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Denver Indian Family Resource Center's Keeping the Circle Whole

U.S. Department of Health and Human Services
SAMHSA Circles of Care Project

Community Needs Assessment Report

August 2007

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With gratitude to the hundreds of
American Indian/Alaska Native community members
and their allies
who contributed their wisdom and insight

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Denver Indian Family Resource Center's Keeping the Circle Whole
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Executive Summary

In 2005, the Denver Indian Family Resource Center (DIFRC) was awarded a three-year planning grant from The United States Department of Health and Human Services, Substance Abuse and Mental Health Services (SAMHSA) to address the needs of youth who suffered from severe emotional and behavior disorders (SEBD). The project is titled Keeping the Circle Whole, and the grant was one of only seven in the country awarded to Native American-serving agencies. The mandate of the grant was twofold.

- Gaining community-wide vision of and participation in the development of a service delivery plan to support mental health for Native American youth
- Using community input as well as additional data collection strategies to conduct a thorough *community-based needs assessment* to inform a *system delivery model* and to conduct a *feasibility study* for the model

This report summarizes the results of Keeping the Circle Whole's in-depth community needs assessment.

The Unique Nature and Challenges of Denver's Indian Community

Denver's American Indian/Alaska Native (AI/AN) community faces its own unique challenges of an urban Indian population. While Denver sits on land that was once home to the tribes of the Great Plains and Rocky Mountains, its present-day tribal diversity is a consequence of multiple punitive federal policies and the migration of individuals seeking economic opportunities, as well as returning World War II veterans. As a result, the Denver Native community consists of representatives of more than 200 tribal communities that are dispersed over 8,551.82 square miles and seven counties.

Needs Assessment Process

The project was launched with a participatory spirit. Consumer/community members, providers and administrators met in facilitated workgroups and agreed on a community definition of SEBD. The Keeping the Circle Whole Steering Committee then combined these into a single, community definition.

The final community definition of SEBD is: *Children and youth requiring assistance to fulfill their spiritual, emotional, physical and mental potential by building on the strengths of the individual, family and their community.*

Using this definition as groundwork, and with the assistance of JVA Consulting, LLC, an outside evaluation team, Keeping the Circle Whole staff launched the largest needs assessment of metro Denver's AI/AN community ever conducted. Over the course of nine months, data were gathered from each of these sources over seven counties:

- Over 15 hours of key informant interviews
- 11 focus groups of youth, mainstream and traditional health providers, education specialists and parents
- Over 700 surveys from youth and adult community members, 53 administrator and providers surveys and 13 crisis intervention education specialist surveys
- Rigorous review of the literature and U. S. Census research

Key Findings and Themes

Needs Assessment findings as reported are organized into three main areas of concern:

- *Risk and resiliency factors* in the metro Denver AI/AN community
- *Current service delivery systems offered* within the community to youth and families, their accessibility, cultural competency, effectiveness and referral systems, as well as gaps in what is offered
- *Community attitudes and recommendations* regarding mental health, barriers to accessing effective services and treatment, and ideas for a system that would support AI/AN youth and their families

Resiliency and Risk Factors

Resiliency	Risks
• Strong cultural identity, sense of history and pride in being Indian • Spiritual events and activities that bind the community together • A commitment to helping on the part of many community members	• Poverty • Geographic dispersion and isolation • High rates of substance use and unhealthy living • High rate of co-occurring mental health disorders such as depression, anxiety, self-medication • Family violence • High rate of AI/AN high school dropouts (graduation as low as 51% in Denver Public Schools and 59% in Arapahoe and Jefferson County Public Schools) • Loss of culture, language and connection to elders • Cultural identity confusion for youth compounded by racism

Top concerns in the community as reported by youth coincide considerably with that reported by adults:

- Teenage drinking (66% youth, 61% adults)
- Dropping out of school (63% youth, 53% adults)
- Peer pressure (62% youth, 50% adults)
- Racial prejudice (62% youth, 46% adults)

Metro Denver's Service Delivery Systems

Strengths in Existing Services	Barriers to & Gaps in Services
• Multiple quality services that serve early childhood; youth, adult and aging populations; and family needs • Sliding scale and no-cost services offered by some providers • Prevention, intervention and treatment services offered by providers • Referral systems and interagency relationships offered by some providers	• Lack of outreach to AI/AN resulting in underutilization of existing services (27% of adults did not know about services in the community) • Fees for service (29% felt they cannot afford services) • Lack of community awareness/education about mental health (11% reported not wanting others to find out; 7% were afraid of what might happen) • Stringent Medicaid and tribal enrollment eligibility requirements, paperwork and limitations of usage, as reported by clients and providers • 16% of adults reported a lack of cultural competency of providers/schools; 41% did not think a non-Native provider would understand them • 14% of adults noted a lack of transportation • 12% reported inaccessibility of locations; others report inappropriate hours of operation • 33% of providers reported the need for interagency bridges, partnerships and referral systems • 50% of providers reported inadequate budget to meet their organizational goals

Top areas for providers in strengthening existing services:

- 75% are very interested in serving the Indian community
- 33% want training in cultural competency
- 33% want help knowing where to send patients when they cannot offer help

AI/AN Community Attitudes and Solutions Regarding Mental Health

Barriers to Access	Solutions for Accessibility
• Fear of being stigmatized, distrust of confidentiality • Lack of awareness or recognition of risk behaviors and symptoms of emotional distress • Risk behaviors prevalent among youth, their families and in the community • Distrust of non and Native providers	• Public education and awareness campaign • Resource directories, hotlines and referral systems access • Early childhood education and screening • Cultural competency referral systems, and professional development for providers and educators • Transportation to and from services • Centralized, multipurpose provider center and school-based health services • Customized family wraparound services and in-home case management • Mentoring programs; elder/youth programs • Workforce development efforts to increase cultural competency of graduates, support the education of youth and graduate more Native providers

Top requests for support from youth illustrate a strong desire for educational and emotional support:

- Schoolwork (39%)
- Getting into college (31%)
- Deciding what to do after high school (31%)
- Dealing with anger (27%)
- Coping with grief and loss (13%)

Recommendations

Overall, stakeholders felt that mental health services in the metro Denver area need a significant overhaul to align with the needs of the AI/AN community. They also express a need for structures that would help serve youth and encourage youth and family involvement in the community.

Community and youth envision wraparound services. Adults and youth want support services that include mentoring; youth groups; and a center that houses a variety of family and community services that including, health, transportation to programs or services at convenient sites (such as schools) and academic support. Youth activities that received high marks are sports teams and ongoing youth discussion groups.

Providers require resources and training. Agencies report the need for ongoing professional development in the areas of cultural competency, referral resources (such as directories and training on interagency policies), comprehensive interagency collaboration and funding.

Public school specialists require additional staff and training to serve AI/AN youth. To eliminate educational disparities, educators recommend early childhood education programs for AI/AN youth, increased staffing, professional development, cultural awareness training, interagency collaboration and community outreach.

Workforce development specialists recommend systems to recruit and retain students. Educators stress the need for funding and multi-institutional systems to recruit, mentor and retain students, especially in the fields of social work, public health and pharmacy. Educators see a critical need to establish a continuum of education from early education through higher education. Youth need individualized postsecondary planning and assistance to ensure that they are prepared to make good choices about their future.

The community wants a center that offers chances to connect with culture, with each other and that assists with health and fitness:

- Intergenerational socializing
- Youth groups
- Sports leagues
- Support groups
- Mentoring
- Educational programming
- Health clinic

Components of a successful system of care would include a full range of customized strategies and supports from intake to service design: public education and awareness about mental health; financial assistance, support with intake and paperwork; centralized, confidential and welcoming services for all tribes; customized treatment based on what works for the family (such as a menu that ranges from traditional healers to Western approaches); assistance with transportation; a family advocate/case manager; and comprehensive wraparound services for the needs of the entire family.

A Heart for Helping

During a gathering of providers before a focus group convened, members stressed that youth are central to the heart of their communities, regardless of tribal affiliation. One informant described the community as having a "heart for helping." Woefully misguided and manipulative federal government policies, historical traumas, and generations of grief and loss have ripped at the fabric of family unity and have caused some community members to lose their way. Nonetheless, there is a strong desire to reclaim the universal themes of a healthy and supportive community that honors and mentors its youth. As one community member reflected during an interview:

> *"When a disorder occurs, confidence crumbles and knocks out the poles that holdthe house up. The vast majority wants to do better and wants the best for their kids and to live with a level of security. We need to create a community where that spark is honored regularly and fostered."*

Denver Indian Family Resource Center's Keeping the Circle Whole Community Needs Assessment Report

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Introduction

Introducing the Keeping the Circle Whole Project

In 2005, the Denver Indian Family Resource Center (DIFRC) was awarded a three-year planning grant from The United States Department of Health and Human Services, Substance Abuse and Mental Health Services (SAMHSA) to address the needs of youth who suffered from severe emotional and behavior disorders (SEBD). The project is titled Keeping the Circle Whole, and the grant was one of only seven in the country awarded to Native American-serving agencies. The mandate of the grant was twofold. One, gaining community-wide vision of and participation in the development of a plan; and two, using community input as well as additional data collection strategies to conduct a thorough community assessment of the current services available, the gaps in services, the barriers to and attitudes about current services, and recommendations for solutions. Out of respect for and recognition of an almost universal norm of American Indian cultures that decision-making is inclusive and nonhierarchical, the three-year grant prescribes a unique ground-up approach and methodology that arises from that community context.

During the course of the community information-gathering activities, understandably, many community members expressed frustration and impatience at past attempts to establish service models and the futility of a lengthy process. However, federal technical advisors have countered those objections, emphasizing the need for community-wide participation and for the investment in time to thoroughly identify a plan that is customized for a specific community in order to ensure success. Thus, while time-consuming, a carefully documented and customized collaborative and a clearly laid-out rationale more competitively positions metro Denver to receive the critical next stage of funding: SAMHSA's Systems of Care grant based on the findings and recommendations from this endeavor.

Denver Indian Family Resource Center History

DIFRC was founded as a result of a deliberate endeavor to address existing service provider gaps for metro Denver's American Indian community. In 1999, a community collaboration of the Denver Indian Center, Denver Indian Health and Family Services, Native American Counseling and Casey Family Programs began working with community members and other stakeholders to identify service gaps, duplicative efforts, system inefficiencies, and culturally relevant treatment methodologies and system infrastructure. The results of the community assessment identified intervention in child-welfare services as a critical, unmet need. Based on this information, the collaborative designed a comprehensive plan to address culturally appropriate service gaps in the child-welfare system to advocate for Indian children and families at risk of losing their children due to neglect and substance abuse. To carry out this plan, the partners proposed the formation of DIFRC. The idea was approved for funding by the board of Casey Family Programs, and the agency began offering family and children's services in July 2000.

The mission of DIFRC is to strengthen vulnerable American Indian children and families through a collaborative service-delivery approach, which is culturally appropriate and highlights a responsible healing process by restoring balance, nurturing pride, recognizing the broader sense of family and embracing a process where everyone has a role. The goal of DIFRC's Keeping the Circle Whole project is to create and enhance mental health systems to effectively serve American Indian/Alaska Native (AI/AN) children and youth affected by SEBD.

Denver is home to a large urban Indian population, but the lack of priority and funding for Indian-specific programs and services, compounded by historical discrimination against and destruction of Indian culture, alienate many AI/AN individuals. AI/AN children and families continue to struggle to access behavioral health services that are sufficient for their needs, affordable and culturally appropriate. The Keeping the Circle Whole program will create a system of mental health and wraparound services to ensure that youth are protected from risks and supported in their striving to thrive spiritually and physically. Through this system, Denver's AI/AN community will continue to support generations of strong Indian children and families.

The Unique Nature and Challenges of Denver's Indian Community

Historic oppression, deprivation, and displacement of and discrimination toward Native peoples throughout the nation have taken their toll, manifesting in poverty, depression, alcoholism and accompanying disorders in greater numbers than non-Indian populations. Consequences for family unity and children are severe. However, Denver's AI/AN community faces its own very unique challenges of an urban Indian population. While Denver sits on land that was once home to the tribes of the Great Plains and Rocky Mountains, its present-day tribal diversity is a consequence of the city's history as a federally designated relocation center, migration of individuals seeking economic opportunities, as well as other social factors.

