SONOMA COUNTY
INDIAN HEALTH PROJECT

Aunties and Uncles Program

Final Evaluation Report

Native American Population

June 30, 2018–June 30, 2021

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Executive Summary

Initiated in March of 2017, the Aunties and Uncles Program, was developed in response to a statewide initiative, the California Reducing Disparities Project, to identify solutions for historically unserved, underserved, and inappropriately served communities in California. The Aunties and Uncles Program (AUP), a prevention and early intervention mental health program, aimed to prevent risk of suicide among transitional-age youth (TAY) by increasing mental health awareness and knowledge, cultural identity, and involvement in traditional practices within the Native American communities of Sonoma County, California.

Following the principles of community-based participatory research, AUP aimed to empower Native communities in program planning, implementation, and evaluation; encouraged the use of Native American practices; ensured a community-driven evaluation process; and engaged a community advisory council to ensure evaluation activities integrated traditional and culture based approaches.

The Aunties and Uncles Program had four strategies:

1. Establish an Inter-Tribal Advisory Council (Eagle Council) and select "Aunties" and "Uncles" to represent the three California tribes in rural Sonoma County;

2. Implement a culture based stigma reduction and health education campaign on mental illness and suicide prevention in Native community settings;

3. Engage transitional-age youth (TAY), ages 12–25 years, in Talking Circles; and

4. Increase screening for depression by primary care providers.

The primary focus of this evaluation study was to measure changes in attitudes, knowledge, and behaviors among the Native population that reduce risk for or early onset of mental illness. The methodology employed a mixed-methods approach, collecting both quantitative and qualitative data, focused on both process and outcome. The evaluation consisted of the following six evaluation questions and corresponding findings:

1. How did knowledge, attitudes, and beliefs (KAB) regarding mental illness change among transitional-age youth (12-25) as a result of the Aunties and Uncles Program?

    a. Post-AUP intervention, 90% of survey respondents felt that talking about emotions is important to Native youth compared to only 68% in the pre-survey results.
    b. Native youth seek out those who they trust, who are non-judgmental, have lived experiences, and have wisdom. For the majority, Native youth feel supported by adults to succeed (school, career), but don't feel as strongly that adults listen or will talk to them when they are struggling emotionally.
    c. However, 78% of the participants reported that they knew someone who would listen to them and understand them if they needed to talk.

d. Sixty percent of the participants stated that suicide remained a taboo subject that is difficult to talk about among community members.

2. During AUP implementation, did more community members (TAY and Adults) seek help and support for mental health issues?

    a. The practice of administering the PHQ-9 depression screening resulted in a high level of referrals made to mental health services and a significant percentage of youth (69%) and adults (71%) following up with an appointment to see a behavioral health specialist.

3. How did the mental health status among TAY Aunties and Uncles Program participants change?

    a. Over half of the AUP participants (56%) reported improvements in mental health status, specifically with depression and anxiety.
    b. Focus group participants, a subset of those who took the surveys, reported a greater awareness of their mental health and an ability to practice self-care.

4. Does the Aunties and Uncles Program contribute to increased community involvement and community connectedness? Is increased community involvement and community connectedness associated with an increase in community wellness as self-reported by attendees?

    a. Over three-quarters of the survey participants cited a high degree of community connectedness in the post-survey.
    b. Focus group participants identified community and belonging as a valuable benefit of attending AUP activities. Direct quotes stated the importance of intergenerational and kinship (non-blood relatives) relationships in building mental health resilience.
    c. All the participants in the Gathering of Native Americans (GONA) reported feeling more connected to family and community and believed they could be a role model to others in the community.

5. How did TAY participants' self-esteem and cultural identity change as a result of the Aunties and Uncles Program?

    a. The value of cultural identity and recognition that culture is prevention was expressed by GONA and focus group participants. Specifically, intergenerational relationships, learning from elders and being with other Native Americans were the most frequently repeated themes.
    b. Over two-thirds of TAY post-survey respondents stated feeling satisfied with their family life, that they were doing better in school and/or work, that they were better able to cope when things go wrong and that they were better at handling daily life.

c. Respondents to the Herth Hope Index signified having a positive outlook toward life (85%) and having short and/or long-term goals (81%). Finally, over 95% reported feeling that their life has value and worth.

6. How did participation in the Aunties and Uncles Program Talking Circles impact TAY and other community members?

    a. Talking circle participants, both youth and adults expressed gratitude to have a safe place to express themselves, learn from others and build trust.
    b. The number of participants for talking circles was small but consistent, indicating importance and benefit to participants in a safe and intimate setting.

AUP program participants articulated the power of being connected to community and culture, and their culture itself, is prevention. Knowing one's culture strengthens identity and pride. Common ancestry and history between community members creates an initial bond and combined with shared understanding builds individual and community resilience. Culture is also seen as a way to carry forth traditions, honor elders and honor self. Sonoma County Native youth and young adults have strengthened their resilience through the cultural activities and community connections that the Aunties and Uncles Project provided.

In conclusion, Native Americans, as all diverse communities, have their definition of what is healing according to their cultural beliefs and practices. Policy makers, funders and leaders need to listen to the stories of diversity and self-determination that are not in the traditional boxes built within our ivory towers. For the participants of the Aunties and Uncles Program, the strength of intergenerational relationships, learning and sharing traditions, honoring elders, celebrating culture, and belonging to community builds and maintains resilience as evidenced by this collective research. When people are connected to community and culture, they reclaim their purpose, pride and resilience: protective factors for both mental health and physical health.

Introduction

According to the 2010 Decennial Census, 0.9% of the U.S. population, or 2.9 million people, identified as American Indian or Alaska Native alone, while 1.7% of the U.S. population, or 5.2 million people, identified as American Indian or Alaska Native in combination with another race. This is an increase of over 39% since 2000. (US Census Bureau 2012) In the 2020 Decennial Census, the population is expected to increase once again. However, due to the relative size of this population compared to Caucasians, African Americans, Hispanics/Latinos, and Asian Americans, the unique racial experiences of AI/ANs are often left out of the national discourse concerning mental health. This absence contributes to disparities in mental health status and access to services among AI/AN populations.

An important factor in the mental health of AI/ANs is historical trauma, and associated historical losses, that impacts generations of Native communities. Historical trauma is a cumulative emotional and psychological response to years of injustices and discrimination, including violent conflicts with invading European settlers and destructive colonialism (e.g., introduction of diseases; clinical research exploitation; loss of land and resources; systemic eradication of cultural practices and spirituality; the implementation of the reservation system; betrayal of treaties; abuses and cultural annihilation of the boarding school era; and federal assimilation policies). (California Reducing Disparities Project 2012)

The impact of trauma is extensive and affects the individual, their family, friends, and community. The effects of historical trauma among Native Americans include changes in the traditional ways of child rearing, family structure, and relationships. Some observed responses to historical trauma may include signs of overall poor physical and emotional health, such as low self-esteem, depression, substance abuse, and high rates of suicide. (SAMHSA 2014) Policies focused on eradicating Native culture, including forced separation of AI/AN children from parents in order to send them to boarding schools, have been associated with negative mental health outcomes. (USDHHS 2001) Additionally, the socioeconomic consequences of these historical policies, such as forced removal from historic and native land, has resulted in high rates of poverty among AI/AN. Research has repeatedly demonstrated the association of lower socioeconomic status with poor general health and mental health.

Given that many Native people live in stressful environments, there is growing recognition of the negative mental health consequences these conditions have on Native communities. (USDHHS 2001) Furthermore, historical trauma and historical loss contribute to distrust of government agencies and health care systems, discouraging help seeking behavior. When AI/AN individuals do seek mental health services, they often have difficulty finding care that is culturally sensitive and bases diagnosis and treatment on Native American experiences. Mental health service utilization rates for AI/ANs are low, which is likely due to a combination of factors, including stigmatization of mental health, lack of culturally trained providers, and lack of available and relevant services. (SAMHSA 2016)

The Aunties and Uncles Program (AUP) of the Sonoma County Indian Health Project, Inc. (SCIHP), a culture based, community-defined evidence practice, was developed to address four

key needs among Sonoma County Native American tribes (Pomo, Wappo, and Coast Miwok) residing in the rural and Rancheria settings of Sonoma County.

