional, spiritual and physical health; access to and use of cultural resources for traditional healing and natural healing supports; and understanding challenges to utilizing and accessing these resources.

Community Readiness Assessment

Key informant interviews utilized a strength-based revision of the Community Readiness Assessment, which in addition to providing insight into the issue of community wellness, further measures the 'level of readiness' to address the issue of AIAN youth wellness.

Focus Group Guide

The following includes key community questions:

1. What do community members currently access regarding resources that allow them to be healthy, and what services are needed?

2. What are some of the important cultural practices that you believe keep people healthy and feel connected?

3. What are some of the challenges that your community faces in meeting health goals?

4. What are some of the things that you feel make your community resilient and able to face new challenges?

Stakeholder Survey

The survey design sought to develop a better understanding of how stakeholders integrate a supportive System of Care (such as mental health and social service providers as well as local organizations providing services to the AIAN community), and how they are currently serving AIAN community members and identify potential gaps in services, capacities, or knowledge that present barriers in accessing these vital resources for wellness.

The following includes key stakeholder questions:

1. How are AIAN people currently being served by your agencies and organizations?

2. How is the AIAN population being identified, tracked and documented regarding service delivery?

3. What are the challenges and opportunities organizations face in serving AIANs in Santa Barbara and Ventura Counties?

4. What current programs or services are offered to AIANs in the county system?

Recruitment of AIAN Participants

Key Informant Interview Participants

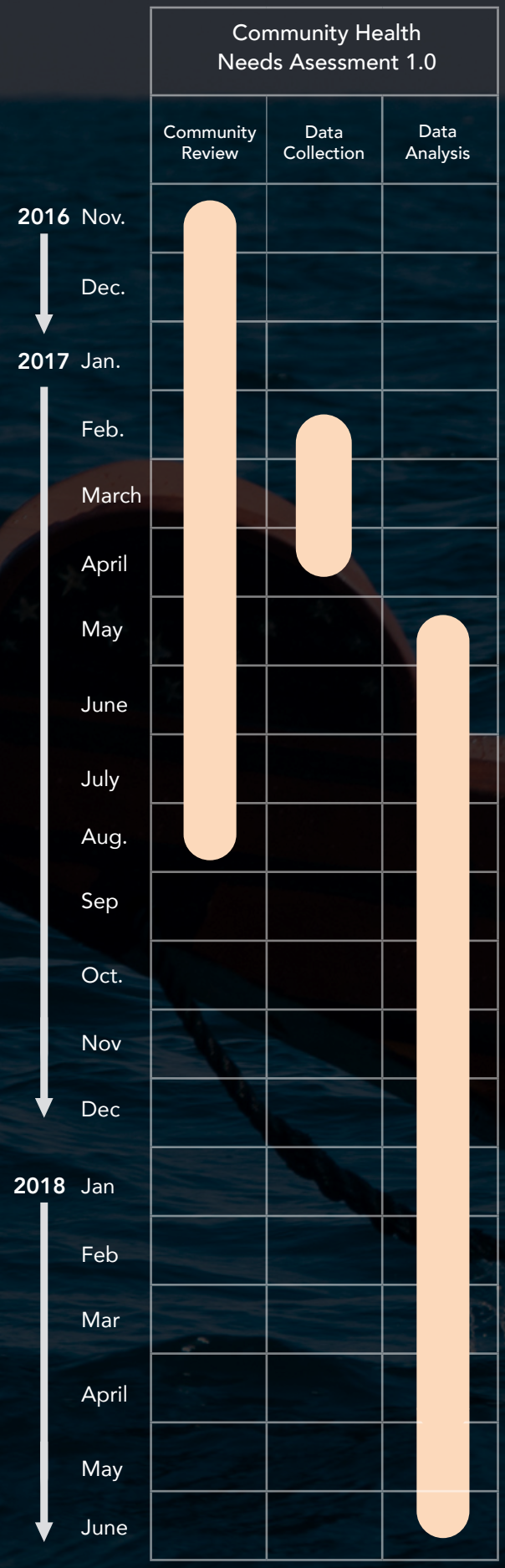
Leaders or experts with knowledge of community based organizations or agencies that provide health services to AIAN Individuals: 18 years of age or older.

Adult Participants: AIAN Ages 19 and up adults from the community.

Youth Participants: AIAN Ages 13-18 youth from the community.

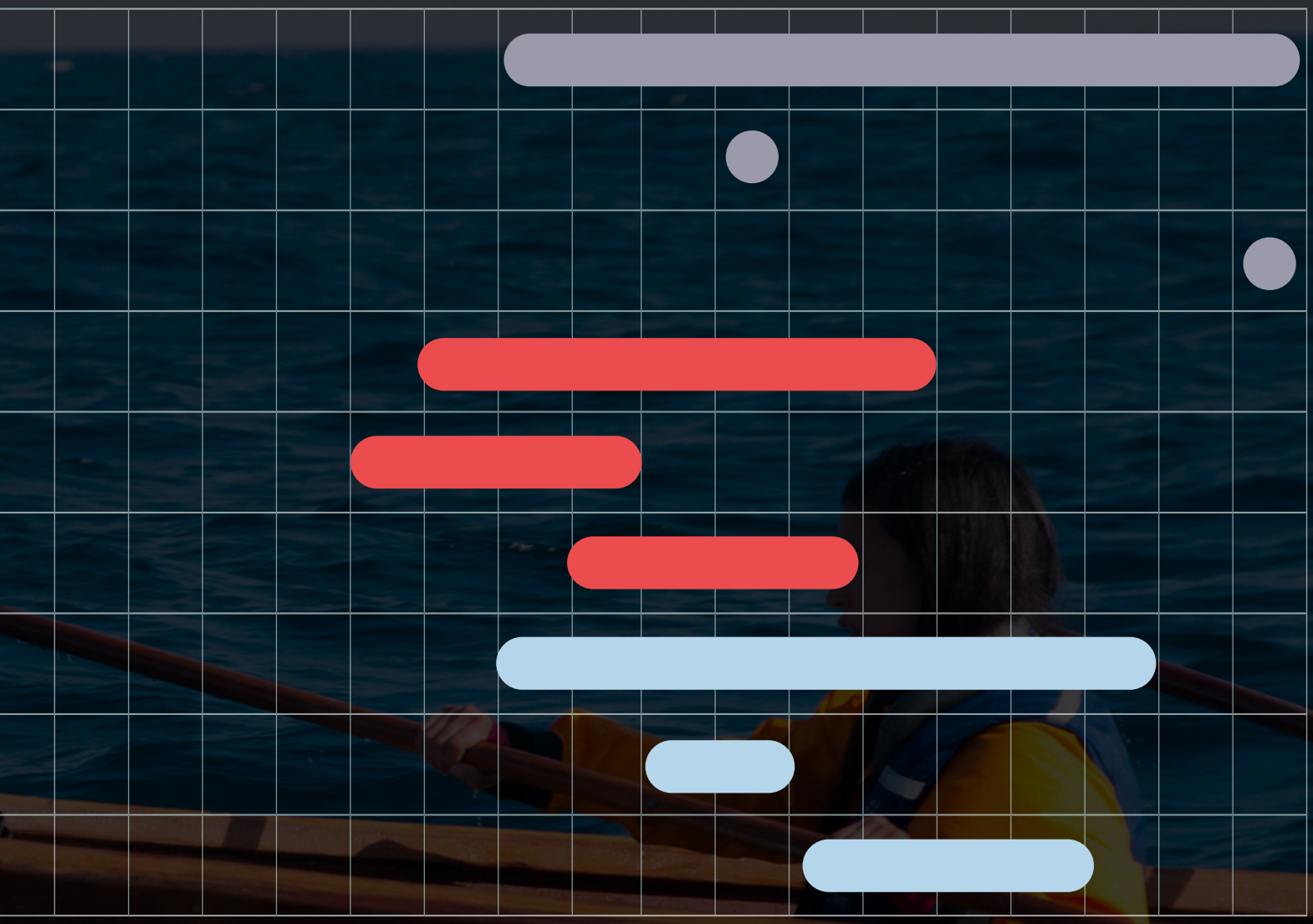
Analysis of Primary Data

All of the data collected was compiled by the Circles of Care team and consultants. The qualitative data was sorted into major categories of strengths and community assets and needs. The community strengths and assets data were then divided into sub-domains by individual community members as assets, activities, values, cultural wisdom, places, events, groups, programs, services, organizations, funders, media and information. The quantitative data was entered from paper surveys to Excel. Quantitative measures were analyzed using descriptive statistics.



Community Health Needs Assessment 2.0 August 2018 – June 2019	Community Review Data Collection Data Analysis
Community Asset Mapping June 2018 – January 2019	Community Review Data Collection Data Analysis
Community Readiness Assessment August 2018 – April 2019	Community Review Data Collection Data Analysis

A Timeline of Circles of Care Data Collection Activities



Calendar of Supplemental Meetings

Community Advisory Council Meetings

Feb. 2018 · March 2018 · April 2018 · May 2018 · June 2018 · Aug. 2018 · Sept. 2018 · Nov. 2018 · Dec. 2018 · Jan. 2019 · Feb. 2019 · March 2019 · April 2019 · May 2019 · June 2019

Youth Advisory Council Meetings

May. 2018 · June 2018 · July 2018 · Aug. 2018 · Sept. 2018 · Oct. 2018 · Feb. 2019 · March 2019 · April 2019 · May 2019 · June 2019

Evaluation Workgroup Meetings

Feb. 2018 · March 2018 · April 2018 · May 2018 · June 2018 · July 2018

History and Community Overview

Native American Community Background

This section includes an historical overview of Native people living in the Santa Barbara and Ventura communities of California. The content is collaboratively authored by community members and project staff with the intent to share the past, understand the present and inform the trajectory of the future. Contained in this section are historical trends for Native people in the area, modern policies that affect the health of these communities and the critical efforts of cultural revitalization and community wellness that is practiced today.

Waves of Community Change

Original lifeways (Origin to 1542)

The Native peoples of California are prolific and diverse; comprised of approximately 200 tribes of varying size and political complexity. Thus far, the archaeological record shows that the ancestors of most of these peoples lived successfully in a multitude of habitats for over 14,000 years. Incredibly sophisticated processes of governance, housing, education, agriculture, ecological management, ceremony and medicine practices at one time formed the entirety of human interaction with what is now known as California. These original life ways have sustained the physical, mental, emotional and spiritual health of Native people since the emergence of their communities.

Many AIAN communities document the origin of their communities through oral traditions known colloquially as 'Creation Stories'. The Chumash,

This section was developed in collaboration with Native community members, elders and experts and contains local cultural knowledge.

The Making of Man

After the flood Snilemun (the Coyote of the Sky) Sun, Moon, Morning Star, and Slo?w (the great eagle that knows what is to be) were discussing how they were going to make man, and Slo?w and Snilemun kept arguing about whether or not the new people should have hands like Snilemun.

Coyote announced that there would be people in this world and they should all be in his image since he had the finest hands. Lizard was there also, but he just listened night after night and said nothing. At last Snilemun won the argument, and it was agreed that people were to have hands just like his.

The next day they all gathered around a beautiful table-like rock that was there in the sky, a very fine white rock that was perfectly symmetrical and flat on top, and of such fine texture that whatever touched it left an exact impression. Snilemun was just about to stamp his hand down on the rock when Lizard, who had been standing silently just behind, quickly reached out and pressed a perfect hand-print into the rock himself. Snilemun was enraged and wanted to kill Lizard, but Lizard Ran down into a deep crevice and so escaped. And Slo?w and Sun approved of Lizard's actions, so what could Snilemun do?

They say that the mark is still impressed on that rock in the sky. If Lizard had not done what he did, we might have hands like a coyote today.

By Eleanor Fishburn

Original Lifeways

native to the areas now known as Santa Barbara and Ventura Counties, have many creation stories, one particularly prominent story within the local community is about how the animals gathered to form the creation of the first human beings:

The original peoples of Santa Barbara & Ventura areas became known as the Chumash, derived from the name of the shell bead monies used for trade with the local coastal communities. Today, the traditional Chumash homeland encompasses all of San Luis Obispo, Santa Barbara, Ventura Counties, portions of Kern and Los Angeles Counties, and includes the Northern Santa Barbara Channel Islands. The AIAN pre-Colonial population is conservatively numbered in the tens of thousands and is spread across these areas in distinct communities with diverse lifeways, languages and cultures. Currently, it is estimated that there are approximately 5,000 Chumash people living within California. Many are affiliated with roughly 10 organized bands of Chumash, while many more are non-affiliated. Only one band is currently federally-recognized, the Santa Ynez Band of Chumash Indians.

What natural challenges in other parts of the globe could not do in more than 14 millennia, colonists nearly succeeded in doing within just 500 years. Beginning in the 16th century, waves of occupying Europeans and Euro-Americans nearly annihilated the original California peoples, including the Chumash, through disease, habitat destruction and violence. Within two or three generations, up to 90% of California's Native population was devastatingly swept away. Three major 'Waves' of history are critical in contextualizing an understanding of how Native communities have previously been affected and continue to be by the disease of colonization. The effects of colonization can be observed as eras of historical changes to the land, community practices of traditional health, changes or disruptions to spiritual & ceremonial life and the health of Native American families for generations.

Three major 'Waves' of histories are critical in contextualizing an understanding of how Native communities have been and continue to be affected by the disease of colonization.

The First Wave 1542-1823

The Mission Period The devastation presented itself in 1542 with the arrival of Spanish explorers who claimed "Alta California" for Spain, and continued in 1769 with the first wave of colonizers. During 1769 to 1823, Franciscan missionaries and soldiers established twenty-one Catholic missions, four presidios (military outposts), and numerous "Asistencias" (auxiliary chapels) from San Diego to Sonoma. Along with a European worldview promulgated by the Church, the colonizers brought a deep misconception of the organic, unattended land as "empty", although California's Native peoples had intimately and successfully worked with their natural environment for over a millennia.

The occupiers did not recognize Native peoples' own sophisticated land managing practices, and couldn't comprehend what they saw as "empty" were well tended and bounteous landscapes. Instead, Europeans imported new diseases, alien grazing animals and foreign plants, which permanently disrupted or destroyed the well-functioning agricultural communities of Native California, which had sustainably provided nutrition, medicine, shelter, tools and clothing for untold generations. This catastrophic loss in population was detrimental to all traditional cultures; artisanal skills, medicine practices, knowledge and access to plants, social interactions among families and neighboring groups and much more. Those who survived lived in captivity, worked inhumanely long hours and had access to meager rations that could not sustain health. Those who escaped were hunted down by soldiers and brought back to be brutalized into submission, often under threat of harm to their loved ones.

California's Native peoples had intimately and successfully worked with the natural environment for millennia.

The Second & Third Waves 1823-1900s

The Mexican, or Rancho, Period When Mexico gained independence from Spain in 1823, a new era of colonization began, commonly recognized as the Mexican or Rancho Period. The Missions were secularized, but the lives of Native families continued much as they had under the padres or priests, with the landowners now in charge. Promises of land and citizenship for Natives were never fulfilled. They were landless, with once unpopulated lands now producing few traditional resources. Native peoples were dependent for survival on the landowners and the work of the ranchos.

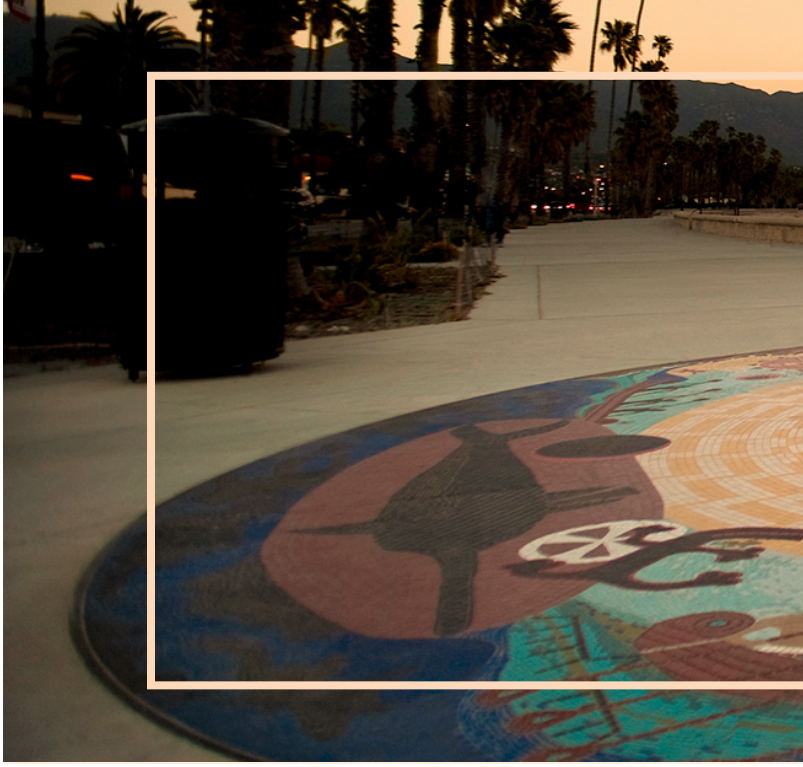
In Northern California, there was an 80% demographic collapse of Native peoples in ten years.

The Third Wave1850-1900's

Manifest Destiny By 1850—the year California gained statehood—the Americans had defeated Mexico and gained Alta California, but also the northern and inland parts of the State to draw its modern boundaries, bringing more than 100,000 Euro-Americans over a several year span. This period is characterized by the democratized and governmentally funded intentional genocide, with state and federal institutionalized policies for the extermination of Indians, in which whole villages were wantonly slaughtered with "legal" cause and no reason other than the racial discrimination of Native people.

In addition, Anti-Native California laws, such as "Manifest Destiny", prevented Native peoples from owning land, allowing for the kidnapping of Natives while the state provided funds for invading Native settlements and bounties for their scalps. These policies forced Natives who were not assimilated to conform to a colonial citizen household and leave their lands for Rancherias or reservations.

Many Native families who were not slaughtered or starved, especially women and children, were kidnapped and sold as "indentured servants" and treated as slaves. In Northern California, there was an 80% demographic collapse of Native peoples in within the first ten years after California was granted statehood. Animal grazing and other non-sustainable practices also devastated traditional resources and permanently damaged the natural functions of land and water.



Relocation & Self Determination In 1924, the Federal government recognized Native Americans as citizens of the United States, which then extended health services to Native people in the US.

The beginning of the Termination Era of 1953 intended to dismantle the reservation system to transfer natural resource wealth of reservations to private non-Native corporations, placing Indians at the mercy of state and county governments. The Indian Relocation Act of 1956 forced Native people to leave reservations and their traditional homelands to assimilate into the general population in major urban areas across the US, such as Los Angeles, San Francisco and Santa Barbara. As a result, relocation caused Native people to become isolated from their communities while facing racial discrimination and segregation during this period. Many found only low-paying jobs with little advancement potential and suffered from a lack of community support, while facing higher expenses in urban areas.

In 1966, numerous laws and executive orders were instituted to protect Native rights, burial sites, cultural resources and sacred places. In 1968, the Indian Civil Rights Act (ICRA) was passed to recognize the tribal sovereignty, citizenship and right to vote for AIAN people. During the 1970s following the end of the Termination period, the motivation for the beginnings of widespread cultural revitalization and Self Determination of AIAN people were born. The Indian Self-Determination and Education Assistance Act of 1975 empowered tribes to exercise sovereignty and solely control affairs including education, healthcare and governance.

Critical self-determination policies continued to be passed, including:

- American Indian Religious Freedom Act of 1978, which sought to end the religious persecution and criminalization of Native American tradition and spirituality.
- The Indian Child Welfare Act of 1978 which seeks to keep American Indian children in American Indian families.
- The Indian Health Care Improvement Act, which was passed in 1978 and made permanent through the Affordable Care Act in 2010, established the Indian Health Service (IHS) to contract and provide grant funding for Urban Indian Health Programs, which provide services to AIAN living in urban areas.

By the 1980s, the Native population of Santa Barbara and Ventura Counties, advocating with non-native allies, established the Santa Barbara Indian Center as a place to gather socially, as well as a center for Native people to find referrals for necessary health services, which evolved into an early version of American Indian Health & Services of Santa Barbara in 1994.

For Chumash peoples and non-Chumash Natives living in California in the South Coastal region, this revitalization has been expressed in numerous ways, described opposite.

Modern Wave 1924-Present

Milestones in Local Cultural Revitalization

- Rebirth of Native maritime culture.
- Reawakening traditional languages including of at least four of the original approximately eight local Chumash languages.
- Reemergence of songs, dances and ceremonies along, with creation of new songs.
- Reawakening of traditional practices regarding the use of native plants in medicine and food.
- Socio-political protection of natural and cultural resources with leadership by and for Chumash people at policy-making tables.

Changing Tides

Our Future

These historical waves of change to land, community and tradition as a result of colonization, have caused profound and lasting effects that directly and unequivocally impact AIAN people today. Thus, the impact of colonization is observed over time throughout these causes of historical trauma, and in understanding its effects, communities can begin to understand how these changes affect Native families today.

By mapping these historical traumas as they are passed down across generations (inter-generational trauma), communities can begin to uncover patterns that manifest as conflicts and violence. Native communities are working to undo the lateral oppression and lateral violence, a natural result of a world out of balance. Racism, poverty, domestic violence, addiction, disease and crime are therefore a result of this loss of culture due to colonization.