The creation of Indian boarding schools that opened in 1878 and continued through the late 1960s resulted in Indian children growing up away from their families in institutional settings and often being indoctrinated into white culture. If children returned to their family, parents of these children sometimes did not know how to deal with them and often could not communicate with their children because they did not speak English. Their children no longer spoke their native dialect and lacked their cultural context. The end result in many cases was loss of the family unit, parents suffering from unresolved grief and loss, a high incidence of mental health problems and alcoholism, and children who grew up not knowing their culture or how to parent when they became adults.[1] This fissure began to break down tribal ties for future generations of Indians and led to urban migration for those in a search for alternative lives.

Another contributor to Denver's AI/AN urban population was a federal government's solution for the "Indian question." As recently as the 1950s, tribes were disbanded and reservations were closed. The severe lack of employment on reservations enabled the U.S. government Bureau of Indian Affairs (BIA) strategy to disperse AI/AN people into cities in an attempt to assimilate them with offers of jobs, which were often marginal in pay and seasonal in nature. One employment opportunity was the railroad, which encouraged a migratory lifestyle.

World War II had an enormous impact on the migration of Indians to urban areas. Nearly 25,000 American Indians served in the military during World War II, while thousands more were recruited to industrial centers to support the war effort in the agriculture and textile industries.[2]

Urban Indians tend to be descendants of the Indian children who "participated" in the Indian boarding school experience, returning veterans who relocated to urban areas following World War II and those that participated in the BIA relocation and job placement programs.

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[1] American-Indian Families—Boarding Schools. Sponsored by Vive! Retrieved April 2007 from http://family.jrank.org/pages/74/American-Indian-Families-Boarding-Schools.html.
[2] Roberts, S. L. (2004). *The Spatial Dispersion of Native Americans in Urban Areas: Why Native Americans Diverge from Traditional Ethnic Patterns of Clustering and Segregation.*

Relocation that separated people from their extended family, tribal networks and traditional life support systems is just one of the causes of historical trauma—*the cumulative emotional and psychological wounding across generations*—that continues to affect Denver's AI/AN people today. The Denver Native community consists of representatives of more than 200 tribal communities that are dispersed over 8,551.82 square miles of rural and urban and suburban areas in eight counties. Many come from high-need reservations in the Aberdeen, Navajo and Albuquerque areas. Data from the AI/AN community survey presented in this report show that 40% of respondents report being a direct descendent of survivors of a traumatic tribal historical event such as the Wounded Knee Massacre, the Long Walk or the Trail of Tears.

Despite these historical traumas, AI/AN people continue to move to Denver in their quest for education, employment, a higher standard of living and to unite with family members. The area is also centrally located to several reservations, making it an urban hub for AI/AN people living on and off reservations in the West. Although Denver's AI/AN community continues to grow, the term "community" does not reflect a specific physical location. Because of this unique history and the geographic nature of the metro area, Denver has no AI/AN "neighborhoods." While many families have lived in Denver since the 1950s, Keeping the Circle Whole survey results indicate that over 46% have moved away and come back multiples times, some more than five times.

In addition to historical trauma associated with their arrival to the area and the lack of a highly visible Native community, AI/AN children and families face significant obstacles to the promise of a healthy and satisfying future. The providers currently available to treat youth exhibiting SEBD are scattered throughout the seven-county region. Each county's health and mental health department has its own set of regulations and policies. Specialty and wraparound services are scattered throughout the almost 8,552 square miles, with some duplicating efforts while other services are lacking. There is no centralized clearinghouse of state, regional, county, city, private and Native-specific services; no unified cultural norm among those in need of services; and no standard fee schedule. There are limited strategies to identify, support and follow-up families in need. Survey results also indicate a lack of trust on the part of consumers in seeking help from agencies due to abusive child welfare government policies.

The Climate to Launch a Program

As one key informant stated, "*This community has a heart for helping*." DIFRC was created because of a void in Indian child protection services, and it once again seeks to repeat that proactive history by creating a system of support that currently does not exist. Local resources include other systems of care projects operating in the human services fields in the Denver area. First, the city of Aurora in Arapahoe County is working with El Paso, Fremont and Mesa counties on an early-childhood development system of care initiative called Project BLOOM. Second, the Systems of Care Collaborative, an ad hoc group of state stakeholders from local system of care projects, meets regularly through the state's Department of Human Services. This group is seeking ways to connect smaller systems of care into a larger, statewide effort to identify and remedy system barriers. Third, Jefferson County's human services providers are exploring collaborations and coordination within the county and larger Denver area; DIFRC participates as a provider and as a consultant within that system. In addition, the recent House Bill 232 has committed a leadership council to create a five-state agency collaboration to address youth prevention, intervention and treatment.

Since its inception, DIFRC has developed a close working relationship with JVA Consulting, LLC (JVA), a Denver-based firm committed to enhancing the capacity and sustainability of community-based groups

throughout Colorado and the nation. JVA's founder has served as an agency advisor, and the firm has provided strategic planning facilitation, resource and fund development, and facilitation. With this established relationship of mutual trust, JVA was selected as the outside evaluation team to conduct and coordinate the community needs assessment project.

The Circles of Care grant has enabled an unprecedented data collection initiative of an otherwise "uncounted" population, with its focus on the mental health of Indian youth in the metro Denver region. Through the process, the Keeping the Circle Whole project team has laid the groundwork for the next phase of collaborative system design. Candid and heartfelt reflections of community members through qualitative interview and focus group methods, together with quantitative data collected through surveys and census data as well as reviews of the literature, have helped defined the gaps in service and in understanding the needs of families and youth to guide and inform the planning process.

The Needs Assessment Report

Groundwork. The needs assessment was created based on the groundwork of a general community kickoff event of almost 60 participants; there were nine stakeholder-facilitated work sessions of community/consumer, administrators and service provider groups, and four Steering Committee work sessions of key health and community advisors over the course of nine months. In addition to developing a vision, mission and working definition of youth SEBD, these work sessions provided an outline of the services available, an identification of needs and key informants, the gaps in services and possible solutions that served as the direction for the assessment to follow.

The report. Denver's Indian community/consumers (youth and adults), Denver's service providers and service administrators have unselfishly given hours of their time in producing the results of the needs assessment. The following report contains the results of a thorough data collection and analysis strategy using those work sessions, at least 150 hours of key informant interviews, 11 focus groups of youth, mainstream and traditional health providers, education specialists and parents, over 700 surveys from youth and adult community members, 53 administrator and providers surveys, and 13 crisis intervention education specialist surveys, along with rigorous review of the literature and census demographic data. The purpose of this report is to present the key themes that emerged during the process of data collection.

To capture authentic voices of members of the community, the report weaves quotations of interviewees throughout the body of its Key Findings section. These quotes are both dynamic and unique yet share a commonality to key themes that are repeated by other sources.

The report contains the following sections:

I. Methodology
II. Data report of the demographics of metro Denver's Indian community and indictors of health and mental health
III. Severe Emotional Behavior Disorder definitions
IV. Key themes that include *risks and resiliency factors* in the community, *system services* report of services and gaps in services, and *barriers to services*, community attitudes and accessibility of services
V. Recommendations from findings
VI. Appendices (data instruments, protocols and full survey reports, list of providers, glossary)

Denver Indian Family Resource Center's Center Keeping the Circle Whole: Methodology

I. General Methods and Sample

This evaluation utilized multiple methods of data collection to obtain information regarding current service system availability and gaps for addressing the needs of AI/AN youth with SEBD and their families in the Denver metro area. Metro Denver is defined as Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas and Jefferson counties. Individual interviews, focus groups and surveys were used to gather information from the AI/AN community, including youth, parents, adults and elders, as well as providers, program administrators and educators. Working collaboratively with DIFRC and other community partners, the evaluation team identified key stakeholders for inclusion, developed protocols to guide interviews, and designed and administered surveys to community youth and adults, providers and educators. Data were actively collected between October 2006 and March 2007.

Data were analyzed using qualitative and quantitative methods. The qualitative techniques included content and thematic analysis of interview and focus groups data, as well as responses provided in open-ended items in the surveys. The quantitative methods were primarily focused on descriptive statistics obtained through data analysis with SPSS statistical software.

Community meetings. Notes and meeting minutes from community planning meetings to develop a working definition of SEBD with providers, administrators, community members and the Keeping the Circle Whole Steering Committee (12 participants) were used as a source of data for the needs assessment. These working groups identified key informant stakeholders, services providers, current services and gaps in services. In total, four Steering Committee meetings and nine stakeholder meetings (three each of consumer/community (16 participants), administrator (six participants) and service providers (nine participants) were conducted by DIFRC and facilitated by JVA.

Interviews. Using the information generated from the core work groups, 16 stakeholder interviews were conducted by telephone in January and February 2007. While each interview followed a standardized format to align with CoC III NOMs Workgroup's recommended domain areas, the process encouraged the reflection of life experiences, expression of subjective opinions, sharing of life stories and opportunities to contribute ideas.

Focus Groups. Eleven focus groups were conducted between October 2006 and January 2007. Each focus group followed a set format of questions to help elicit information related to the domain areas as well as to encourage personal reflections and expression of subjective opinions. Most of the youth focus groups included youth who were currently or formerly participating in school district Indian Education classes. The results from these groups may reflect a similarity in levels of identification as Native Americans. The focus groups included (with number of participants):

- 6 youth groups 35
- 3 parent focus groups 23
- 1 workforce focus development group 6
- 1 provider/community mix 10

Surveys. The youth and community surveys were largely administered at community events and Native-specific settings such as powwows, school district Indian Education classes and health clinics. As a result, the data collected may not include the experience and opinions of AI/AN in Denver who do not choose to identify publicly as Native American or who express their identity in alternative ways.

- Paper/pencil and online surveys were administered to 486 AI/AN adults in the Denver metro area in January and February 2007. Surveys were administered primarily by DIFRC staff at community events such as powwows, cultural events, meetings and at health clinics. Partnering community organizations such as the Denver Indian Center also administered surveys to clients and families they serve. This methodology was selected because the AI/AN population is scattered broadly throughout the Denver metro area and presents challenges to reach.
- Paper/pencil and online surveys were administered to 213 AI/AN youth in the Denver metro area in January and February 2007. As with the adult community surveys, these were administered at a variety of community and cultural events.
- Web-based surveys using Survey Monkey were administered to 229 service providers across the Denver metro area, and 53 completed the survey.
- Web-based surveys using Survey Monkey were administered to 43 educators across the Denver metro area, and 13 completed the survey.

Demographic analysis and literature review. JVA conducted a thorough review of the literature, including local and national reports and publications, Web sites, peer-reviewed journal articles and books to gather information on SEBD, the needs of AI/AN urban youth, and best-practice and emerging research on model service delivery systems. In addition, JVA conducted a thorough demographic analysis on the AI/AN community in the Denver metro area using various data sources such as the U.S. Census Bureau, Colorado Department of Public Health and the Environment, Colorado Department of Education and National Indian Child Welfare Association.

Denver Indian Family Resource Center's Center Keeping the Circle Whole Community Characteristics of the Metro Denver AI/AN population

II. Sociodemographics *(NOTE: Additional national evaluation statistics can be found in Appendix D, National Measures Table)*

Background

Denver's AI/AN community has a unique and diverse population, a diversity in tribal identity and beliefs, and its own set of richness and challenges. While the Ute Mountain Utes and the Southern Utes are the two sovereign Indian nations within Colorado, both located in the southwestern region of the state,[3] few of their members actually reside in Denver. Urban Indians tend to be descendants of the Indian children who "participated" in the Indian boarding school experience; returning veterans who relocated to urban areas following WWII; and those who participated in the BIA relocation and job placement programs. During the 1950s and early 1960s, the BIA launched a concerted effort to assimilate Indian people into the majority society through the relocation of American Indians from multiple states to cities, including Denver, for jobs or job training. Far from improving their living conditions, they were often given seasonal annual and agricultural work: "The lowest paying and least secure" employment the area had to offer.[4] Many failed to adjust because they were placed far from family support and a community with which they were familiar. In fact, "25 years of relocation…has succeeded in increasing substantially the probability that young Indian families will live at least part of their lives in urban poverty and that Indian women will be raising their children in city slums."[5] In fact, as of 2000, 66% of all AI/AN lived in metropolitan areas.[6]

American Indian and Alaska Native Persons by County, 2005 (Estimate)

County	Specified Population	Total Population
Adams	5,723	399,426
Arapahoe	4,098	529,090
Broomfield	279	43,478
Boulder	1,975	280,440
Denver	7,547	557,917
Douglas	1,189	249,416
Jefferson	4,505	526,801
Total	25,316	2,586,568

Source: FedStats, U.S. Census Bureau: State and County QuickFacts

The AI/AN population in Colorado was approximately one percent of the total state population, according to the 2005 U.S. Census estimate. The population in Colorado has shown an increase of 16,465 from 1990 to 2000 due to Native Americans choosing to acknowledge, their heritage according to tribal officials and

[3] *The American Indian Population—Health Status*, p. 24. CDPHE.
[4] Fixico, D.L. (1986). *Termination and Relocation: Federal Indian Policy, 1945-1960.*
[5] Metcalf, A. (1982). Navajo women in the city: Lessons from a quarter-century of relocation. *American Indian Quarterly.*
[6] Henson, E., Taylor, J., et. al., The Harvard Project on American Indian Economic Development, The First Nations Development Institute and the Udall Center for Studies in Public Policy. *The State of the Native Nations: Conditions Under U.S. Policies of Self-Determination* "Native America at the New Millennium." unpublished.

because of recent changes in the 2000 Census methodology, which has allowed for the option to choose more than one racial category.[7]

Tribal Affiliation

Cherokee is identified most often either alone or in combination with other tribal affiliations, followed by Navajo, Sioux, Apache and Ute.