High rates of suicide

North America's Indigenous peoples have disproportionately high rates of suicide deaths, attempts, and ideation. Suicide deaths are approximately 60% higher for AI/AN people than for the general population. (CDC 2019) There is increasing evidence of how insufficient mental health support and services impact the California Native American communities in Sonoma County. In 2017, the local Native population had three completed suicides of youth 17–21 years old. SCIHP is aware of four other incidents that the community members and family members believe were incomplete suicides. Suicide is the second leading cause of death among AI/AN adolescents and young adults, and their rate of suicide is 2.5 times as high as the national average across all ethnocultural groups. (Goldsmith SK 2002) It is the highest youth suicide rate among all races/ethnicities in the country. (Curtin SC 2019)

High rates of depression, anxiety disorders, and post-traumatic stress disorder (PTSD)

Significant disparities exist in the prevalence of mental health conditions among AI/ANs and other races. While there is not a definitive assessment of the prevalence of depression and other common mental health concerns among all AI/ANs, available data point to disproportionately high rates of depression. According to the CDC, AI/ANs are 50% more likely to experience feelings of worthlessness as compared to non-Hispanic whites, and 60% more likely to report feeling that everything is an effort. (CDC 2021) Approximately 21% of AI/AN adults reported past-year mental illness, compared with 17.9% for the general population. (Whitesell NC 2021) Although AI/AN communities have significant intergroup differences (e.g., geography, language, traditional practices) (Ogunwole S 2006), in aggregate they have a higher risk of experiencing traumatic life events than any other ethnic or racial group and are twice as likely as the general population to develop PTSD. (Bureau of Justice Statistics 2000) High rates of substance use disorders, post-traumatic stress disorder (PTSD), suicide, and attachment disorders in many AI/AN communities have been directly linked to the intergenerational historical trauma, such as forced removal off their land and government-operated boarding schools which separated AI/AN children from their parents, spiritual practices, and culture. (Office of Minority Health 2017)

High level of stigma

Stigma attached to mental health illnesses is one of the main barriers for seeking help among general populations. Among AI/AN there are high levels of stigma toward accessing and utilizing mental health services, as well as significant levels of discrimination against people with mental illness. These factors can deter Natives from asking for help or seeking services. Stigma and discrimination can occur at both the individual and organization or community level, making it difficult for individuals to access resources and care.

Poor access to mental health services

Native communities' historic negative experiences with mainstream services have contributed to suspicion towards the federal government and health care systems, limiting access to mental health care for many Natives. (Grandbois D 2003) Additionally, Native Americans in the rural and Rancheria settings in Sonoma County have further difficulty accessing mental health services due to economic barriers, lack of transportation, isolation, and lack of culturally appropriate providers. Natives residing in rural areas of Sonoma County may have to travel 90 minutes to two and a half hours to access the Sonoma County Indian Health Project clinic. Due to the far distances rural residents must travel to access services, many wait to access care until mental health needs have reached a crisis point.

Prevention Strategy: Culture as a Protective Factor

Protective factors, positive conditions in one's life, are universally recognized as supporting psycho-social and emotional wellbeing. Enhancing protective factors have been demonstrated to mitigate risk factors and negative outcomes such as suicide, depression, alcoholism, and addictions. Categories of protective factors positively associated with health and social outcomes for American Indian and Alaskan Native (AI/AN) youth include personal wellness, positive self-image, self-efficacy, familial and non-familial connectedness, positive opportunities, positive social norms and cultural connectedness. (Henson M 2017) Due to the cultural context that underlies inequities in mental health, cultural connectedness and cultural practices are important foundations for Native wellness. When interventions focus on the individual, they miss the importance of culture as a determinant of health, which for AI/AN cultures includes the risk factor of loss that can be addressed through strengthening connection with culture as a protective factor. (Masotti P 2020) There are many aspects of Native culture that buffer the impact of harmful historical and current circumstances and experiences. (Walters KL 2002; Garroutte EM 2003; Bassett D 2012)

A strong connection to one's cultural or racial identity is associated with positive mental health outcomes for racial/ethnic minorities. (Burnett-Zeigler I 2013) Specific to AI/AN populations, positive self-image, familial, non-familial and cultural connectedness positively influenced substance use, depression, and suicide attempts. (Henson M 2017) AI/AN populations also put more emphasis on a strength based approach versus a deficiency based approach, which has been validated by the finding that increasing protective factors is more effective than reducing risk factors in reducing suicide attempts. (Borowsky IW 1999) Native youth participating in a program that included cultural values and a connection to elders showed a significant protective relationship for substance use. (Morris SL 2021)

The Aunties and Uncles Program was designed to address a number of risk factors for the Native communities residing in rural and Rancheria areas of Sonoma County, including: isolation and sense of hopelessness; diminishing community connectedness and cultural pride; inadequate coping skills for addressing historical and present-day trauma; mental health stigma and discrimination against individuals with mental illness; and a distrust of health care services, especially those that do not employ culturally-sensitive and appropriate approaches. The Aunties and Uncles Program integrated a number of culture based interventions that have shown benefit,

such as Gathering of Native Americans and cultural connectedness. (Masotti P 2020; Johnson C 2021) Furthermore, AUP incorporated many traditional practices that are recognized as important components of healing, including traditional healers, talking circles, ceremonies, sweat lodges, storytelling, drumming, and basket weaving. (California Reducing Disparities Project 2012)

Community-Defined Evidence Practice—Purpose and Description

The Aunties and Uncles Program (AUP) was a prevention and early intervention program aiming to prevent risk of suicide among transitional-age youth (TAY) by increasing mental health awareness and knowledge, cultural identity, and involvement in traditional practices. Employing a community-based participatory research model, AUP included all levels of community and partner engagement, including tribal leaders, tribal advisory boards, community members, and Sonoma County Indian Health Project (SCIHP) staff. Initiated in March of 2017, the Aunties and Uncles Program, a community-defined evidence project (CDEP), was developed in response to a statewide initiative to identify solutions for historically unserved, underserved, and inappropriately served communities in California.

The statewide initiative was funded by the Mental Health Services Act (MHSA, or Proposition 63) that was passed in November 2004. Under the California Department of Public Health's Office of Health Equity (CDPH–OHE), the California Reducing Disparities Project (CRDP) established Strategic Planning Workgroups (SPW) for the five priority populations, including Native Americans. The SPWs engaged community members to identify CDEPs and make recommendations for reducing mental health disparities in their communities. The second phase of CRDP was to implement the solutions identified in the first phase. AUP was one of five projects funded to implement and evaluate a CDEP for the Native American population. CDEPs are an essential strategy for expanding, testing, and replicating practices that are culturally relevant.

Community-defined evidence is "a set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community." (Martinez K 2011) Community-defined evidence is particularly important among Native American communities in California, as the reach of current mental health services has failed to include mental health disparities experienced by these communities. (California Reducing Disparities Project 2012) To reduce disparities for ethnic communities, services need to be provided in a manner that is congruent rather than conflicting with Native cultural norms (USDHHS 2001). While evidence is increasing regarding the importance of resilience, cultural connectedness, and community capacity, mainstream programming and evaluation often focuses on individual illness and risk. (King J 2019) Also, given the great diversity among AI/AN communities, there is a need for assessing diverse approaches. To do this effectively, Native Visions recommends that tribes "determine and implement programs and practices that will best serve their communities" and that "Native American specific research and evaluation methods unique to each community" are incorporated. (California Reducing Disparities Project 2012) By honoring these recommendations, CRDP programs, including Aunties and Uncles,

provide additional insight into effective ways to reduce disparities in mental health among Native Americans in California.