Changing the tides of history is the restoration of connections to culture. In order to chart a new course toward a future of wellness and balance, addressing the effects of colonization on Native families through the healing of historical trauma is required.

By working to address the social determinants of health which are mostly responsible for health inequities and acknowledging the effects of prejudice, discrimination, and inequity on the body, the start of rebuilding the fabric that weaves health, trust, support and love into AIAN communities, collectively moving from hurting to healing and helping can take place. The intergenerational empowerment of AIAN communities and families offers a pathway from colonization towards Indigenous self-determination and health sovereignty. In order to heal, communities must move from lateral oppression to lateral goodness, remembering the ancestors and drawing on their wisdom to change the course of history, toward a future of love, justice and health built on a foundation of culture.

Terminology Definitions

Historical Trauma

Historical trauma is the cumulative emotional harm an individual experiences that results from traumatic events such as forced assimilation, extermination, genocide, relocation and forced containment. Historical trauma also occurs through one's identifications within the historical experiences of family and community.

Intergenerational Trauma

Intergenerational trauma is considered as the transmission of historical oppression and its negative consequences across generations. "A collective complex trauma inflicted on a group of people who share a specific group identity or affiliation—ethnicity, nationality, and religious affiliation. It is the legacy of numerous traumatic events a community experiences over generations and encompasses the psychological and social responses to events."[39]

Lateral Violence & Lateral Oppression

Lateral oppression is defined as the shaming, humiliating, damaging, belittling, and sometimes violent behavior directed toward a member of a group by other members of the same group. It is seen most often in oppressed groups who have been rendered helpless to fight back against a powerful oppressor and who eventually turn their anger against each other. Examples of lateral op pression include: non-verbal intimidation, sarcasm, name calling, blaming, belittling a person's opinions, making spiteful comments, using putdowns and gossiping/rumor mills.

Lateral Goodness

Lateral goodness is the opposite of lateral oppression. Using strength-based language, lateral goodness is a resilience factor and a way to promote positive change that empowers individuals and communities. Examples of lateral goodness and collaboration include: prayers and ceremonies, building relationships, listening with respect, strength-based communication, open communication, sharing information/resources, avoiding judgment and criticism, reflecting strengths while celebrating successes.

Health Sovereignty[1]

The right to access, without discrimination, self-organized, community viable forms of both western and traditional approaches to medicines that effectively meet an individual, family, or communities physical, spiritual, mental and emotional health needs.

Community Wellness Timeline

The Original Lifeways

These original life ways have sustained the physical, mental, emotional and spiritual health of Native People since the emergence of their communities. The original peoples of Santa Barbara & Ventura areas became known as the Chumash, derived from the name of the shell bead monies used for trade with the local coastal communities.

The First Wave (1542-1823) Missionization Period

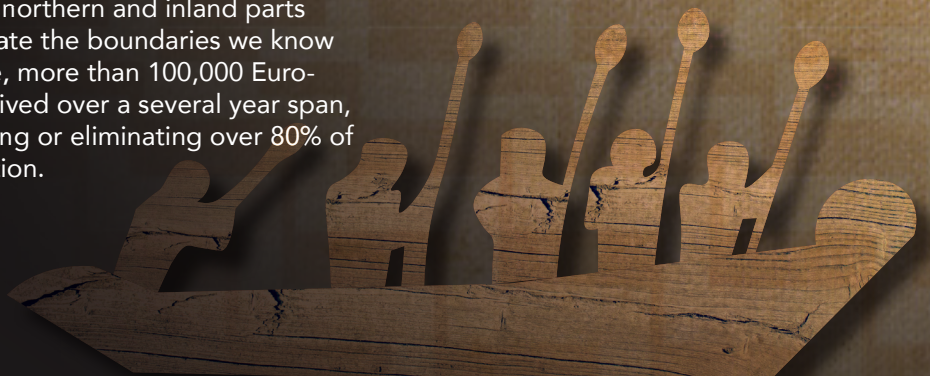
- 1542 the arrival of Spanish explorers who claimed "Alta California" for Spain.
- 1769 with the first wave of colonizers.
- 1769 to 1823, Franciscan missionaries and soldiers of the Spanish Crown established twenty-one Catholic missions, four presidios (military outposts), and numerous "Asistencias."

The Second Wave (1823-1850) Mexican or Rancho Period

Mexico gains independence from Spain in 1823, a new era of colonization began, commonly recognized as the Mexican or Rancho Period.

The Third Wave (1850-1900s) Era of "Manifest Destiny"

1850 California gains statehood after the defeat of Mexico by the Americans, who absorbed Alta California and the northern and inland parts of the state to create the boundaries we know today. By this time, more than 100,000 Euro-Americans had arrived over a several year span, displacing, removing or eliminating over 80% of the native population.



Modern wave
(1924 – Present)

1924: Native Americans Gain Citizenship

Federal government recognizes Native Americans as citizens of the United States which first extended health services to Native people in the US.

1953: Beginning of the Termination Era

The era intended to dismantle the reservation system, to transfer the natural resource wealth of the reservations to private non-Indian corporations.

1975: The Indian Self Determination Act

The Indian Self-Determination and Education Assistance Act of 1975 empowered tribes to exercise their sovereignty and control their own affairs including education, healthcare and governance.

Community Health Developments

- Founding of Santa Barbara Indian Center 1980s.
- 1978 Indian Child Welfare Act, which seeks to keep AIAN children in American Indian families.
- Indian Health Care Improvement Act, which was introduced in 1978, and made permanent through the Affordable Care Act in 2010.
- Founding of American Indian Health & Services in 1994.
- United Nations Declaration on the Rights of Indigenous Peoples in 2007, which outlines individual and collective rights of Indigenous peoples internationally.

Changing Tides: Our Future

Knowledge Rediscovery ***Spiritual Renewal***

Language Reawakening ***Health Sovereignty***

Cultural Revitalization

American Indian Health & Services Background & History

Founding Vision

In 1994, American Indian Health & Services was founded from the vision of a vibrant community where AIAN people and the surrounding community of Santa Barbara and Ventura counties are supported through an environment of peace, balance, and harmony to nurture the mind, body and spirit. Founders envisioned a community health center that provided the care, education, resources and gathering space to enable clients to sustain a lifetime of health and wellness, while in balance within the urban setting of Santa Barbara and the surrounding communities of the "South Coast" region. American Indian Health & Services was founded as a Santa-Barbara based non-profit to work towards making this dream a reality. The mission statement of AIH&S is to promote and provide quality services to improve the health and well-being of American Indian/ Alaska Natives and other community members. AIH&S is governed by an independent Board of Directors who are knowledgeable about issues affecting the community, bringing a range of experience to the fields of medicine, science, law, health, technology, finance, education and culture of the AIAN community to list a few.

Programs and Services

American Indian Health & Services is a community health center that provides programs and services based on the organization's founding values; 1) supply patient-centered medical, dental, psychological, legal, social, educational and related services to eligible American Indian/ Alaska Natives, 2) develop and improve quality techniques and approaches that best serve the needs of the American Indian/Alaska Native community, and 3) encourage the formation and operation of programs and services that address emergent needs as they develop.

AIH&S is one of 41 nonprofit Urban Indian Health Organizations nationwide which seek to provide culturally competent care to meet the needs of the Urban Indian communities they serve.

American Indian Health & Services provides a wide array of clinical and non-clinical services to the community, regardless of tribal affiliation or ability to pay, including: **1)** Medical services such as family practice, pediatrics, women's health, confidential HIV & STD testing, family planning services, minor office procedures, laboratory services, eye exams, immunizations, school physicals and urgent appointments for youth; **2)** Dental Services, including x-rays, cleanings, deep cleanings, fillings, removable dentures, orthodontics and endodontics; **3)** Behavioral health services for all ages, including individual and group counseling and substance abuse counseling; **4)** Community Health Programs and Services, including free tattoo removal in partnership with the Liberty Program, Comprehensive Diabetes Care, Diabetes Prevention Programs and management, Healthy Eating and Active Living activities, and Clinic on Wheels for mobile diabetes services; **5)** Community Wellness Programs and Outreach Services, which include transportation assistance, community outreach and engagement, education for health promotion/disease prevention, fitness activities, youth programs, elder programs, family programs, traditional arts activities, cultural programs and activities, community garden, and prevention/early intervention of suicide and substance abuse.

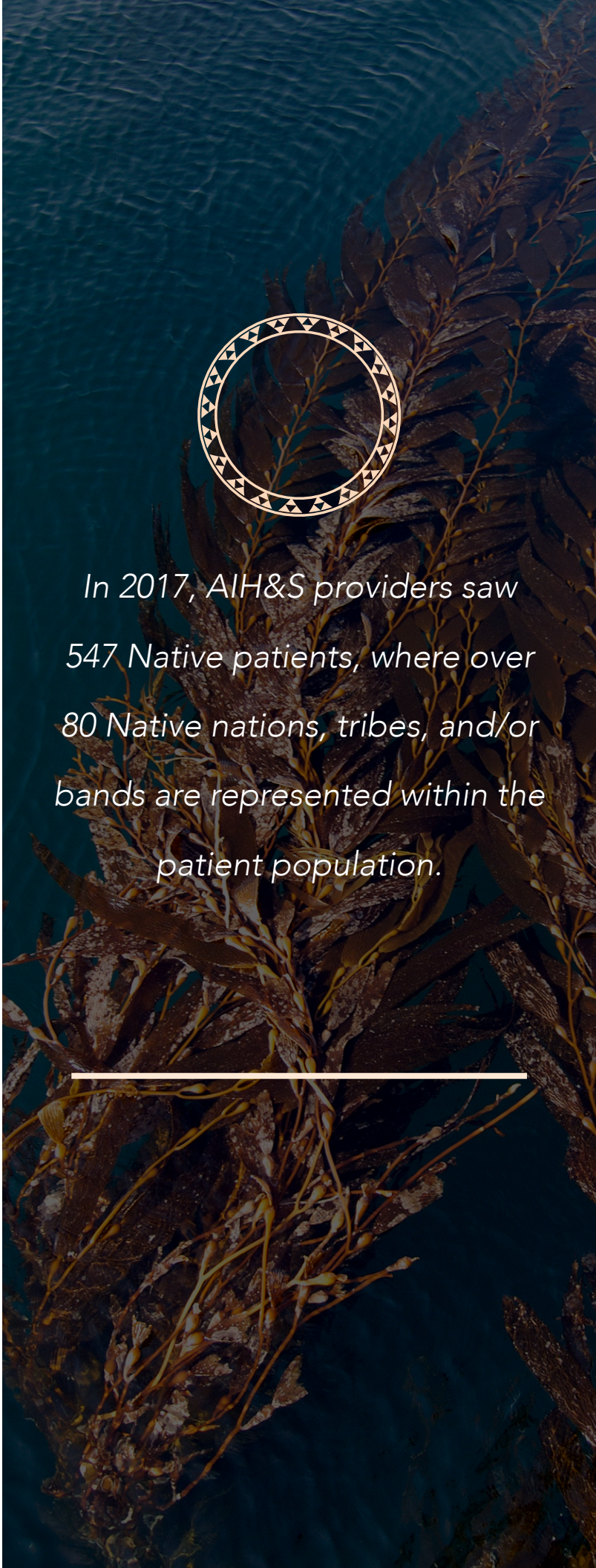
Who We Serve

American Indian Health & Services (AIH&S) is a Santa Barbara based nonprofit community health center that offers medical, dental, pediatric, behavioral health, and community wellness services to both Native and non-Native clients. The mission statement of AIH&S is to promote and provide quality services to improve the health and wellbeing of American Indian/Alaska Natives and other community members.

The American Indian Health & Services is located in the heart of the ancestral territory of the Chumash peoples and includes Santa Barbara, Ventura, and San Luis Obispo counties ("South Coast" region), where a majority of the clinic's clients reside. By 2010-2014 estimates, the service area is home to an estimated 1,541,529 residents and there are around 28,755 (1.9%) individuals identified as solely American Indian/Alaska Native or in combination with one or more race. As well, there are approximately 5,000 Chumash persons living within California.

In focus to provide culturally-responsive services, AIH&S serves a diverse Native patient population. In 2017 alone, 547 Native patients were seen by AIH&S providers, with over 80 AIAN nations, tribes, and/or bands represented within this patient population. AIH&S is one of 41 nonprofit Urban Indian Health Organizations nationwide which seek to provide culturally competent care to meet the needs of the Urban Indian communities they serve, and plays a vital role in fulfilling the federal government's obligations to provide free or low-cost health care to American Indian/Alaska Natives under Title V of the Indian Health Care Improvement Act. In ensuring this act, AIH&S was incorporated in 1994 as a California nonprofit and has served the health needs of American Indian/Alaska Native peoples in the South Coast region for over 25 years, regardless of tribal affiliation or ability to pay.

AIH&S also serves non-native patients, providing care to the entire community of the South Coast region encompassed by AIH&S' service area. Designated as a Federally Qualified Health Center (FQHC) through a contract with the Indian Health Service (an agency within the U.S. Department of Health & Human Services), AIH&S is able to provide low to no cost healthcare services to all non-Native, medically underserved populations in its service area, regardless of race, ethnicity, income or residency. In 2017, 5,996 non- Native patients were seen by AIH&S providers. The priority population are families living below 200% of the federal poverty line and/or patients who are uninsured or underinsured in the service area.



In 2017, AIH&S providers saw 547 Native patients, where over 80 Native nations, tribes, and/or bands are represented within the patient population.

Service System Overview of AIANs in Santa Barbara & Ventura Counties

While the intent of this report is to highlight the strengths and needs of the AIAN community in Santa Barbara and Ventura counties, the need to articulate the realities and current landscape of health disparities among community members is essential. In highlighting, but not focusing solely on the disparities faced by AIAN communities, this report seeks to build bridges with allies, stakeholders, community supports and agencies to develop partnerships that work toward system change resulting in positive health outcomes for AIAN families.

The data presented in this service overview section does not speak to the vast breadth of equally valid data, which tells the story of resilience, hope, excellence, skill and tenacious heart that community members express each day. It is impossible to capture the cultural, intellectual and social contributions that have sustained for generations the wellbeing of AIAN community members. At the center of this project to build a System of Care are the efforts to celebrate and further develop the health and wellness services available to community members and to sustain these efforts for generations to come.

The AIAN population within each of the represented counties in this report are small, often between 0.1% and 2.2% of the total. This data, therefore, must be interpreted with caution. Various data resources did not report on the AIAN population specifically. In this instance, county level data are used as are community-level data.

In order to fully understand the AIAN population from available data is a challenge for various reasons. The first is that different data sources have varying definitions of AIAN. For instance, in one data report, it could be that the person is only counted as AIAN if they do not identify as any other race in addition to AIAN or that some enrollment in a federally recognized tribe is required, while others rely only on self-identification.

Another challenge is that the AIAN population may be so small for a given measure, that providing any data could risk identification of the individual. Furthermore, many sources simply fail to report on AIAN populations, reporting only White, Black, Hispanic, Other, and Asian statistics.

In 2018, the US Census Bureau reported that 757,628 (2.3%) individuals identify as AIAN alone or in combination with one or more other races in California. In Santa Barbara and Ventura counties, 27,553 (2.03%) identify as AIAN alone or in combination with one or more races.

The data presented in this service overview section does not speak to the vast breadth of equally valid data, which tells the story of **resilience, hope, excellence, skill, and tenacious heart** *that community members express each day.*

AIAN Population

AIAN Alone or in Combination

As % of Total Population

2.3%	757,628 CA
2.1%	10,151 Santa Barbara
1.97%	17,402 Ventura

AIAN Alone

As % of Total Population

0.8% or **296,475**
California

1.0% or **4,389**
Santa Barbara

0.8% or **7,069**
Ventura

California has a population of 18,522,036 children under the age of 18. For the state, over 289,792 (1.15%) children have been identified as AIAN alone or in combination with another race. Santa Barbara and Ventura counties have child populations of 206,398 and 39,4310 respectively. Santa Barbara and Ventura Counties are home to over 7,000 AIAN youth under 18 in the counties. Additionally, AIAN youth identified as Transitional Age Youth or 'TAY' (18-24) include 124,426 in CA with 3394 residing in Santa Barbara and Ventura counties.

Children in California	Santa Barbara	Ventura
33,914 AIAN Alone	**284** AIAN Alone	**393** AIAN Alone
212,000 AIAN Alone or in Combination	**2,448** AIAN Alone or in Combination	**4,537** AIAN Alone or in Combination
124,427 TAY (18-24) Alone or in combination	**1,596** TAY (18-24) Alone or in combination	**1,798** TAY (18-24) Alone or in combination

Education

Educational attainment is an important indicator for lifelong health status.

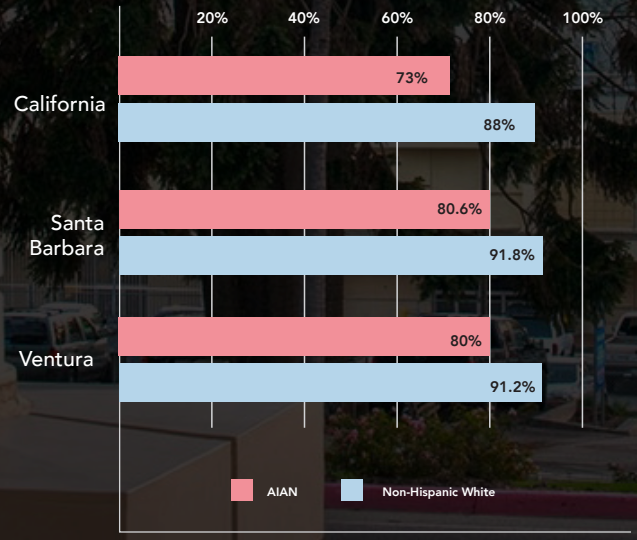
K-12

The California Department of Education reports that 32,500 AIAN students were enrolled in California's K-12 public schools in 2018, representing 0.53% of the total enrollment in CA. In Santa Barbara and Ventura Counties, 586 students enrolled in the K-12 public schools were identified as AIAN, representing 0.28% of the schools' populations. Though not defined by the Department of Education, it is assumed that these numbers represent those who are identified as AIAN alone. The actual numbers of AIAN students may be higher.[34]

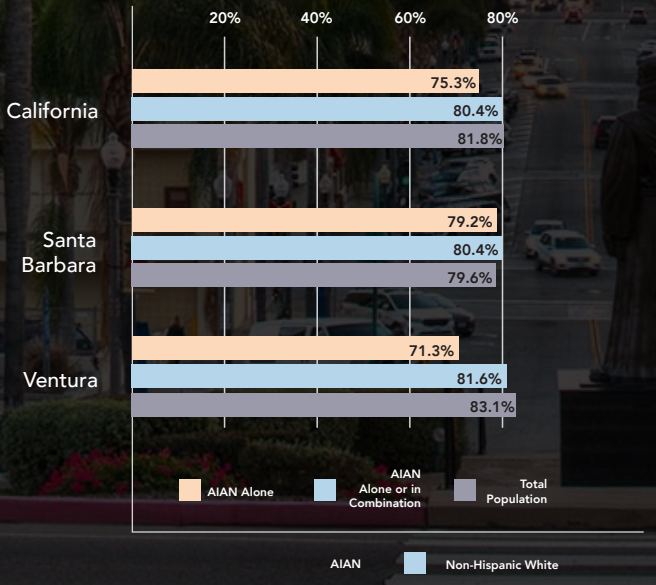
The California Department of Education additionally reports the 2015 high school graduation rate for AIAN students in the state to be 73.1%. In comparing that rate to their Non-Hispanic White (NHW) counterparts, we see a substantial decrease from the NHW rate of 88.0%. Though rates are higher in Santa Barbara and Ventura counties, similar trends in graduation rates are seen when comparing AIAN students to NHW.[15]

2015 American Community Survey data show the percent of the AIAN alone population over the age of 25 who have attained a high school diploma or higher in Santa Barbara County and Ventura County to be 79.2% and 71.3%, respectively. When including those AIAN who identify as AIAN and another race, this percentage improves substantially, meeting or exceeding those for the total population.[26, 27]

Graduation Rates of AIAN Compared to NHW Students



High School Diploma Attainment of AIAN Compared to Total Population



College and Graduate School

In the fall of 2017, 6,864 AIAN students were enrolled in California's community colleges–62 of these students were enrolled in Santa Barbara County and 104 in Ventura County. The California Community Colleges Chancellor's Office reports that of their total enrollment, AIAN students represent less than half a percent. The 2015 ACS reports that of the total number of CA students enrolled in college or graduate school, 0.74% of these are AIAN. At the local level, AIAN students represent 0.55% of the college, professional, and graduate school students in Santa Barbara County, while they represent 1.06% of those enrolled in Ventura County.

For the AIAN population over 25, the percent of individuals with a bachelor's degree or higher is only a fraction of that for the population at large. Across California, 31.4% of the total population holds a bachelor's degree or higher. For the population that identifies as AIAN alone or in combination with one or more races, this rate drops by more than a third to 19.1%. For those who identify as AIAN alone, this percentage drops even further to 13.9%. Similar trends are seen at the local level in Santa Barbara and Ventura counties.