Top 10 Tribal Affiliations in Colorado

American Indian and Alaska Native tribes	American Indian and Alaska Native tribe alone or in any combination
Cherokee	13,326
Navajo	6,858
Lakota	4,897
Apache	4,438
Ute	3,312
Mexican American Indian	2,703
Choctaw	2,016
Blackfeet	1,564
Chippewa	1,555
Pueblo	1,474

In 2000, Navajo was spoken at home by 2,382 persons age five and over, the most spoken AI/AN language in Colorado.[8]

Economic Demographics

National vs. State

Poverty and the lack of economic opportunities for AI/AN people in the United States has been a serious problem for several decades, and it has not drastically improved in recent years. Nationally, 24% of AI/AN people live in poverty, compared with 18% AI/AN in Colorado.[9] While Colorado's population has a lower percentage of individuals living in poverty compared with the national average, the percentage of the AI/AN population living in poverty is still twice the average of the general population of the state at close to 10%.[10] In the nation, the unemployment rate of urban AI/AN is 2.4 times that of urban whites. [11]

State vs. Region

The average per capita income level in 1999 among the AI/AN population in Colorado was $15,672, compared with the total Colorado level of $24,049, a difference of almost $10,000. The median household income levels of the AI/AN population and the general population in Colorado are much higher at $36,384 and $47,203, respectively, but still reflect a vast disparity in income earning when comparing both groups.

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[7] Steindorf, S. American Indians on the Rise. (2001, Dec. 06). *The Christian Science Monitor*; and *The American Indian Population—Health Status*, p. 24. CDPHE.

[8] Characteristics of American Indians and Alaska Natives by Tribe and Language: 2000. Table 48, U.S. Census Bureau.

[9] U.S. Census, United States: Census 2000 Demographic Profile Highlights.

[10] Census 2000. Colorado Demographic Profile Highlights.

[11] Henson, E., Op. Cit.

County Level

Among the counties that comprise the Denver metropolitan area, Douglas County has the highest median household and per capita incomes for both the AI/AN and general populations, while Denver County has the lowest median household income for both populations. Per capita income most often falls within the $12,000 to $24,000 range. The median household income falls most often from $36,000 to $45,000, with the far end reaching from $19,000 to $52,000. These numbers also indicate multiple income earners within one family.

Educational Attainment

State Level[12]

A comparison of the educational attainment between selected AI/AN tribes in Colorado and the general state population shows that as education level increases, so does the disparity between both populations. There is approximately a 6% difference between the AI/AN population and the total state population of 16- to 19-year-olds not enrolled in high school and not high school graduates, approximately a 10% difference between both groups of 25-year-olds and older with a high school degree or higher, and an 18.6% difference of 25-year-olds and older with a bachelor's degree or higher. In general, urban Indians are 1.7 times as likely to lack a high school diploma as urban whites.[13] *(Because data are figured by county, see Appendix D for specific breakdown by county.)*

County Level

High school graduation rates of AI/AN vary throughout the metro Denver area with pockets of great concern. *Douglas County shows 51.7%, Jefferson County is 59% and Arapahoe County is 60%;* the overall state graduation rate for the AI/AN population is 62.6%. Dropout rates are consistently higher for AI/AN students, with the largest discrepancy in Adams County, which is facing 64% of it total student population dropping out of school compared with *77.7% AI/AN*. The overall educational attainment of selected American Indian tribes in the Denver/Boulder/Greeley area is slightly higher compared with the state overall, but the disparity between the American Indian and the total population of this area remains constant with the state differences.

Although AI/AN make up less than one percent of the total student population in the seven-county area, AI/AN students represent 1.8% of discipline actions taken, including suspensions, expulsions and referral to law enforcement.[14] A lack of commitment to school has been established by many studies as a risk factor for substance abuse, delinquency, teen pregnancy and school dropout.[15] A 2006 report of Denver Public Schools indicates that, as compared with other ethnicities, AI/AN students ages seven to 16 consistently show the highest rate of chronic truancy from 2002–2005 (26%–28%).[16]

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[12] Statistics in this section from *Characteristics of American Indians and Alaska Natives by Tribe and Language: 2000*. Table 45. U.S. Census Bureau.

[13] Hanson, E., Op. Cit.

[14] CO Department of Education, Op. Cit.

[15] U.S. Department of Health and Human Services. (2001). *Youth Violence: A Report of the Surgeon General*.

[16] *Truancy in Denver: Prevention, Effects and Intervention.* (2006). Produced by National Center for School Engagement for National Truancy Prevention Association and Office of Juvenile Justice and Delinquency Prevention, U.S Department of Justice.

Community Characteristics: Health Status

Characteristics of Native American Youth

Compared with the national general population, excessive violence and gang activity have been reported in high rates among AI/AN youth. The Bureau of Justice Statistics reported that nearly one-third of all AI/AN victims of violence are 18–24.[17] The factors that commonly predict gang involvement among this population include "living in a single parent household, family history of dysfunction, large numbers of life transitions and losses, and perceived discrimination."[18] The AI/AN crime rate remains high into adulthood and beyond—the average AI/AN crime rate is approximately 2.5 times greater than the national rate. Further, AI/AN have the highest rate of incarceration among all racial and ethnic groups in the United States. Unfortunately, these adults represent negative role models for youth in the community. In Colorado, where the overall AI/AN student population is less than one percent, *4% of youth reported to be in detention are AI/AN.*[19]

Drug and Alcohol Abuse

AI/AN youth have substantially higher abuse rates of drugs and alcohol, the latter of which is associated with other adverse conditions that affect these communities such as crime, driving under the influence, automobile accidents and many alcohol-related health conditions. A staggering 75% of all AI/AN youth deaths are related to alcohol, and the lifetime prevalence rates for alcohol use among adolescents have been shown to average 80% or higher.[20] Studies show alcoholism is over five times more prevalent among AI/AN males than females,[21] while female drug-related deaths among 15- to 24-year-olds is higher than males.[22]

One of the issues in the AI/AN population prevalent both nationally and in Colorado is death at earlier stages in life.[23] "Five of 10 major causes of death among the American Indian population are directly attributable to alcohol (automobile crashes, cirrhosis, alcohol dependency, suicide and homicide)."[24]

Severe Emotional and Behavioral Disorder (SEBD)

Another community health issue is mental illness as expressed through depression, alcohol and drug abuse, loss of sleep and doing poorly in school. When asked to identify the most common problems for youth, 66% teenage drinking, 64% identified drug abuse, 63% doing poorly in school, 42% depression, , and 34% suicide, to name a few. Adult alcohol abuse rated 50%. *(Please see **Figure 6** in Appendix A for detailed listing)*. In the AI/AN community, there are strong associations between poor parenting skills and addictions with historical trauma suffered by past generations such as boarding school experiences, resettlements and tribal termination, and they are still felt today.

In the nation, the prevalence of mental, emotional and behavioral disorders among families and youth is substantial—almost one in five children and adolescents may have a diagnosable mental disorder. This

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[17] Fox, K. et al. (2005). *Native American Youth in Transition: The Path from Adolescence to Adulthood in Two Native American Communities*, p. 15. National Indian Child Welfare Association.
[18] Ibid.
[19] Colorado Department of Education. Retrieved April 2007 from http://www.cde.state.co.us/index_stats.htm.
[20] Ibid, p. 21.
[21] Indian Health Focus Youth 1998–1999, p. 30. U.S. Department of Health and Human Services, Indian Health Services.
[22] Ibid, p. 32.
[23] *The American Indian Population—Health Status*, p. 24. CDPHE.
[24] Fox, K. et al. (2005). *Native American Youth in Transition: The Path from Adolescence to Adulthood in Two Native American Communities*, p. 21. National Indian Child Welfare Association.

calculation is likely higher for Denver's AI/AN community due to higher prevalence of co-occurring disorders, socioeconomic factors, misdiagnosis and inadequate treatment. In addition, children of parents with alcohol and substance-addicted parents are more likely to develop mental health problems than other children.[25] Disorders noted by providers in the data collection process include bipolar disorder, attention deficit/hyperactivity disorder, learning disorders, self-mutilation, eating disorders and schizophrenia. Metro Denver counties' admitting diagnoses include 22 categories, the highest of which are anxiety, major depressive, bipolar, schizophrenic, attention deficit and conduct. Others include autism, alcohol abuse and sleeping disorders.

AI/AN Youth Treated for Mental Health by County 7/1/2001–6/30/2002

County	American Indian ages 12–17
Adams	76
Arapahoe	32
Boulder	30
Denver/Aurora	96
Jefferson	81

Source: Colorado Mental Health Services Data and Evaluation Section. Ages 17 and over are considered adult population and not tallied separately.

Major Health Issues

The most prevalent leading causes of death among the AI/AN adult population nationally and in Colorado are diabetes, cirrhosis and injuries. The diabetes death rate of the AI/AN population is the highest (between 34.1 and 45.9 per 100,000) among all racial and ethnic groups nationwide and in Colorado.[26] Cirrhosis death rates for this population are also the highest among all ethnic groups nationally and in Colorado. The AI/AN population, however, has much lower mortality rates, attributable to conditions such as heart disease, cancer, Alzheimer's disease and cerebrovascular disease compared with the general population.[27]

Parenting

Reports indicate that AI/AN become mothers much younger than the general population—47.5% of AI/AN women have their first child before reaching 20 years of age, in contrast to a 25% average for all races in the U.S.[28] This trend poses many difficulties for American Indian mothers and their children and has far-reaching impacts that affect their well-being. Urban Natives have lower rates of prenatal care and higher infant mortality than their counterparts on tribal lands, and their children are more likely to be victims of child abuse and neglect.[29]

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[25] Ibid, p. 32.
[26] *The American Indian Population—Health Status*, p. 25. CDPHE.
[27] *The American Indian Population—Health Status*, p. 27. CDPHE.
[28] *Indian Health Focus Youth 1998–1999*, p. 2. U.S. Department of Health and Human Services, Indian Health Services.
[29] Tsethlikai, M. (2005). *The Status of Urban American Indian and Alaska Native Children and Families Today* prepared for National Urban Indian Family Coalition. Retrieved April 2007 from http://redwebz.org/modules.php?name=News&file=article&sid=965.

Domestic Violence

Nearly one in three American women experience at least one assault by their partners during adulthood.[30] However, even more frightening, Native American women are seven times more likely than average to suffer domestic violence, according to U.S. attorney Troy Eld, a practicing member of the Navajo bar.[31] Domestic violence is the leading cause of injury to women in America today, making this issue of severe concern to metro Denver's community.

Foster Care

Colorado is listed as a "high disproportionate state" for foster care placement, according to Ruth McRoy in her paper produced for the NYS Citizen's Coalition for Children, 2006. While the AI/AN population is 1% of the population, it represents 2% of foster care cases. Colorado HB 1064 was passed to ensure compliance with the federal Indian Child Welfare Act of 1978, requiring that Indian children of child welfare proceedings be identified. The Denver Indian Family Resource Center works to assist in ensuring that these children be placed in culturally appropriate homes and receive the case management support they need.