Following the principles of community-based participatory research, AUP aimed to empower Native communities in program planning, implementation, and evaluation; encourage the use of Native American practices; ensure a community-driven evaluation process using mixed methods; and engage a community advisory council to ensure evaluation activities integrate traditional and culturally based approaches.

The Aunties and Uncles Program had four programmatic strategies:

1. Establish an Inter-Tribal Advisory Council (Eagle Council) and select "Aunties" and "Uncles" to represent the three California tribes in rural Sonoma County;

2. Implement a culture based stigma reduction and health education campaign on mental illness and suicide prevention in Native community settings;

3. Engage transitional-age youth (TAY), ages 12–25 years, in Talking Circles; and

4. Increase screening for depression by primary care providers at the Sonoma County Indian Health Project clinic.

Aunties and Uncles Education and Engagement

The program name "Aunties and Uncles" was selected because of the special role that Aunties and Uncles and extended-family members play in Native American cultures, as described in the Native Visions report compiled by the Native American Strategic Planning Workgroup. (California Reducing Disparities Project 2012) In Native cultures, Aunties and Uncles can be familial, but are also influential and active community members. In their positions at work, in the family, or in the community, Aunties and Uncles are the people who have wisdom, are trusted and respected. They may be of any age, though elders often fill this position. They may have lived experience that is known, maintain traditional practices, be in recovery, or provide a role-model for those in need. Aunties and Uncles have the ability to say both difficult and encouraging words to youth and their caregivers, providing support, guidance, teachings, and protection for youth.

AUP staff and local tribal councils identified community members to take on the role of "Auntie" or "Uncle" to facilitate connections between their community and AUP. They were provided training and adopted various roles such as: outreach to their community about AUP and other services; participated in the Eagle Council to plan and evaluate AUP activities; or participated in AUP events as presenters, teachers, or facilitators.

Mental Health Prevention and Education Campaign

Community outreach regarding the Aunties and Uncles Program was foundational in order to develop partnerships, increase visibility of the program, and engage community members all which contributed to the success of the program.

AUP developed partnerships with other local Native agencies, county agencies, schools, and other entities to assist with reaching the broader Native American community. This enabled staff to conduct education and outreach about mental health and available resources at school campuses, community events and other relevant gatherings. Information was provided verbally, as well as through written materials such as brochures provided by Sonoma County Behavioral Health, Each Mind Matters materials, flyers about SCIHP mental health services and upcoming AUP community activities. Various modes of interaction included tabling at events, cultural presentations, and panel discussions, all offering opportunities for one-to-one conversations. When presenting to a group, AUP would offer a cultural component, such as a traditional prayer or story, if not already included in the event. Mental health information was given in a cultural context, such as providing information about how the topic particularly affects the Native community. In addition, AUP conducted safeTALK suicide prevention trainings at high schools.

Most of the prevention and education activities took place prior to the Stay-at-Home order in March 2020. The target population was Native community members, especially Native transitional-age youth (TAY). The events took place primarily at the Sonoma County Indian Health Project community room, at local high schools, and at the Kashia Community Center on the remote Sonoma Coast. After March 2020, all events hosted by SCIHP were provided online.

The AUP Grant Program Coordinator and Community Outreach Specialist conducted most of the prevention and education, while “Aunties” and “Uncles” also participated as guest speakers, co-facilitators, or cultural educators.

Cultural Intervention—Community Wellness Gatherings and Cultural Workshops

Community Wellness Gatherings

Community Wellness Gatherings provided a space for community members of all ages to take part in Native specific practices and activities. Community Wellness Gatherings included Family Fun Nights, Memorial Gatherings, Youth Wellness Gatherings, Natives Got Talent, and Gathering of Native Americans (GONA). Each gathering included traditional California Native dancers, drummers or storytelling performed by local tribal members that incorporate the messages of wellness. Community Wellness Gatherings provided critical space for community members to come together to honor and recognize ancestors, elders, and present members. Providing space and time for cultural grounding, collective healing, and sharing, these gatherings also served as an appropriate setting to promote awareness for mental wellness, break down stigma associated with mental illness, and share resources in the broader community. The consistent theme in all gatherings was how cultural connectedness relates to healing and supporting positive mental wellness.

AUP staff collaborated with community tribal councils, key tribal members, AUP Eagle Council advisory committee and other community members to plan and conduct the events.

Cultural Workshops

Cultural Workshops were organized to teach community members of all ages various cultural arts and practices such as basket weaving, beading, making clapper sticks and dream catchers. Some Aunties and Uncles adopted the role of "cultural teachers" and led workshops, sharing the history and techniques of the cultural practices. The common theme of cultural connectedness and supporting positive mental wellness and healing was woven into the conversations led by AUP staff.

From early 2019 through early 2020, AUP hosted five in-person cultural workshops lasting one to two hours each. These workshops were open to all ages and were held in accessible locations both central to the county seat and remotely on the coast. In 2021, three workshops were conducted online, lasting one to two hours. For the virtual workshops, pre-registration with contact information and mailing address was required so that AUP staff could mail the proper materials for participation in the workshop. AUP staff collaborated with community tribal councils, key tribal members, AUP Eagle Council advisory committee and other community members to plan the workshops and identify cultural teachers.

Cultural Intervention—Talking Circles

Talking Circles are utilized as a method for identifying and solving problems in many Native American communities. The circle represents inter-connectivity, balance, and the importance of each member in the circle. The circle reflects equality and all that is shared in the circle is meaningful, valuable, and sacred. The Talking Circle symbolizes an entire approach to life and to the universe, in which each being participates in the circle, and each one serves an important and necessary function that is equally valued.

This intervention was conducted in schools, community sites, and online. AUP collaborated with the Office of Indian Education to provide Talking Circle's at existing school-based Native Clubs. Each Talking Circle began with traditional practices such as an opening prayer. Participant check-ins and conversations were structured around traditional concepts such as the medicine wheel. In addition to providing a context for cultural connection and support from peers and elders, the Talking Circles were used to provide education and awareness about mental health issues and resources.

For youth, Talking Circles were conducted every few months from late 2018 until early 2020 at five high schools for the Native Clubs. After the Stay-at-Home order, the Cultural Wellness Series for Youth offered 88 Talking Circles virtually from May of 2020 through June of 2021. Each Talking Circle was one hour long. Talking Circles were initiated for adults in 2020 and offered twice per month, first in community settings and then online.

The AUP Community Outreach Specialist led the Talking Circles with the Grant Program Coordinator providing support. Aunties and Uncles supported the Talking Circles as guest speakers with lived experience or other wisdom to share.

PHQ-2 and PHQ-9 Depression Screenings

Due to the extensive exposure to trauma, daily microaggressions of social oppression, and poor quality of life circumstances, Native Americans are at high risk of experiencing poor self-esteem, pessimism, high incidences of depression and anxiety, hopelessness, and high incidence of substance abuse. PHQ depression screening is an evidence-based tool used to identify early signs of mental illness and risk for developing a mental health disorder or condition. One of the goals of conducting depression screenings is to facilitate access and linkage to additional mental health assessment and treatment.

The PHQ-2 and PHQ-9, components of the longer Patient Health Questionnaire, are reliable and valid screening tools used to assess symptoms and severity of depression in adolescents, adults, and older adults. The PHQ-2 has two questions that inquire into the frequency of depressed moods in the past two weeks. The PHQ-9 can be used as a follow-up to a positive PHQ-2 result to assess for the likelihood of a depressive disorder and to monitor treatment response.

Sonoma County Indian Health Project began to track the administration of depression screenings and corresponding referrals to behavioral health services for all consenting clients ages 14 and older in the medical clinic from June 2018 through June 2021. A trained Medical Assistant administered the PHQ-2, continuing with the remaining seven questions for those who scored with positive indicators. This screening was conducted at every medical visit. Using the Mental Health Professional (MHP) re-interview as the criterion standard, PHQ-9 scores of 5, 10, 15, and 20 represented mild, moderate, moderately severe, and severe depression, respectively. A PHQ-9 score ≥10 has a sensitivity of 88% and a specificity of 88% for major depression. If a client scored 10 or more on the PHQ-9, they were referred to SCIHP's Behavioral Health Department.