19.1% hold a bachelor's degree or higher.

"Throughout the data, it is clear that those who identify as AIAN alone are experiencing worse outcomes compared to those who identify as AIAN in combination with another race. Further research must be done to identify reasons for this difference and to improve outcomes for those who identify as AIAN alone"

Social Services & Foster Care

According to a report released by the Urban Indian Health Institute (UIHI), AIAN communities in Santa Barbara and Ventura counties face many socioeconomic and health disparities compared to the NHW population. AIAN families and children experience poverty at five-times the rate for NHWs. Between 2010 and 2014, the poverty rate for AIAN families in the service area was 22.5% while that of the NHW community was only 4.2%. Rates of poverty were also higher for AIAN children (29.8%) and AIAN single-mother families (33.4%) during this time. In Ventura county, AIAN children have the highest disparity in childhood poverty of any race or ethnic group, with 33% of AIAN children living in poverty.[2, 14] In addition to higher rates of poverty, UIHI also reports the AIAN community experiences increased rates of unemployment. At the time of their report, the rate of unemployment for the AIAN community was 50% higher in the AIAN community compared to the NHW population, 12.5% an 8.2% respectively.

While the unemployment rates across California have improved since 2010, 2017 Bureau of Labor Statistics reports that at the statewide level, AIAN communities continue to experience higher rates of unemployment compared to the aggregate population–8.9% in the AIAN population compared to the aggregate rate of 4.9%.[28, 29]

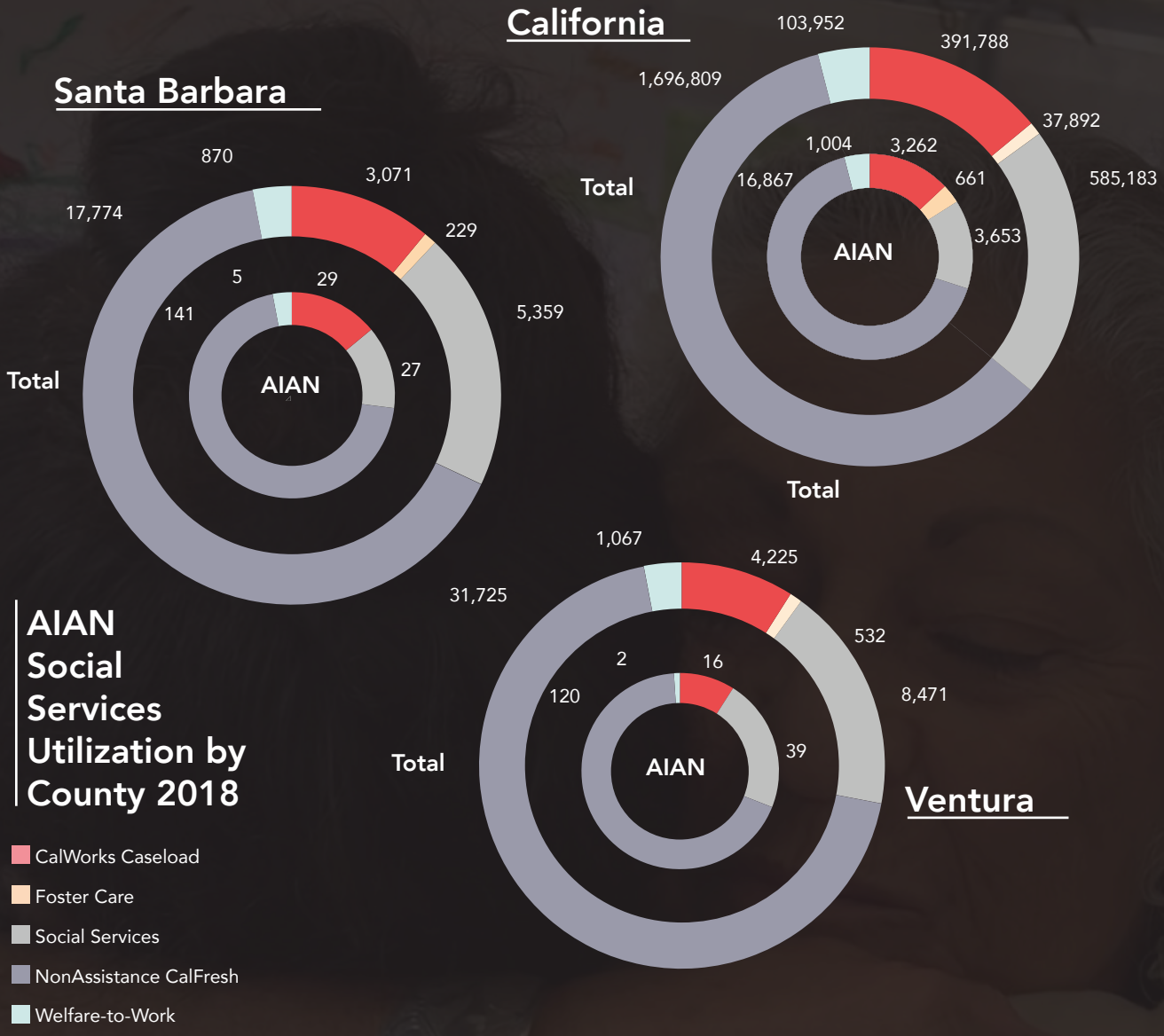
With higher rates of both poverty and unemployment, it would be expected that AIAN communities would utilize local and federal social services at higher rates compared to other populations. This is true for the utilization of Food Stamp/SNAP benefits by AIAN alone and in combination with one or more races. The 2015 ACS report shows a 15.7% utilization rate for California's AIAN population while the total utilization rate for the state was only 9.2%. In Santa Barbara, the same trend is seen–10.7% of AIAN families are utilizing SNAP, while only 7.0% of the broader population is. For Ventura these rates are similar at 14.3% and 7.0% respectively.

2018-19 CalWORKs data for the counties presented, however, do not show the same trend of higher AIAN utilization. Though the AIAN population in Santa Barbara and Ventura counties is close to 2%, the display below shows that the caseload represented by AIANs, for various services, remains substantially below that percentage. These lower numbers are likely due to CalWorks reporting only the population that identifies as AIAN alone and aggregating the rest of the AIAN population into categories such as "other", "multi-racial" or "two or more races."

Between 2010 and 2014, the poverty rate for AIAN families in the service area was 22.5%

Rates of poverty in the service area for AIAN children were over 30%

The rate of unemployment was 50% higher in the AIAN community compared to the NHW population



Though the data reported from CalWORKs above show no AIAN youth in the foster system, according to the U.S. Department of Health and Human Services, Administration for Children and Families, AIAN youth represent 2% of the total foster youth population. AIAN and African American youth are the only race/ethnic demographics to experience a higher percent representation in the foster system than in the general public school population. Various factors exist that contribute to the underreporting of AIAN youth including racial misclassification and barriers placing AIAN youth in the foster care system. Several practices to establish the estimated total of AIAN foster youth in county systems that undercount and/or underreport these numbers exists including population data formulas.[16]

There are no data available from Ventura and Santa Barbara counties on substantiated cases of Child Abuse & Neglect in 2015. Aggregated data in California for 2015, however, show that for every 1,000 AIAN youth, there are 21.9 substantiated cases of child abuse & neglect, the highest rate of abuse and neglect compared to all other racial and ethnic groups.[24]

Mental Health

Measuring child and adult mental health for the AIAN community at the local level can be challenging due to the size and geographic disbursement of this population. For this reason, state- and federal-level data are presented in this section. Additionally, local data not specific to the AIAN community is used to show a broad and general need in the community.[18]

Data from 2013-2015 Healthy Kids Survey shows that AIAN students at the state and local level experience higher rates of both depression related feelings, suicidal ideation, bullying and harassment. In Santa Barbara County, Ventura County, and at the statewide level, 30% or more AIAN students report having depression related feelings. For white students, this rate ranges from 22.6% to 27.6%. AIAN students report from 2.5-8.6% higher rates of suicidal ideation and 1.9-9.2% higher rates of bullying and harassment.[19]

Though the rates displayed on the right are concerning for the AIAN population, in the case of suicidal ideation, the counties represented by the AIH&S service area are lower overall compared to the statewide rate.

A 2015 report released by the California Rural Indian Health Board on the California Tribal Behavioral Risk Factor Community Survey (CTBRFCS) shows that across California, 9.7% of the CA Indian population reports experiencing poor mental health for more than half the month, 18.4% report sadness or depression more than 10 days in the month, 17.8% have been diagnosed with a depressive disorder, and 20.3% have been diagnosed with an anxiety disorder.

The SAMHSA National Survey on Drug Use and Health (NSDUH) report from 2014-2016 shows that in Santa Barbara and Ventura counties, 17.18% of the adults 18 years and older have been diagnosed with a mental illness in the past year and 3.93% have been diagnosed with a serious mental illness.

The 2017 SAMHSA NSDUH data show that while a lower percent of the AIAN population in the US are diagnosed with mental illness, they experience double the rate of attempted suicide and have lower rates of mental health service utilization.

AIAN Depression Related Feelings

31.7%	30.3%	30.4%
CA	*SB*	*Vent.*

27.6%	22.6%	27.6%

White Depression Related Feelings

AIAN Suicidal Ideation

26.6%	17.6%	21.2%
CA	*SB*	*Vent.*

18.6%	14.2%	18.7%

White Suicidal Ideation

AIAN Some Bullying or Harassment

39.3%	31.3%	46.2%
CA	*SB*	*Vent.*

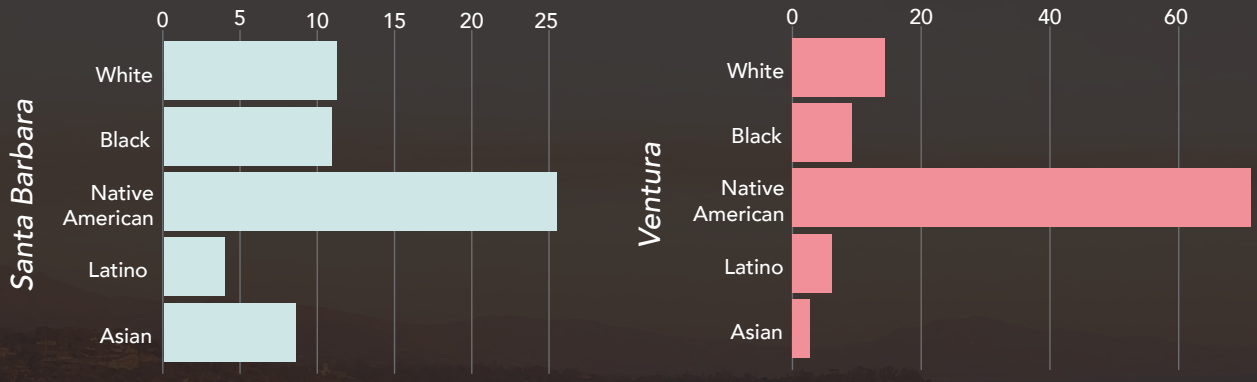
37.4%	29.3%	37.0%

White Some Bullying or Harassment

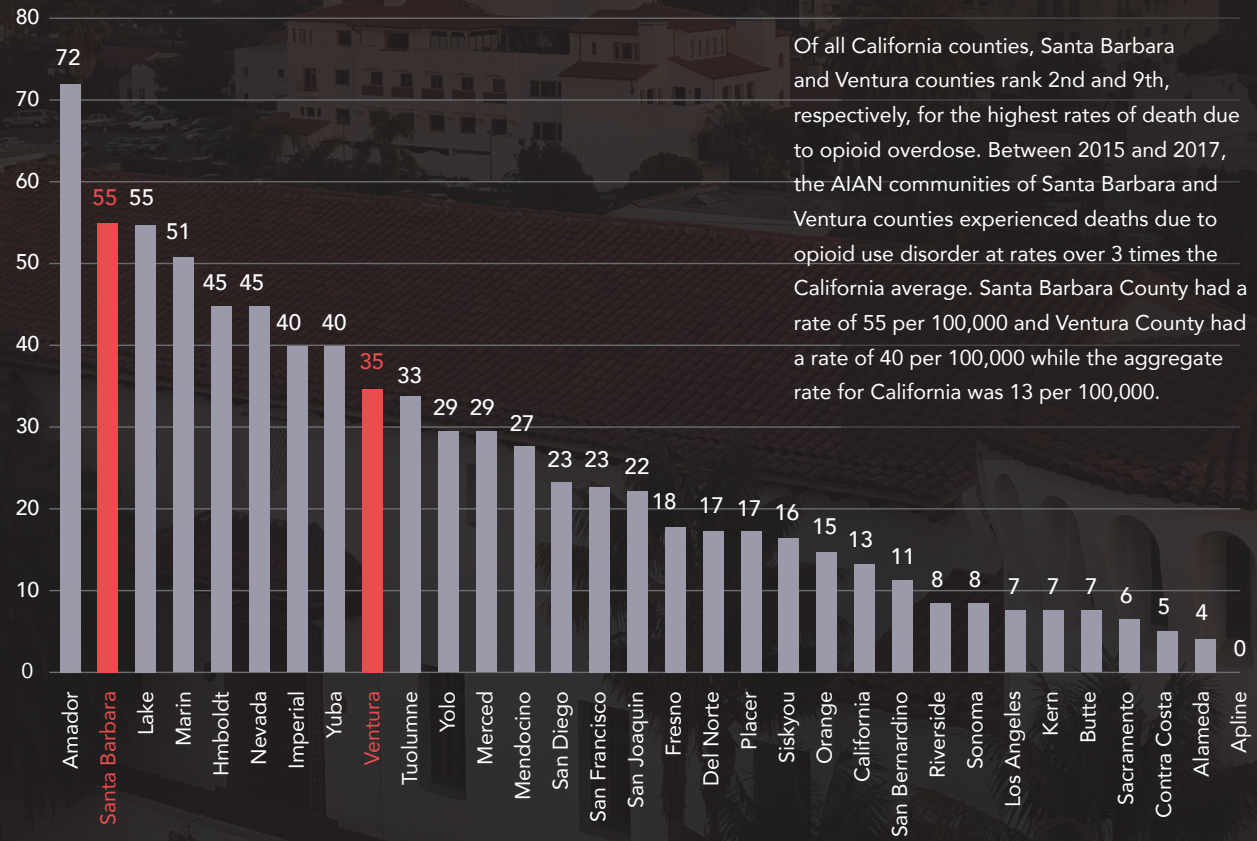
Substance Use Disorder

Data collected by the Centers for Disease Control and Prevention from 1999-2016 show the AIAN population has over twice the rate of alcohol-related deaths than all other demographics at 28.5 per 100,000. Additionally, AIAN people have the highest rate of drug-induced deaths at 33.0 per 100,000.[23]

2017: Race/Ethnicity: All Opioid Overdose Deaths: Age-Adjusted Rate per 100k Residents



2015-2017 Average Native American Opioid Overdose Age-Adjusted Death Rate per 100,000 Residents by County



Of all California counties, Santa Barbara and Ventura counties rank 2nd and 9th, respectively, for the highest rates of death due to opioid overdose. Between 2015 and 2017, the AIAN communities of Santa Barbara and Ventura counties experienced deaths due to opioid use disorder at rates over 3 times the California average. Santa Barbara County had a rate of 55 per 100,000 and Ventura County had a rate of 40 per 100,000 while the aggregate rate for California was 13 per 100,000.

Drug & Tobacco Use

While the 2014-2016 SAMHSA NSDUH Report does not include data regarding the AIAN population specifically, it does provide county-level data on individuals 12 years of age and older. In the region, individuals are significantly more likely to have used marijuana or cocaine in the past year, compared to the federal probability. Additionally, these same individuals are less likely to have used cigarettes or tobacco in the past year compared to the federal level. Statewide data from the California Tribal BRFCS conducted by CRIHB in 2015 show that 56.5% of respondents had used marijuana, 33.3% had used cocaine, 29.4% had used methamphetamine, 30.3% had used speed, 17.9% had used inhalants, 29% had used alcohol within the past month, and 24.9% currently smoke cigarettes. The information here illustrates that in many these categories of substance use that Santa Barbara and Ventura counties exceeds percentages in California and national substance use.[22]

Tobacco Use

Cigarette Use *in Past Month Among 12+*

US **19.76%**

SB/Ventura **13.90%**

CA **14.34%**

Tobacco Use *in past year among 12+*

CA **17.37%**

SB/Ventura **17.72%**

US **24.22%**

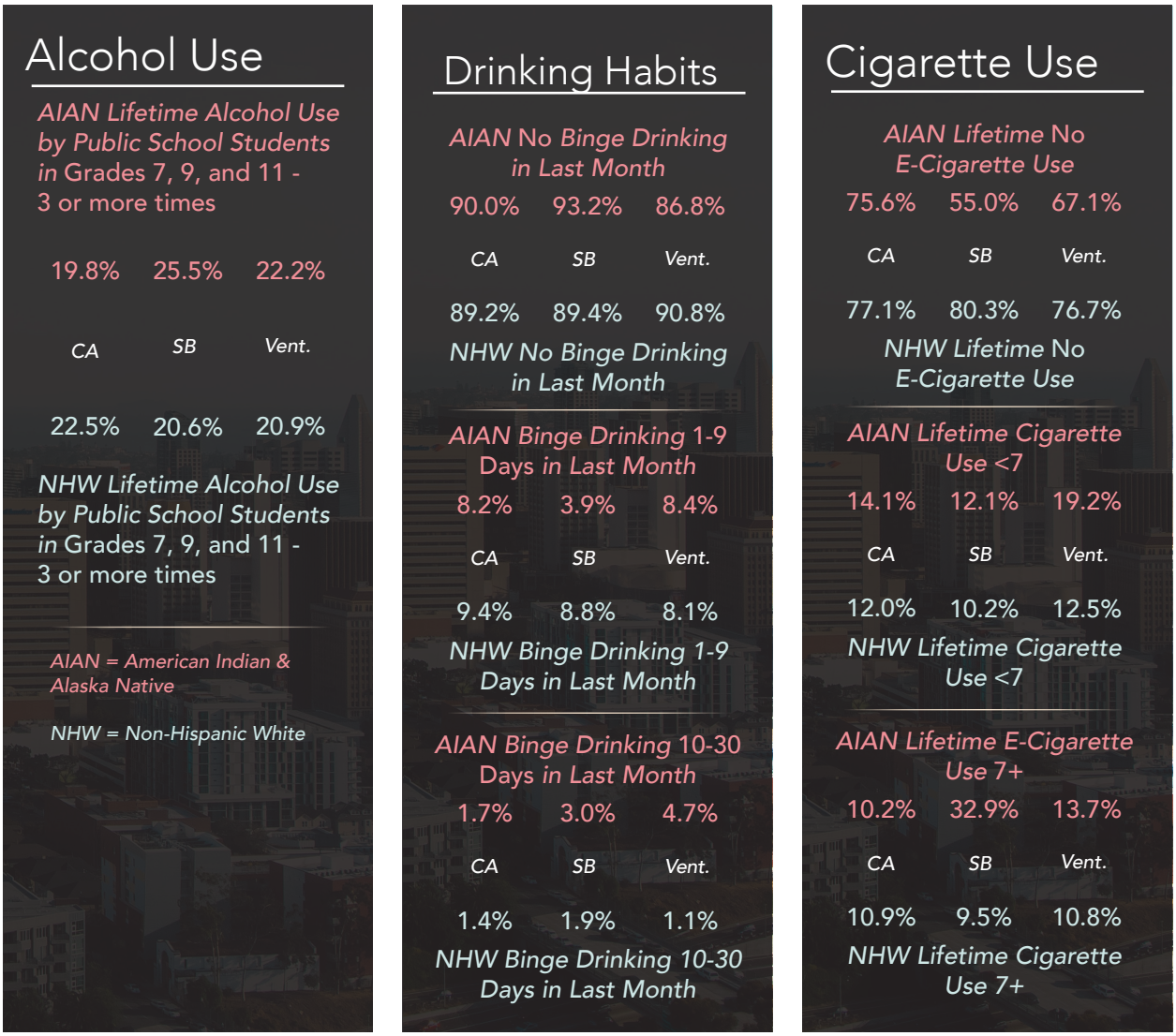
Alcohol Use

Alcohol Use in Past Year **Among 12+**	*US* **51.70%**	*CA* **50.27%**
	SB/Ventura **53.49%**	
Alcohol Use in Past Year **Among 12-20**	*US* **20.82%**	*CA* **19.75%**
	SB/Ventura **23.77%**	
Alcohol Use Disorder *in Past Year Among 12+*	*US* **5.96%**	*CA* **6.37%**
	SB/Ventura **7.55%**	

Drug Use

Marijuana Use *in Past Year Among 12+*	*US* **13.55%**	*CA* **15.87%**
	SB/Ventura **16.99%**	
Cocaine Use *in Past Year Among 12+*	*US* **1.80%**	*CA* **2.44%**
	SB/Ventura **3.48%**	
Heroin Use in Past Year Among 12+	*US* **0.34%**	*CA* **0.21%**
	SB/Ventura **0.22%**	

Data from the 2013-2015 California Healthy Kids Survey show that at the state level AIAN students are less likely, compared to NHWs, to have consumed alcohol three or more times. At the local level, however, AIAN students in Santa Barbara and Ventura counties have a higher percentage of alcohol use, comparatively. For binge drinking data, AIAN students are less likely to have binged on alcohol in the last month, but for those youth who have, they are likely to have done it more often compared to NHW youth. AIAN students are also more likely to have used e-cigarettes compared to their NHW counterparts. AIAN youth are also more likely to have used e-cigarettes seven or more times based on county-level results.[23]



Health Services Access

The U.S. government has identified Santa Barbara and Ventura counties as a Health Professional Shortage Area. This designation indicates a greater need for providers to serve the AIAN population in the service area.