Injuries and death

Among AI/AN youth ages 5–14, accidents were the leading cause of death in 1995 in a survey of AI/AN living in IHS services areas. In this category, motor vehicle-related death was the primary cause for the general population, followed by "other accidents." A distant second and third were homicide and suicide.[32]

The Uninsured

More than half of the AI/AN population does not permanently reside on a reservation and therefore has limited or no access to IHS services.[33] The resulting implications of lack of health insurance are delays in needed health care services, less access to these services and greater risks for unfavorable health outcomes.[34]

The greatest number of uninsured individuals was found in Colorado's urban centers, with Denver's rate reaching 23% during 2002–2004[35] and children under 18 years at 14.4% statewide in 2002–2004.[36] Although the statistics for AI/AN are not well-documented in the state, 2004 national studies showed one out of three AI/AN being uninsured.[37]

Homelessness

Homeless population count is always difficult to determine, and particularly so for AI/AN. However, research shows that urban American Indians and Alaska Natives are three times as likely to be homeless than those on tribal lands.[38]

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[30] Newton, C.J. *Domestic Violence, An Overview.* Retrieved July 2007 from findcounseling.com.
[31] Miller, Ellen. Special to the Rocky. *Rocky Mountain News.* April 2007.
[32] *Indian Health Focus Youth 1998–1999*, p. 27. U.S. Department of Health and Human Services, Indian Health Services.
[33] CDC Office of Minority Health. American Indian and Alaska Native Populations.
[34] *Profile of the Uninsured in Colorado*, p. 2. (2004). Colorado Health Institute.
[35] Ibid, p. 10.
[36] Ibid, p. 3.
[37] Ibid, p. 7.
[38] Tsethlikai. Op. Cit.

III. Definitions of Serious Emotional and Behavioral Disturbance

Consumer/community members, providers and administrators met in facilitated workgroups, agreed on a community definition of SEBD and submitted each of their definitions to the steering committee of key stakeholders. The Keeping the Circle Whole Steering Committee integrated a single definition based on the three.

Keeping the Circle Whole collaborative definition of SEBD:
Children and youth requiring assistance to fulfill their spiritual, emotional, physical and mental potential by building on the strengths of the individual, family and their community.

SED according to Co-occurring Center for Excellence of SAMSHA states:
Children with a *serious emotional disturbance* (SED) are defined as persons from birth up to age 18, who currently or at any time during the past year have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the [DSM-IV], which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities. Such roles or functioning include achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills.

Disorders include:
Anxiety disorders, severe depression, bipolar disorder, Attention deficit/hyperactivity disorder, learning disorders, conduct disorder, eating disorders, autism, schizophrenia.

Provider members of the project steering committee noted that the final community definition of SEBD does not support the severity of the disorders mentioned above. It is a reflection, members agreed, of the reluctance on the part of community members to address the severe nature of some of their youth's emotional disorders. *Please find additional comments on page 28, "Community Attitudes Toward Mental Health."*

IV. Community Needs Assessment Key Themes

The following is an abstract of the key themes in three areas: 1) Resiliency and Risks, 2) Service Systems and 3) Barriers to Accessing Systems. The report themes surfaced during the data collection process from community sources of focus groups; in-depth interviews with key informants; and provider, educator, adult and youth community surveys. This report captures as authentically as possible the voices of participants to lend credence and humanity to their stories, to offer a vehicle to preserve and promote their voices, and to illustrate the themes that surfaced. The report does this by sharing their quotes and weaving these "voices" throughout the three domain areas listed above.

Resiliency and Risks

Maintaining Culture: What Supports Does the Community Offer?

Key themes regarding connections:

Strong feelings of pride. Most youth and adult survey respondents reported strong feelings of pride regarding their native heritage and culture and they participate regularly in spiritual and traditional practices. While the historical trauma of the Indian people is quite salient to respondents, it is a source of courage and pride rather than guilt or emotional stress. Yet many respondents report a sense of responsibility for undoing the pain of the past.

The following is a list of current community resources that help community members connect to their culture, although some are mentioned with a caveat:

- Title 7 Indian Education programming through school districts
- Denver Indian Center (D.I.C) cultural classes such as beading, language and dance classes
- Language classes such as Cherokee and Lakota
- Contact with elders
- Unofficial gatherings such as talking circles, the Dinee of Denver and sweat lodges
- Powwows (but these only serve those who like big events and are already connected)
- Youth mentoring (but not nearly enough)
- The family unit (but many are dysfunctional or disconnected so they do not pass on a sense of belonging to their kids)
- Lacrosse

Are Youth and Families Connecting to Culture?

"I feel lost myself but there is no location or place. Youth and elders are not connecting. How do we pass on our stories? Popular music and their peers make it easy for the younger ones to forget their culture. They are getting lost from whom they are."

"My tribe has been in Denver almost 40 years. There has been never any type of initiative to maintain culture."

"When my family came to Denver we didn't even know there were other Indians in the state."

Key themes regarding connecting to culture:

Limited cultural connection for youth. Informants, including those who were among the most active members in the metro Denver AI/AN community both as providers and activists, expressed the feeling of being lost, unable to connect their own children to consistent support services and being dissatisfied with the resources available to stay connected to their culture. In addition, multiple interviewees feel there are thousands of residents that are "hidden" and unidentified. While there are a number of activities throughout the community that offer Native-specific support, there were repeated qualifiers that the activities target a narrow portion of the community or are narrow in their focus.

Youth feel connected by traditional activities. Of the six youth focus groups, members report wearing jewelry, attending ceremonies, learning Native languages, going to elders to hear stories and visiting their families on the reservations as part of their cultural experience.

Concern for loss of Native language skills. Some individuals expressed the difficulty of distance and diversity of tribal membership as a block to getting connected. With almost 18% of adult respondents reporting that they understand their native tribal language fluently, and 11.5% who speak it fluently, the lack of connective community supports could be alienating. Among youth, 30.5% could speak and understand their native language to some degree, although only 5.6% are fluent at understanding and 3.8% are fluent at speaking. *This indicates both a transmission of culture and a rapid generational decrease in transmission of language skills.* Language skills are a key, according to some providers interviewed, to cultural transmission and protective factors.

Specific comments regarding connecting to culture include:

- The community falls into three main categories: 1) There is a small group of families that actively seek out activities. 2) A large group remains hidden and does not want to surface, perhaps due to substance abuse in the family. It interacts mostly with those who share the same lifestyle. 3) There is another group of middle-class professionals that does not participate.
- If there is not parent buy-in, kids do not have much choice of involvement in activities.
- Many AI/AN return to the reservation for connection
- "There are a few spiritual advisors but not many followers."

Provider Support or Protective Structures

"Elders and parents help transitions into an ever-changing world."

Key themes regarding protective structures that do or should exist:

What exists?

Comments regarding support structures for youth mental health included:

- Colorado LINKS for Mental Health (Linking Interagency Networks for Kids Services) is working to build a system for all youth.
- The Colorado Department of Mental Health has increased an emphasis in training and awareness about child welfare for its staff.
- Family to Family project has been an effective delivery of wraparound services.

Regarding partnerships/referral systems:

- Colorado HB232 Prevention Leadership Council of five state agencies is working to connect prevention, intervention and treatment for youth.
- There is a statewide initiative driven by foundation and state agencies to address health disparities.

Successful services include efforts of cultural sensitivity. Some providers that currently serve the AI/AN population report using diverse reading materials and toys for children in waiting rooms, cultural decorations in the office, cultural training for staff as a means of supporting their consumers, and seeking effective partner collaborations.

What barriers hinder family and youth involvement in their community and in protective structures?

"Because they feel they don't know enough and lack pride, they don't want to get involved. They make themselves invisible so that they don't get asked to get involved."

"There needs to be more family involvement in activities. Often kids set off to activities but with no parental involvement, there are other distractions."

Comments regarding barriers to involvement include:

- Lack of family involvement prevents kids from staying involved. "Only highly functioning families get involved."
- Transportation: "Cars don't work or don't work consistently and parents can't drive."
- Varied tribal representation in the community leads to fears and feelings of not being accepted.
- Lack of trust to ask for and expose themselves to what they need. "Families who do no live in a sober way do not expose themselves and remain under the radar."
- Racism
- Lack of appropriate communication, outreach, promotion and marketing of services
- Counties do not know where to refer or whom to contact to offer culturally appropriate treatments.

What services would contribute to youth and family involvement in protective structures in their community?

- Education: a focus school; classes to study history and talk with adults using the Internet and museum trips
- A place for people to go to give a sense of belonging

- Specialty clinic such as those for African Americans, Latinos or Asians
- Family advocates are no longer funded and were helpful in accessing families in need of services and completing assessments of their needs.
- Family-run organizations were successful in the past. Parents and families were more willing to use these types of clinics. A family association could work with the state mental health center.
- Mentoring. "There is an individual who goes to homes but the need is far greater than he can meet."
- Sustained activities that build trust of organizations and among tribal members and offer exposure to spiritual and cultural programming

The Prevalence and Significance of Co-occurring and Behavioral Health Disorders

"There are many split households directly related to their historical trauma. Many elders went to boarding schools and lost parenting skills. This has led to domestic violence and abuse. We need to break the cycles beginning at preschool and continue throughout their lifetime."

"When students can't cope and there are challenges in the family, youth just want to escape from that. As a result, some youth are out on the street and don't come home for weeks. Their parents call me worried that they haven't seen them in days."

"When a disorder occurs, confidence crumbles and knocks out the poles that hold the house up."

Key themes regarding co-occuring disorders:

Providers and community members acknowledge that depression and risk behaviors are interwoven with multiple other disorders. The disruption stemming from displacement from tribal homelands and the boarding school experiences still haunt the community in devastating and destructive ways. Many parents lost mentors during formative years of their youth, lost the opportunity to learn parenting and effective life skills, and never developed necessary job skills. As the stresses of racism in an alien environment, poverty, and loss of family members with accompanying grief compound their own experiences, many members of the community seek relief through substance abuse, live in denial of their unhealthy lifestyles, and do not recognize when their children engage in risky behavior.

The following figures reveal challenges for parents and extended family members.

Figure 1. Adult Problems for Self in the Past Five Years by Gender

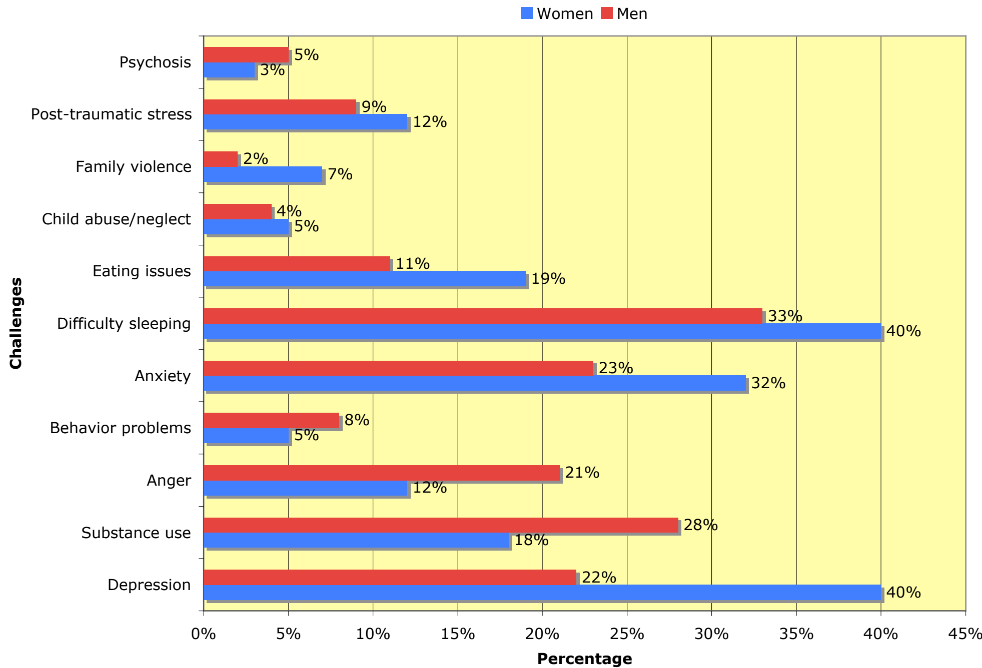
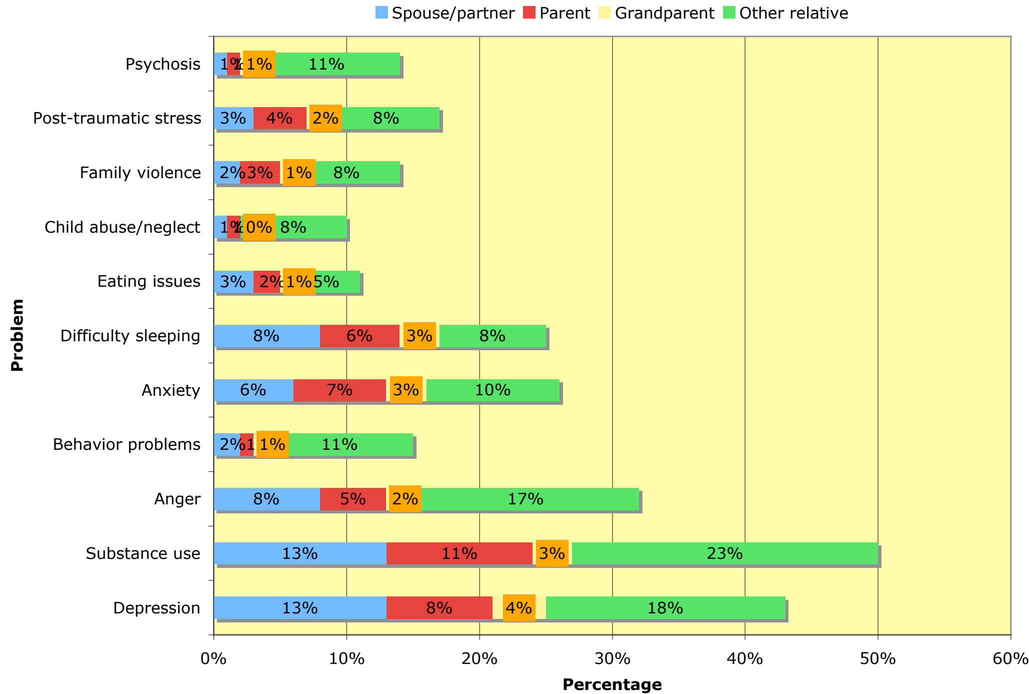


