



NATIVE AMERICAN HEALTH CENTER

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PROPOSITION 63

POSITION AND RECOMMENDATION PAPER

The Native American Health Center, Inc., is a nonprofit tribal organization with a Board of Directors that is democratically elected by the adult members of the American Indian community in the San Francisco Bay Area. Formerly known as the Urban Indian Health Board, Inc., the Native American Health Center is an urban Indian health board with maximum participation of Indians in all phases of activities, as defined by the Indian Health Care Improvement Act in Title 5 (25 USC 1600). The San Francisco Bay Area includes Alameda, San Francisco, Contra Costa, Marin, and San Mateo counties. This area includes two major cities: Oakland and San Francisco. There are 57,262 American Indians and Alaska Natives (AI/ANs) living in the San Francisco Bay Area, one of the largest concentrations of Native Americans in any urban area in the United States. Almost one-half of the Native Americans living in the bay area live in Alameda County (U.S. Census, 2000).

The Native American Health Center (NAHC) has provided medical, dental, and human services since 1972, with offices in Oakland and San Francisco. NAHC opened the doors of the Family & Child Guidance Clinic (FCGC) in 1985 to provide much needed outpatient mental health and substance abuse services for urban Indians. NAHC works closely with its sister program, the Friendship House Association of American Indians, Inc. (FH), a residential substance abuse program with facilities in San Francisco and Oakland that has provided services since 1963. Together, NAHC and FH provide a basic infrastructure for health and human services for AI/ANs in Alameda County. We welcome the unique opportunity provided by the Mental Health Services Act to obtain resources for our community to overcome the barriers that keep urban Indians in self-perpetuating cycles of mental illness, violence and substance abuse, and to articulate our tribal organization's vision of a holistic system of care for Native Americans in an urban environment that blends evidence-based science with traditional American Indian healing practices.

The AI/AN population within Alameda County is very diverse. Our clients come from many of the 570 federally- and/or state-recognized Indian tribes in the United States. Each tribe has its own language, customs, and ceremonies. Although English is the dominant language, it is a second language for many AI/ANs. Some of the other languages spoken are: Navajo, Blackfeet, Sioux, Creek, Apache, Comanche, Kiowa, Anishinabe, and Spanish.

Indians from various tribes began migrating in significant numbers from reservations to major urban areas like Oakland and San Francisco during the 1950's under the Bureau of Indian Affairs (BIA) Relocation Program. Ultimately, the BIA did not

deliver on its promises of transitional assistance, and relocation resulted in creating a chronically disenfranchised urban Indian population. As a result of the assimilation policies of the relocation program, there are no Native American neighborhoods in the Bay Area and few opportunities for Native Americans to congregate and meet one another. Both adults and youth express that they benefit greatly from programs that bring Native Americans together (Lobo, 2002).

In the 500 years since the arrival of Europeans, Native Americans have experienced genocidal policies that included forced assimilation, boarding schools, involuntary relocation and displacement. The long history of oppression of Native Americans in the United States has had a devastating effect on the health and well-being of Native people. Among America's most disenfranchised and underserved communities, Native Americans have the lowest per-capita incomes, the highest unemployment rates, the highest school dropout rates and the highest rates of infant mortality, teen suicide, diabetes, cancer, and alcoholism (Mail & Johnson, 1993; Denny et al, 2003). According to the *Surgeon General's Report on Mental Health: Culture, Race and Ethnicity* (2001), AI/ANs are over-represented among people who are homeless, people who are incarcerated, and people with substance abuse problems. The estimated rate of alcohol-related deaths for AI/ANs as a whole is much higher than it is for the general population. Many AI/ANs suffer from *historical trauma*, a type of intergenerational post-traumatic stress disorder (PTSD), attributed to a cultural history of oppression (Brave Heart, 2003; Duran & Duran, 1995).

Of the nearly 500,000 Californians who indicated on the 2000 census that they were of AI/AN heritage, nearly 70% live in urban areas. Nearly 25% of AI/ANs residing in urban areas live in poverty, and 48% live in households with incomes below 200% of the federal poverty level. In addition, several disparities pertaining to AI/ANs living in urban areas are evident with respect to higher rates of death due to accidents (38% higher than the general population), chronic liver disease and cirrhosis (126% higher), and diabetes (54% higher). Additionally, 46% of urban AI/AN households were reported as being headed by a single parent. In 2002, nearly one in four AI/ANs reported having a disability (UIHI, 2004). In addition, the rates of home ownership, education, literacy, and employment are far below the national averages (U.S. Census, 2000).