In addition to service availability, insurance status also determines access to health services. The 2015 ACS Data shows that the AIAN population is more likely to be uninsured or to utilize public insurance programs compared to the total population–this is true at the statewide and county levels. By the same token, those in the AIAN population who identify as AIAN alone are more likely than those who identify as more than one race to be uninsured.

California	Total Population	AIAN Alone	AIAN Alone & in Combination*
% with Health Insurance Coverage	85.3%	78.7%	83.4%
% with Private Health Insurance Coverage	61.2%	47.7%	53.7%
% with Public Health Insurance Coverage	32.6%	39%	37.8%
% with No Health Insurance Coverage	14.7%	21.3%	16.6%
% Children <18 with No Health Insurance Coverage	6.4%	11.6%	7.8%

Santa Barbara	Total Population	AIAN Alone	AIAN Alone & in Combination*
% with Health Insurance Coverage	84.2%	77.7%	83.3%
% with Private Health Insurance Coverage	63.2%	53.1%	57.4%
% with Public Health Insurance Coverage	31.9%	33.8%	35.8%
% with No Health Insurance Coverage	15.8%	22.3%	16.7%
% Children <18 with No Health Insurance Coverage	8.2%	12.7%	6.4%

Ventura	Total Population	AIAN Alone	AIAN Alone & in Combination*
% with Health Insurance Coverage	86.2%	76.1%	83.1%
% with Private Health Insurance Coverage	66.8%	47.8%	58.9%
% with Public Health Insurance Coverage	29.1%	34.3%	31%
% with No Health Insurance Coverage	13.8%	23.9%	16.9%
% Children <18 with No Health Insurance Coverage	6.4%	10.5%	10.7%

AIAN child rates of uninsurance are less than that of their adult counterparts. However, AIAN children under the age of 18 are more likely to be uninsured compared to the general population of children at both the state and county levels.

In effect, the available 2017 ACS data reveals that the uninsurance rates have decreased substantially for the total population. However, updated data on the AIAN population specifically is not yet available.

* In combination with one or more other races.

Juvenile and Criminal Justice

Criminal justice data specific to the AIAN community is difficult to access for many reasons. One issue is that the criminal justice system is fragmented and therefore lacks coordinated reporting systems that adequately track AIANs. Another reason for this challenge is that in the criminal justice system, race is assigned by a third party, rather than by the individual. This means that if a person identifies as AIAN, but appears to be any other race, they are not likely to be counted.

In California, of all individuals served by the criminal justice system in 2014, 152,315 (0.4%) were recorded to be AIAN. At the county level, those who were recorded as AIAN represented a slightly higher percent in Santa Barbara County (0.5%, 2,173) and a slightly lower percent in Ventura County (0.3%, 2,527).

The Center on Juvenile and Criminal Justice reports the adult and juvenile felony arrest rates as well as the incarceration rates for these populations, both as a rate per 100,000. For adults, Santa Barbara County saw a 6% higher felony arrest rate compared to the state rate (1,089) and Ventura County saw a 3% lower rate comparatively. Both counties, however, experience lower rates of adult incarceration compared to the state level. Compared to the state rate (478), Santa Barbara (687) and Ventura (513) counties both experienced higher rates of juvenile felony arrests–44% and 13% higher, respectively. The population in juvenile halls and camps is, however, significantly higher in Santa Barbara County (235) compared to its neighbor, Ventura County (92), and compared to the state of California as a whole (106).

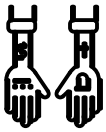
Correspondingly, the 2015-2017 CA Healthy Kids Survey data show that AIAN students are more likely to report gang membership compared to their NHW counterparts.[21]

Adult Felony Arrest Rate (per 100,000)

CA	SB	Vent.
1089	1154	1055

Total Adult Incarceration Rate (per 100,000)

CA	SB	Vent.
700	623	556



AIAN Youth Gang Membership

CA	SB	Vent.
6.2%	5.3%	9.1%

Juvenile Felony Arrest Rate (per 100,000)

CA	SB	Vent.
478	687	513

Total Pop in Juvenile Halls & Camps Rate (per 100,000)

CA	SB	Vent.
106	235	92

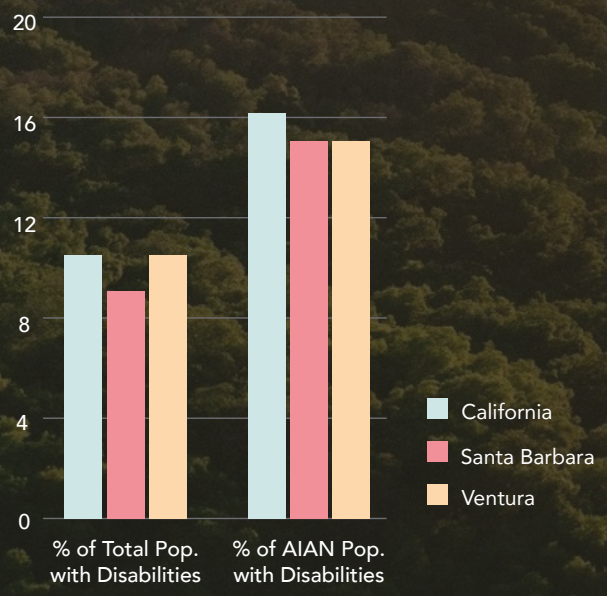
NHW Youth Gang Membership

CA	SB	Vent.
3.9%	3.6%	4.8%

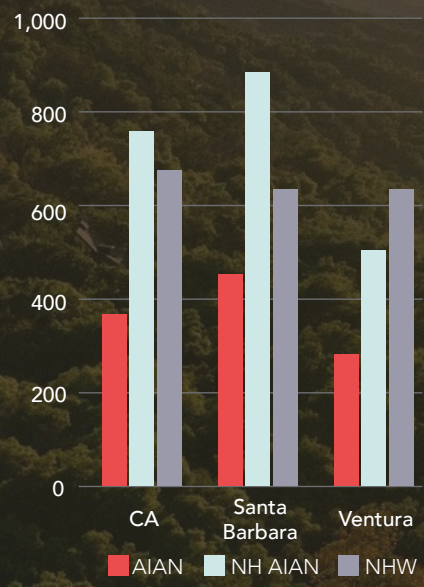
Morbidity & Mortality

Compared to the NHW population, the AIAN population at the state and local levels experience a lower age adjusted compressed mortality rate. NHW population in Santa Barbara and Ventura counties experienced a lower mortality rate compared to the California mortality rate. However, AIAN individuals living in Santa Barbara County have an increased mortality rate. In contrast, the non-Hispanic AIAN population experienced a higher mortality rate compared to NHW in Santa Barbara County and at the state level.

% Of Population with Disability



Age Adjusted Compressed Mortality Rate per 100,000

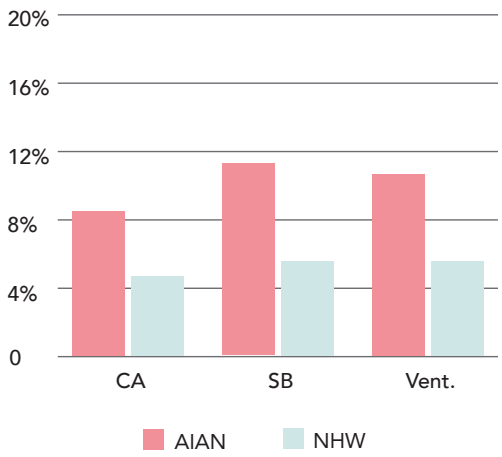


The 2017-2018 California Physical Fitness Test tests students in grades 5, 7, and 9 on physical fitness, testing: aerobic capacity, body composition, abdominal strength, trunk extension strength, upper body strength, and flexibility. Across California, AIAN students have a higher percentage of scores indicating a need for improvement in physical fitness measures. The fitness report shows AIAN students in Santa Barbara and Ventura counties have a need to improve aerobic capacity and body composition for all grades. 9th grade AIAN students in these counties experienced the highest risk markers for these measures, a trend seen in AIAN students across the state when compared to non-AIAN students.[25]

Closely related to physical health is physical safety and violence. According to the CA Healthy Kids Survey, AIAN youth are more likely to report dating violence compared to their NHW counterparts.

Furthermore, AIANs in Santa Barbara and Ventura counties are potentially exposed to higher crime rates compared to that of the state. The counties, however, experience lower rates of violent crime, robbery, and murder compared to the state level, while rates of theft, property crime, rape, and assault are higher than the state average.

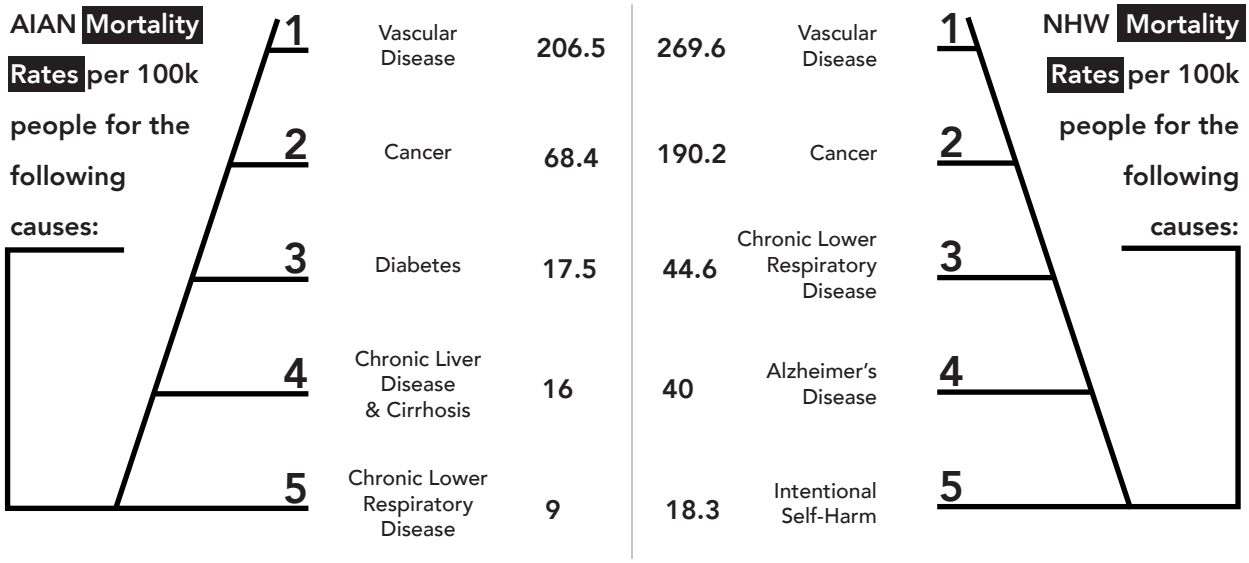
Dating Violence



Crime Rates

(per 100k People)	CA	SB	Vent.
Total Crime	2,946	3,109	3,725
Murder	4.6	0	1.8
Rape	37.2	72.4	57.3
Robbery	143.2	86.5	100.9
Assault	264.2	248.6	258.2
Violent Crime	449	408	418
Burglary	446.9	353.5	531.8
Theft	1623.9	2127.4	2469.9
Vehicle Theft	425.9	220.5	305.4
Property Crime	2497	2701	3307

Top Causes of Mortality for AIAN and NHW in AIH&S Service Area



Community Strengths & Assets

The following section outlines the assets and strengths that contributes to the health and wellness of the AIAN community of Santa Barbara and Ventura Counties. Identifying community assets and strengths is integral to building a strengths-based System of Care.

This overview of community assets and strengths integrates multiple data collection activities in Year 1 and Year 2. Based on the CAC's definition of community assets, community asset data are presented in the following categories: **individuals, activities, values, cultural wisdom, places, events, groups, programs and services, organizations, funders, media and information.**

What are our Community Assets?

The Native American community of Santa Barbara, Ventura counties and surrounding communities seeks to identify, analyze and strengthen the assets and resources that contribute to our wellness and make up a System of Care for Native youth and families.

We define a community asset as any service, organization, program, community group, partnership, policy, financial support, natural resource, gathering place or cultural wisdom that nurtures physical, mental, emotional and spiritual health across all cycles of life including infancy, adolescence, adulthood, and elderhood.

We evaluate the strength of these assets based on their Accessibility, Availability, Suitability, Adaptability, and Sustainability to our vision of holistic community wellness.

– AIH&S Community Advisory Council, Summer 2018

Community Assets

Individuals

The Native community has many individuals who contribute to the wellness of youth and families in Santa Barbara and Ventura counties. These individuals have ecological, historical, cultural, traditional knowledge, are Native language speakers, as well as artistic and facilitation skills. Diverse individual strengths and abilities are integral to forming a community strengths-based System of Care. Categorical examples of individuals that are community assets include:

- Healthcare providers that are culturally aware and culturally competent
- People who care, are supportive, and are passionate (such as educators, community members, parents, siblings, family, elders, and peers)
- Native language keepers
- Spiritual teachers and traditional leaders
- Medicine Persons
- Traditional Healers
- Native artists and teachers
- Ecological teachers; environmental activists
- Animal advocates
- Public speakers and facilitators
- Elders
- Storytellers
- Native history knowledge keepers

Activities

The following activities have been identified as strengths from AIAN community members. Individual and community-level behaviors are important strengths, as behaviors promote resiliency and well-being. Youth and adult individuals in the community have individual needs, preferences, and capabilities, which are reflected in the following diverse and multi-dimensional activities.

- Song and Dance: Drum circles, Sundance, Bear Dance
- Traditional Healing practices: ceremony, song, prayer, sweat lodge, sage/smudging
- Activities: music, art, reading, horseback riding, walking, exercise
- Taking care of the earth; educating others about climate change
- Taking care of animals
- Helping others; stopping further abuse
- Listening to others
- Healing self
- Using technology intentionally
- Connecting with nature
- Spending time with elders
- Revitalization of Native values, customs, practices
- Spiritual practices
- Native cultural arts

Values

AIAN community-defined strengths include values, which are motivators that drive behaviors supporting well-being and wellness. The following list includes values that have been specifically stated as strengths by community members, as well as values that have been qualitatively coded as strengths based on community-identified activities.

- Using survival skills and resiliency in response to challenges
- Community responsibility and leadership
- Altruism, generosity, kindness, sharing, and respect
- Importance of spirituality and medicine
- Importance of self-care and mindfulness
- Living in the present moment
- Importance of community connectedness, extended family, social support, interdependence
- Intergenerational learning and support; respect for elders
- Inter-tribal connections
- Environmental activism
- Connection with land/nature; respect for the environment
- Re-indigenization of values, protocols, practices

Programs & Services

Programs and services are vital strengths to a comprehensive AIAN-centered System of Care plan that meets the comprehensive needs of the Native community in a coordinated way. The following list was compiled by community members, AIH&S staff, partners and stakeholders. Programs and services include those that cover the spectrum of wellness needs for children, youth, families, adults, and elders. These include the following services: mental health, substance use, physical and emotional health, prevention, environmental, recreational, social, academic, financial, occupational, and cultural/traditional services. Various services that are specific to certain demographic cohorts include: disability support, Veterans, college student support and elder support services.

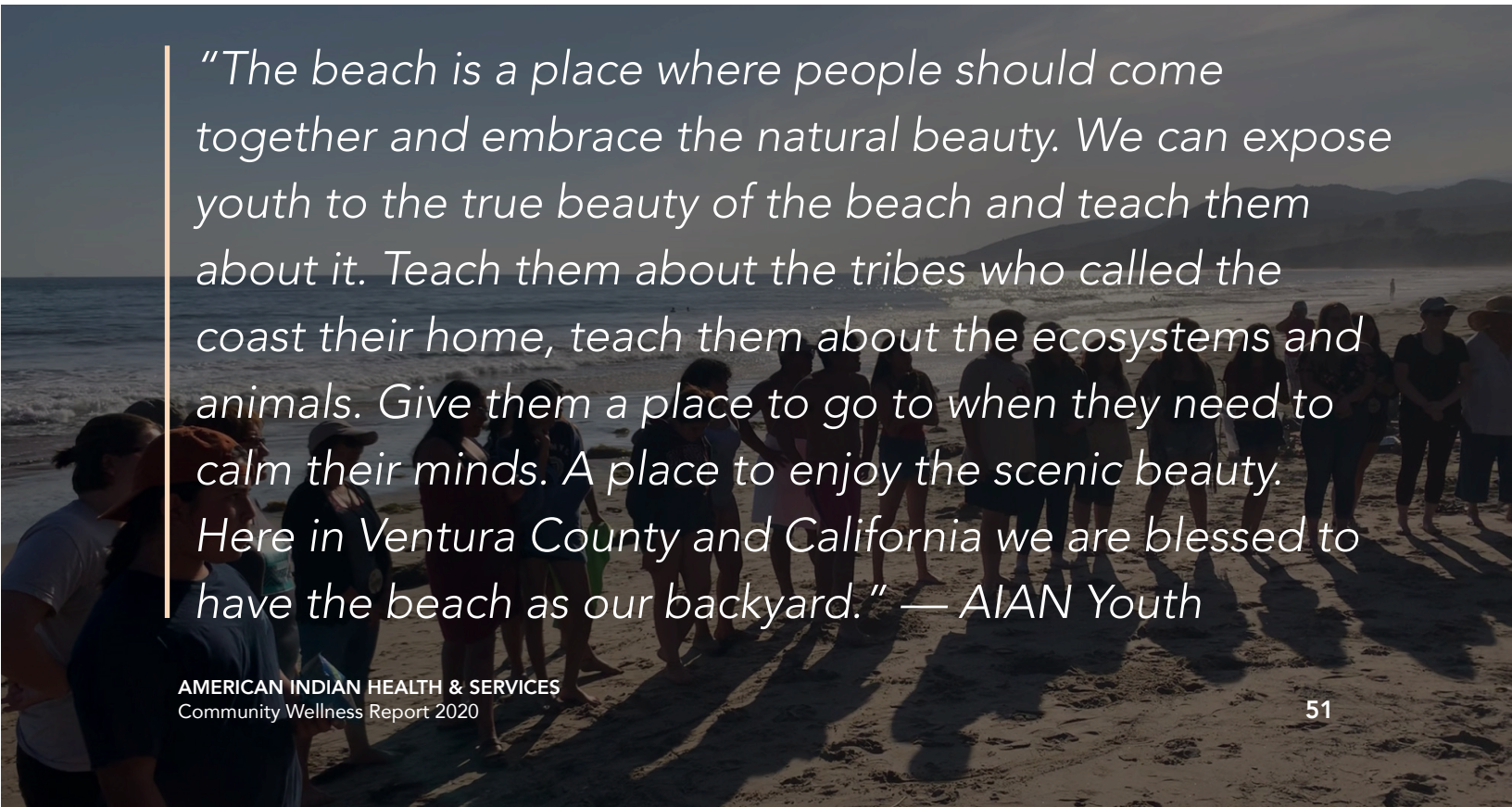
- College student support services
- Early childhood and parenting programs
- Youth enrichment and summer programs
- Educational Support
- Youth workforce and leadership programs
- Diversity and cultural sensitivity training programs
- Prevention services
- Mental health services, crisis support, and substance use treatment
- Veterans and Elders support services
- Cultural, Traditional, and Tribal services
- Environmental Services
- Recreational Programs
- Financial and Occupational Workforce Services
- Disability support services

Places

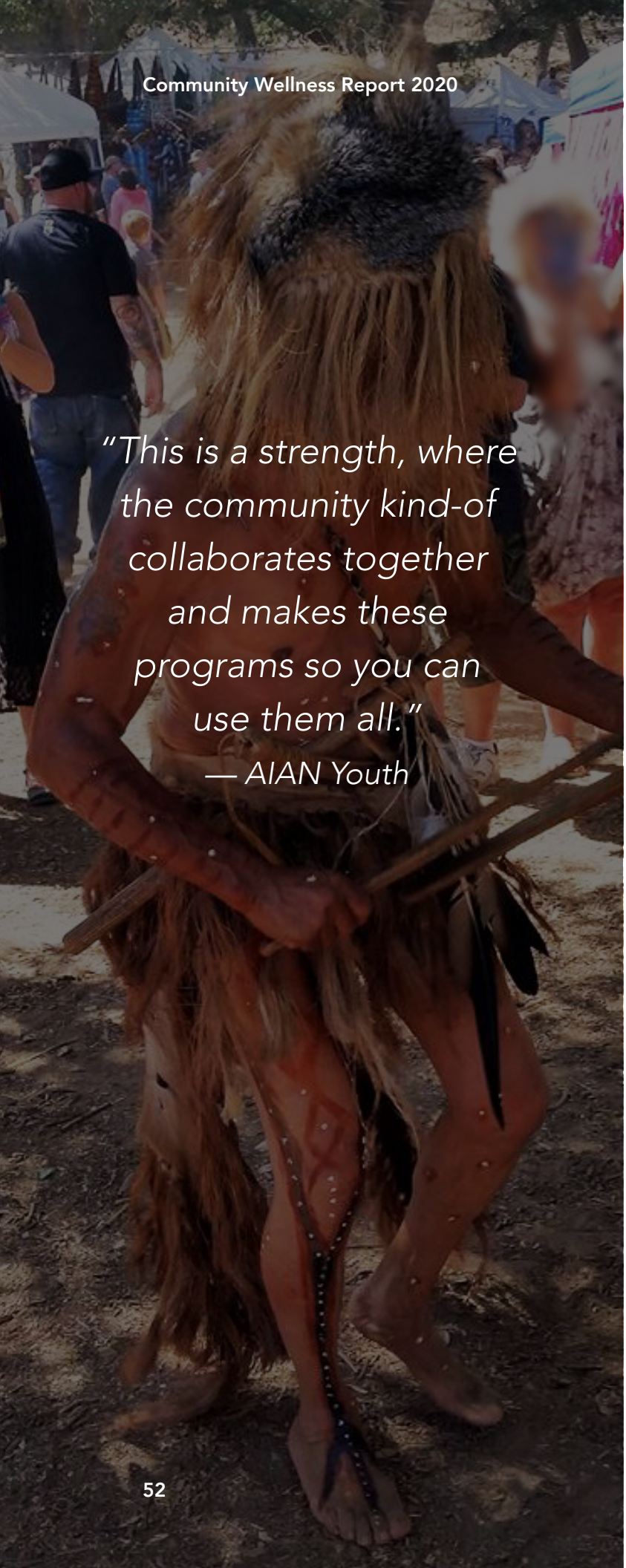
Community members highlighted the need for spaces and places to meet, gather, and learn together as a community. Therefore, there were many educational and meetings spaces identified in the Asset Mapping process, which included UCSB and public grade schools, as well as museums and community centers to name a few. However, more than half of the spaces and places that the AIAN community named were natural, traditional and religious sites used for ceremonies and Native community events. Additional natural sites like gardens, ancestral tending and gathering sites were also named, where the Native community shares a reciprocal relationship with the land to proliferate food and medicine. Environmental and natural sacred spaces were identified as safe spaces for activities that foster community connectedness, reflection, learning and self-care. Community members identified the importance of cultural gathering spaces that support traditional healing, ceremony, learning ecological history, and teachings of ecosystems.