Figure 2. Adult Problems for Other Family Members in the Past Five Years

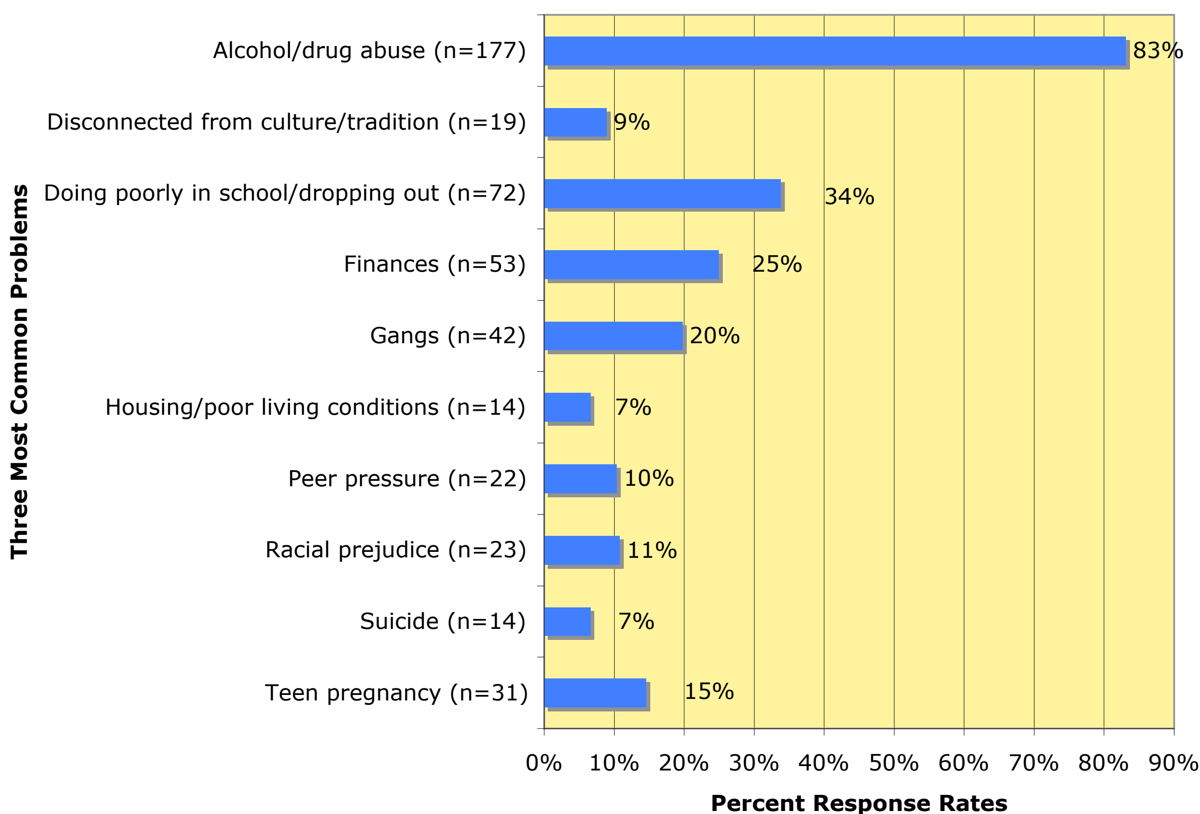


Youth encounter multiple family and community challenges. The casualties of their families' struggles are the youth. Some informants see youth becoming responsible for their parents who struggle to survive, while others see them taking a backseat to addictions, other siblings, issues of poverty and of single

parenting. Among the 11 focus groups, including six youth groups, that were asked how AI/AN youth exhibit emotional problems, the most prevalent answers were gang membership, substance abuse, trouble in school, acting out and trouble with the police. The following figures illustrate a breakdown of problems encountered as reported by adult and youth survey respondents. As shown in **Figure 3**, youth overwhelmingly report alcohol and drug abuse as the most prevalent problem, followed by school performance and dropout rate. Adults also reported substance abuse (by youth and adults) as the biggest problem, along with poverty and school.

Two noteworthy points in comparing the results is that 1) youth are extremely concerned about their educational advancement and 2) there is a high level of alignment between youth and their parents as to what the concerns are (see **Figure 3** and **Figure 6**). When asked what the top three most common problems that face youth, 10 major issues in total were identified.

Figure 3. Three Most Common Problems For AI/AN Youth as Reported by Youth



Specific observations regarding co-occurring disorders include:

- "Parents are too often in denial of kids' substance abuse and mental health issues."
- "American Indians have been underserved by substance abuse treatments that consider and address historical trauma."
- "Parenting skills have been lost because of separation from their families and growing up in boarding schools. As a result, there is a prevalence of domestic violence and abuse."
- "Due to multiple risk and hardships such as racism, loss of children, bipolar disorders, poverty anxiety, fetal alcohol syndrome, learning disabilities, lack of safety and single parenting, kids take

on a huge responsibility because parents are dependant on the children and it affects their mental health."

- "At the same time, kids become a lower priority in the family life."
- "Co-occurring difficulties keeps the family in a poverty cycle."

What Can the Community Do to Ensure Support?

"Elders need to tell the stories [about] how they got here, adopted, relocated, their economics. They didn't come willingly. Boarding school bred a victimization into us. We don't know how much we own our own lives and we need to teach our kids that they do."

"If you get caring adults into the lives of youth, you can give them hope."

Key themes on ensuring support for youth:

"We need applications that address the specific needs of Native Americans from providers to contractor—throughout the system. It is crucial to find methods in cultural contexts, including ceremonies, values and beliefs—they are critical for mental health and substance abuse treatment."

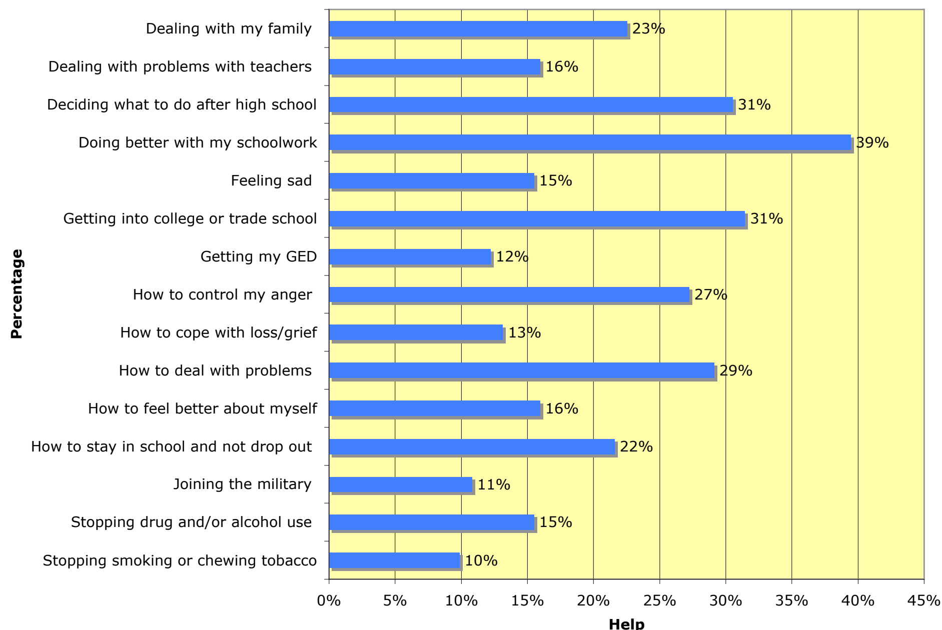
The context: support programs for youth need to understand the challenges of dual identity: Many see youth as carrying multiple identities and caught between two worlds: the family and the school and greater community. Even those who have active and involved parents experience acute pain under the stress of racism, rampant substance abuse in the community and poverty that is somehow linked to a past they do not understand. They are confused as to whom they are, who they want to be and how to deal with the chaos they experience. Many youth do not know the stories of their history and the wisdom of survivors and of spiritual leaders who could serve as protective factors. To compound their disconnectedness, the metro Denver AI/AN community consists of representatives of almost 200 mixtures of tribal communities and is dispersed over 8551.82 square miles of rural and urban and suburban areas. Some tribes have historic rivalry beneath the surface of everyday interaction between people.

The need for positive mentoring. Mentors, key informants suggest, can model positive ways to be Indian, to find universal values and to thrive while helping youth direct their anger and depression in positive ways. Many informants suggest youth groups in a variety of forms to help children bond with others who experience similar confusion and mitigate their feeling of alienation. In addition to youth/adult mentors, the idea of peer-to-peer mentoring for adults was suggested.

Family health education and delivery should combine nontraditional elements with existing successful models. This kind of treatment and programming would offer an attractive option to AI/AN that may be reticent to accept Western medicine but do support traditional ways. Home service delivery, alternative education and support groups are examples. Aggressive community education outreach was consistently offered as vital to a successful effort.

Youth request help to achieve in school and coping with stress. Youth focus groups were enthusiastic about sports teams and educational programming such as help with schoolwork, getting into college or trade school and deciding what to do after high school (**Figure 5**). Other areas of assistance include self-esteem, coping with grief and loss, dealing with anger, and drug abuse intervention.

Figure 5. Areas Where Youth Want Help



Specific ideas of community support include:

- Mentors
- Preschool services with high quality early childhood education
- Youth groups:
    - That offer a place where parents or elders share stories, share pitfalls and strategies for survival
    - That change what being cool means
    - That can help youth sort out how they want to identify
    - That offer athletic afterschool programs
    - That hold rites of passage
    - That consist of boys and girls groups so they can develop common bonds despite diverse tribal backgrounds
    - Father/son, mother/daughter, fostering kinship and extended family relationships
- Health education groups using a model such as diabetes groups or Kaiser Permanente to address healthy living, alcoholism, using positive modeling and herbology, with all integrated into healthy living concepts
- Alternative mental health services:
    - That are non-stigmatizing, such as quilt making or art projects that include support group strategies
    - That offer healing options of choice
- Mental health services offered at point of entry such as justice or detention centers using a “no wrong door” approach instead of having to go to multiple agencies
- Mental health services offered in school settings
- Provider improvements

- Educating and training providers in serving the population
- Have counties participate in Core Services and offer family broad support addressing poverty life skills, substance abuse assistance and home-based services
- Provide home visitation (family preservation workers or "Auntie Corps" of community people) that includes babysitting or dropping by to check in on the household

• Help for AI/AN professionals to stay involved in their community
• Promote/get the word out in the community to get buy-in and educate families on how much this issue affects us all

Observations on Community Attitudes Toward Mental Health and Helping Youth and Families

"If I see a young man of a different tribe, I might pass him by. But someone from my own clan I am prone to be supportive, help with money or housing. It's the way I was taught."

"The Indian community has a heart for helping. It is a priority. The need is so big it is overwhelming. I almost lost myself in helping because the need is so great."

Key themes on attitudes toward mental health:

Parents do not identify children at risk because they do not recognize the symptoms, do not want to recognize them or do not want to make them public. While Native cultures are community-based with children at their heart, informants identified significant and complex difficulties regarding assistance when problems of mental health are at issue. Providers feel unable to help even when they see problems because families do not ask for help. Families attempt to protect their privacy in Denver's close-knit community and want to protect the family unit from being torn apart by government intervention. All of these factors contribute to the underutilization of mental health services currently available.