Consumer and Family Involvement

Youth and adult consumers and their families have been involved in the preparation of this paper and must be involved in all phases of the implementation, evaluation and sustainability of the Mental Health Services Act. They should provide input and feedback on the implementation and evaluation through a Consumer Council or similar model. Input for the current paper was gathered through several focus groups and surveys. Fifteen residential clients participated in a focus group discussion of expanded services. The question asked was, "What services would enhance your recovery and quality of life?" Figure 1 shows the percentage of clients who responded in terms of the services listed below.

Service	Percentage
Spiritual Advisor Sessions	93%
Sweat Lodge	67%
Drug and Alcohol Education	67%
Men's and Women's Group	60%
Family Counseling	40%
Healthy Relationship Classes	40%
Parenting Classes	40%
Cultural Identity Groups	40%

Figure 1
Friendship House Focus Group Results

Several other focus groups were held in the spring of 2005. These groups were asked to discuss any issues they felt to be important in addressing mental health and substance abuse issues. The first group was held at Skyline High School with seven youth as participants. They reported that the main drug of choice among peers was marijuana and that many of their peers were curious about experimenting with other drugs. They emphasized that programs should include activities they enjoy, such as sports, disk jockeying, eating, and hanging out. In regards to HIV/AIDS prevention, they stated that they wanted to learn more, but through the straight facts, not sugar coated through pictures and videos.

The second group was held with 15 Native American adult males, many of whom had spent time in jails and prison, representative of the reentry population. This group reported that physical exercise, spiritual advisor sessions, relapse prevention, wellness education, men's groups and anger management skills to counter domestic violence should be available. Maintaining sobriety was seen as a key factor in mental health and HIV/AIDS prevention.

A third focus group was conducted among members of the **Urban Trails Community Council**, a group of parents and significant others whose children receive services at NAHC. This focus group suggested establishing a mentor program to break the thinking among youth that expressing emotion is a sign of weakness. They indicated that prevention should include stigma reduction and peer support. Community members made the following recommendations:

- Peer mentoring, such as middle school students being mentored by high school students.
- Make sure we reach the homeless community.
- More counseling is needed.
- Some teens are coping with parents who are at risk.
- Tribal athletic programs should be expanded.
- Young men's and young women's groups would be helpful.

The **Native Circle Community Advisory Board (CAB)** was also included in the preparation of this paper. This group consists of HIV positive clients in our mental health

program, including those who are LGBT. Ten members filled out a written survey to give feedback and present suggestions to the Family & Child Guidance Clinic. These included:

- “Process Groups – where people share their issues that make them vulnerable.”
- “Outings to purify and cleanse – with Elder speakers.”
- “Guest Speakers on various health topics and Mental Health topics around HIV.”
- “Have small gatherings in special places where not a lot of people go – talking, smudging, praying, and eating.”
- “Focus on what triggers relapse, learn the difference between physical dependence vs. somatic addiction and mental dependence.”

Finally, several elders were interviewed to get their input about mental health transformation. Many provided testimonies of the lack of mental health services that are culturally sensitive and relevant (aside from Native American Health Center). All of the elders felt that mental and emotional wellness get compromised eventually when other health issues are not adequately addressed. All of the elders strongly supported this recommendation to establish funding leverage from the county and state for Native Americans.

Mental Illness

Mental illness is a major problem for AI/ANs in a vicious cycle that includes substance abuse and violence. Large-scale prevalence studies of mental disorders among AI/ANs are lacking. Beals, Manson et al (2005) studied 3,384 members from one southwestern and two northern plains tribes and found that lifetime prevalence of DSM-IV disorders averaged 41.9% for the Southwest Tribe and 44.5% for the Northern Plains tribes.

In Alameda County there is a current trend of misrepresenting the mental health needs of and services to AI/ANs. In the county MHSa planning meetings, for example, handouts that were distributed to participants implied that the total Native American population in Alameda County is only 2,024, and that only 134 of these people suffer Severe Emotional Disturbances (SED) or Serious Mental Illness (SMI) and that they are currently served at a rate of 107.5%. These numbers *directly contradict* data published by the U.S. Census Bureau, SAMHSA, several bay area foundations that study rates of mental illness for Native Americans, and even the county itself, yet they are being included in a planning process that will ultimately allocate resources in favor of or against certain populations.