Evaluation Questions

The local evaluation was designed to track and capture the activities and outcomes associated with the five program components described above. By co-designing the evaluation with the Aunties and Uncles Program Director, Grants Program Coordinator, Community Outreach Specialist, and the Eagle Council consisting of community members and tribal council members, the evaluation team of Kawahara & Associates ensured the use of data collection methods that were culturally responsive while presenting minimal burden to SCIHP staff, AUP staff, and community members. Emphasis was placed on collecting data regarding the implementation of AUP, community participation in AUP, and the impact of AUP on the community and transitional-age youth (TAY).

The primary focus of the evaluation was to measure changes in attitudes, knowledge, and behaviors among the Native population that reduce risk or early onset of mental illness. The methodology employed a mixed-methods approach, collecting both quantitative and qualitative

data, focused on both process and outcome. The evaluation consisted of the following six evaluation questions:

1. How did knowledge, attitudes, and beliefs (KAB) regarding mental illness change among transitional-age youth (12–25) as a result of the Aunties and Uncles Program?

2. During AUP implementation, did more community members (TAY and adults) seek help and support for mental health issues?

3. How did the mental health status among TAY Aunties and Uncles Program participants change?

4. Does AUP contribute to increased community involvement and community connectedness? Is increased community involvement and community connectedness associated with an increase in community wellness as self-reported by attendees?

5. How did TAY participants' self-esteem and cultural identity change as a result of AUP?

6. How did participation in AUP Talking Circles impact TAY and other community members?

These six evaluation questions did not change in the course of the program implementation or during the evaluation study.

Methods

CDEP Implementation

The Aunties and Uncles Program (AUP) was intended to engage the Native communities in Sonoma County. The Pomo, Coast Miwok and Wappo have historically resided in Sonoma County, although now Native Americans from other parts of the state and nation also reside in the county. Events and activities were open to any Native or non-Native persons. Native residents primarily live in or near the urban center of Santa Rosa and in more remote areas around Cloverdale (north county) and on the Sonoma coast. AUP served both the urban and remote populations, although it took longer to establish relationships with and deliver services to the more remote tribes and Rancherias. Due to the distance between locations, it was essential to conduct events within coastal communities.

NATIVE POPULATIONS PARTICIPATING	
Tribe/Rancheria	**Estimated Population**
Cloverdale Rancheria of Pomo Indians of California	500
Dry Creek Rancheria Band of Pomo Indians	1000
Federated Indians of Graton Rancheria (Pomo, Coast Miwok)	1080
Kashia Band of Pomo Indians of the Stewarts Point Rancheria	86
Lytton Rancheria of California (Pomo)	275
Manchester Band of Pomo Indians of the Manchester Rancheria	500
Other affiliations (Round Valley, Sioux, Sherwood Valley, Big Valley)	3000

The Aunties and Uncles Program implemented many of the core activities that were planned, but there were four significant adaptations made during the project. These four areas included:

1. Hiring staff to include a local Native American;
2. Responding to the COVID pandemic and Stay-at-Home public health order issued in March 2020 by moving all events and activities to an on-line platform;
3. Expanding the age group from the traditionally defined transitional-age youth (TAY) of 14–24 years to be more inclusive (12–25 years) and responsive to the Native community and intergenerational programming; and
4. Modifying the defined role of "Aunties" and "Uncles."

The project funding for AUP was initiated in February of 2017 and over the course of the first year, SCIHP experienced staff turnover both at the program level and at the administrative management level. Program continuity suffered as there was no real overlap for transition or transfer of knowledge. SCIHP's Behavioral Health Director, along with the Grant Program Coordinator and Community Outreach Specialist, were hired in the fall of 2018. A key aspect of these hires was the fact that the Community Outreach Specialist was a local Native of Pomo and Wappo descent.

An unexpected and novel disrupter to the program implementation was the COVID pandemic and related restrictions that occurred in March of 2020. Initially, the program implementation was paused as SCIHP management and AUP staff adjusted to the Stay-at-Home public health order requiring the workforce to work remotely and SCIHP to provide the proper equipment, connectivity and accountability to do so. Once established in their new work environment, program staff conceptualized how to continue program offerings, moving from in-person to an interactive online platform. The number and type of gatherings offered had to be adjusted to be appropriate for an online platform. For example, large in-person gatherings were replaced with virtual Gatherings of Native Americans (GONA), an adaptation of another community-defined and culturally based model. Smaller in person activities were replaced with an increased number of Talking Circles, as they adapted well to an online platform.

Outreach and engagement suffered in that connecting to the community was primarily based on visibility in the clinic and in community settings, complemented with word of mouth from community members. Once services were online, participation was sparse, often seeing one to three individuals at a Talking Circle or Eagle Council meeting.

The third modification to the program implementation consisted of expanding the TAY age group. AUP originally focused on transitional-age youth (TAY)—a recognized age group in behavioral health as 14–24 years. Due to the nature of community and family structures in the Native American community, events were all inclusive and open to all ages. Through the influence of community members and based on the defined age groups adopted by the project's statewide evaluator, AUP ultimately included 12–25 year-olds in the TAY focused activities and in the evaluation.

The fourth modification to the program involved redefining the role definition of an "Auntie" and "Uncle," the specifics of which are described below.

Aunties and Uncles Education and Engagement

A key aspect of AUP was engagement with community members, utilizing a community-based participatory approach. To reach the three tribes and six Rancherias, AUP established relationships with tribal councils and community leaders. AUP's Community Outreach Specialist acted as the liaison between the project and the tribes. The Outreach Specialist developed relationships with Tribal Rancherias, Tribal Councils, and tribal administrators and educators to cultivate their support for and engagement in AUP activities. Native individuals from various tribes and agencies attended event planning meetings to shape the program activities.

The initial plan included identifying eight "Aunties" and "Uncles" from four Rancherias in Sonoma County to be trained mental health liaisons and to serve on an Inter-Tribal Advisory Council, the Eagle Council. Although the tribal leadership was very supportive of the intention of the program, the model of identifying potential "Aunties" and "Uncles" in a defined role was challenging. Many individuals who were approached for this role were hesitant to accept a position of leadership in mental health outreach, education, and advocacy. Some expressed feeling unqualified with a lack of self-confidence even though they were informed that training and support would be provided. In the second year of the program, an adjustment to the

definition of "Aunties" and "Uncles" was developed holding true to the intention of having community leaders who understood the importance of wellness, mental health challenges in the community, and how culture and traditions provides strength to wellbeing. Rather than a limited number of formal "Aunties" and "Uncles," a larger number of community members participated, each filling one or more aspects of the "Auntie" and "Uncle" role and utilizing their own natural strengths and assets.

These community leaders supported the CDEP and served the community in various ways throughout the duration of the CDEP. They received an orientation to AUP and their role within the project. A variety of opportunities to engage with the program were provided: conducting outreach about AUP, attending mental health training, attending Eagle Council quarterly meetings, helping at events, conducting cultural workshops, and supporting Talking Circles in the community and at schools.

All the community members taking on "Auntie" and "Uncle" roles were Native and were known as informal leaders in the community. They held jobs or roles in the community that put them in contact with many families. They conducted their AUP roles within their jobs and communities, as well as attending AUP events held throughout the County and online. The AUP Grant Program Coordinator, Community Outreach Specialist, and local Evaluator engaged and trained the Aunties and Uncles. Other SCIHP staff and engaged community members also assisted in identification and recruitment.

Ultimately, seven community members participated in the Eagle Council; 11 were presenters or teachers at Wellness Gatherings and Cultural Workshops; and two were trained in safeTALK suicide prevention and assisted with events. In addition, five SCIHP staff who are also members of the community staffed events and conducted outreach in the community. The number of active individuals varied throughout the project, depending on the activities underway.