Other observations included:

- Lack of awareness or denial of mental health substance abuse and risk behaviors such as gang involvement. *"There is a deep sense of wanting to maintain integrity and fear of losing self-worth, so they stay hidden and private. No one wants to be seen with a mental health issue. As a result, it is hard to reach out to help a family, even when there is a problem, until it may be too late."*
- There is often not an acceptance of Western-based medicine.
- Basic needs are often too much of a struggle, leaving parents just trying to survive.
- Providers and clinicians have a fear of inability of working effectively with the population, so they shy away from providing services.
- Reservations operate totally differently, and when Indians come to the city, they don't know who or how to ask.

Stressful Conditions That Prevent Youth From Achieving

"The ones who are confused about their cultural identity are the most vulnerable, and then there is the poverty that consumes their life and the stress that comes from that."

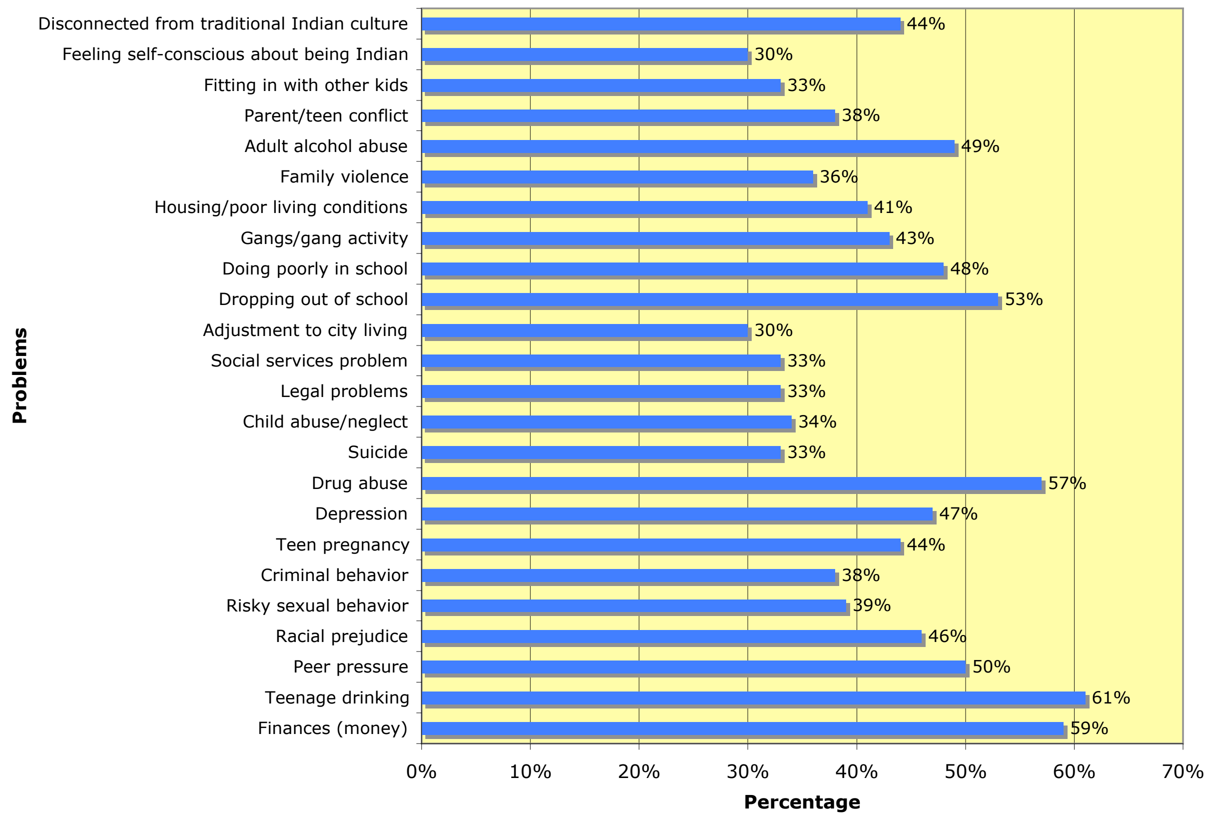
"We have been so battered that we don't pass our wisdom on to our children."

Key themes regarding prevalent stressful conditions:

Multiple challenges interfere with youth achieving their potential. Family and personal challenges include lack of education and job skills of their parents, the prevalence of racism, living in poverty, transience, addictions, disrupted families, health risks, poverty and issues of self-identity. Of the six youth focus groups, five brought up racism as a stress factor, ranking it the highest, and cultural-identity confusion and lack of cultural knowledge. In three of the youth groups, every member had experienced a direct family member's act of suicide.

High correlation with youth in school intervention programming and alcohol abuse. Over half of educators in school-based intervention programs who serve students from the ages of 6–18 reported chemical dependence as the reason students seek them out or that they seek students out. **Figure 6** from community adults bear out these reports.

Figure 6. Risk Factors and Concerns for Youth as Identified by Adults



Additional stressful conditions that confront youth include:

- Bullying and ridicule
- School not being culturally appropriate and causing dropping out
- Lack of parenting skills and parental involvement
- Lack of quality daycare
- Health risks that are higher than the general population such as liver disease, cancer, diabetes, suicide
- Transience from the reservation to city life, not knowing people and that there are organizations that could serve them
- Violence
- Family chaos

Service Systems

"In general, we lack coordination of efforts and we duplicate services; it takes time and money to coordinate, so people and agencies end up working by themselves."

What Services Are Available?

The following is a list generated during focus groups and interviews:

- Mentoring programs, but not nearly enough
- Denver Indian Center (D.I.C.) afterschool cultural classes

- DIC workforce development, dietician
- Indian Education programs in Jefferson County and Denver schools, Native American Multicultural Educational School, Native American Student Services
- Denver Indian Health and Family Services (DIFHS): diabetes clinics, alcohol drug and drug placement *for tribal members*
- Substance abuse treatment: Eagle Lodge, Four Winds
- Private practices: Native American Counseling and other practitioners addressing mental health
- Native American Cancer Research family wellness powwow
- DIFRC with child welfare and family unity, parenting classes
- Priests and faith leaders and medicine men
- Medicaid now accepts substance abuse treatment *for those who are eligible*
- State Core Services to families at immediate risk that provides comprehensive support for life skills, family therapy, childcare and contracts services
- Stout Street Clinic
- The Gathering Place for homeless talking circles
- DU Indian Law program for students
- Ben Nighthorse Campbell Center at CU Health and Sciences Center
- Denver Health pharmacy for students at DU
- County services: Jefferson Center for Mental Health, Foothills Behavioral Health, Arapahoe Mental Health Center
- Cultural competency curriculum for students at CU Health Sciences Center

Gaps in Services

"My daughter is in prison; what more can I say? There is a huge gaping hole. Mental health funds have shrunk in the last 10 years. A person can't get it unless they have insurance, Medicaid or are in the emergency room."

Financial Assistance Gaps

Concerning funding, comments included:

- Medicaid cuts off services in three months.
- Providers/families are allotted 36 sessions to complete treatment. When treating a family, individuals and family use up those well before treatment is completed.
- Insurance for counseling, outpatient programming, medicine and substance abuse programs are inadequate.
- Providers are discouraged from taking on subsidized patients. If clients forget to fill out the right paperwork, providers don't get paid.
- IHS money will be available for tribes only, due to recent legislation.

"The amount of time it takes to invest in receiving compensation from the state is enormous and most providers don't have the resources to keep up with the paper work. Dealing with system is a TREMENDOUS hassle: phone calls, progress notes, case managers…and they are low paid compared to the industry standards."

Providers' Capacity Gaps

"I think our community is not sensitive to the culture and needs of Native Americans and thus they have to adapt to mainstream standards. There are few providers that speak their language and so they are left without services because they don't speak English. Many people moving into the city still speak their own language and we then make them learn the language in order to survive. They end up losing their own language."

Participants observe the following about services in the community:

- No centralized place for families to get to services. "They need to seek services out over the entire metro area."
- Lack of evidenced-based family support services. "There is no evidence that out-of-home placement and long-term residential treatment works. This alienates kids from families and community."
- Lack of workforce development for AI/AN providers
- Underidentification of AI/AN providers
- Lack of communication to link people to resources; lack of visibility of services; lack of collaboration between services

Provider Service Delivery Gaps

"Only the most persistent, culturally identified and individuals and families who also know the staff at the front desk can make use of the Native services."

- Lack of services in which people feel trust
- No in-home services
- No long-term management after services. "Parents get frustrated from feeling abandoned and unimportant, then family issues escalate again."
- Probation officers are overworked and cannot adequately oversee the activities of youth.
- Provider staff behavior is unwelcoming and discourages client participation.
- Agencies need ongoing training on how to collaborate, on existing regulations and accessibility of other agencies.

Gaps in Services in Schools

- Lack of afterschool programming
- Lack of prevention programming and initiatives
- No early childhood education to start kids out with school readiness on equal footing with other children and within district standards
- Lack of teacher training: They may not be prepared for identifying issues or dealing with issues, and therefore youth fly under the radar, unidentified.
- A need to identify children at risk in the community

Gaps between providers

> *"Employees are limited by hours, but there was one person who went all out for my kid. She called on weekends, got me help, made all the calls. I would never have been able to get medication and the help I needed without her."*

> *"I went to school counselors, children's hospital, DIFRC…there was no bridge. I had to advocate for myself."*

When asked about working relationships with other providers in surveys, only 18% responded that they had strong relationships with schools, 17% had strong relationships with Native or tribal service providers (8% had poor relationships because of past history), 17% had strong relationships with substance abuse centers and *33% had strong relationships with law enforcement*. Thirty-four percent said they were unaware of services provided by AI/AN or tribal providers. Currently, work is underway to create systems for service youth at risk at a state level.

Key themes regarding gaps in services for youth and families:

Parents and providers report poor referrals between services. While providers' surveys reported 17 types of services or agencies to whom they refer their clients, only 50% of educators report having adequate information to refer participants to appropriate agencies.

Difficulties with the policies and bureaucracy of Medicaid and lack of insurance blocks access to services. According to data presented in the demographic analysis section, one in three AI/AN is thought to be uninsured. Results from the adult community survey reflects this projection, with 37% reportedly uninsured. Of those that do have insurance, 65.2% have mental health insurance.

Providers need cultural competency and interagency partnerships with culturally specific providers. Providers who were interviewed also cited lack of culturally competent service providers and the lack of reference directories of competent contractors. Interviewees saw the lack of a centralized location and in-home care as gaps in services available. The multiple challenges provider surveys revealed in their ability to work with AI/AN families include: 41.7% with cultural barriers, 12.7% cannot provide follow-up services, 33% either have lack of referral agencies or do not know who to refer the family to, and 33.3% feel they do not have the training/knowledge adequate to treat specific AI/AN issues.

Providers lack resources. Fifty percent responded that they do not have funding to serve this population. When participants were asked if there was adequate budget to meet their organizational goals, survey results show that only 8% feel they have enough (50% disagreed and 25% strongly disagreed) and only 17% feel they have enough staff (58% disagreed and 17% strongly disagreed).

School personnel need training/staff development. Schools, identified as a potential location for service delivery among many informants and youth and parent focus group members, lack some key elements, according to educators. These included trained staff, adequately identified students and services in early childhood education through high school. Three youth focus groups reported that teachers make inappropriate comments about reservations or are not even-handed in their approach to kids of color. Another challenge linked with school staff training raised by Indian Education staff is the prevalent

misdiagnosis of learning disorders, resulting from youth not attending school because of chaos at home, not acquiring subject content and falling behind. When surveyed, however, intervention program educators reported that those students who come to them with special needs typically have learning disabilities, speech/language disability and emotional disabilities. Currently, 37 AI/AN are served with special intervention initiatives for at-risk students in the schools within the seven-county area.

Barriers to Accessing Existing Services

"Documentation is a barrier. Unless you have a paper, you are excluded. What does that make you? You feel like you don't belong."

"For households that are significantly stressed, it's just not in their frame of reference to come to an office from their home. Only the high functioning show up to the office."