Using data in a way that is skewed in order to create a false picture of the AI/AN community is not just irresponsible, it’s a form of “statistical genocide.” The misrepresentation of AI/ANs as being over-served when it comes to mental health services is extremely dangerous because it helps ensure that services for AI/ANs are not available to help combat serious mental illness or substance abuse. Data collected both

locally and nationally demonstrate that AI/ANs remain one of the most disenfranchised populations within the United States.

The prevalence of suicide for AI/ANs is 1.5 times the national rate. Since 1979, suicide and homicide have been leading causes of death among young AI/ANs. The rate of violent victimization of AI/ANs is more than twice the national average. The higher rate of traumatic exposure results in a 22% rate of PTSD for AI/ANs, compared to 8% in the general U.S. population (Wallace et al, 1996; MMWR, 1998).

According to epidemiological studies, 6% of California's population suffers from schizophrenia, bipolar disorder, or major depression, and an estimated 13% have a diagnosis of dysthymia, panic disorder, phobia, obsessive-compulsive disorder, or antisocial personality. In the 5-county Bay Area prevalence rates for SED in children ages 0-17 ranged from 9-11% for the general population (California Mental Health Master Plan, 2003; Meinhardt et al, 1994).

The California Mental Health Master Plan listed the following barriers to providing services for AI/ANs: the DSM-IV is limited in dealing with cultural issues; high unemployment rates among AI/ANs in California limit their ability to purchase insurance; and the long history of broken treaties has led to a feeling of mistrust of the mainstream culture (Hodge, 1997).

Co-occurring substance abuse and mental health disorders are a significant problem among AI/ANs. Risk factors for co-occurring disorders among AI/ANs include poverty, unemployment, historical trauma, contemporaneous trauma, violence, child abuse and neglect, negative role models, and easy availability of alcohol and drugs. Resiliency factors include strong group affiliation, extended family, cultural respect, spirituality, community support, wisdom and strength of elders, and sense of humor (Clark et al, 2004).

In a pilot study funded by IHS, a review of clinical files from 200 clients who received outpatient mental health services at the NAHC Family & Child Guidance Clinic showed that 85% had a history of alcohol abuse and 73% had a history of drug abuse. Additionally, 64% of these clients were diagnosed with substance induced disorders, 58% with anxiety disorders, and 50% with mood disorders, indicating a significant number of clients with dual diagnoses of substance abuse and mental illness (Duran & Yellow Horse-Davis, 1996). In 2003, there were a total of 10,469 unduplicated clients, and 25,181 client visits for services at NAHC. In FY 04-05 there were a total of 771 unduplicated clients who received mental health and/or substance abuse services at the Family & Child Guidance Clinic.

Anger and violence are prolific within the Native American community. Among AI/AN admissions to substance abuse programs, 40% were referred from the criminal justice system (DASIS, 2005). In 1997, an estimated 1 out of every 25 AI/AN adults was involved in the criminal justice system (Surgeon General, 2001). AI/ANs experienced a per capita rate of violence twice that of the general U.S. population. During FY 2001, AI/ANs were 16% of all offenders entering federal prisons for violent crimes. Nearly 27% of AI/ANs leaving prison in 1994 served time for violent offenses, and 18% served time for drugs. Within the first 6 months of their release, 26% of the AI/AN offenders were arrested for a new crime (Perry, 2004).

Family violence accounts for 18% of all violent victimizations experienced by American Indians. Gender-based trauma has emerged as one of the most serious public health problems facing American Indian women today (Williams, 2002). In a study of lifetime exposure to trauma for Native American women, over half the sample experienced physical or sexual assault (Walters & Simoni, 1999). In a study of high-risk women at NAHC, 41% reported feeling afraid of being beaten or threatened by a sexual partner during the past 12 months (Klein et al, 1995).