The seven Eagle Council members were key in the application of Community-based Participatory Research methods. Two members were on the original planning committee of AUP. Members met quarterly to review and give input into program implementation, evaluation design, data collection and interpretation. Eagle Council members received gift cards for their participation. Representation on the Eagle Council from the various tribes and Rancherias was intentional. In addition, Eagle Council members often attended AUP events and activities.

Other support from Aunties and Uncles included Cultural Workshop leaders, co-facilitators for GONAs, and guest speakers at Talking Circles. These individuals brought their wisdom of culture, history, "walking in a good way," and tools for connection, self-care, and spirituality. Further detail is provided in the Cultural Intervention sections below.

AUP staff and partners also conducted outreach by presenting to local health agencies including St. Joseph Health, NAMI Sonoma County, Buckelew Programs, California Indian Museum and Cultural Center, California Office of Indian Education, and the Indian Child and Family Preservation Program. Native and non-Native partner agencies filled an important role in conducting outreach about the AUP program and supporting events by providing information about community resources.

Mental Health Prevention and Education Campaign

Initially, community outreach was not identified as a core component, but during the project it became clear that these efforts were a significant intervention of their own. Outreach, prevention, and education was conducted in several ways throughout the project, including tabling and presentations at health and cultural fairs, community events, schools, and conferences. AUP also used radio shows and social media, such as the SCIHP Facebook page, Instagram, and monthly newsletter, to share information about AUP and upcoming events. Materials were shared with the four tribal Rancherias and communities for them to disseminate on their social media accounts. Paper flyers were also provided for tribal offices to share in their offices, community boards, events, and mailers.

SCIHP's various departments (medical, dental, nutrition, senior services) also received information about AUP to disseminate. AUP benefitted from requests to be interviewed for radio shows and newspaper articles. In March 2020, after the Stay-at-Home order was issued, AUP adjusted their outreach activities. Since SCIHP and other agencies were not able to share information in person or through posted signs in their buildings, AUP relied on staff and partners to increase engagement through phone calls, emails, and social media. SCIHP has a history of hosting community events, thus early participants in AUP were a mix of individuals and families who were familiar with SCIHP and others who were more likely to engage in community and cultural events. Over time, additional community members participated, most likely due to word of mouth. New programs like AUP generally take time to become known and trusted.

AUP staff built strong working relationships with the participating Tribal Councils, California Rural Indian Health Board, Child Family Preservation Program, County Regional Parks, Santa Rosa Junior College, Indian Education Specialists from the public-school districts, and others. This enabled staff to conduct education and outreach at school campuses, community events and other relevant gatherings.

AUP was invited to provide prevention and education at 38 community and school events. Five were conducted on the coast and four were conducted virtually after the Stay-at-Home order. All the events, other than the Bioneers Conference, were organized by and for the community. Attendance ranged greatly based on the type of event: 5–14 students at high school Native Club events; 75–250 at health fairs; and hundreds of people at major community events like Winter Wonderland Skate Night and Memorial Gatherings. All of the events were open to the public and did not require a formal intake/client registration process. For a full list of events and attendance numbers see ***Appendix 2: Events Conducted and Attendance***.

At all events AUP staff provided information about mental health and community resources, as well as written materials provided by Sonoma County Behavioral Health, California's Each Mind Matters, and flyers about SCIHP mental health services and AUP activities. AUP generally combined prevention and education with a cultural component and outreach. For example, at a Native American Cultural Awareness Day event hosted by Santa Rosa Junior College, AUP staff participated in a panel discussion that included local tribal members who shared insights on

growing up Native American and health challenges in tribal communities that include mental health, violence, and suicide. AUP staff also tabled throughout the event to engage community members and college students in AUP activities.

As part of addressing suicide among Native youth, two AUP staff and two community leaders were trained in safeTALK, a suicide prevention course. The AUP staff then modified the course to be conducted in one hour and provided the condensed training at high schools prior to the Stay-at-Home order. Three safeTALKs were provided to general high school classes and one was provided to a high school Native Club. Over 80 students attended in total, with 20 attendees identifying as Native.

Cultural Intervention—Community Wellness Gatherings and Cultural Workshops

Community Wellness Gatherings

Between September 2018 and May 2020, AUP conducted 18 Community Wellness Gatherings. These intergenerational gatherings were held in accessible locations both near the county's urban center and on the Sonoma coast. Larger Community Wellness Gatherings were usually held on weekends and would last about six hours (10a–4p). Opening ceremonies, prayer and acknowledgements were followed by a day filled with children's activities, community resources, dancing, arts and crafts, games, raffles, and a meal. Depending upon the theme, elders would share a prayer and their wisdom, tell stories, and introduce performers. Community Wellness Gatherings included a youth focused Big Time, Memorial Gatherings to honor those who have passed, Native Wellness, and the annual Natives Got Talent.

In addition, information about mental health was woven in throughout the day, focusing on the importance of cultural and community connectedness, as well as information about suicide, community resources and AUP activities. These events also provided opportunities to provide individual and family support and linkages to services as community partners were invited to table and be a part of the community. Of the 18 events, two were conducted on the coast, 11 in central Santa Rosa, and five were conducted virtually after the Stay-at-Home order. Attendance ranged from 15 to 287 people.

Some of the specific events are described in greater detail below:

Youth Wellness Gathering: AUP staff organized an event in May of 2019 at a local regional park to provide a space for community members to celebrate youth, come together for a BBQ, share stories, and learn about cultural practices. Lunch was provided, as well as a variety of activities. A local Pomo basket weaver guided participants on how to weave using reeds, acorn beads and other materials to make friendship bracelets, and art supplies were provided for children to make buttons. SCIHP's Healthy Traditions department provided yoga sessions and nutritional resources. The County Park coordinator led nature walks throughout the park to teach youth and their parents about the park and Native plants. "Wellness Gathering" t-shirts were given to everyone that attended, which aligns with the traditional practice of generosity. Thirty youth and parents attended this event.

Memorial Gathering: AUP staff hosted this annual event in September 2018 and August 2019 at Ya-Ka-Ama Indian Education and Development Center in Forestville, California. The intention of the Memorial Gathering was to provide a space for community members of all ages to honor their loved ones who have died by suicide, overdose, or other causes. Throughout the events, guest speakers shared personal stories related to loss, suicide, opioids and the missing and murdered indigenous women and girl's movement. Three traditional dance groups performed, and a spiritual healer led a Forgiveness and Letting Go ceremony. The ceremony offered a safe space for community members to offer prayers, good intentions, healing, and renewal of self after loss. During the ceremony individuals offered tobacco and prayers to the fire to help move on from pain, anxiety, sadness, depression, or anything related to loss. Ten local health and mental health agencies tabled during both events to share their information and resources. There was a space for all ages to paint on a canvas with the intention of portraying what their family or community looks like. Two meals prepared by SCIHP staff were provided and a prayer was offered by an elder prior to each meal. Community members who attended expressed they were honored and thankful for the space to grieve, be with their families, and learn about other community resources. The Memorial Gatherings were attended by 287 and 222 individuals respectively.

Family Fun Nights: Family Fun Nights were held quarterly on Friday evenings offering prayer, community dinner, a short talk on a mental health topic, Pomo or other traditional dancing, crafts for the kids, and social time. Family Fun Nights usually lasted three hours. At one FFN, dinner was provided, as well as beading and coloring activities for kids. There was traditional dancing and a guest speaker from the Behavioral Health Department spoke about the importance of self-care since Sonoma County was exposed to smoke from wildfires. At another FFN, dinner was provided, and a drumming group called Native Resistance performed. AUP handed out backpacks with school supplies for kids and SCIHP's medical department provided fresh vegetables for families to take home. Traditions were honored, such as elders offering a prayer before meals. Six Family Fun Nights were held between November 2018 and February 2020, one being on the coast at Point Arena Tribal Center. Attendance ranged from 30–137 per event. After the COVID Stay-at-Home order was issued, Family Fun Nights were hosted online. Two events were hosted with activities that included interactive storytelling, games, and a raffle. Attendance ranged from 18–34.