- Natural spaces and landscapes – oceans, beaches, mountains
- Ceremonial spaces
- Sacred sites
- Powwow sites
- Gardens and plots
- Museums
- Grade school and collegiate spaces

> *Youth identified the importance of natural landscapes that provide a space for mindfulness, reflection, inter-tribal gathering and connection, identification with the natural environment and overall healing. As a commentary to a photo of the ocean, islands, and clouds, an AIAN youth stated: "This picture is showing something that can connect natives of all tribes because it's a sign of gathering and sort of shared experience."*



> *"The beach is a place where people should come together and embrace the natural beauty. We can expose youth to the true beauty of the beach and teach them about it. Teach them about the tribes who called the coast their home, teach them about the ecosystems and animals. Give them a place to go to when they need to calm their minds. A place to enjoy the scenic beauty. Here in Ventura County and California we are blessed to have the beach as our backyard." — AIAN Youth*



Events

Cultural, social and recreational events were identified as integral to community wellness, offering potential opportunities to deliver education, ceremony and healing. The community named California Native tribal ceremonies, annual Native community events, and cyclical, sacred events the most. Chumash and California Native events like the Tomol Crossing, Acorn Gathering and Santa Ynez Culture Days are important forms of cultural reclamation and resistance. When using this perspective to frame these assets, it is no surprise that the Native community named cultural and traditional events most frequently. AIH&S holds many events that bring the Native community together and create space for healing and culture sharing. These events include youth and community GONAs, Storytelling Festivals, Women's Talking Circle and the Elder's Holiday Luncheon. Additional events that the Native community identified were the Veterans Stand Down event and Earth Day, which are other important events the Native community uses to gather.

- California Native cultural events
- Native language conferences
- Community dinners/luncheons
- Elder's gatherings
- Gathering of Native Americans (GONA)
- Life events – birth, puberty, graduation, weddings, funerals
- Ceremony
- Veterans events
- Earth Day

Cultural Wisdom

Cultural wisdom includes teachings of elders and mentors on traditional and inter-tribal practices, protocols and customs. This wisdom is an important community strength as it is central to building AIAN identity, culture-based resiliency, spiritual knowledge and healing. Cultural wisdom teachings also provide a mechanism for intergenerational and inter-tribal community connectedness, which is a core value identified by community members. Furthermore, inter-tribal teachings provide a method to develop and understand multiculturalism and variations in cultural identity, which is essential to our tribally diverse community. It is the project vision to build a strengths-based System of Care that incorporates the cultural strengths of the diverse inter-tribal community while fostering cultural wisdom to build community pride, positive cultural identity, and community connectedness, which are all factors of resiliency. The following list includes various themes and values of cultural wisdom that has been identified by AIAN community members.

- Living traditional Native values (generosity, responsibility, respect, accountability)
- Re-learning old traditions, Making room for new traditions
- Learning cultural and ethnographic history
- Spiritual healing teachings
- Responsibility of preserving and sharing cultural protocols
- Native and generational knowledge and wisdom
- Historical perspectives and connecting to ancestors
- Retention and reclamation of Native language learning
- Ability to "walk in two worlds" (Native culture and non-native culture)

Funders

The community named several categories of funders who could support the System of Care plan through one time and continued funding. Some community foundations that are already supporting System of Care work are the Santa Barbara Foundation, The Fund for Santa Barbara and United Way. Additional funders the Native community identified were the Alzheimer's Association and the American Cancer Society who provide monetary support for specific health needs, and whose funding could be leveraged into System of Care funding. The Tribal Trust Foundation and Catholic Charities could also provide funding for certain aspects of the final System of Care plan.

- County/State Funding
- Local Foundations
- National Grants
- System of Care (SAMHSA)

Organizations

Mapping diverse organizations in Santa Barbara and Ventura counties that deliver services to the Native community is essential for comprehensive System of Care planning that encourages agencies and partners to have open lines of communication to increase access and availability of services. Multiple organizations support AIANs, including government entities, athletics and cultural organizations. As for Federal government entities named, the Native community considered health funding resources like Medicare and as well as natural space management through the National Park Service as organizational assets.

Food assistance, health and treatment centers and fitness organizations are among organizations named as assets in the Native community. Urban agriculture, co-ops, nature camps and environmental justice organizations show that the Native community values the environment and their connection to nature. Repeatedly, the Native community selects collegiate resources as assets. Some of these are the American Indian & Indigenous Gardens Alliance, American Indian & Indigenous Collective at UCSB, American Indian Student Association, and Tribal Learning Community & Education Exchange at UCLA.

- Tribal, Federal, State, County, and City services
- Community and trauma resources and family wellness
- Health and treatment centers
- Food assistance
- College and university organizations
- Environmental justice
- Urban agriculture and co-op
- Advocacy organizations
- Arts and culture organizations
- Recreational and nature-based organizations
- Youth-centered organizations
- Athletics organizations

Media & Information

Media and information are integral to System of Care planning and improving access to services through social marketing, outreach and resource information sharing. The Native community considers various forms of media assets from local newspapers, podcasts, social media platforms to streaming services. The Native community is plugged into Native-specific media outlets such as Radio Indigena, Indian Country Media, and NativeFlix. Other media that were named were local papers and radio like KPEK, Ventura County Reporter, and the Breeze Bi-Weekly Press.

- Social media
- Podcasts, radio stations, streaming services
- Printed media and newspapers
- Online new media
- Newsletters
- Video camera loans

Groups

Various groups provide services that promote AIAN wellness and are vital to forming a comprehensive System of Care. Most frequently, the Native community named Native youth and family support services like Health Linkage, Santa Ynez Tribal Health Clinic (SYTHC) and Casa Pacifica. Cultural groups that sustain Native language, culture and promote social justice was the second largest category. Some of these groups were the Smuwich Language Program, Chumash Family Singers, and the Beading Circle at AIH&S. Collegiate and university groups which meet to support Native students were UCLA American Indian Student Association and Students Taking Action for Native Dreams of Success. Lastly veterans, women's, environmental and professional groups were also identified.

- Family support groups
- Trauma, mental health, and recovery support groups
- Professional development and associations
- Cultural groups
- Cultural arts, dance, and song groups
- Veterans support groups
- Student associations
- Meditation circles and prayer groups
- Diverse religious groups
- Youth groups (recreations and leadership development)
- Advocacy groups (cultural and Tribal)

"The path of wellness can be confusing and chaotic, it's hard to find the right path. People need encouragement to find their right path to wellness, they will find their right path eventually."

(AIAN Youth)

Community Wellness Needs

Introduction

Defining and understanding the unique and comprehensive needs of the AIAN community is vital to building a culturally-centered System of Care. The following section integrates the combined wellness needs of adults and youth. The majority of this information was identified during a 2017 AIH&S Community Health Needs Assessment Survey and a Community Workgroup engaging in a community-based participatory research project. Workgroup members joined one of four focus groups: Elder Group, Youth Group (ages 16-23), Adults in Recovery, or Friends and Family Members of those in Recovery.

This section of the report addresses community wellness needs from a strengths-based, culture-based approach by using the Medicine Wheel visual as a symbol representing the journey of seeking balance between multiple dimensions of wellness. The AIAN community also offers their definitions of the multiple domains of health.

Santa Barbara County Native American Community Health Needs Assessment Demographics

The Santa Barbara County Native American Community Health Needs Assessment (CHNA) was completed in 2017 and received 134 completed surveys with 64% of respondents identifying as female, 29% identifying as male, 2% identifying as Two-Spirit, and 2% identifying as transgender or non-binary gender. Survey respondents ranged in age from 18-90 years old with the largest age category represented being respondents 55 years of age and older. There were 37 different tribal affiliations listed by respondents with 71% of affiliations being California Native tribes.

Understanding AIAN Community Wellness

The AIAN community model of wellness is informed by counseling-based theories of wellness and Native American cultural values. Wellness is "a way of life oriented toward optimal health and wellbeing, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community."[9] Other resources describe wellness as creating balance and meeting needs across multiple dimensions: emotional, spiritual, intellectual, physical, environmental, financial, occupational and social.[3,4] Native American values of wellness includes harmony between different levels of experience (including the mind, spirit, relationships, and nature), balance between all aspects of the person and their social and environmental surroundings, as well as spirituality life tasks of oneness and purposiveness.[7,8,9]

Community Advisory Council Definition of Wellness

The presence of wholeness and balance of the body, mind and spirit that nurtures the individual and community and promotes pathways to recovery and healing from the effects of trauma.

Youth wellness includes developing programs and support systems that empower youth in their self-care, self-reflection, and commitments and activities in the community; it embodies strengthening spiritual and cultural connections in order to achieve life goals.

Some of our Native youth have identified wellness as having a safe space that promotes balance and healthy habits. Youth recognize that building relationships with elders and other youth is critical to sustaining wellness.

Overall Wellness

Overall, 79% of respondents reported being in good or better overall health. As compared to middle-aged and older adults, transitional age youth and young adults reported greater overall health. Over three-quarters (84%) of survey respondents reported life satisfaction at the time of taking the survey. Approximately half of all respondents reported functional impairment due to physical health, poor physical health or receiving medical treatment. Most survey respondents reported good spiritual health. Overall, this suggests that good spiritual health is likely a protective factor to improve overall health ratings despite poor physical or mental health. When asked to identify the top community needs from a list, where respondents could check all that apply, the highest-ranking priorities included: affordable housing, prevention and treatment of drug or alcohol abuse, improved eating habits and interventions addressing obesity.

AIAN Perspectives on Wellness Needs

With the intention of understanding wellness needs from an AIAN community wellness and cultural perspective, the Medicine Wheel visual will be used as a symbol for representing the journey of holistic wellness by describing multiple domains of health (spiritual, mental/substance use, emotional, and physical/environmental). The following data integrates information collected from Native-identified community Members in Santa Barbara, Ventura and surrounding areas of community-defined domains of wellness. The Medicine Wheel visual symbolizes that wellness is a journey of creating balance and harmony between multiple needs.

Please Note: Just as there is great tribal diversity in spiritual beliefs, there is also diversity in Medicine Wheel teachings, with varying meanings for the directions and colors. It is the intention of this Wheel to incorporate the Medicine Wheel teachings to support Native-identified community in harmony and balance, and invite conversations about the exploration of spiritual teachings, while honoring and respecting multiple tribal perspectives. Finally, respectful cultural protocol includes asking permission before using specific tribal practices or images from outside one's own culture/s.

Spiritual Health & Traditional Healing

"[Spiritual health is] relearning old tradition, making room for new traditions" — AIAN Youth

Spiritual Health & Traditional Healing Summary:

- Prayer, ceremony, worship, meditation, singing
- Tribal healing practices, having a spiritual teacher
- Learning Native language
- Community connectedness, healing circles

The community had much to share about spirituality. They emphasized that spirituality is a personal practice that looks different for each individual and may include a variety of beliefs. The community mentioned not only cultural and traditional spiritual practices, but also Western and Eastern beliefs that have been helpful to them. Although institutionalized religions have brought violence and trauma to the Native community, the Community Advisory Council believe that exploring Western religions in a modern and educational context can provide "a space to heal from it."

85%

Visited or are interested in visiting a medicine person, traditional health, elder, or having ceremony performed for health/well-being.

Eighty-five percent of survey participants identified spiritual health as a priority for themselves or their families. Over two-thirds of all respondents reported being in good, very good or excellent spiritual health (69%). Participants utilized a wide variety of spiritual practices (see the box below). Respondents most frequently reported traditional song, dance, prayer and/or saging/smudging as their preferred spiritual practice (53%). 40% of respondents reported engaging in their spiritual practices once a week or more frequently.

53%

Preferred traditional song, dance, pray or saging/smudging as a spiritual practice.

The focus groups identified the following activities as being a part of their spiritual health: *traditional burials, fire circle, drum circle, ceremonies, sage, sweat lodge, drumming, prayer, nature, spiritual advisors (family), singing, coming of age activities,* as well as maintaining a sense of connection to others and to a higher power/Creator.

Many survey participants expressed an interest in engaging with traditional healers, medicines, and participating in ceremonies. Over two-thirds (69%) of survey respondents had visited or expressed interest in visiting a medicine person, traditional healer, elder, or had a ceremony performed for their health and well-being in the past year. Out of those who had not visited a medicine person, traditional healer, elder, or had a ceremony performed in the last year for health and well-being, forty-one percent reported an interest in these activities. Among those who have never visited with a

"Connection to each other is a strength!" —Focus Group Participant

medicine person, traditional healer, elder, or had a ceremony performed; 65% said they would be open to accessing this type of spiritual support. Through this Needs Assessment process, youth and adults shared that their spiritual health is strong, and they want to explore new spiritual teachings to continue to strengthen their spiritual health.

"I remember when I got out of the sweat… I swear I felt like I was walking off the ground. I was reborn, spiritually high!"

— AIAN Adult

Defining Spiritual Health

The Native youth of Santa Barbara pointed out that spiritual health means talking to and connecting with a higher power, but also being proud of their connection to a higher power/creator. Youth say that spiritual health is different for everyone, it is very personal and for each individual to define for themselves.

1. Prayer and worship – giving thanks, talking with their higher power/creator, being in touch with their divine being, and going to confession.
2. Going to powwows—attending powwows helps youth get in touch with their divine being and promotes their spiritual health.
3. Voicing what you believe in – when spiritual wellness is achieved, they feel confident to voice and *stand up for what they believe in.*

40%

Engage in spiritual practices frequently (once a week or more).

Spiritual Health Needs

1. Opportunities to try new things – having opportunities to try new things can help to form those beliefs that help Youth reach balance.
2. Learning new ways of thinking – meeting new people and new ideas can introduce different spiritual ideas that could give new meaning to Youth lives.
3. Traditional healing – experiencing traditional healing is meaningful, rather than being introduced through a workshop with a handout.

"Among those who have never visited with a medicine person, traditional healer, elder, or had a ceremony performed, ***65% said they would be open to accessing this type of spiritual support."***

Mental Health & Substance Use

Mental Health Summary

- Happy with a clear mind, positive outlook
- No stress or anxiety
- Social support
- Confidence
- Free and clear of drug & alcohol use

Youth and adults expressed that they have difficulties with addressing their mental health needs. Over half of adults in the community (63%) reported "not good" mental health in the past 30 days, but only (28%) say that their poor mental health days did not impede their normal activities.

63%

Reported "not good" mental health in the last 30 days.

Eighteen percent reported experiencing between six and twenty-nine days of being in "not good" mental health. Additionally, fifty-three percent of participants reported that poor mental health (e.g., stress, depression, and problems with emotions) did prevent them from completing their usual activities, such as work or recreation, in the past 30

28%

*Reported mental health did **not** keep them from doing their usual activities.*

days. Although most of the participants reported mental healthcare as a priority for themselves (74%) and their household (71%), over three-quarters of respondents were not receiving mental health treatment (e.g. counseling, psychotherapy, medications for depression, anxiety, stress, or antipsychotic medications) (76%).

Youth and adults identified the same barriers including insurance coverage, possible cost and knowledge of resources. Adults cited lack of transportation and lack of childcare as barriers they face to accessing services. After reviewing the data, the Community Advisory Council was surprised at how much the youth mentioned "stress."

"[Mental health is] to be able to deal with trauma, setbacks, and losses in a productive way"

— AIAN Youth

Defining Mental Health

1. No stress or anxiety – waking up excited to meet the day, calm, happy, and without anger or negative thoughts.
2. Coping skills - being able to deal with trauma and setbacks in a productive way are important.
3. Participating and communicating with others – the ability to participate with community and help address the community's needs.

Mental Health Needs

1. Difficulty accessing and finding resources

Out of all mental health service needs identified in the survey, the highest-rated among respondents were individual counseling (24%), treatment for co-occurring disorders (15%), counseling services in the community (e.g., at a park or coffee shop) (13%) and family or couples counseling (13%). Learning disability assessments and support for individuals with learning difficulties or challenges were also highly ranked as mental health service needs (16%). Also, the Native Youth Focus Group identified therapy as a need. Additionally, the Recovery Focus Group identified a need for trauma to be addressed in services. Furthermore, during the Recovery and Elders Focus Group, Alcoholics Anonymous and other recovery programs were identified as a supportive resource. Additionally, Wellbriety was identified as a needed resource in the Family and Friends of those in Recovery Focus Group. Focus group participants identified that they had a hard time knowing where to go for services and expressed concern about the cost associated with receiving professional help, insurance coverage, and scheduling conflicts. Almost half of adults (45%) say that being unable to afford mental health services is a barrier for them.

45%

Reported cost or inability to afford services as a barrier.

2. Focus group respondents expressed an interest in the following mental health services for themselves and their families: stress reduction groups, mindfulness medication groups, general talking circles, grief groups, LGBTQ+/Two-Spirit support groups, caretaker support groups, single parent support groups and parenting programs/parenting skills groups. Of these groups, there was the most interest in stress reduction groups and talking circles (47% and 41%, respectively).

   With regards to Youth, Child, Adolescent, and Family Services, there was moderate interest in increased services. Nearly one-half of survey respondents stated they or their family members had an interest in youth services (e.g., youth groups, study groups, youth advocacy groups) (46%). One-third of respondents reported they or a family member had an interest in intergenerational youth mentorship programs (33%). Nearly a quarter of survey respondents reported an interest in youth-oriented groups (22%).

3. External, structural, environmental stressors

Participants reported experiencing constant pressure from all areas of their lives like school and family, and reported society in general as extremely stressful.

4. Structural/contextual causes of mental illness vs. individual pathologies

Participants believe that the mental health treatment focus is on the diagnosis and definition, rather than on addressing what is causing the imbalance.

5. Inappropriate labeling/silencing of Native peoples

Participants identified that there is a lack of culturally appropriate mental health care–the greater society labels American Indians as "angry," without considering the historical circumstances. Clients have experienced the care they receive to be dismissive of youth experience. Participants believe that there are not enough providers who are culturally aware or offer culturally appropriate care.

Substance Use Needs:

Over half of respondents identified prevention and treatment of drug or alcohol abuse as a top community need (60%), while 11% of respondents reported being in need of alcohol and drug abuse prevention, education and treatment services. Over half of survey participants identified "clean living" (defined as being free and clear of drug and/or alcohol use) as a priority for themselves, while

about a third reported clean living as priority for their households (62%, 37%, respectively).

60%

Reported drug or alcohol abuse as a top community need.

Self-reported tobacco use was uncommon among respondents, with over three quarters (78%) of survey participants reporting that they never use tobacco recreationally (e.g., smoking, chewing, vaping, snuffing). However, for those exposed to tobacco use in their households, nearly two-thirds (63%) identified quitting smoking as a health priority for their households. Of those who were smoking cigarettes at the time of the survey, fourteen percent had tried to quit smoking for one day or longer in the past year. Nearly an eighth of respondents (10%) reported an interest in smoking cessation programming. Although overall tobacco use was relatively low among the community respondent sample, almost a quarter (19%) of respondents chose tobacco use cessation (other than for sacred purposes) as a top community need.