In 1985, Dr. Gerald Hill conducted a community needs assessment funded by the Robert Wood Johnson Foundation. An analysis of 550 surveys of American Indian community members in the San Francisco Bay Area indicated that mental health, medical care, employment, dental care, substance abuse, housing, family services, health education, and traditional healing were perceived as major unmet needs (Hill, 1987). As a result, the Family & Child Guidance Clinic (FCGC) of the Native American Health Center was established to provide mental health and substance abuse services. Initial funding of \$36,000 came from Alameda County to hire a .25 FTE psychologist. That same year an additional \$116,000 came from Indian Health Service through Title V of the Indian Health Care Improvement Act that set aside funds for mental health and substance abuse programs at urban Indian clinics (Duran & Yellowhorse-Davis, 1996).

Assessment

The **Alameda County Health Care Services Agency** oversees the Alameda County Public Health Department and Alameda County Behavioral Health Care Services. Mental health, drug and alcohol services are administered by **Alameda County Behavioral Health Care Services**. The strategies of the **Alameda County Public Health Department** are to focus on positive determinants of health, diversify the range of partnerships, and serve as a resource for communities to maximize their own potential to address and resolve their health issues or to enact healthy changes, and develop a constituency for prevention.

In March 2002, an MOU was signed by the Directors of the Alameda County Health Care Services Agency, Alameda Behavioral Health Care Services, Alameda County Public Health Department, Oakland Department of Human Services, and Chief Executive Officer of NAHC to:

- Coordinate efforts in developing and implementing each agency's strategic plan.
- Participate in a structured dialogue to integrate planning efforts, prevention initiatives and service delivery impacting Native Americans in Alameda County.
- Give particular attention to prevention and early intervention efforts for Native American children in the schools and community.
- Explore mechanisms for aggregate data sharing on the utilization of services by Native Americans in Alameda County.
- Discuss ways to improve cultural competency for practitioners and programs working with Native Americans in Alameda County.

In August 2002, NAHC signed an MOU with the **Alameda County Social Services Agency** to collaborate in strategic planning efforts to meet the human service needs of Native Americans in Alameda County. The Alameda County Social Service Agency will identify Native Americans receiving its services and make referrals to FCGC, participate in a structured dialogue to integrate planning efforts and service delivery impacting Native Americans, discuss ways of improving cultural competency for Agency staff, and work together with NAHC in obtaining resources for Native Americans needing social services in Alameda County.

In 1993, the Native American Health Center, Friendship House and five other American Indian organizations began to collaborate in the **Community Mobilization Project**, a multi-year comprehensive effort funded by private foundations to assess community needs and develop a strategic plan based on a “community-as-village” response to meet those needs. Its mission was:

"To set in motion a process of change that would facilitate the efforts of urban American Indians to create the structure and means necessary to reach their social, cultural, economic, and political goals as they perceive and define them."

Stakeholders met quarterly in Community Visioning Meetings. Community Councils were established to identify issues, assess needs, and set priorities for education, health, and economic development. Strategic planning provided a rich opportunity for community participation at all levels of system design and implementation, building a sense of unity and serving as a model for future efforts. Significant input came from agency directors, staff, parents, youth, community members, traditional healers, and consumers. The need for mental health and substance abuse services was identified as one of the highest priorities in the *Strategic Plan for American Indians in the San Francisco Bay Area* (Nebelkopf, Phillips & Granados, 1996). *Native American Postcolonial Psychology* (Duran & Duran, 1995), the first book that addressed the specific mental health needs of AI/ANs in the context of historical issues, introduced the concept of intergenerational post-traumatic stress disorder, and conceptualized the need for a holistic approach—one that included both Western psychology and traditional American Indian healing practices—based on the model being piloted at the Family & Child Guidance Clinic of NAHC.

In 2001, our community reached consensus to adopt a vision for a holistic system of care for Native Americans in an urban environment. This vision was articulated in *Circle of Care Strategic Plan: Holistic System of Care for Native Americans in the San Francisco Bay Area* (Nebelkopf, Phillips & King, 2001). The plan linked treatment with prevention; mental health with substance abuse; and evidence-based practices with cultural healing. The strategic plan outlined the principal components necessary in an integrated system of community health care that links mental health, substance abuse, medical and social services based on Native American values and culture. This model has been instrumental in obtaining federal and local support through collaborative efforts with other urban Native American nonprofit agencies and public entities such as the City of Oakland (Nebelkopf & King, 2004; Nebelkopf & King, 2003).

Key stakeholders from ten Native American organizations signed a pledge to implement the strategic plan for a holistic system of care for our youth. See Figure 2.