Natives Got Talent: AUP staff introduced this new community wellness event in June of 2019 at a local community center. This event provided a safe place that encouraged artistic expression and promoted self-confidence for all participants. In addition to intergenerational community building, there was an opportunity to recognize the importance of cultural values and teachings. There was an opening prayer and elders were acknowledged and honored by serving them dinner first, a traditional practice. Suicide awareness literature and other mental health resources for all community members was provided. Attendance was recorded at 143 youth and adults. After the Stay-at-Home order was issued, a second Natives Got Talent was held online. Contestants were asked to submit a video that was then produced into a combined show for viewing by the Native community. Community members were then asked to participate in an online voting process. As with before, all contestants were awarded a prize. There were 15 groups or individuals viewing at the time of the initial showing, as well as additional views post-event.

Gathering of Native Americans (GONA): After the Stay-at-Home order was issued, AUP found a wellness gathering option that had been adapted to an online platform. The GONA curriculum has been recognized as an effective community-defined culture based mental health prevention activity. The GONA framework has a structure consisting of four themes: Belonging, Mastery, Interdependence and Generosity. Within those themes, local projects have the latitude to expand on those themes and promote teachings on important issues identified by the community. Each of the four days included an opening prayer or song, traditional story, lesson on one of the themes, and an activity for the family to do together. Attendance was intergenerational with 18 and 36 family members at the two GONA series respectively.

Cultural Workshops

AUP offered eight cultural workshops between February 2019 and June 2021. Four cultural workshops were held centrally at the SCIHP Community Room, one was conducted on the coast, and three were virtual. Local elders and cultural teachers, "Aunties" and "Uncles," led workshops on basket weaving, making dreamcatchers, jewelry, and medicine bags. They taught the cultural significance and the healing quality of the practices. AUP staff shared information about mental health, stigma, suicide prevention, and community resources. For a full list of cultural workshops see **Appendix 2**. Attendance for the eight workshops ranged from three to 13, with no notable differences between in-person or virtual. The activities at one of the events are described here.

A Basket Weaving Workshop was offered twice, once at SCIHP in January 2020 and once on the coast at the Kashia Community Center in February 2020. The workshops were led by a fourth-generation basket weaver from the local tribal community. The basket weaver taught participants the history of basket weaving, about gathering materials, and how weaving can be healing. Throughout the workshop participants shared their reasons for attending and how it keeps them well. Information was shared about AUP, upcoming workshops, events, and behavioral health resources.

Cultural Intervention—Talking Circles

Talking Circles for transitional-age youth (TAY) were a significant AUP intervention, in part due to the ease of adapting the model to a virtual setting. The premise of conducting Talking Circles on school campuses was to provide convenience as TAY often do not have good modes of transportation. However, school-based services present limitations on access due to the logistics of coordinating with school personnel and scheduling. Although SCIHP and AUP had a contract with Santa Rosa City Schools and a good working relationship with the Office of Indian Education, there were still challenges in scheduling Talking Circles for Native students. These challenges resulted in an inconsistent presence in the schools and varying attendance, sometimes as low as one to three participants. Thirty-nine talking circles were conducted with central Sonoma County high school Native Clubs (Ridgeway, Santa Rosa, Elsie Allen, and Piner) and coastal Point Arena High School from November 2018 to March 2020.

The virtual Cultural Wellness Series for Youth offered 88 talking circles virtually from May 2020 through June 2021. From March 2020 to June 2021 Talking Circles were offered twice a

week, and then once per week after that. Each Talking Circle was one hour long. Attendance ranged from one to 23 Native TAY, with an average of 3.7.

Talking Circles were also conducted monthly for adults in 2020 and early 2021. The first four were in person on the coast, while the rest were virtual. Attendance ranged from two to six Native American adults, with an average of 3.3.

AUP's Community Outreach Specialist conducted the Talking Circles, with community leaders joining as guest speakers in about 15% of them. Talking Circles began with an opening prayer, song, and intentions. There was a check-in question, such as, "How are you using the four components from the medicine wheel?" Then a topic was introduced, such as self-care or healthy relationships, inviting everyone to contribute to the conversation. Mental health education and awareness was woven into the conversation. AUP staff also provided information about community mental health, suicide prevention, and resources, as well as providing referrals for services as appropriate.

PHQ-2 and PHQ-9 Depression Screenings

The PHQ-2 and PHQ-9 are reliable and valid screening tools used to assess symptoms and severity of depression in adolescents, adults, and older adults. A trained Medical Assistant provided the PHQ-2 depression screenings for all consenting clients ages 14 and older at each medical appointment from June 2018 through June 2021. If a client scored positive on the PHQ-2, the full PHQ-9 was administered. If a client scored 10 or more on the PHQ-9, they were referred to SCIHP's Behavioral Health Department (BHD). Based on availability, an Associate Clinical Social Worker would meet with referred clients after their medical appointment. If that was not possible, the BHD would follow-up on the referral and call the client later to schedule an appointment. All referrals and completed referrals were tracked and documented for this evaluation study.

Responsive Community Support and Services

The mission of the Sonoma County Indian Health Project is to "continually improve and maintain a comprehensive healthcare system to serve the needs and traditional values of our American Indian Community." Their commitment to being comprehensive includes medical, dental, pharmacy, behavioral, nutrition and food distribution, environmental health, and emergency response. In the last four years, multiple natural disasters have occurred (see table below) and SCIHP staff responded by distributing food, water, clothing, household items, and Personal Protective Equipment (for COVID) provided by the Tribal Council. In addition, computers were provided to families for at-home school and work. Poor Wi-Fi connectivity was a barrier for families living on the Sonoma coast and other remote locations. Whenever possible, staff also provided transportation for community members for food, supplies, and medical appointments. Navigation support for government benefits, unemployment insurance, educational support, counseling, and other services were also provided. In addition, wellness activities such as Talking Circles, drive-through vaccinations, and food and supply pick-up were conducted to mitigate the effects of these rolling emergencies. SCIHP and AUP are relevant and trusted due to their responsiveness to community needs.

Oct 2017	Oct-Nov 2019	Mar 2020	Jun-Jul 2020	Aug 2020	Sep-Oct 2020
Tubbs Fire ● Sonoma, Napa Counties ● 5,643 structures lost ● $1.2 billion impact	**Kincade Fire** ● Sonoma County ● 190,000 evacuated ● 120 structures lost	**COVID-19 Stay-at-Home Order Issued** ● Estimated 30,135 jobs lost in 2020 (Sonoma EDB) ● 1450 active COVID cases, 330 deaths, 31,100 recovered (DHS, 8/1/21)	**BLM Protests** ● Over 100 events and protests in Sonoma County ● Law enforce-ment found to have used excessive force against demonstra-tors	**LNU Lightning Complex Fire** ● Sonoma, Napa, Lake, Solano, Yolo Counties ● 57,500 acres burned ● Kashia Rancheria evacuated	**Glass Fire** ● Sonoma, Napa Counties ● 1,555 structures lost ● Estimated 70,000 evacuated

Evaluation Study Participants and Recruitment

Evaluation Sample Size

The Aunties and Uncles Program evaluation was a community-wide, ecological study incorporating a convenience sample expected to engage over 100 transitional-age youth (TAY) and 150 community members during the study period. As noted in attendance data specific to each event conducted (see **Appendix 2**), the program hosted 18 Wellness Gatherings with an attendance ranging between 15 and 287 individuals at any single community event. Events and activities were voluntary and open to the Native community at-large, thus tracking unduplicated participant numbers and consistent attendance by any one individual was challenging as there was no defined cohort or defined program requirement. The evaluation was primarily focused on TAY that were identified and engaged through focused community gatherings and/or school-based Talking Circles. The universe of participants was anticipated to be comprised of the following:

- 5–6 Aunties and Uncles participating in the Eagle Council Advisory Board
- 3–5 Aunties and Uncles supporting community events and activities
- 15–20 TAY (per school) participating in the school-based Talking Circles
- 15–20 community members attending the Community Talking Circles
- 150–200 community members participating in community-level gatherings (Wellness Gathering, GONA, Memorial Gathering)

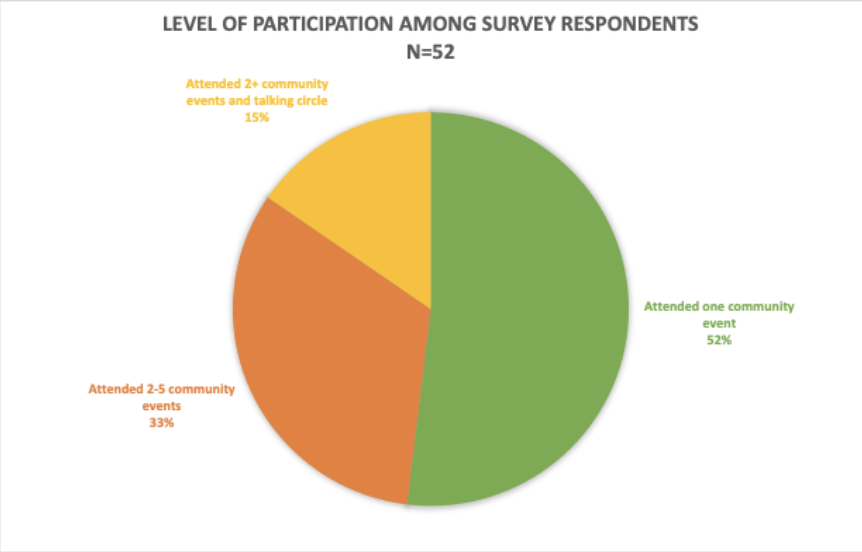
- 40 PHQ-9 assessments administered at the SCIHP health clinic each month, totaling 480 screenings annually

The evaluation stated a sample size of 50 TAY based on an expected engagement of 100 TAY and a 50% participation rate in completing the pre- and post-SWE core measures and the pre- and post-local survey. This group of 50 TAY, with an estimated average age of 17 was represented by the local tribal communities of Dry Creek, Manchester-Point Arena, Stewarts Point-Kashia, and Cloverdale Pomo tribal communities. The final matched sample of 50 TAY is believed to be a good representation of TAY in the community, diverse in age, balanced in gender, and various levels of exposure to community services.

Convenience Sampling

The project did not have a defined cohort of TAY or community members participating in AUP interventions, so a convenience sampling methodology was utilized. All TAY attendees were invited to participate in the AUP evaluation, which required informed consent to participate. Those under 18 years of age were required to have parental consent in addition to their own assent. Participation in program and evaluation activities were both voluntary, and participation in the evaluation was subject to outreach during events. An open invitation to partake in the evaluation, initially consisting of the pre-surveys, was offered to all TAY attendees at AUP events (community gatherings and talking circles). The date of completion of pre-surveys was tracked by individual in order to offer the post-surveys one year after the pre-survey. Outreach and notification by text message was sent to those eligible for the post-surveys, inviting completion by appointment or at an upcoming AUP event.

Voluntary participation in the evaluation was only limited by age, 12–25 years, and was incentivized with gift cards. A total of 106 TAY completed the pre-surveys and 52 TAY completed both the pre- and post-surveys. Of the matched 52 pre- and post-survey responses, 27 (51.9%) of the survey respondents attended only one community event, and 17 (32.7%) attended more than one community event but did not participate in Talking Circles. Only 8 (15.4%) of survey participants attended two or more community events and participated in at least one Talking Circle, with half of those attending three or more Talking Circles.



Community members participating in the evaluation focus groups were individuals who were more engaged in AUP activities during

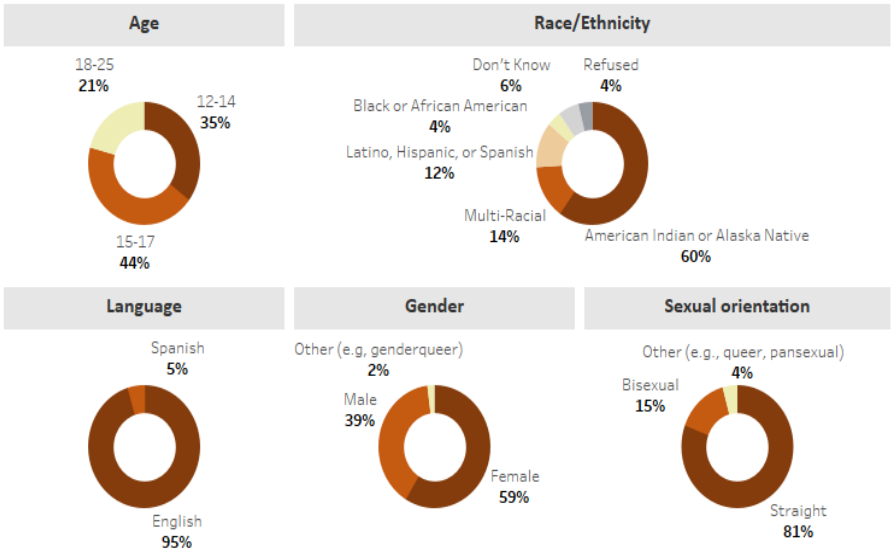
COVID. There were seven TAY and five adults, all Native community members, that participated in AUP Wellness Gatherings, Talking Circles, and/or were designated "Aunties" and "Uncles."

Recruitment and Retention Plan

Recruitment and retention efforts were ongoing and occurred on multiple levels: 1) Aunties and Uncles were engaged to serve on the Eagle Council, provide teachings at cultural workshops, and support community events; 2) Community members, especially TAY, were engaged to attend Wellness Gatherings, Family Fun Nights and Cultural Workshops; and 3) TAY were engaged to attend school-based, community, or online Talking Circles. The AUP Grant Program Coordinator and AUP Community Outreach Specialist developed materials to conduct community outreach for Aunties and Uncles to serve on the Eagle Council Advisory Board. Similarly, AUP staff developed flyers for community events to post on social media, distribute to Tribal Council offices and their newsletters, and share in various community locations, including throughout SCIHP's programs. AUP project staff, Eagle Council members, key tribal community members, and staff from the Office of Indian Education conducted outreach and recruited TAY tribal members to participate in the AUP evaluation. As noted earlier, program participation, as well as evaluation participation was inclusive and voluntary.

Number and Demographics of Participants in Evaluation

A total of 106 respondents were recorded as completing the SWE pre-core measures. The statistical analysis of the SWE core measures consisted of a matched sample of 52 transitional-age youth (TAY) participants completing both the pre- and post-surveys. Of the TAY, ten were between 18 and 25 years of age and therefore completed the adult version of the SWE core measures. Forty-two were between 12 and 17 years of age and therefore completed the adolescent version. Among those, 60% identified themselves as American Indian or Alaska Native, and 14% identified themselves as multi-racial (Native American and Mexican). Almost all participants spoke English and over half were female (59%). The majority said they were straight (81%), while 15% said they were bisexual. In addition, some data was drawn from the local evaluation pre-surveys (81) and post-surveys (52).



N=47-50

Early in the project's implementation, there were 25 records missing from the pre-local survey database due to technology issues in migration of data to a secondary platform (*SurveyGizmo* to *Alchemer* online platforms). After data migration was completed by the secure on-line company, there were no further issues in securing and maintaining accurate data collection

Evaluation Measures and Data Collection Procedures

The Aunties and Uncles Program (AUP) evaluation plan incorporated a community-based participatory approach; thus, the design and implementation of the evaluation was an iterative process. AUP remained a culturally appropriate and community inclusive mental health prevention and early intervention project with refinements to program components so that the activities could be conducted with increased fluidity and responsiveness to the community. Furthermore, external events, such as annual wildfires and the global COVID pandemic, impacted the program administration, activities, and timelines.