Approximately a third of survey respondents (34%) report binge alcohol use. In contrast, only eleven percent of respondents reported interest in substance abuse prevention/treatment. Additionally, the Family and Friends of those in Recovery Focus Group identified a need for additional support from AIH&S in addressing alcoholism, abuse, trauma, and drug use in the community.

Participants also identified several barriers to mental health care, including overall access to care, lack of transportation to care, and knowledge of available resources.

"We need a place where Indian people can go during the daytime or whatever just to feel safe!"

— Focus Group Participant

They also shared an increased need for culturally aware, culturally competent, knowledgeable, well-trained mental health care providers. Half of all respondents agreed that there is a lack of providers that are aware and competent of AIAN culture. Thirty-two percent of respondents reported a lack of knowledgeable and well-trained mental health care providers while twenty-eight percent of survey participants reported that there was a lack of culturally appropriate help or crisis lines. Case management was acknowledged as a possible support for community members seeking mental health services, with six percent of respondents self-identifying a need for case management and five percent already utilizing case management services.

Recreational Tobacco Use / Tobacco Cessation

78%
***Never** use tobacco recreationally.*

63%
Quitting smoking is a health priority.

19%
Tobacco use (non-sacred purposes) is a top community need.

14%
Tried quitting smoking in the past year.

"...this community, I think, is lacking doctors or psychologists… that are of Native descent that [have] an understanding of cultural sensitivities or needs."

— Focus Group Participant

Substance Abuse Health Priorities

60%

Drug or alcohol abuse is a top community need.

62%

Clean living is a priority for themselves

Barriers to Accessing Mental Health

Insurance Status
46%

Cost / Being Unable To Afford Services
45%

Scheduling Conflicts
34%

Unable To Find Referrals
22%

Availability Of Emergency Childcare During A Crisis
17%

Limited Access To Help or Crisis Line
13%

Connection to Each Other Love Forever Seeking Help Walking Being a Student Music Ways of my people Horseback Riding Forgiveness But Not Forgetting Listening Stopping some of the generational Abuse and Trauma Art Hope Spirituality Reading Nature Stopping Further Abuse Helping Others Being a Mom

Emotional Health

Emotional Health Summary:

- Happiness
- Social Support & Community Connectedness
- Intergenerational circles
- Learning from experiences and failures
- Helping others in need, activism
- Strong cultural identity
- Music, art, reading, being in nature

Most (74%) Native community members say that they have someone they can count on for emotional support. However, across all age cohorts, the overwhelming majority reported a sense of disconnection with the local native community (72%), while middle-aged adults were most at risk for poor emotional health. As with other aspects of health, spiritual health and emotional health outcomes were interdependent in the Native community. Through the Needs Assessment process, analysis of the data revealed that those who reported poor spiritual health were also more likely to lack external supports and have poor connection to the Native community. Emotional needs identified in the community also included ways to address past trauma. The youth and adults in the community consider the following to be their emotional health needs.

Survey respondents reported significant levels of trauma exposure in terms of individual trauma, as well the trauma experienced by family members and friends. Over half of all respondents (53%) reported having experienced abuse themselves or having a friend or a family member that has experienced emotional abuse. Over a third (39%) of participants reported that they or a friend or a family member had experienced domestic violence. Over a third (38%) of survey participants disclosed that they themselves, or a friend or a family member was raped or sexually abused as a child, while over one-fifth of respondents reported that they or a friend or a family member was raped as an adult (22%). Additionally, over a third of participants reported that they or a friend or a family member have a friend or family member (self or other) that was physically abused as a child (36%). Finally, thirty percent of respondents said they or a friend or a family member attempted suicide. A quarter of respondents reported domestic violence support as a top community need, however, there was extremely low interest in domestic violence treatment or support.

"Positive change and good feelings can be contagious."

— AIAN Youth

Defining Emotional Health

1. Happiness—being happy, but also being able to experience all emotions good and bad is important to establishing and maintaining emotional health.
2. Feeling supported by others—having a support system which includes people who make you feel cared for and thought about is important.
3. Learning from experiences and failures—failure is inevitable, but being able to learn from mistakes and regroup is a part of sustaining emotional health.
4. Routine and organization—Youth say that being organized and having a healthy routine are strategies to reduce stress and be ready to "take on the day."

5. Over one-quarter of respondents prioritized addressing of domestic violence/intimate partner violence (28%) and nearly a quarter reported the need to address abuse and/or neglect (21%) in the community.
6. Of the top community needs related to emotional health, over a third of respondents reported a need to address racism/discrimination (35%).

96%

If community social activities were offered on a regular basis they would attend.

Emotional Health Needs

1. Resources and information on stress reduction skills—at High School, there are not enough resources to help them excel. Youth would like to know more about time management, how to take breaks and not procrastinate.
2. Lack of knowledge of available resources, other than school-based or friends/family support systems—resources clearly defined to know where to go.
3. Spaces to be a kid—activities and workshops that are not overbearing, but instead engaging, energetic, and stimulating.
4. Have social gatherings that are for fun—a time and space to relax, de-stress and take a break.
5. Processing emotions with supportive community members.

The CHNA survey identified several barriers to accessing spiritual and emotional health including a lack of:

- Knowledge or information on what is available **(38%)**
- Knowledgeable contact/ spiritual teacher **(37%)**
- Knowledge or awareness of tribal healing practices **(34%)**
- Education on protocols for spiritual practices **(28%)**
- Transportation **(11%)**
- Access to medicinal plants **(11%)**

Youth Focus Group:

Resources and information on stress reduction skills- Youth observed that in High School, there are not enough resources to help them excel. Youth would like to know more about time management, how to take breaks and not procrastinate because youth believe that learning these skills will help lower stress and prevent anxiety.

Current resources include – Youth say that there are clubs, activities, sports, and opportunities for social interaction that help bolster their emotional wellness.

Needs Regarding Healing from Violence or Abuse

1. Lack of knowledge of available resources—clearly defined resources so they know where to go.
2. Spaces to be a kid—activities and workshops where youth are not stressed, angry, or triggered.
3. Have social gatherings that are just for fun—time to enjoy and savor life.

Community Defined Solutions to Spiritual and Emotional Health

Community Gatherings & Connectedness

Nearly all (96%) respondents reported they would attend community social activities (such as storytelling, social dances, community meals, etc.) if they were offered regularly. Over two-thirds (68%) of survey participants reported an interest in organized outings (such as cultural centers, sites, nature walks, native plant walks, herb gatherings, etc.). Additionally, this segment of participants reported an interest in community or traditional events (e.g. pow-wow, seasonal festivals, etc.). Nearly half of all respondents (49%) also indicated an interest in

joining social groups (e.g., bingo, book club, etc.). Almost half of all respondents (42%) said they had an interest in drum circles.

The Elders Focus Group identified some solutions to increase the spiritual and emotional health of the community including increasing knowledge in the community of what resources currently exist, growing participation in community gatherings and implementing phone outreach.

Focus group participants from multiple groups listed a wide variety of healing practices utilized for spiritual and emotional health. Overall, participants are most interested in engaging spiritual healing practices, traditional healing, and increasing community connectedness.

Traditional Health and Lifeways

Over half of survey respondents conveyed they or a family member had an interest in traditional healing (e.g. herbal remedies, sweat lodges) and Native arts/crafts (e.g. beading, basket weaving) (60% and 67%, respectively). Focus group participants identified the sweat lodge being of increased interest as a way to connect with traditional health practices. Focus group participants also expressed an interest in having more opportunities to engage in ceremony and traditional practices, such as burials, fire circles, ceremonies, coming of age activities, sweat lodges and prayer groups. Overall, participants expressed a desire to have an increased sense of connection to nature and traditional wellness.

Native Language

Sixty-four percent of survey respondents reported that they do not speak their native/tribal language. In contrast, over half of all respondents indicated an interest in attending a Native language class or group (55%). All focus groups identified reconnecting to Native language as a potential solution to social and emotional health needs of the community.

Barriers to Accessing Spiritual or Emotional Health

Knowledge Or Information On What Is Available

38%

Knowledgeable Contact or Spiritual Teacher

37%

Knowledge Or Awareness Of Tribal Healing Practices

34%

Education On Protocols For Spiritual Practices

28%

Transportation

11%

Access To Medicinal Plants

11%

Resiliency

Physical & Environmental Health

Physical and Environmental Health Summary:

- Active, using your body
- No aches, pains, or sickness
- Access to healthy food, water, healthcare
- Stable housing, neighborhood safety, employment
- Protecting land, plants, and animals
- Relationship with natural world
- Traditional, Native foods

Over half (55%) of all CHNA respondents reported being in "not good" physical health in the past 29 days while forty-eight percent of respondents stated physical health prevented them from participating in their usual activities. Additionally, the classification of being in "fair to poor overall health" was associated with "not good" physical health for at least six days in the past month. Half of all survey respondents reported they are currently receiving medical treatment for a health condition.

"Physical health is checking in on your body to see what it needs"

— AIAN Youth

Survey participants identified a number of community health priorities including a need for improved: active living habits (e.g., outdoor exercise groups and yoga classes) (97%), healthy eating habits (88%), safety (82%) and community connectedness (72%). Sixty-six percent of respondents reported a need for improved food security. Additionally, 50% of respondents desired increased access to culturally proficient health care services. Over a quarter (28%) of respondents lacked reliable transportation. Nearly one-third rely on cash assistance and are seeking career/job services (29% and 32%, respectively). Finally, 17% of survey participants identified a need for access to legal support services.

Youth and adults in the Native community focused on different aspects of environmental health. While youth consistently spoke about wanting relaxing, Native spaces where they could be themselves and recharge; adults were more focused on financial needs associated with living expenses. Overall, both adults and youth wanted safe spaces from violence and judgement. Youth focused more on cultural and traditional aspects of foods and fitness, while adults felt their day-to-day behaviors could be improved with more physical activity and nutrition education resources.

Nearly two-thirds (65%) of survey respondents reported having good health of their teeth and mouth. Almost a quarter (22%) of respondents report not having dental insurance, which could be a barrier to receiving dental care. Furthermore, thirty-nine percent of respondents said dental insurance coverage with private insurance, twenty-five percent reported insurance through Denti-Cal/Medi-Cal and three percent reported dental insurance through the IHS.

Defining Physical Health:

1. Having the ability to be active and use your body.
2. A body free from pain, aches, or sickness.
3. Access to healthy food, water, and healthcare—not having healthy food available affects their ability to exercise, and therefore manifests a cycle of unhealthiness.

Physical Health Needs

1. **Food Security & Nutrition** Over half (66%) of survey participants reported experiencing food insecurity in the past year and identified themselves as being in need of food supplement programs, with only eleven percent of these participants already utilizing food supplement

programs. Over three quarters (78%) of survey participants identified having access to sufficient food as a health priority. Almost a quarter of respondents (23%) identified having little or no access to food as a top community need.

Additionally, eighty-seven percent of survey participants place healthy eating habits as a priority while nearly half (44%) acknowledged poor eating habits as a top community need. Although many people (43%) endorsed a need to address obesity and poor eating habits, sixty-five percent of respondents reported eating nutritious meals frequently and fifty-seven present reported exercising regularly. Community focus group participants reported that there are not enough traditional foods available and that too many available foods are unhealthy and highly processed.

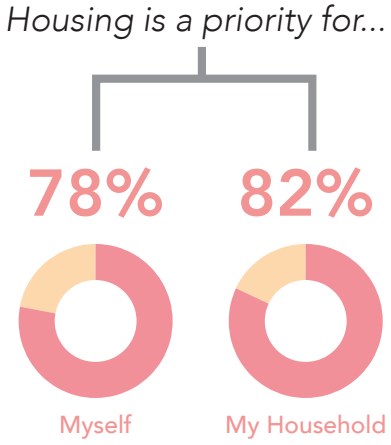
2. **Active Living** Over three-quarters (90%) of survey participants reported that regular exercise is a health priority while over half report regular participation in physical activity (57%). In regard to the approach to physical fitness, over half of respondents report low-intensity physical activity (such as walking) while over a third report moderate to high-intensity physical activity (such as biking) or higher (54% and 38%, respectively). Nearly half of respondents (46%) reported attending outdoor exercise groups, while over a quarter engaged in one of the following activities: creating/maintaining Indigenous community gardens, creating/maintaining a community garden, creating/maintaining a farmer's market or attending yoga classes (36%, 32%, 26%, and 28%, respectively). Community focus group participants reported that they desire more traditional games for exercise because current options are not appealing.

3. **Education** Youth and adults would like to learn how to improve their physical health, about traditional medicines, more community trainings on caring for their bodies, cooking classes and healthy eating information.

4. **Adequate Insurance Coverage** Approximately one-quarter of adults who took the CHNA survey said they were without dental insurance coverage. Those who do have insurance say that they are unsure if certain mental health services are covered.

57%
Currently participate in regular physical activity.

5. **Housing** Affordable housing represents a significant priority for survey respondents and is a critical social determinant of health. Eighty-two percent of respondents conveyed that housing is a priority for themselves, and seventy-eight percent reported that housing is a priority for their household. Additionally, seventy-one percent of participants reported a worry about having enough money to pay for rent or mortgage. Most frequently, participants reported renting an apartment as their current living arrangement (25%). Nearly a third (32%) of respondents reported being in need of housing assistance, with ten percent of respondents already receiving assistance. Housing, as a health priority, is congruent with Santa Barbara County Public Health Department's 2016 Community Health Assessment.



"[Environmental health is] having access to traditional ecology, continued and constant."

— AIAN Youth

6. **Environment** Neighborhood safety is another significant community health need that emerged in the CHNA survey results. Eighty-six percent of survey respondents identified neighborhood safety as a health priority for themselves. Over one in ten respondents reported a need for safer neighborhoods (14%). Focus groups themes identified a need for safe/Native spaces where youth do not have to explain their Native identity is important to maintaining a positive mood. Participants also identified a desire for increased access to green space such as a community garden or other quiet, spaces where youth can connect with nature.

"A center with youth hours, various activities, homework time, sports, workshops. Led by an advisor"

— AIAN Youth

Desired Activities for Physical Health

Outdoor Exercise Groups

46%

Creating/ Maintaining Indigenous Community Gardens

37%

Creating/ Mainaining A Community Garden

34%

Creating/ Mainaining A Farmer's Market

28%

Yoga Classes

11%

Spirituality

Discussion & Future Directions

Introduction

In order to build a comprehensive, culture-based System of Care, the holistic needs as well as unique risk and protective factors of the community must be addressed. This discussion utilizes the framework of social determinants of health to integrate the primary and secondary data into the discussion of the overall wellness of urban AIAN community in Santa Barbara and Ventura counties (for more information, please see "Methodology"). Specifically, the risk and protective factors impacting the health of the community are considered by examining multiple domains of health. In building a System of Care plan that integrates community strengths and needs, a review of existing service barriers and future directions for the service system will also be presented.

Secondary Data Tell a Story: Indicators and Data Gaps in AIAN Wellness

This report identifies a number of studies that quantify the social, structural and health indicators and outcomes among the urban AIAN community. When specific data has been unavailable, population-level data for AIAN people in California or other relevant population-level data based on demographic or specific health indicator were highlighted. The secondary data shines light on social, structural and health issues of the Santa Barbara and Ventura populations, with a focus on the AIAN population.

In the domain of education, a number of factors may contribute to the overall well-being of children, teens and transitional age youth, including quality of education and attainment. Graduation rate data was high-lighted, revealing a greater than ten percent disparity in rates between NHW and AIAN youth in the counties of interest. Furthermore, higher-education attainment disparities based on race were identified at both the county and state level. Education is an upstream factor for opportunity for social mobility, access to healthy food, and for onset and progression of health problems.[32, 33, 38] Furthermore, lack of quality education as well as disparities in education attainment may adversely impact AIAN youth both during childhood and well into adulthood. In contrast, there is ample evidence that education grounded in AIAN culture and community best meets the needs of AIAN youth.[31]

In the domains of mental health and substance use, AIAN youth fare worse in depression, suicidal ideation and bullying or harassment than their white counterparts. Notably, in Ventura County, nearly fifty percent of AIAN youth had experienced bullying or harassment. Although the etiologies for bullying and harassment are not elucidated in the Healthy Kids Survey, it may be that AIAN racial and cultural identity plays a role in youth being targeted in bullying or harassment. Research shows racism and discrimination are predominant themes among bullying for racial and ethnic minority youth in the United States.[35] Nationally, AIAN adults are also known to have higher suicide attempt rates than their NHW counterparts. Substance use rates are of major concern in AIAN communities locally and nationally, the rates of drug-induced deaths in the AIAN population nationally is higher than any other race or ethnic group. Locally, AIAN youth in Santa Barbara and Ventura counties have higher rates of alcohol use compared to NHW youth, which presents an opportunity for substance use prevention programs among this population.

Ultimately, the secondary data tell a story of a multitude of health disparities faced by local AIAN communities. The data reveal large gaps in indicators of health outcomes, especially for AIAN youth. An increase in coordinated data collection efforts across county-level and California agencies has the potential to generate additional information regarding the needs of the AIAN youth and adult populations in Santa Barbara and Ventura counties. Improving access to medical and social services grounded in cultural humility has the potential to greatly increase wellness among the AIAN population in Santa Barbara and Ventura counties.[36]

Building a System of Care from a Social Determinants of Health Perspective: Addressing Risk and Protective Factors

Visioning for the future is an important strategy for creating a System of Care plan, as it provides a direction for the compass of systems-level planning efforts to aspire to. The community-led

vision for the future of the AIAN community of Santa Barbara and Ventura counties is a future with improved social determinants of health across multiple domains: improved individual lifestyle factors, improved social and community networks, improved living conditions (such as health, housing, health care services, agricultural and food availability, water/sanitation), improved working and educational conditions, and improved socioeconomic, cultural, and environmental conditions.[40,41,42]

To build a System of Care from a social determinants of health perspective, all data from years one and two community data collection activities on risk and protective factors will be presented. The goal of our community-led System of Care is to address health disparities of AIANs in Santa Barbara and Ventura counties (as outlined in "Service System Overview"), as well as risk factors identified by community members in years one and two data collection. Risk and protective factors are presented in a socio-cultural-historical context, which incorporates historical, community, and cultural factors (For more information see "Native American Community Background.")

It is the intention of this section on risk and protective factors to demonstrate community wellness needs and strengths from a "Social Determinants of Health" perspective, by summarizing the risk and protective factors that impact the wellness of AIANs in Santa Barbara and Ventura counties. This perspective is enabled thorough a System of Care planning and demonstrates a strengths-based and culture-based model that incorporates all gathered data on the unique and comprehensive risk and protective factors of the community.

Risk Factors

Risk factors include social and environmental determinants of health, which impact health and disease by increasing "wear and tear" on the body's stress-response systems and physio-logical coping, pre-disposing individuals to health disparities, disease and poor mental health. Additionally, Risk factors contribute to health and social challenges and/or impedes wellness. Data on the following risk factors as they relate to AIANs in Santa Barbara and Ventura counties are presented: historical, cultural, and community risk factors, as well as spiritual, mental, physical, environmental, and emotional health factors,.Addressing the comprehensive risk factors that impact the AIAN community of Santa Barbara and Ventura counties is vital for the community-led System of Care plan.

Historical Risk Factors:

Risk factors of historical trauma and intergenerational trauma impacts the overall wellness of AIANs today. Historical trauma is the cumulative emotional harm that is experienced by individuals due to traumas inherited from ancestors (such as genocide, relocation, and displacement), and the activated trauma response though identifying with the experience of one's ancestors. Furthermore, the legacy of numerous traumatic experiences that a community experiences over generations that continues to impact the psychological and social responses to current events and stressors is a phenomena known as "intergenerational trauma."

Youth and adults voice the impact of traumas on their current emotional wellness, including grief, anger and sadness due to a loss of language and land, genocide, displacement, relocation, loss of cultural practices and traditional ways of living. Furthermore, due to a history of genocide and oppression, the AIAN community currently experiences lateral oppression and violence, which greatly impedes physical health and safety in the community, as well as emotional health in forming healthy relationships. Finally, in the historical context of genocide and oppression, AIAN community members identify current experiences of discrimination, racism and mistrust of authority figures.

Cultural Risk Factors:

Due to a legacy of genocide, the loss of cultural healing, traditional tribal practices and traditional ways of life, is a risk factor that greatly impedes the cultural identity and resiliency of the community. In the displacement and relocation of AIAN people, the knowledge and healing of cultural practices and ceremony in sacred sites has caused a great disconnect within the current generations suffering from grief, sadness, anger, mistrust, as well as loss of one's sense of direction, safety, identity, and cultural centeredness.

Community Risk Factors

Community risk factors of family separation and lack of community connectedness have been reported by youth and adult community members.

The legacy of genocide and displacement causes the AIAN community to experience grief due to the loss of family and tribal community. Family separation is a present-day social symptom that is prominent within these family households. Furthermore, the displacement and relocation from ancestral homelands across generations into inter-tribal, urbanized communities, has contributed to the overall loss of connectedness with one's tribal identity and community. Loss of community connectedness is a current social phenomena that is likely rooted in feelings of isolation, mistrust, alienation and silencing.