WE, the undersigned members of the American Indian Community in the San Francisco Bay Area, today make a pledge to invest our time, energy and resources to invest in our children, who represent the future of our community.

WE pledge that we will support our youth as they become adults and take more responsibility for themselves, their families and their community.

WE pledge that we will support the blossoming leadership of our youth.

WE pledge to participate in developing, refining, adopting and implementing a strategic plan for a holistic system of care for Native American youth and their families in the Bay Area.

WE pledge to do whatever it takes to find solutions to heal the wounds in our community: alcoholism, substance abuse, violence, mental illness, homelessness, and AIDS.

WE pledge to take the time to show our love and appreciation for our children, each and every one of them, our most precious resource for the future.

Figure 2
Community Pledge

The strategic plan made the following recommendations in the areas of program development, mental health reform, family advocacy, youth leadership, and wellness education:

- Develop cultural competency training for public officials.
- Develop mental health programs that strengthen the family.
- Support advocacy efforts of parent groups
- Ensure that parents and family members play an essential role in providing input into implementation of new programs.
- Incorporate HIV/AIDS prevention into mental health and substance abuse programs.
- Expand leadership training opportunities for youth.
- Work with juvenile justice officials to develop programs for Indian youth.
- Advocate for a holistic system of care as an alternative to the medical model.
- Advocate for statewide set-aside funding for Native American programs.

The strategic plan stressed the simultaneous planning and implementation of pilot projects based on the holistic model, thus positioning the urban Indian community to take

advantage of the unprecedented funding opportunities made available through the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Capacity Expansion/ HIV Services programs in 1999-2002. This was a major breakthrough in acquiring resources to meet the needs of urban Indians as Indian Health Service (IHS) funding dwindled.

In 2002, NAHC, in collaboration with FH, received funding from the Health Resources and Services Administration (HRSA) for the **Holistic Native Network**, a holistic, integrated, and culturally relevant HIV/AIDS treatment system, linking primary medical care with substance abuse, mental health, dental, and social services. This was one of six Native American programs funded by HRSA in its *Special Projects of National Significance (SPNS)* program. In 2002, CSAP awarded NAHC, in collaboration with FH, a three-year grant, **Urban Native Youth**, to implement a substance abuse/HIV prevention curriculum for youth (ages 9-22) in schools in the San Francisco Bay Area.

Overcoming huge barriers has been a major theme in our struggle to attain resources to transform our community. Eligibility for the *Child Mental Health Initiative* that would allow us to implement the strategic plan we developed in the **Circle of Care** is limited to public entities and tribes. Since urban tribal organizations are not tribes, they are not eligible for these resources. This was very frustrating, seemingly another insurmountable obstacle for urban Indians. Nevertheless, in the spring of 2002, the City of Oakland, Alameda County Health Care Services Agency, and NAHC signed an MOU to collaborate in the planning and implementation of a system of care designed by and for urban Indians based on the working model developed through the **Circle of Care**. In a unique and innovative public-private partnership, the City of Oakland agreed to be lead agency with NAHC as subcontractor in a proposal to CMHS for the *Child Mental Health Initiative*. In 2003, **Urban Trails**, a six-year grant to implement our holistic system of care, was funded.

In 2006, NAHC would like to extend our innovative system of care for Native American children and their families to adults and elders, furthering our transformation efforts through **Native Visions**, a proposed project under the CMHS *Mental Health Transformation State Incentive Grant*. Yet, despite everything we have accomplished, our inventory of resources is small compared to states. Our tribal community will enormously benefit from additional resources to enhance infrastructure of mental health services and implement our community's vision of wellness.

Our Vision

We view mental illness, substance abuse, HIV/AIDS, homelessness, poverty, and violence as symptoms of historical trauma, family dysfunction, and spiritual imbalance. Our community-adopted model focuses on the whole person in the context of the immediate and extended family, ancestral history, and social environment. It encompasses the mind, body, spirit, and emotions. It emphasizes assets rather than liabilities. It strives for balance, internally and externally. It functions on individual, family, and community levels. See Figure 3 below.