Key themes regarding barriers:

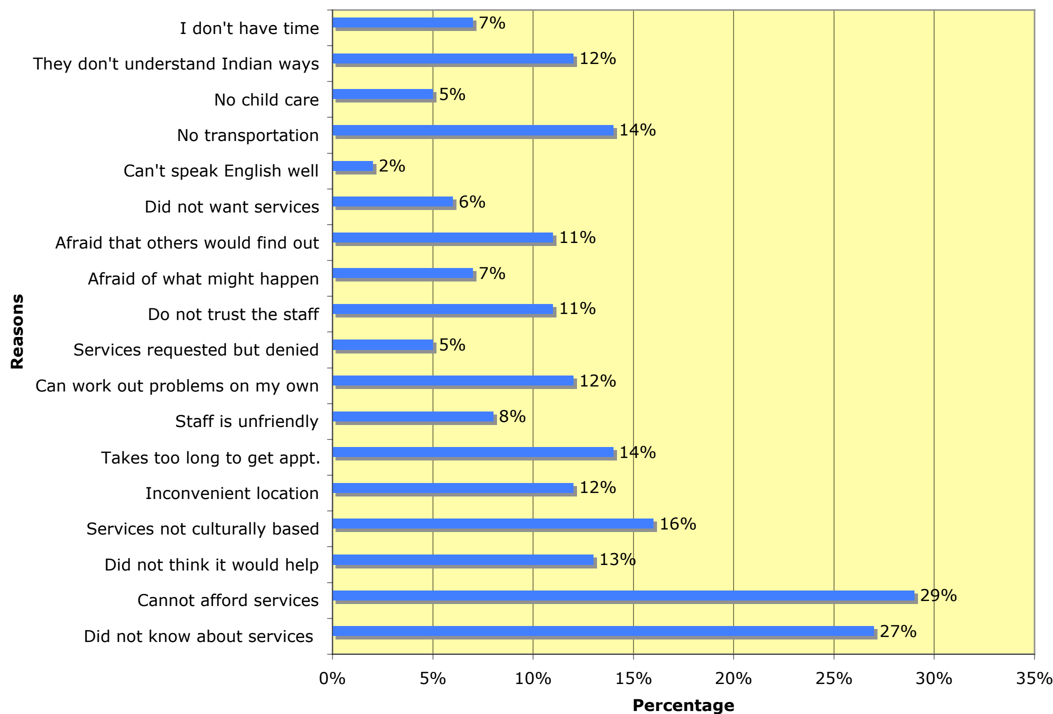
Transportation to out-of-home services presents difficulties. Unreliable transportation or lack of automobiles, dispersed populations, as well as no single service delivery center make it difficult to get to providers. Another factor is the hours that clinics and offices are open, and the overwhelming challenges that prevent a poorly functioning family unit to keep appointments. Many interviewees stressed the need for in-home provider services and family advocates who can conduct thorough assessments, make referrals and continue to walk the family through processes as they work toward a higher functioning, more stable lifestyle.

Parental involvement with youth services is limited. Community mental health centers were reported to be underutilized. The prevalent distrust of available services and in seeking assistance stems from two main concerns of parents: protecting the family from vulnerability to the potential loss of their children because of poor, inadequate parenting and the fear of breach of confidentiality.

Financial barriers and the overwhelming bureaucracy of the state and Medicaid assistance present obstacles. Providers admit that it is a burden to provide Medicaid reimbursement services and that the federal standards for approval and prescription for services is inadequate and unrealistic. For the adult survey respondents, the most common reasons for not receiving services were they cannot afford them (29%) or they did not know about them (26.5%).

Tribal enrollment as a requirement for service is a "huge, huge" problem. Tribal enrollment for metro Denver's AI/AN population is not possible for many of its members. According to the adult surveys, 23% were not enrolled in a tribe. Denver is the site of massive resettlement of diverse tribes. A large number of people have mixed ancestry, do not know their ancestry or have never pursued attaining tribal enrollment. Families themselves are often of mixed heritage. The one Native-specific health agency in the area has most recently served only tribally enrolled or Medicaid-covered clients. The thousands who are outside of those stipulations do not have a place to turn.

Figure 7. Reasons for Not Receiving Services



Other specific barriers mentioned include:

- Services available only for crisis
- Fear of being identified as having a mental health issue in the family
- Services spread out and hard to reach, to navigate, to identify
- No phone referral system
- Lack of trust of government assistance
- Hours of operation inconvenient and incompatible with traditional norms
- Lack of culturally competent practitioners; shortage of college-level preparation for providers to increase multicultural competency

How Often Are Services Accessed?

"When we came to Denver, we weren't treated well when we attempted to use services. So my family grew up not accessing services from the Indian community."

"Many families have support from each other but don't have support from us in the field. They would rather depend on each other than reach out to us."

Services are underutilized. Providers and community members cite the barriers and hesitancy to access services mentioned above as roadblocks to taking advantage of what is offered in the community. Providers state that they are unsure how to reach the population, are not aware of any AI/AN who have come for services and may not have a reputation within the community due to cultural issues.

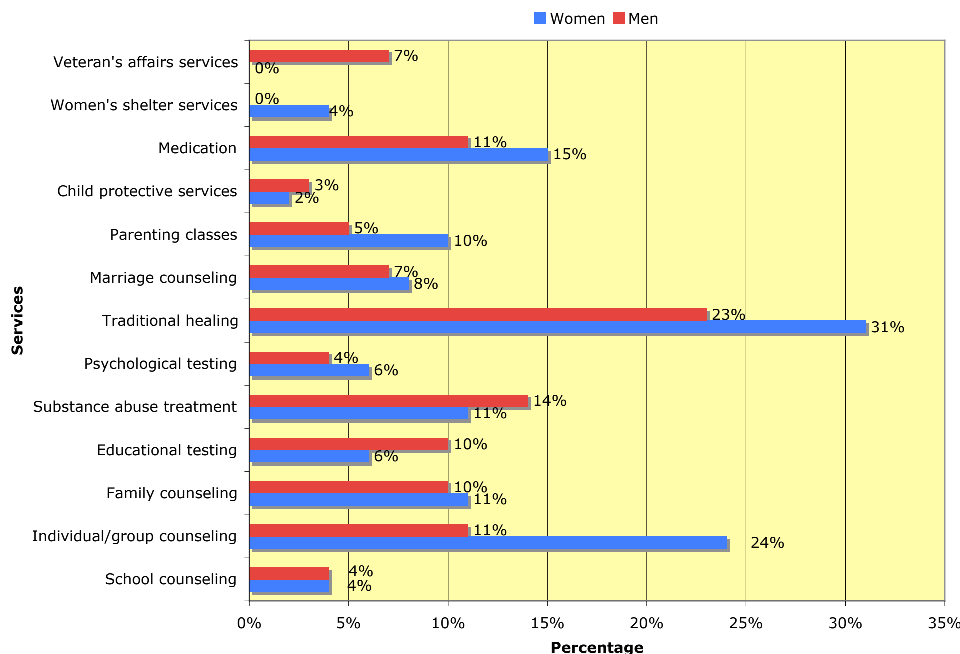
Despite the reports from almost 20% of community respondents that their children experienced behavior and anger problems, no more than 11% reported that their child(ren) received services in the past five years. The highest percent of those who did use services was 12% for individual counseling and 12% for school counseling (may be the same service). While the youth entered a great variety of services they would like help with, almost 40% stated they received no help at all.

Additional comments include:

- Individual contact is the most effective way to get families engaged. Active outreach is necessary.
- Small group support opportunities would be an effective approach.
- People tend not to follow up with referrals.
- There is reluctance due to privacy issues.
- Those transient between the reservation and city, the homeless and those who lack transportation are the hardest to reach.

The following figure details the use of services by adults. The notable preference is for traditional healers.

Figure 8. Services Received by Gender in the Past Five Years



How the Community Serves Low-Income Families

"The poverty, the stress is tremendous. Provider efforts need to have awareness of it and address it so that the next generation isn't caught up in it."

The services available to low-income families mentioned during interviews and focus groups were few:

- DIFHS
- Westside clinic
- Lakewood Section 8 housing wraparound services
- County mental health agencies
- Some clinicians who can afford to work on sliding scale and Medicaid-based fees, but the bureaucracy is too massive to do without assistance
- Churches offer assistance
- State income assistance, TANF, WIC
- Emergency assistance: housing, food banks, energy

Interestingly enough, while 29% of community survey respondents used lack of money as a reason for not accessing services, 71.4% of providers responded that they provide services when a source of payment is not available. Some list a sliding scale, one does free eligibility evaluations for infants for early intervention, and one city has a limited number of sessions provided free of charge for residents. Various providers mentioned targeting services for Medicaid, underinsured and uninsured, and the homeless.

Climate for Adopting System of Care Principals and Values

There is much agreement within the community about the risk factors that AI/AN youth face in the metro Denver area. Factors include issues with finding their identity in an urban environment, poverty and addictions within the family and community, as well as the stigma attached to mental health. Community respondents also agree on multiple barriers to accessing current provider services. The overwhelmingly consistent issues are that of confidentiality and a perception that the services are not suited to the life and norms of AI/AN families. However, as one community informant stated, "*This community has a heart for helping*." The needs assessment participants presented creative and achievable ideas for partnerships; acceptable settings; and flexible models of prevention, intervention and treatment for youth and their families. *Page 39 begins a detailed description of specialized structures and action steps that community members have offered.*

The need for public awareness in metro Denver, targeting the AI/AN community concerning the risks of mental health and the pursuit of healthy living, is a vital first step in order to overcome the current community stigma regarding mental health.

Youth respondents clearly voiced readiness in their desire for assistance in achieving academically, for cultural programs that reinforce their AI/AN identity and for afterschool programming that pursues healthy goals and objectives.

Local supportive resources include other systems of care projects operating in the human services fields in the Denver area. First, the city of Aurora in Arapahoe County is working with El Paso, Fremont and Mesa counties on an early-childhood development system of care initiative called Project BLOOM. Second, the Systems of Care Collaborative, an ad hoc group of state stakeholders from local system of care projects, meets regularly through the state's Department of Human Services. This group is seeking ways to connect smaller systems of care into a larger, statewide effort to identify and remedy system barriers. Third, Jefferson County's human services providers are exploring collaborations and coordination within the county and larger Denver area; DIFRC participates as a provider and as a consultant within that system. In addition, the 2007 House Bill 232 has committed a leadership council to create a five-state agency collaboration to address youth prevention, intervention and treatment. Private funding in Colorado has begun to recognize the issue of health disparities dramatically illustrated by the Colorado Trust's statewide $13.1 million Equality in Health Initiative, a seven-year project that will support non-profits and educational institutions.

Of the 53 providers that responded to the surveys, 75% said they were very interested in serving the AI/AN population. A list of services local providers offer can be found in Appendix C.

Although the community is intertribal, it also shares many traditional values of strong family and the sacredness of its youth. These characteristics as well as the climate in the region and the state places metro Denver in a prime position to adapt a successful system of care.

Key themes regarding community perceptions of services offered:

"About five years ago, I worked with a woman who was raising a child who was schizophrenic. She had never been on drugs, never in the hospital. When I mentioned mental health, the parent was shocked."

"In order for folks to seek out services, they need to trust. How do you get people services if they don't trust? It's historic and pervasive. It is a small community, so there is a trust issue about violating confidence. How to overcome the barrier if they don't ask?"

"There is a disconnect and misinformation between the expectation of the community members and the limited capacity of existing agencies and of their programming mission."

Parents have concerns of confidentiality, distrust and misunderstanding. Due to an understandable hypersensitivity and lack of information as mentioned above, community members may be quick to feel rejected when they approach the wrong agency or do not qualify under an agency's target population. In fact, 25% of providers surveyed stated that client expectations are unrealistic.

Of the adults who participated in the surveys, 63% agreed or strongly agreed that they do not care about the ethnicity of their service provider as long as the provider respected their culture. However, they also felt that for some problems, they prefer an AI/AN provider who is more likely to understand them.

Youth rated provider services favorably. The majority of respondents to the youth survey agreed or strongly agreed that they were treated with respect and that staff listened to them, and over 60% felt that staff understood their culture.