Risk factors that impact the functioning of AIANs in the community are inclusive of poor educational functioning, socioeconomic status and unemployment. AIAN students have high educational disparities when compared to their Non-Hispanic White (NHW) counterparts, including a lower high school graduation rate (For more information, please see "Service System Overview of AIANs in Santa Barbara & Ventura counties"). Furthermore, those who identify as "AIAN Alone" experience worse educational outcomes compared to those who identify as "AIAN in combination with another race," specifically with regards to HS diplomacy/equivalency attainment and bachelor's degree attainment. In terms of socioeconomic status, AIANs have higher poverty rates than NHW, especially AIAN children of AIAN single mother families. Finally, AIANs experience a higher rate of unemployment than NHW population.

Health service access and insurance status are community risk factors that impact the availability and accessibility of needed services to treat and prevent illness. Santa Barbara and Ventura counties are Health Professional Shortage Areas, indicating a greater need for providers to serve the AIAN population in this service area. Additionally, the AIAN population is more likely to be uninsured or to utilize public insurance programs compared to the total population at the statewide and county levels. AIAN minors are more likely to be uninsured compared to the child population totals at state and county levels. Finally, the AIAN alone population have a higher uninsured likelihood than those who identify as more than one race.

A prominent risk factor that impacts the positive contribution of youth to society is the high rate of AIANs in the juvenile justice system. Compared to the state rate, AIAN youth in Santa Barbara and Ventura County experienced higher rates of juvenile felony arrests.

Spiritual Health Risk Factors:
AIAN community members have voiced the importance of spiritual health in their overall wellness and functioning. AIAN adult community members with poor spiritual health are more likely to lack external supports and have poor connection to the Native community. This suggests a connection between spiritual health, connecting to others and seeking out others for support.

Mental Health and Substance Abuse Risk Factors:
AIANs experience mental health symptoms at an alarming rate that report multiple external, structural and environmental stressors contribute to poor mental health. Adult community members rate their mental health functioning as "not good". AIAN students at the state and local level experience higher rates of both depression related feelings, suicidal ideation, bullying and harassment. AIANs experience double the rate of attempted suicide, while having lower rates of mental health service utilization.

Substance abuse is a significant risk factor for premature death and poor overall functioning. Youth state that substance use stems from peer pressure, the normalization of substance use and using substances as a proxy for coping skills or healing mechanisms, such as in the form of self-medication. AIAN population has over twice the rate of alcohol-induced deaths than all other demographics, as well as the highest rate of drug-induced deaths. Between 2015 and 2017, the AIAN communities of Santa Barbara and Ventura counties experienced deaths due to opioid use disorder at rates over 3 times the California average. Finally, youth age 12+ in SB and Ventura County more likely to have used marijuana or cocaine in past year compared to federal probability.

Barriers to Seeking Mental Health and Substance Abuse Treatment Services:
Adults community members report multiple barriers to seeking mental health services. Accessibility barriers include: difficulty accessing and finding resources, limited/no access to crisis lines, insurance status, possible cost or inability to

afford services, scheduling conflicts, lack of transportation and childcare. Acceptability barriers include a lack of culturally competent providers, well-trained providers and overall stigma related to mental health care. Adults voiced a low interest in substance abuse treatment given the stated community need for treatment, likely due to stigma of substance abuse treatment, lack of cultural awareness by providers, disinterest in treatment, lack of knowledge about resources and the sociocultural normalization of binge alcohol use.

Physical and Environmental Health Risk Factors:

Risk factors that impact the physical health of the community includes disability status, mortality rate, medical issues, poor physical fitness, food insecurity and accessibility barriers to medical care. AIAN population at both the state and local level has a higher percent of disability compared to the total population. Compared to the NHW population, the AIAN population at the state and local levels experience a lower age adjusted compressed mortality rate. Across California, AIAN students have higher percentage of scores indicating a need for improvement for physical fitness testing. The fitness report shows AIAN students in Santa Barbara and Ventura counties have a need to improve aerobic capacity and body composition for all grades. AIAN adults state the need for learning about how to improve physical health and caring for their bodies. Food insecurity and lack of access to healthy foods is a prominent concern of AIAN adults. In conclusion, AIAN adults stated that lack of insurance coverage, knowledge of services covered through insurance, and transportation needs are barriers to accessing overall medical care.

Risk factors for environmental health include financial stressors, lack of affordable housing, legal assistance needs and community safety. Adults describe financial and housing stressors, such as difficulty paying rent or utilities, cash assistance needs and need for housing assistance and legal aid services. Additionally, Community safety is a prominent concern of AIAN youth and adults. In Santa Barbara and Ventura counties, rates of theft, property crime, rape and assault are higher than the state average. Furthermore, AIAN youth are more likely to report dating violence compared to their NHW counterparts, and are more likely to report gang membership compared to their NHW counterparts. Finally, AIAN community members stated that there is a lack of open and understanding Indigenous spaces, where they can go to have a positive mood and not explain their native identity. They also report the need for improved ecological relations and time in green, safe spaces in nature.

Emotional Health Risk Factors:

Community members state that lack of accessibility and suitability of services is a significant risk factor for their emotional health. For example, community members state a lack of resources and information on stress reduction skills, and a need for clearly defined resources to heal from violence and abuse. Furthermore, youth state that there is a lack of spaces to "be a kid," where they can relax, de-stress and process emotions with supportive others.

According to California aggregated data, AIAN youth have the highest rate of abuse and neglect compared to all other racial and ethnic groups. AIAN adults state the need for trauma-specific services (domestic violence, intimate partner violence) to heal from the effects of violence. Emotional needs identified in the community included strategies and services to address past trauma. Furthermore, given the high amount of trauma reported by self or others and low interest in trauma specific treatment, this indicates possible hesitation or fear of DV treatment, and likely reflects barriers for seeking services and/or greater desire for other areas of formal and informal supports.

The community health needs assessment findings indicate challenges with emotional health functioning. Most at risk for poor emotional health are middle adults; more were likely to report having zero internal supports compared to transitional age youth (ages 18-25). In looking at only female respondents, transitional age youth reported having more internal supports than female middle adults. This suggests that for females, internal supports decrease after age 24.

Protective Factors

Protective factors help prevent problems, increase resiliency and promote overall wellness. Protective factors are present within the following domains: cultural and community factors, in addition to spiritual, mental, physical, environmental, and emotional health factors. The integration of these protective factors are vital for a comprehensive, strength based and culture-based, AIAN community-led System of Care plan.

Cultural Protective Factors:

Community members voiced cultural wisdom, native language learning, traditional healing and ceremony in sacred sites as protective factors that are vital to cultural identity. Cultural wisdom is a source of strength, as it connects community members to the cultural practices of their ancestors and invigorates spiritual healing, trust, purposiveness, hope, and connection to others. Regarding learning and living cultural wisdom, community members report the strength of their ability to "walk in two words" the Native and non-Native or western world.

As cultural wisdom is learned from elders, mentors and teachers, it builds relationships and connections to others and promotes the following:

- Sharing of Native and generational knowledge and wisdom
- Responsibility of preserving and sharing cultural protocols
- Historical perspectives and connecting to ancestors
- Living traditional Native values (generosity, responsibility, respect, accountability)
- Learning cultural and ethnographic history
- Historical perspectives and connecting to ancestors
- Re-learning old traditions, Making room for new traditions

Furthermore, adults and youth voiced the importance of cultural revival and language to preserving and invigorating tribal knowledge, as the retention and reclamation of Native language learning is a process of overcoming the harmful effects of historical trauma.

Finally, Connection to the land and Native healing practices and ceremony are core components of cultural revival and resiliency. Adults and youth reported the need for ceremony and traditional practices, such as burials, fire circles, coming of age activities, sweat lodges, prayer groups, and connection to nature. Cultural gathering spaces, traditional religious sites, and natural sites are vital to support healing practices, where the community shares a reciprocal relationship with the land to proliferate food, medicine and healing.

Community Protective Factors:

Native youth and adults shared the importance of community connectedness and other values that are strong community protective factors to promote safety in relations to others. Values include the importance of intergenerational learning, interdependence, lateral goodness and collaboration, equality, and sharing community resources. AIAN adults with high community connectedness are also likely to report positive life satisfaction.

Community protective factors also include community-based programs, services and organizations that are accessible and suitable to their needs. For example, regarding utilization of Food Stamp/SNAP benefits, community members (both AIAN alone and AIAN in combination with another race) utilize Food Stamp/SNAP benefits at a higher rate than the broader population. Community-connectedness is a powerful value that has been identified by the local community; it promotes resiliency through trust-building, relational healing and interdependence.

Spiritual Health

Protective Factors

Adults and youth report that spiritual health is integral to wellness and are enthusiastically eager to learn diverse spiritual and traditional healing practices in an intergenerational community environment. The community reports diverse spiritual beliefs, with many people engaged in spiritual practice. Community members report spiritual health is a source of resilience; adults reported overall good physical and spiritual health, given the amount of trauma reported, which suggests strong resilience in overcoming the impact of these traumas, and strong engagement in spirituality to heal from trauma exposures. Individual worldview as well as external, collective, intergenerational support networks are known to bolster resiliency.[37]

Data findings support the importance of spiritual health within a System of Care. In a study of AIAN adult community members, "good" spiritual health was associated with increased connection to community, and "poor" spiritual health was associated with zero external supports (health care providers, counseling centers, programs and services). Data suggests a connection between

spiritual health, utilizing external supports (health care providers, counseling centers, other programs and services), and connecting to others in the community. Findings support the importance of building community engagement services within a healthcare environment and utilizing external supports within a community engagement framework.

Mental Health and Substance Use Protective Factors

Adults and youth report the importance of internal supports (friends, family members, supportive others), external supports (mental health and substance use programs and services) and coping skills (positive self-esteem, self-care activities) for positive mental health and recovery from substance use. Acceptable and suitable programs and services include those that are culturally-competent and culture-based with well-trained providers.

Physical and Environmental Health Protective Factors

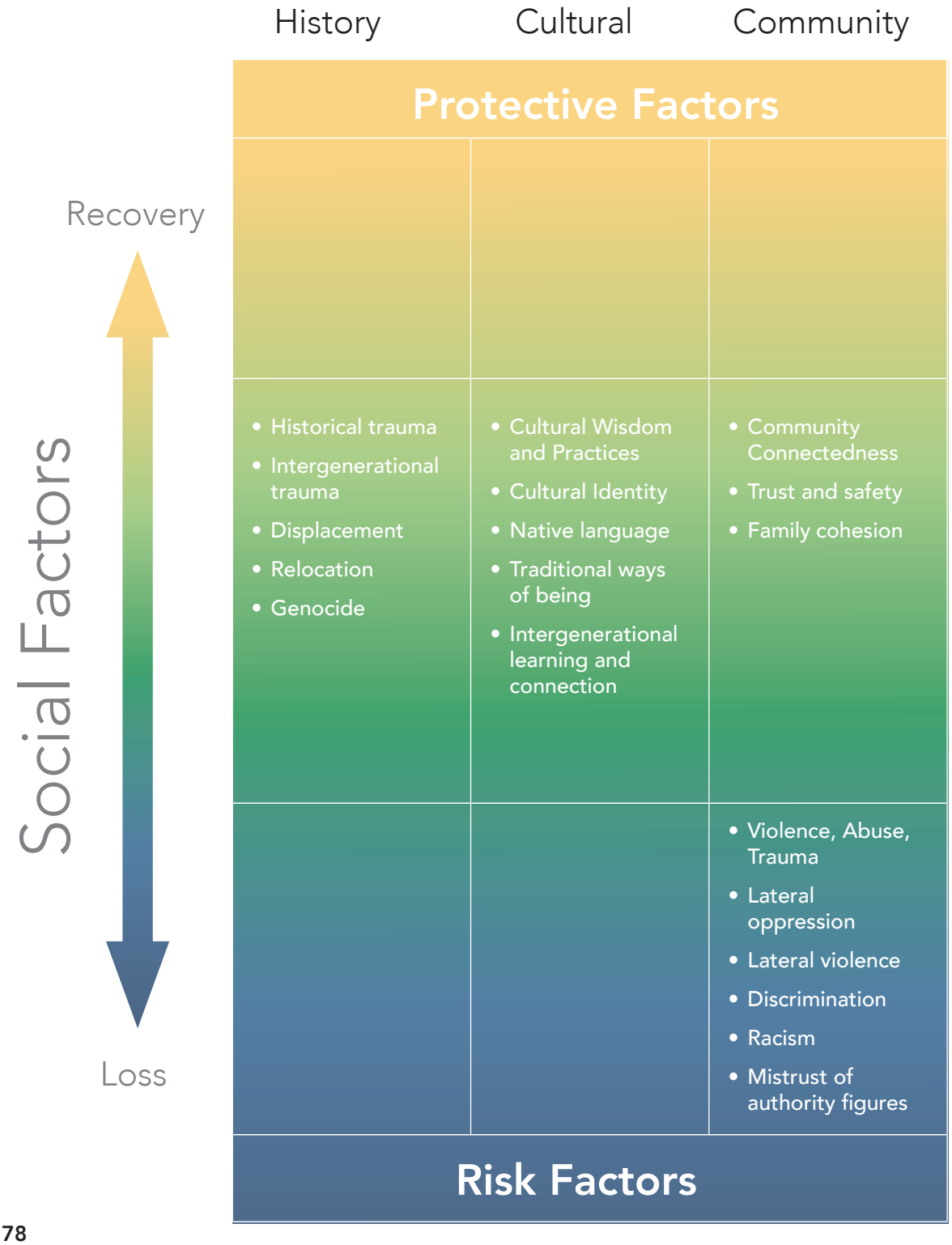
Community members have also reported various physical and environmental health protective factors. Physical health protective factors include healthy eating, active living and exercise, help-seeking behaviors for medical services. Youth report the importance of basic needs of food, water, and shelter being met. Adults report that regular exercise is a top health priority, as well as interest in positive health behaviors, such as healthy cooking classes. Regarding help seeking behaviors, adults with poor overall health report high utilization of medical health services, suggesting high trust, confidence, and/or dependence on medical treatment for overall health needs. Furthermore, community members overall report the importance of natural sacred spaces for their well-being, as they provide space for activities that fosters community connectedness, reflection, learning and self-care.

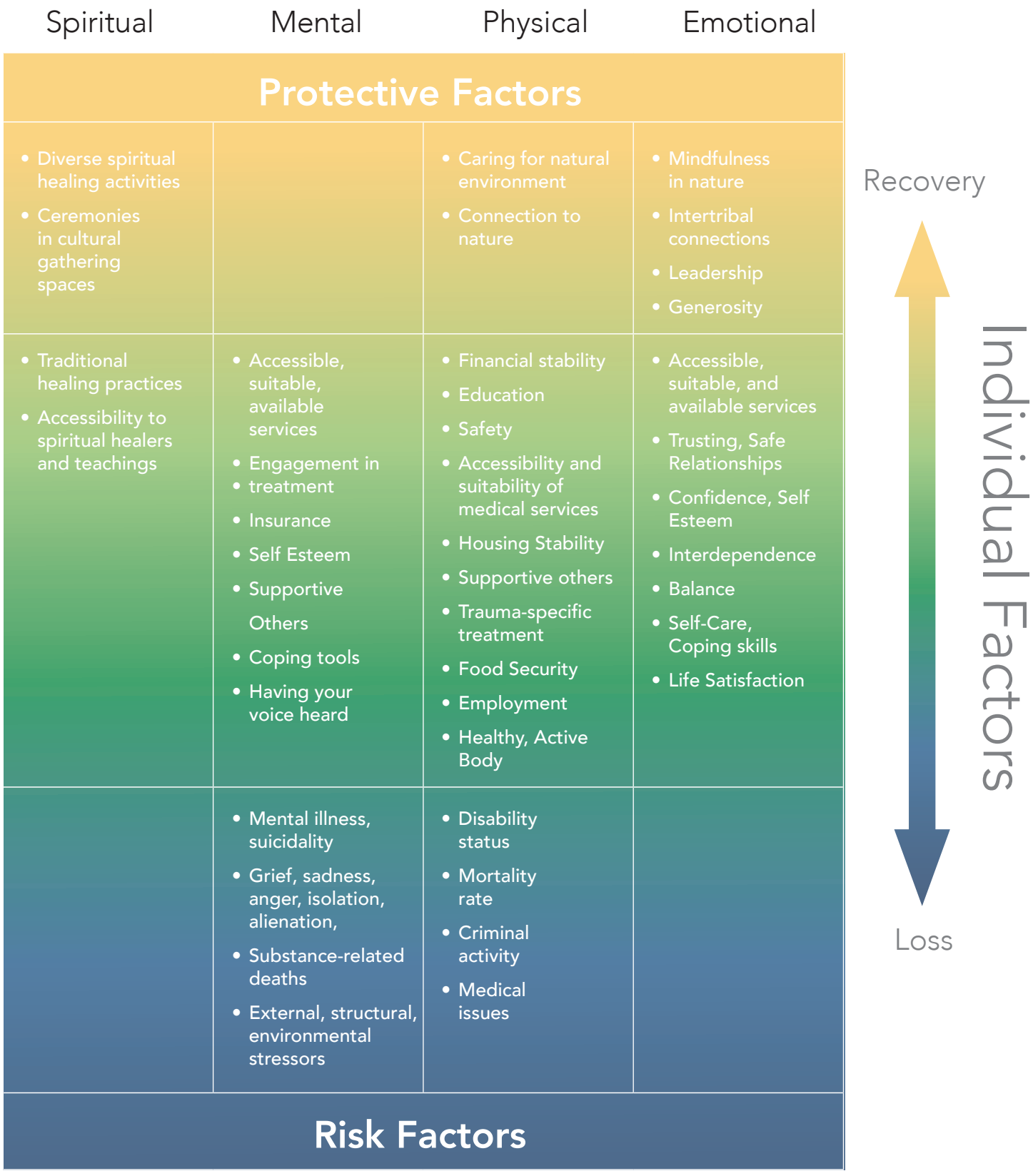
Emotional Health Protective Factors

Youth and adults describe various values, relational attributes, and factors that are important for their emotional health. Values such as kindness and generosity support positive relations with others, interpersonal connectedness, and trust and safety within relationships. Other factors that support positive emotional health include confidence, coping tools, self-care, peacefulness and balance. Finally, adults and youth report the importance of being in nature to support their emotional health, as natural landscapes provide a space for mindfulness, reflection, inter-tribal gathering and connection, identification with the natural environment, and healing.

Summary of Risk and Protective Factors: A Continuum of Loss & Recovery

This graphic displays an integration of the risk and protective factors. The central row of the visual demonstrates factors that are either risk factors (areas of loss), or protective factors (areas of recovery) based on the relative presence or absence of the factor.




Spiritual
Mental
Physical
Emotional
Protective Factors
• Diverse spiritual healing activities
• Ceremonies in cultural gathering spaces
• Caring for natural environment
• Connection to nature
• Mindfulness in nature
• Intertribal connections
• Leadership
• Generosity
• Traditional healing practices
• Accessibility to spiritual healers and teachings
• Accessible, suitable, available services
• Engagement in treatment
• Insurance
• Self Esteem
• Supportive Others
• Coping tools
• Having your voice heard
• Financial stability
• Education
• Safety
• Accessibility and suitability of medical services
• Housing Stability
• Supportive others
• Trauma-specific treatment
• Food Security
• Employment
• Healthy, Active Body
• Accessible, suitable, and available services
• Trusting, Safe Relationships
• Confidence, Self Esteem
• Interdependence
• Balance
• Self-Care, Coping skills
• Life Satisfaction
• Mental illness, suicidality
• Grief, sadness, anger, isolation, alienation,
• Substance-related deaths
• External, structural, environmental stressors
• Disability status
• Mortality rate
• Criminal activity
• Medical issues
Risk Factors
Recovery
Loss
Individual Factors

Accessibility, Acceptability, Availability

Accessibility of Services

Community members described numerous barriers to accessing services for their wellness. Some external barriers include lack of transportation, geographic dispersal across two counties, food insecurity, housing instability, lack of adequate health coverage, prohibitive eligibility requirements for some services, inability to afford services and scheduling conflicts with currently available services. Youth highlighted the lack of school and community-based prevention programs specifically for Natives and a need for physical space for youth to grow, learn and heal. Barriers internal to AIH&S discussed by community included the stigma of reaching out for mental health and substance use disorder recovery services, lack of trust between community members and non-Native providers, lack of wholistic coordination of health services and social service programs that focus on Native families.

These barriers contribute to lower levels of AIAN community members accessing critical resources to address specific health needs and sustain healthy lifestyles. Attention must be paid to addressing these barriers in order to expand access for Native families to existing services. Transportation is a critical access need, especially for youth and elders, in order to engage in community health programming across Santa Barbara and Ventura Counties.