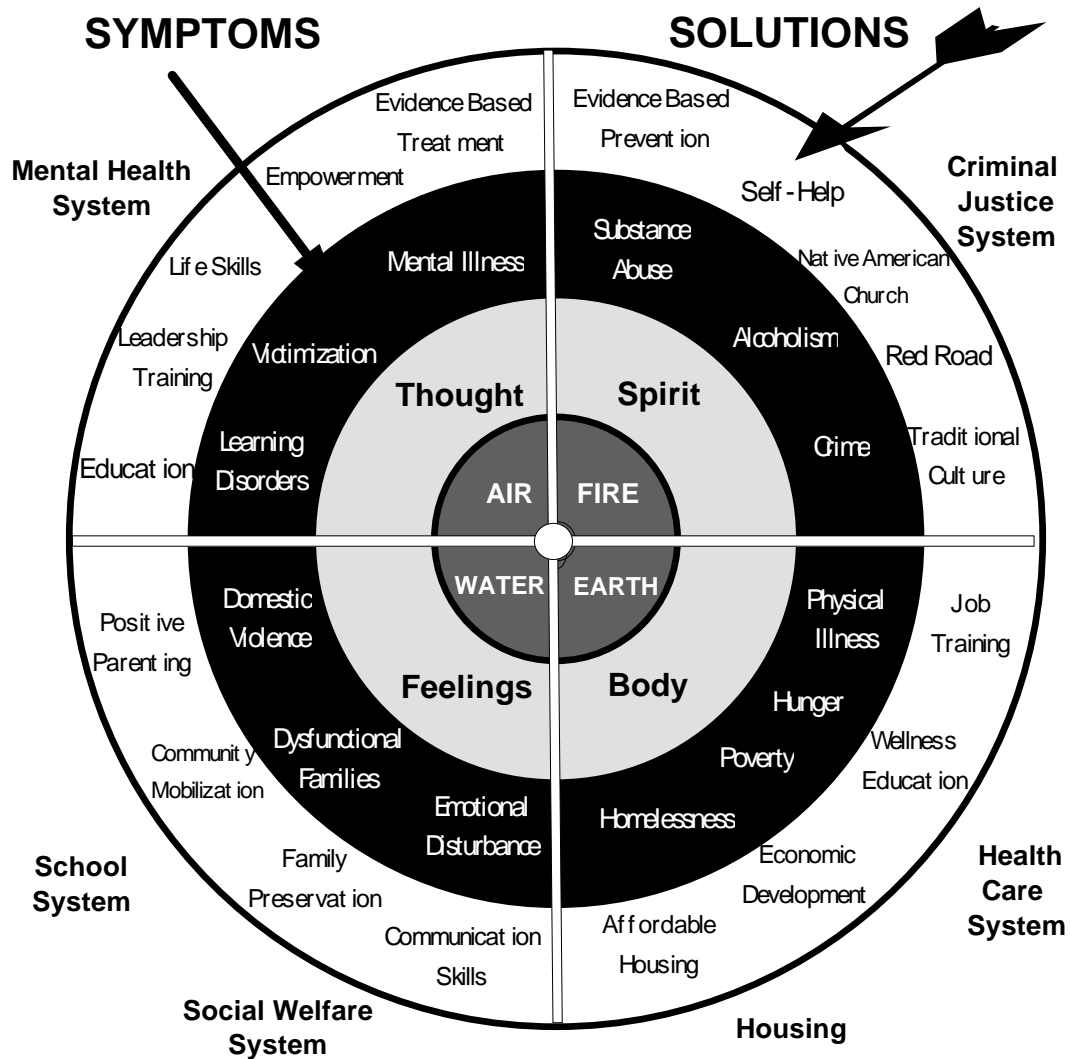


Figure 3
Holistic System of Care for Native Americans in an Urban Environment

Native Americans have a relational worldview, rooted in tribal culture. Every event in one's circle of life relates to all other events regardless of time and space. Interventions are focused on bringing the person back into balance (Cross et al, 2000). Although there is tremendous diversity among Native people, most have a concept of balance as integral to well-being. Wellness consists of symmetry among different parts of a whole. The Medicine Wheel, a concept central to the cultures of many Native nations, illustrates the importance of balance for wellness. While the Medicine Wheel has many different levels of meaning, its basic elements are a circle divided into quadrants. There are many layers of symbols associated with different parts of the wheel. All areas must be in balance and harmony for true wellness to exist. A problem in one area upsets the balance and affects other areas. Wholeness of individuals, families, communities, and nations are all facets of wellness. Too often, indigenous people have

been and continue to be defined by others—which is disempowering, demoralizing, and often devastating to the sense of self. Wholeness reinforces and is reinforced by a sense of cultural identity. It is crucial to the well-being of Native communities to retain the ability to define and name themselves, as well as to address imbalances in a culturally-congruent way (Weaver, 2002).