Figure 9. Youth Perception of Services They Received

Question	Rating			
	Strongly disagree	Disagree	Agree	Strongly agree
They helped me deal with my problems (130)	6.2%	27.7%	53.1%	13.1%
The staff understood my culture (129)	5.4%	31.0%	43.4%	20.2%
The staff asked me the right questions (131)	6.1%	34.4%	47.3%	12.2%
The staff listened to me (130)	3.8%	16.9%	56.2%	23.1%
I was treated with respect (130)	.8%	9.2%	60.8%	29.2%
I felt comfortable (129)	8.5%	26.4%	45.0%	20.2%
I felt self-conscious about being Indian (123)	33.3%	24.4%	31.7%	10.6%
I could talk openly about my problems (129)	9.3%	31.0%	45.0%	14.7%
I could talk easily about being Indian (127)	7.1%	18.9%	42.5%	31.5%

Key informants offer the following:
• Results from a state provider "Youth Satisfaction Survey" had the following concerns surface:

- Services were in remote locations to those in need
- Services were not culturally appropriate
- Families did not know where to turn for help
- Services didn't address the needs of the family
- There were long waiting lists for families that could not wait for services
- There was difficulty at intake
- There is a perception of favoritism in rendering services
- People feel all on their own and that services are fragmented

"All agencies have good reputations. Sometimes there are different gripes about the agencies but we are working with wounded people who are attacking themselves and each other."

How Can the Community Address Unmet Needs?

"The vast majority want to do better and the best for their kids and have a level of security. We need to create a community where that spark is honored regularly and fostered."

"I believe it's time for the mental health system to incorporate traditional methods along with Western therapies for both health and mental health. It is time to start giving a choice for families to be involved in their care."

"Clients need to see that cultural competency is beyond language, more than what we say we do. What does the place feel like? If they don't get a sense of hospitality, they may not come back."

Key themes about serving the unmet needs of youth and families:

The vision for structured services:

- Mentoring
- Youth groups, someone to "talk to," sports
- A center that houses a variety of family and community services, including but not limited to health, transportation to services or services at convenient sites (such as schools).
- A structured family service that would provide personnel to advocate for the family.
- Comprehensive wraparound services for the needs of the entire family unit
- A technically sophisticated phone referral line that might mitigate both the issue of transportation and reticence to get involved. Many AI/AN just don't know where to turn and are hesitant to ask.
- A resource directory for referrals to connect and partners with each other.
- A multipurpose facility: they do not want to walk into a location where they can be identified and labeled pejoratively.

Increasing community participation and answering unmet needs:

- Financial assistance, sliding-scale services
- Ease of intake at service site
- Increase community information and education about this initiative, about services available and about the issues of mental health and substance abuse
- A community lodge for invited guests, healers, visiting guests and elders; sweat lodges; a place for people to go without the threat of stigma; a place that creates an environment conducive for generational interaction; a place that offers educational, athletic and cultural programming for youth, families and elders.
- Centralized services
- Confidential and welcoming services for all tribes
- Assistance with transportation
- Financial compensation for mentors, community healers and helpful family elders
- A self-sustaining funding stream for providers to reduce "chasing the money," vulnerability to funding trends and continual efforts focused on fund development rather than service delivery

System improvement suggestions:

- Medicaid should allow broader criteria for mental health needs such as poor academic achievement as an indicator and ways for families to reauthorize.
- Client-centered therapies that include healing approaches according to the spiritual identity and comfort level of the client integrated with effective Western practices.
- Case management should be offered with full-time energy within a family association or family advocate who can go to the home, meet the family and create a family plan.
- The whole family should be supported, not just the individual.
- DIFHS had a "One Mile" health education program that went directly to schools and talked about healthy living, goal setting, exercise and healthy eating. Kids are still asking for that program. This strategy for outreach is necessary because kids are so spread out in urban areas.
- Cultural competency curriculum should be required as part of licensing for health providers.

- Find an existing successful ethnocentric healthcare delivery model to follow

One provider echoed what many have expressed:

> *“A family should be able to chose the approach that is right for them. They may need a Christian or faith-based service. You just don’t know. They may need a sweat lodge. It might be a peer-to-peer mentoring that would work for them. It should be consumer or family driven.”*

Health educators recognize the need for funding to recruit and retain students, especially in the fields of social work, public health and pharmacy, as well as in general higher education for youth. This focus group agreed on the need for improving systemic barriers such as curriculum failures and marginalization of students of color. Suggestions included faculty that can relate to AI/AN students, community-building activities, mentoring and cohorts such as that used by the pharmacy program at CU, resulting in improved completion of degrees. Ideas for serving the AI/AN population included graduating nontraditional paraprofessionals. This would be important because 50% of adult survey respondents feel that a provider who is not AI/AN cannot truly understand them. All educators agreed on the need to start students no later than middle school with mentoring, visits to colleges, college fairs and summer programs on campus.

Our dropout rates are ridiculous. When you have 35–40% going to community college and only 8% going on to a four-year college, you just lose them. I don’t know. What do you do? We need to start at an early age.

V. Recommendations

Based on the observations and hopes expressed by participants of the community assessment for healthy support systems for AI/AN Denver youth, there is no one single answer to building a protective system for AI/AN youth and their families. Denver's AI/AN youth are exposed to multiple risks and obstacles that threaten their mental well-being. However, the encouraging news is the high number of providers surveyed who are very interested (75%) in serving this population, as well as the positive climate in Colorado for developing collaborative systems with state and county partners. In fact, the vision of the Colorado LINKS for Mental Health Implementation Group is, "To promote partnerships among state agencies and key stakeholder organizations by weaving together existing efforts to create a more coordinated continuum of mental health services for Colorado youth and their families."

In addition, DIFRC has a history of pursuing and developing active provider partnerships to carry out its programming of protecting children and families. The agency has embraced community collaborations in all phases of decision-making as it has grown, and it has a steering committee of dedicated and creative stakeholders that includes consumers, administrators, providers and decision-makers in the community. These are critical factors because the framework needed for a successful system of care, as expressed by numerous informants, will by necessity be unconventional and broad-based. Perhaps the most important resource, however, is the AI/AN community that honors and cherishes its youth and is committed to shepherding them into healthy adults who will find strength in Indian tradition, culture and values in a contemporary context. As one parent described, "Our youth have a strong sense of self and traditional ways."

The following recommendations are a summation of themes expressed during the course of the community assessment to be used in setting the direction for the next stage of design.

Public Education and Community Unity Campaign

The very best of services systems is only as effective as its ability to attract and retain consumers. A successful system should institutionalize a dramatic and multidimensional public awareness campaign, reaching AI/AN community members. The campaign should use a variety of outreach strategies due to the diversity of its residents and their wide geographic distribution. Recommendations include slogans, billboards, grocery bags placement, media blitzes, articles, interviews and community meetings. The acceptance of healthy living and the support of mental health should become a household concept much like that of linking tobacco with cancer decades ago. It should involve high profile community leaders, schools and Native-specific agencies as well as public and private health agencies. Education should also include who to contact and how to ask for help. Strategic provider audiences (agencies, administrators, educators) should be identified and messaging about this initiative should be tailored to these audiences.

In addition to addressing and overcoming the stigma of mental health, a successful campaign should encourage unity in the community by building on shared multitribal values such as pride of culture, community support, care for the young and the importance of intergenerational interaction. According to informants, families have a fear of being judged as inadequate and of feeling like outsiders. A repeated

message of goodwill and community unity will ultimately reap positive support structures for youth in many ways.

Other points to consider in educational design strategies are to target and conduct outreach to providers regarding the project and to adequately prepare all active program stakeholders so that they can carry the key messages of the project to their areas of influence.

Collaboration and Alliances

Steering Committee members and staff of DIFRC, as well as additional key stakeholders as needed, will study the results of this assessment and convene to agree on priorities and set direction based on the information provided. Using the leadership and level of connectedness among the members, representatives should begin to serve on decision-making bodies such a Colorado LINKS, State Department of Mental Health, the Colorado Department of Public Health and Environment, Office of Health Disparities and The Colorado Trust's Equity in Health Initiative to ensure that the unique needs of AI/AN consumers are considered. Because these entities are already working on issues of connectedness, this report recommends engaging within an existing system rather than recreating a new work group. Included in the final outcome should be a cadre of trainers who can assess agencies' climate and receptivity for AI/AN and be available to offer staff training.

Higher education outreach, recruitment, retention of students in various professions of health and mental health service delivery and cultural competency training should be included in the design of a successful system. Educators emphasize the importance of beginning outreach to students early and providing a continuum of education that prepares them and encourages their pursuit of professional careers. The perspective of health education providers will offer valuable contributions to work group decisions. In addition, their active participation in a system design will increase the chances of incorporating curriculum that graduates non-Native health professionals who are in tune to the needs of AI/AN youth and their families.

In collaborative efforts, care should be taken to avoid agency "territorial" concerns as noted by informants. It is incumbent on all partnering organizations and stakeholders to put aside differences to create a strong atmosphere of support for families and youth.

Required Service Delivery Elements

Community outreach, education and communication are essential to ensure effective access and delivery of services. The gaps between what the community perceives is available and what providers say they offer is striking. Consumers should be able to find out with ease where they can go for free or sliding-scale services, the age range of the population agencies specialize in, and what wraparound serviced are offered.

Likewise, provider agencies should provide regular professional development to all staff, from point of entry through all points of client contact, in order to respectfully and successfully serve the AI/AN population. This will help retain clients and establish a positive community reputation that will ultimately serve the best interests of youth and their families. Staff training should include: the nature of partnerships with other agencies, interagency policies, cultural competency and issues of the AI/AN population they serve. Trainings should be updated regularly and repeated as part of a cycle of training to bring new staff up to speed.

An effective service system for families with SEBD youth will include thorough assessments, case management, customized treatment according to the spiritual and cultural identity of the client, family services and wraparound services.

As important as *what* elements make up a successful service delivery system are *where* services are delivered. For instance, schools were identified repeatedly as a way to reach youth. Both prevention and intervention programming can serve to address multiple strategies such as alleviating feelings of alienation, achieving early identification and assessment of needs, overcoming transportation difficulties and the stigma of going to a mental health institution. In-home services are also a necessity to successfully reach families in need or in crisis and to support them in a context that is safe and comfortable.

According to the feedback from consumers and providers, key elements of an effective service system for AI/AN youth and families include the following features:

- Services available that include prevention (such as mentoring, youth groups and school programming), intervention (such as school site programming, parenting classes, case management and family-tailored referrals) and treatment (such as Western and traditional programs, culturally responsive agency policies, affordable treatment, interagency partnership and system of referrals) and follow-up (such as case management, mentoring and extended treatment programs).
- Centralized site that has small satellite clinics located throughout the eight-county area such as schools or other health clinics
- Client-centered therapies that include healing approaches according to the spiritual identity and comfort level of the client that are integrated with effective Western practices.
- Full-time family advocate/case management within a family association who can go to the home, meet the family and create a family plan of care.
- Comprehensive referral resource database of contractors who can be used by agencies
- Extensive wraparound services database for providers and consumers
- School satellite sites for service delivery with transportation for outlying students to attend afterschool culturally based prevention and intervention programming and family counseling
- Collaborative educational strategies that keep youth in school, assist with academics, prepare them for professional careers and help entry into higher education
- Dedicated staff for Medicaid, TANF, tribal enrollment and insurance paperwork
- Services available to low-income consumers
- Comprehensive phone referral service
- Compensation for paraprofessionals

Wraparound Services for Families

Mental health is intrinsically linked with poverty, substance abuse, lack of parenting skills and alienation. Wraparound services should be available to mitigate those conditions. Services requested by respondents include:

- Comprehensive youth and family intake assessments conducted by in-home practitioners
- Transportation to and from locations and activities
- Culturally appropriate substance abuse education intervention and treatment for parents
- Referrals to youth programming, support groups and comprehensive family services
- Job-skills training and placement
- Academic support

- Respite and babysitting care
- Assistance with paperwork
- Referrals to spiritual leaders and healers

Support Structures for Youth and Community

Community members spoke of disconnectedness and the lack of support programming for youth, especially when families are undergoing stress. Programming should be readily available that helps youth bridge mixed tribal affiliation and addresses the experience of urban AI/AN youth that helps them find their place as an individual. Families should have access to a central hub: A community center that offers a geographical location for mixed generations to come together described below. Youth spoke of the need for academic support.

- Mentor programming, for youth and adults, including peer-to-peer options
- Tutoring and college-bound programming
- A community lodge for invited and visiting guests, healers and elders; sweat lodges; a place for people to go without the threat of stigma; a place that creates an environment conducive for generational interaction; a place that offers educational, athletic and cultural programming for youth, families and elders
- Sports league
- Youth groups (see detailed list under what the Community Can Do)
- Indian center/lodge with Native-specific focus for treatment

Research on Current Models

There are other health and community models that offer a menu of traditional and Western health serves and that serve specific ethnicities. A comprehensive review of these models may help point the way to a new, customized model for the metro Denver AI/AN community. Some approaches to look for include:

- Integrating traditional care with Western methods
- Family-run agencies
- Alternative support group settings
- Ethnocentric clinics
- Centralized location
- In-home case management