> *"We need a place where Indian people can go during the daytime or whatever just to feel safe!"*
>
> *— Adult Focus Group Participant*

Stigma reduction education campaigns and interventions could significantly increase the utilization of health and recovery services for AIAN community members. Youth observed their school councils spreading awareness about mental health and its importance. They expressed a desire to replicate this offering in the Native youth community. They identified a need for a meeting space that has hours for youth to come freely, and one which has activities, workshops, and homework time led by an adult advisor. Youth suggested approaching local, public figures to assist with fundraising, and to recruit volunteers to help run this facility. Providing a safe, supportive space and opportunities for youth to gather will expand access to critical resources, educational interventions, prevention programs and help to develop more opportunities for AIAN youth leadership development and wellness. Furthermore, the youth expressed an interest in activities and resources to assist them in processing their emotions. Activities suggested included: journaling, poetry writing, quiet space, time spent outdoors, attending church, and having someone to talk to about their feelings. Various service needs that are specific to certain demographic cohorts include: disability, Veteran, and college student supports, as well as elder support services.

Acceptability of Services

Community members identified several prominent themes related to accessibility of services including cultural centered care and quality care coordination, due to a lack of culturally competent providers, spiritual and traditional healing services. Youth focused particularly on the lack of available approaches to cultural and traditional aspects of foods, fitness and environmental health.

A lack of trauma informed approaches to health and wellness with regard to medical and behavioral health services was also highlighted.

Community members identified the importance of integrating traditional AIAN practices into prevention, recovery and treatment services for wellness and expressed difficulty in accessing these resources, especially across the two county systems and surrounding rural areas. Culture-based services like sweat lodges, prayer circles, talking circles and ceremony were discussed as requiring a more central role in the healing and recovery process of the AIAN community. Community members implored these services be administered by traditional healers, elders and cultural supports in an integrated practice with medical and behavioral health services. Youth believe that having traditional healers and elders available to them will provide an avenue to connect with their creator/higher power, as a means of spiritual connectedness. The acceptability of these services includes increasing the availability of informed and educated providers through cultural awareness training and trauma informed approaches to care. Community members requested the training of organization staff to increase trauma-informed practices in cultural awareness, as well as the growth of AIAN providers to expand utilization of services across Santa Barbara and Ventura counties. Youth requested resources and information regarding stress reduction skills, cultural approaches to mindfulness, including time management and how to take healthy breaks and not procrastinate, which they believe will help lower stress and prevent anxiety. Youth highlighted that sharing their experiences with each other and community members contributes to overall mental health.

"In this community I think is lacking doctors or psychologists… that are of Native descent that have an understanding of cultural sensitivities and needs"

— Adult Focus Group Participant

Availability of Services

The centrality of diverse cultural approaches to wellness were highlighted by community members and stakeholders in addressing the wholistic health of Native youth and families in Santa Barbara and Ventura counties. Connection to external support such as healthcare providers, behavioral health counselors and centers were prioritized by community members. The connectedness of community engagement and external supports was identified as an important strategy to improve spiritual, physical, mental and emotional health of the community. In providing prevention programming and resources that integrate cultural values and approaches to healing are critical in engaging community and building healthy AIAN identities and lifestyles. Youth want to be able to experience a variety of activities and discover diverse spiritual practice in order to enhance their spiritual health. Youth stated having a community where spiritual health is discussed openly, would help to nurture and care for their overall spiritual wellbeing. In addition, the youth seek enjoyable, stress free activities like music, arts, and crafts as these activities positively impact their mental and emotional health. Community members believe there should be more publicity for counseling and behavioral health services in the Santa Barbara and Ventura communities with the goals of reducing mental health stigma and increasing awareness of the strengths and needs within the AIAN community.

"This is a strength, where the community kind-of collaborates together and makes these programs so you can use them all."

–Youth Focus Group Participant

Service System Recommendations

Introduction

While the AIH&S Circles of Care Project continues to develop a 'Blueprint' of services to address the needs of the AIAN community, several immediate recommendations emerged from the findings highlighted within this report. AIAN families in Santa Barbara and Ventura counties depend on various service systems including, but not limited to Medi-Cal, TANF, child welfare, public schools in addition to other county and state programs and services. To create a well-functioning System of Care grounded in the local culture of the community, organizations and agencies across the two county system must work to partner with the local AIAN community in developing solutions to meet the highlighted needs. It is critical that these partnership continue to work in a community based process that values community members as experts in their own health and wellness and leverages the strengths of the community to bring about positive change.

In order to meet the evaluated needs of AIAN community, the following are the priority recommendations based on the report findings:

1. Increase coordination of wellness resources and services for AIAN youth and families across Santa Barbara & Ventura Counties.
   a. Seek funding for mental and behavioral health services.
   b. Network with AIAN serving agencies to develop mutually reinforcing services for Native Families.
   c. Host annual events to foster collaborations and partnerships for services delivery.

2. Engage stakeholders, community partners and local agencies in addressing the needs of the AIAN community.
   a. Streamline and establish higher level of coordination for AIAN client referrals across agencies and partners.
   b. Establish inter-agency agreements, MOUs and joint funding opportunities with AIAN serving organizations.
   c. Increase funding to local AIAN-serving organizations.
   d. Coordinate inter-agency data sharing agreements, referrals and reporting systems.

3. Increase youth services and programming to address wellness needs.
   a. Increase school-based outreach and prevention programs for native youth.
   b. Increase culture-based activities that keep youth engaged in wellness.
   c. Implement youth-specific mental health and trauma-informed support programs and curriculum.
   d. Increase traditional outdoor engagement and educational opportunities: ie hunting, crafting, foraging, gardening, etc.
   e. Increase culturally centered activities and promote adult role models and elders from within the community.
   f. Develop a 'youth only' space: where Native youth can have a healthy safe-space and be connected to programming and services.
   g. Increase youth engagement in scholarship and training programs for workforce development.

4. Address stigma related to mental health and wellness services for youth, families and elders.
   a. Implement Social Marketing Plan to address Native youth wellness and reduce mental health stigma.
   b. Distribute culturally adapted mental health campaigns and materials.

5. Workforce development and economic development.
   a. Assess youth workforce development needs further and develop programming to support youth readiness and skill building.
   b. Establish workforce development programming for youth and adults including resume, building, interview skills and internship/job placement.
   c. Engage community members in entrepreneurship and small business development programming.

6. **Address housing resources and economic development programing and services for Native families.**
   a. Support small business and entrepreneurial development.
   b. Build financial education resources and annual tax support.
   c. Engage local resources to create educational and technical assistance for Native families seeking housing support.

7. **Develop resources and programming for Native Youth in the foster care system.**
   a. Engage system partners to improve data and tracking of AIAN foster care youth.
   b. Provide trainings on Indian Child Welfare Act (ICWA) compliance and reporting.
   c. Develop training and programs to increase AIAN parental readiness for adoption services.

8. **Develop a resource guide for AIAN youth and families with services in Santa Barbara and Ventura Counties as well as national wellness resources and help lines.**
   a. Identify comprehensive resources for mental/behavioral health and wellness based services across the Santa Barbara and Ventura county services area.
   b. Utilize mapping, web-based and printed resource to reach Native families.
   c. Promote resources and programming available to AIAN families through social media.
   d. Update and distribute a resource guide biannually.

9. **Increase access and utilization of culturally centered recovery resources.**
   a. Increase culturally centered recovery programming across Santa Barbara and Ventura counties.
   b. Develop coordinated calendaring and resource guides for recovery services.
   c. Increase partnerships among recovery based organizations for referral systems.
   d. Facilitate the creation of ceremonial opportunities for AIANs in recovery (annually and as needed).

10. **Develop training for providers in Santa Barbara and Ventura counties on cultural humility/sensitivity and best practices for working with Native peoples.**
    a. Youth led presentations on issues facing the AIAN youth in the community.
    b. Create a request portal for agencies and organizations to request cultural competency trainings.
    c. Engage community partners in distributing culturally adapted materials and supporting cultural awareness campaigns.
    d. Lead discussions with community partners on health equity across agencies.

11. **Engage local tribal partnerships to coordinate activities and service delivery strategies for youth and families.**
    a. Coordinate with local and statewide Tribal partnerships on joint programming and initiatives.
    b. Seek funding to support AIAN care coordinator roles across the service system.
    c. Develop formal care coordination with local tribal health programs.

12. **Increase the availability of culturally centered programs and services for youth and families.**
    a. Increase parental programming and support services such as positive Indian parenting and Wellness recovery Action Plan trainings.
    b. Increase healthy families evets and programming.

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Appendix A: Acronym List

AIAN	American Indian Alaskan Native
CAC	Community Advisory Council
CAM	Community Asset Map
CBPR	Community Based Participatory Research
CHNA 1.0	Community Health Needs Assessment 1.0 (Adult)
CHNA 2.0	Community Health Needs Assessment 2.0 (Youth)
COC	Circles of Care
CRA	Community Readiness Assessment
GONA	Gathering of Native Americans
NHW	Non-Hispanic White
SMPE	Social Marketing & Public Education
SOC	System of Care
TAY	Transitional Age Youth
YCM	Youth Council Meetings

Community Readiness to Address Native Youth Wellness

Addressing Native Youth Wellness Using a Strategic Plan

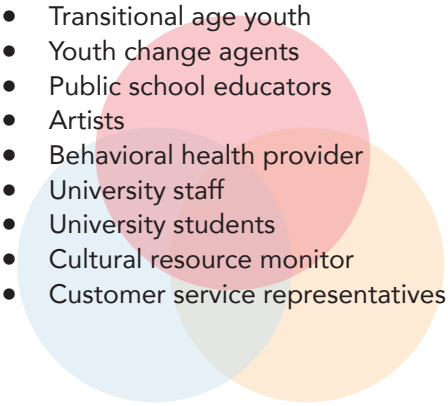
An understanding of community readiness allows a community to tailor an intervention or strategy to what the community is willing to accept and get involved in. Once you know your community's level of readiness, you can plan your effort to start at that level and move the community to the next, and to continue to move the community, one level at a time.

The Community Readiness Assessment (CRA) was conducted to inform the degree at which the community is ready to take action and informs a strategic plan for elevating readiness towards a specific community-identified issue. Understanding community readiness allows the community to tailor interventions, in this case regarding Native Youth Wellness, and move the community to the next level of readiness.

The community-driven plan to address Native Youth Wellness utilized 9 key Native-identified informant interviews. Results identified a specific level of awareness that the community (both native and non-native community) has regarding the issue of Native Youth Wellness. CRA results determined that there was vague awareness (e.g. little motivation to address the issue) currently regarding Native Youth Wellness within Santa Barbara and Ventura counties, within both the native and non-native community.

A Cross Section of Our Community:

- Multiple gender identities
- Multiple tribal affiliations
- Multiple socio-economic statuses
- Community elders
- Transitional age youth
- Youth change agents
- Public school educators
- Artists
- Behavioral health provider
- University staff
- University students
- Cultural resource monitor
- Customer service representatives



Strength Based Revision: A Contribution to the CRA Tool

The community identified Youth Wellness as the 'issue'. As a problem or deficit-based tool, the CRA typically measures disease as opposed to wellness. In mock interviews and CRA training, staff noticed the script read awkwardly, particularly the section: 'Knowledge About The Issue'. The evaluator worked with evaluation team members and community members on potential revisions (readiness for wellness priorities vs readiness for the issue). Evaluator then worked with the original CRA tool authors to review revisions. The CRA tool authors approved revisions and the updated strength-based version was made available to all Circles of Care grantees.

Dimensions of Readiness

By determining the Dimensions of Readiness, we are seeking to measure the community's preparedness to take action on a given issue (Native Youth Wellness). The six dimensions identified and measured in the Community Readiness Model provide a tool for diagnosing the community's needs and for developing strategies that meet those needs.

Higher Dimensions of Readiness

Leadership:
To what extent are appointed leaders and influential community members supportive of **Native youth wellness**?

Community Knowledge of 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?

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

Priority Dimensions of Readiness

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

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?

Resources Related to the Issue:
To what extent are local resources–people, time, money, space, etc.–available to support efforts?

Stages of Community Readiness

Measuring

The 9 stages of community readiness are measured for each dimension and an over all community readiness score is calculated by averaging each of the 6 dimensions. After determining the readiness score for each dimension, goals and strategies for raising the readiness level are developed by the community.

The 9 Stages of Readiness

1. No Awareness

Youth Wellness is not generally recognized by the community/leaders as an issue.

2. 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.

3. Vague Awareness

Most feel that there is local concern, but there is no immediate motivation to do anything about it.

4. 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.

5. Preparation

Active leaders begin planning in earnest. Community offers modest support of efforts.

6. Initiation

Enough information is available to justify efforts. Activities are underway.

7. Stabilization

Activities are supported by administrators or community decision-makers. Staff are trained and experienced.

8. Confirmation/Expansion

Efforts are in place. Community members feel comfortable using services, and they support expansions. Local data are regularly obtained.

9. High Level Community Ownership

Detailed and sophisticated knowledge exists about youth wellness prevalence and consequences. Effective evaluation guides new directions. Model is applied to other issues.

Focus Areas for Increasing Awareness of Native Youth Wellness

The following domains are areas of focus the community has identified for increasing awareness of Native youth wellness.

Existing Community Efforts The Native and non-native community is aware of existing efforts, but no motivation currently exists to do anything ("unless Native they probably won't care").

Knowledge of the Issue The native and non-native community recognizes the need for Native Youth Wellness, but aren't sure how to support it, and there is stigma and resistance in the community, and people don't know who to trust or what the next steps are.

Resources The native and non-native community are less aware of resources to support Native youth wellness, there is currently no coordinated effort, and little recognition that something can be done.

3. Vague Awareness

Goal: Raise Awareness that the Community Can Do Something

- 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.

4. Preplanning

Goal: Raise Awareness with Concrete Ideas

- 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 audiences 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.

Current Challenges, Resources & Strengths to Increasing Awareness of Native Youth Wellness

The Community and Youth Advisory Councils analyzed and identified challenges, resources, and strengths within the CRA domains of "Knowledge of the Issue," "Resources," and "Existing Efforts":

1. Challenges to increasing Native Youth Wellness (within native and non-native community): Continuity/consistency [of programs/services], staff turnover, leadership, meeting place, low interest/disinterest/outreach efforts, low self-esteem, programmatic design/ issues, meeting community needs, funding, youth engagement, communication, transportation, competing demands/priorities, limitations in creativity, conflicting dates.

2. Strengths (native and non-native community) for Native Youth Wellness: People who care and are passionate: Parents, siblings, elders, and peers. Conviction, Youth Organizations/ Youth Councils, Outside Resources, Tomol Paddle, Ceremony, Community and elder Participation, Evaluations, Culture, Youth Driven, Educators, Morgan (youth perspective attendance), AIH&S.

3. Resources in the community (native and non-native community) for Native Youth Wellness: Community space, youth outreach, youth, youth councils, youth organizations, youth-driven programs, AIHS, collaborating agencies, elder's circle, women's circle, tribal organizations, existing programs, knowledgeable community members with past experiences, circles of care program, intergenerational support.
    - CRA Results: The community rising to the challenges
    - Strategic plan for elevating readiness.

Social Marketing & Public Education for Community Wellness Promotion

The Social Marketing & Public Education (SMPE) plan serves as a vehicle for fulfilling the overall goals of the System of Care by promoting community wellness and encouraging positive behavior change. Social marketing for a System of Care lets the community be targeted in how they want to achieve defined outcomes which are outlined in an action plan. The Social Marketing plan incorporates data from the Year 1 and 2 and reflects community defined goals and strategies that educate, activate, and motivate system change.

Goals of the Social Marketing & Public Education Plan

For Native families in Santa Barbara & Ventura Counties, cultural responsiveness and education are primary external objectives that seek to inform stakeholders and county agencies about Native Youth Wellness and the needs and strengths of the AIAN community overall.

Social Marketing & Public Education plans are organized by three outcome-based Goals:

Action/Behavior Goal:
Incentivizing new behaviors and helping motivate a specific action or sustained behavior change.

Education Goal:
Increasing awareness of or informing about different community resources, issues, and services.

Policy Goal:
Facilitating coalition building, organizing, or persuasive campaigning to achieve policy change in a local institution or entity.

Given the Community Readiness Assessment (CRA) results that identified the native-and non-native community as having a **'vague awareness'** of the issue of ***Native Youth Wellness***, the primary **goal** of the social marketing plan is ***increasing awareness of native youth wellness*** in the wider Santa Barbara & Ventura Counties. **This first goal** is to increase awareness regarding the specific issues youth are facing regarding their health and wellness needs. Secondly the strengths, strategies and resources youth can use to increase wellness in their selves in their families and in their communities.

Audience

The primary audiences, those who we want to impact most significantly, are Native youth and young adults in the community. Parents and other family members, community stakeholders, and service providers will also be targeted by the campaign to bring about a community-wide increase in knowledge of Native youth wellness issues.

Messaging

To accomplish the goal of raising the community's stage of readiness from 'vague awareness' to 'preplanning', the messaging of the social marketing campaign will emphasize the place of culture in one's overall wellness, the importance of accessing social supports and services in the community, as well as empower youth to affect positive change in their community and provide them the knowledge to lead those changes. The SMPE plan aims to increase understanding of Native youth wellness to the point where the community can begin planning interventions, campaigns, and actions that are youth-driven.

Channels

The social marketing campaign will use multiple platforms and methods for disseminating its key messages, including social and print media, as well as various outreach events, meetings, presentations, and trainings, each designed to target the intended audience as effectively as possible. Channels and spaces that are preferred by youth and other community members will be prioritized as places for delivering messages and information.

Activities, Events, Materials

In order to engage target audiences in manners most appropriate and relevant to their positions in community and desires as individuals, the SMPE plan includes a mixture of methods for engaging them, including in-person outreach events, educational collateral materials, regular cultural programs, and youth-centered activities.

Social Marketing & Public Education Evaluation

Evaluation for the SMPE plan will involve measuring the reach of promotional materials to community members and community partners across the identified channels. Because the target communities are spread across Santa Barbara and Ventura counties, the community has prioritized tracking geographical distribution to ensure materials are reaching deeper into their communities. A combination of quantitive tracking of distributed materials and qualitative feedback from community forums will be evaluated.

In 2020, American Indian Health & Services will launch a Community Wellness page on their organizational website. The number of visits to this new page will be tracked and the number of resources that are accessed, including health tool kits, promotional flyers or other resources, will be counted.

The existing Native Sun Newsletter is mailed to approximately 200 homes across the two counties. With the inclusion of youth wellness campaigns, stigma reduction and other social marketing materials, increased distribution of and subscriptions to the newsletter will be tracked. Other methods for evaluation include a Youth Wellness Zine project that will continue elevating issues Native youth are seeing their communities and promoting healthy, positive solutions to their challenges. Distribution of the AIH&S Community wellness Report and presentations to stakeholder and community partner agencies will also be tracked and combined with qualitative feedback to improve outreach and messaging to provider communities.

Targeted Strategies for Increasing Awareness of Native Youth Wellness

The following strategies to raise awareness of Native Youth Wellness were identified by the Community and Youth Advisory Councils. Targeted strategies were identified given the unique challenges of vague awareness of the issue, vague awareness of resources, and vague awareness of existing efforts:

Specific Strategies to Best Meet Current Challenges of Native Youth Wellness

Who Are the target audiences?	Youth & Young Adults	Parents & Family Members	Providers & Community Partners
What do we want audiences to do?	Become educated about their own wellness. Collaborating and informing youth about other local organizations with mental health and wellness resources. Empowering youth to share their ideas with leaders, decision makers, and other stakeholders.	Increase awareness of how to support their own and their children's access to the. Participation and encourage youth partcipation in cultural programs and events.	Increase awareness of how to participate in system of care network in a culturally responsive manner to effectively address Native Youth wellness needs. Increase awareness and understanding of Native issues in community.
What are the messages?	Culture is a resource for healing and tool for prevention. Seeking services for your wellness is acceptable (should not be stigmatized). Healthy self image and raise self esteem. Reach out for social support from peers and community. Positive change in your communiy is possible through you.	We must build trust and create commonalities to have unity in the community. Finding enabling access to resources is possible and important for youth's well-being. The youth need your support to create change and healing in their community.	Native-specific and cultural needs must be understood in particular. The Native community must be actively engaged as partners in their wellness.

What channels will we use?	Social media. Regular Youth-specific events and gatherings Community wellness specific section of clinic website. Outreach events.	Newsletter. Parent support meetings that will parallel youth meetings. In-person outreach.	Face-to-face outreach. Periodic Stakeholder convenings.
How will each channels be used?	SM will be used organize, promote, and share resources related to youth wellness issues and campaign materials. Outreach events will be used to educate and provide information about opportunities for partcipation.	Dissemination of newsletter to community in order to inform about existing and upcoming programs. Parent meetings will give them a space to voice their needs for supporting youth and participating in programs and opportunity for education.	Presentations educating about community issues, needs, and priorities. Collateral materials will be shared to educate and promote participation.
What activities will support this?	Youth council planning sessions. Peer to peer meetings. Trainings for youth advisory group to have ownership over content creation.	Establishing Intergenrational circles for exchange of knowledge and support. Engage parents in creation of collateral materials.	Sharing of community wellness report and findings. Working with Adult/ Youth Council to develop materials for sharing.
What events will support this?	Periodic youth events focused on providing space for discussion, cultural exposure, and peer bonding. Intergenerational activities to interface with community adults and elders.	Outreach events.	Trainings on cultural competency and responsiveness to community needs.
What materials will support this?	Fact sheets, presentations, and art.	Collateral materials targetted at parents with strategies for representing their children's interests and health needs.	Presentations on Native issues and data findings. Print and collateral Materials on cultural competnency.

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