The path to wellness in Native communities is often referred to as the Red Road. Many Native people embrace the Red Road, a holistic lifestyle that integrates health-related phenomena in an inclusive, circular path of living according to the traditional instructions received by Native people (Weaver, 2002). The **Red Road to Recovery**, taught by Gene Thin Elk, has helped thousands of American Indians to attain balance and recover from both substance abuse and mental illness. The **Red Road** is analogous to Twelve Step in that it focuses on self-help. This approach is not limited to a single tribal philosophy, but draws on all aspects of Native culture to address the cognitive, emotional, and experiential needs of Native Americans who are rebuilding their lives from substance abuse (Thin Elk, 1993).

In our vision, change starts from within. Our community empowers the individual to take responsibility for change, whether the symptom is mental illness, poverty, substance abuse, homelessness, unemployment, domestic violence, or hunger. Our programs are designed to build a healthy community that supports recovery, role models, and peer support. We understand that individuals function in the context of interpersonal relationships, family, tribes, communities, and social institutions. Services aim at restoring overall balance, not only on targeting specific symptoms. In most cases, even though the “identified client” seeks help, the entire family and network of social relationships are addressed in the individual care plan. We believe that individual change and social change are two sides of the same coin—transformation from different perspectives.

Fragmentation of service delivery is a large problem for our community members. AI/AN communities have dwelled on the multiple barriers, immense needs, and severe disparities facing its people for far too long. The focus in the holistic model is on *solutions* rather than *problems*. These solutions have been pilot-tested in our community and have proven effective in improving the spirit and quality of life for Native Americans living in the Bay Area. These solutions consist of evidence-based practices such as treatment for co-occurring disorders, life skills training, job readiness training, substance abuse prevention, HIV/AIDS prevention, positive parenting, community mobilization, wellness education, empowerment, and self-help, as well as traditional American Indian healing techniques and cultural practices such as talking circles, sweat lodge, Red Road to Recovery, and a value system based on AI/AN culture.

Our community members prefer to receive services from Indian organizations and report that these services are effective. The community has identified several principles as a foundation for the system of care:

- We do not “treat” people, we teach them to help themselves.
- We do not use the label mentally ill; we see these people as our most vulnerable and needy community members.

- We emphasize prevention as well as treatment.
- We encourage our most vulnerable members to participate in community activities with everyone else.
- We discourage labeling and scapegoating of our most vulnerable members.
- We seek resources to build our own programs because mainstream programs have a poor track record in helping Native families and their children.
- We build linkages between substance abuse and mental health services.
- We encourage empowerment and self-help; we discourage entitlement and victimization.
- We encourage consumer input in our system of care.
- We support a community-based methodology that includes professionals, traditional healers, and peer support in a “wraparound” team approach to care.

Many Native Americans maintain traditional beliefs and values while they participate in the contemporary world. Successful prevention efforts incorporate the notion of bicultural identity in practice, employing interventions tailored to the community to strengthen the ability to “walk in two worlds.” Traditional Indian ways are being successfully used to address current social problems (Fleming, 1992; Beauchamp, 1998; Coyhis, 1999; Moran, 2001; Murillo, 2004). Our vision for transformation utilizes evidence-based practices in a culturally-sensitive context that have been found to be effective in pilot projects implemented in our community during the past decade. Building a healthy community includes empowerment, self-help, promotion of positive mental health, a commitment to the family, and development of a broad funding base. A recovery vision of community development is based on the premise that people can recover from mental illness and substance abuse, and that the system of care must be based on this knowledge (Anthony, 2000).

Strategic planning not only enabled us to leverage resources from a wide variety of funding agencies, but also helped to build cohesion, and a vision for the future. In *Pathways*, published by the National Indian Child Welfare Association, Hunt & Castaneda (2001) wrote:

“In Oakland, there are community events that American Indian agencies like the Native American Health Center sponsor to create gathering places for Native people to come together where they have a place to belong. Their system of care replicates the traditional healing processes found on many people’s home reservations, and it accepts all children in all stages of their development. Of all the Circle of Care projects, the Oakland project has been the most successful in including youths as well as parents in its planning efforts.”

The Holistic System of Care for Native Americans in an Urban Environment

emphasizes solutions, fosters linkages among providers, Indian and non-Indian, and includes community education and outreach. Events are designed monthly and with the changing of the seasons to develop community cohesion. Community members look forward to participating in pro-social, clean and sober events, conferences, powwows, barbeques, recovery celebrations, dinners, ceremonies, giveaways, health fairs and other rituals. These events combat isolation and give everyone a sense of being part of a therapeutic community that is larger than any one individual—a community that is culturally and spiritually based.

The vision described in this paper not only represents the work of our Native American community, but the spirit of mental health transformation in general. It is our strong recommendation that Alameda County include the following strategies, as laid out by the California Department of Mental Health, when it develops its proposal.

- Cultural and gender-sensitive outreach and screening services at schools, primary care clinics, and community programs in ethnic communities, which proactively reach children who may have emotional and/or behavioral disorders and which can provide easy and immediate access to mental health services when needed;
- Services located in racial ethnic communities to reach children, youth and families who may be more responsive to services in these settings; linkage for these families to the full range of community services and supports, intergenerational strategies for children/youth and their families in which parents may have their own mental health problems. Services are delivered within the context of a single child/family services and supports plan;
- Integrated services and supports for children/youth and their families with co-occurring mental health and substance use disorders within the context of a single child/family services and supports plan;
- Integrated substance abuse and mental health services where a client/member receives substance abuse and mental health services simultaneously, not sequentially, from one team with one service plan for one person; specialized housing to accompany these services as appropriate;
- On-site services in primary care clinics or other health care sites to provide individualized, inter-disciplinary services coordinated with other health care providers. These services are particularly needed to reach people with co-occurring chronic or life-threatening medical conditions, people who are frequent users of hospital emergency rooms or inpatient care and others who may be more responsive to services in this setting. Linkage must be provided for these clients to a full range of services;
- Culturally appropriate services to reach persons of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings;
- Community cultural practices – traditional practitioners, natural healing practices and ceremonies recognized by communities in place of or in addition to mainstream services.

Mental Health Services Act

The Native American community was not consulted or included in the creation of the MHSA. The Act makes funds available to individual counties as a pass-through from the state Department of Mental Health. American Indians are a sovereign people, under the umbrella of the federal government just as each individual state is. Using the state as the central agency in charge of the MHSA without including tribal representation is a blow to our sovereignty status and infringes upon our government-to-government relationship with the State of California and its individual counties.

The planning process that began after the passage of the MHSA was another blow to the Native American community, as most counties chose not to include any form of tribal representation in their stakeholders process. Alameda County has the opportunity to demonstrate leadership in this capacity and build a bridge between local government and the more than 20,000 Native Americans who call Alameda County their home.

There are several opportunities available because of the additional funds created by the MHSA. The county could take a role in sustainability of programs that have been recently created and are demonstrating measured success, but for which federal funding will be running out shortly. These programs were created in the same spirit as embodied in the MHSA, and the undeniable impact they are having is not something we can afford to lose.

Another option is to use MHSA funds to partner with innovative programs that are being created with federal funds, but that require match amounts by the providing agency. NAHC, for example, has several proposals at the federal level that would require match amounts to be raised in order to establish the type of innovative programs and services as described in the text of the MHSA. As one of many providers of mental health services in Alameda County, NAHC receives just 1% of its funding from the county, 2% from the state, and the bulk of its funding from the federal government.

The residents of Alameda County have long benefited from the work done by NAHC and many other distinguished providers, and the MHSA provides a venue for the county to begin contributing a share of monies to these successful, innovative programs that more closely reflects their fair share.

Our community is willing and eager to work with Alameda County Behavioral Health on how to best implement the MHSA so that it is beneficial to and supportive of all of the residents of Alameda County. The vision documented above is not a small undertaking, but it is one that the Native American community believes to be vital for the survival and development of our people.

As we walk down this path to transformation, our Native American community is glad that Alameda County is our partner in this endeavor. We look forward to a day when all of our people, Native and non-Native, enjoy lives that are free of mental illness and substance abuse. With the support of Alameda County, that day may not be far off.

Respectfully submitted.