There were no changes to the evaluation questions as stated in the original evaluation design. The mixed-methods evaluation design included both implementation (process) and outcome measures. The process portion of the evaluation provided insight as to how AUP was being implemented and documented the experiences of those engaged in and participating in the program. The process evaluation also included understanding important contextual factors (organizational capacity, community resources, environmental factors) that are necessary to consider when interpreting findings and making decisions about potential modifications to AUP.

The process evaluation included collecting both quantitative and qualitative data that allowed the exploration of several evaluation questions, such as: Is AUP serving the intended population? Was AUP being implemented as planned? What are successes and challenges of implementation? Data collected for the process study included event logs documenting the dates, location, and topics discussed at all events and activities; sign-in sheets documenting the number of attendees at events; and number of PHQ-9 depression screenings administered, number of referrals made to SCIHP's Behavioral Health Department, and number of referrals completed.

The primary goal of the outcome evaluation was to determine whether key program outcomes are changing in the anticipated direction (e.g., increase in self-care and help-seeking behaviors, increase in social/cultural connectedness, etc.). These include measures of knowledge, attitudes, and behaviors related to mental health; changes in psychological distress and functioning; and experiences of community and cultural connectedness. Quantitative outcome data was collected through a local pre/post-survey (**Appendix 3: AUP Local Pre/Post-Surveys**) as well as utilizing relevant Statewide Evaluation (SWE) pre/post-core measures (e.g., cultural connectedness, protective factors, psychological distress, and psychological functioning) (**Appendix 4: Statewide Evaluation IPP** Pre/Post-Core Measures: Adolescent and Adult). The two pre/post-surveys were administered to TAY attending AUP community events and participating in the school-based Talking Circles. Pre/baseline measures were administered upon first contact and post/follow-up measures were administered at the one-year anniversary of taking the pre-surveys (**Appendix 5: Survey Administration Protocol**).

Qualitative Design

Designing an evaluation plan is a non-linear and iterative process, particularly when using community-based participatory approaches. The qualitative portion of the evaluation included the Eagle Council Advisory Board members in the development of focus group protocols, focus group questions, data collection and analysis (**Appendix 6: Focus Group Protocols** and **Appendix 7: Focus Group Questions**).

Qualitative data provides an opportunity to triangulate the data and either reinforces or challenges quantitative data. Furthermore, qualitative data adds a nuanced understanding of how AUP has impacted program participants. The qualitative data collected focused on three primary audiences: 1) TAY engaged in AUP activities; 2) TAY engaged in Talking Circles; 3) Aunties and Uncles supporting the project as Eagle Council members, cultural workshop teachers, and community role models. Qualitative data was collected through three focus groups: two focus groups for TAY and one focus group for Aunties and Uncles involved in the project. The focus group questions were designed to investigate how AUP impacted participants' knowledge, attitudes, and beliefs regarding mental health; their sense of cultural identity, connection to community and culture as a protective factor; and their mental health status. These questions were aligned with the psycho-social and cultural connectedness questions of the quantitative data surveys to add descriptive depth to the final analysis.

Collection Procedures

Data collection of Statewide Evaluation (SWE) core measures and the local survey was initiated October 2018–July 2020 for pre-surveys and October 2019–June 2021 for post-surveys. Initially, the SWE and local pre/post-surveys were completed in-person at Aunties and Uncles Program events. AUP program staff and local evaluation team members were trained according to protocols prior to administering surveys and collecting data (**Appendix 5: Survey Administration Protocol**). At AUP community events, TAY were invited to participate in the evaluation and were provided an orientation to the process (with parents, if desired and/or necessary). For minors, consent forms were signed by the parent/guardian and assent forms signed by the youth. Legal adults signed their own consent forms (**Appendix 8: Consent and Assent Forms**). Participants completed both the SWE and local pre-surveys on a computer tablet in a quiet and private room. The two surveys collected data on independent platforms: SWE surveys were administered on *Qualtrics* and the local surveys were on *SurveyGizmo* (converted to *Alchemer)*. Survey participants were instructed that they could skip questions and a trained data collector stayed nearby to answer any questions and to assist with the transition between the first and second survey. After completing both surveys, the participants were provided a gift card for their participation.

On March 17, 2020, in response to the COVID-19 viral spread, the local Health Officer issued a Stay-at-Home (SAH) public health order that brought in-person activities to an abrupt stop. To continue programming and evaluation activities, a new protocol was developed (**Appendix 9: Remote Administration and Data Collection for SWE Core-Measures and Local Survey**) and an updated IRB was submitted to the Office of Statewide Health Planning and Development. Under this new protocol for survey administration, all TAY attending virtual AUP events were

invited to participate in the evaluation. If TAY were interested, their contact information was obtained and an individual appointment for orientation and consent was established. During the individual appointment, data collectors would solicit verbal consent/assent from the TAY, and parent/guardian if needed, and an orientation was provided. Forms to gather electronic signatures were then sent via text or email. Once the signed consent/assent were obtained, TAY would be provided specific instructions, survey links, and a unique ID number to use when completing the forms online. Data collectors were available by phone/text while the TAY completed the surveys. Once completion was confirmed, a gift card was mailed to the TAY.

Focus groups were facilitated by two adults: the Local Evaluator and a trained Eagle Council member. Participants completed a registration form in advance, including contact information. Consent and assent forms specific to the focus groups were sent electronically. Closer to the date, a FAQ sheet on the evaluation and appointment reminder were sent. Focus groups were conducted on a virtual platform, *Zoom*, as they occurred after the COVID-19 Stay-at-Home public health order was issued. During the focus groups, an opening prayer was offered, permission to record for note-taking purposes was requested, introductions were made, and ground-rules were set. A set of questions, developed and vetted by Eagle Council members, were administered (**Appendix 6: Focus Group Protocols** and **Appendix 7: Focus Group Questions**). Each focus group was up to 90-minutes in length. Gift cards were mailed to those who attended the duration of the group.

Evaluation Fidelity and Flexibility

When evaluating a program for expected outcomes, the examination of implementation fidelity and flexibility provides additional information for interpreting data findings. Although the expectation is to maintain a high level of implementation fidelity, there are always circumstances that may require flexibility and modifications to the original design and methodology.

During the implementation of the Aunties and Uncles Program, there were three significant factors that influenced program implementation fidelity:

- Program staff and local evaluation team turnover: Stability and continuity of program implementation was interrupted by unfilled staff positions, including the Community Outreach Specialist, and turnover of the Grant Project Coordinator position. Complete staff hires were achieved in October 2018. The local evaluation team was replaced in February 2019. There was a lack of evidence of data collection prior to October 2018.
- A community-based participatory research approach was incorporated through the establishment of the Eagle Council and feedback forms for various activities in 2019. Information obtained from the community about needs and interests influenced activities and methods of implementation.
- Environmental disasters, including wildfires and evacuations in 2019 and 2020, and the COVID-19 pandemic and Stay-at-Home public health order caused shut-downs of service delivery and in-person events respectively. The SAH order required staff to set-up remote workstations and the need to adapt programming to be delivered on virtual platforms such as *Zoom*.

Criteria and tools used to measure and track fidelity and flexibility include the following:

- Attendance records;
- Event logs describing activities by date, location, type of event, participants, strengths and challenges;
- Quarterly reports to state funder;
- Semi-Annual Reports to the statewide evaluator; and
- Feedback forms received from participants after specific activities.

The following table is an assessment of key elements contributing to implementation fidelity:

Components	Activities	Adherence (Y/N)	Exposure: Planned v Actual	Quality (1-3)	Responsive-ness (1-3)
Aunties and Uncles Outreach and Engagement	Establish and Maintain Eagle Council	Y	Quarterly meetings planned and implemented	3	3
Mental Health Prevention and Education Campaign	Public presentations, outreach, social media, school-based training	Y	Based on opportunities, impeded by COVID for up to 6 months	3	3
Cultural Intervention	Talking Circles	Y	Dependent on school schedules, coordination with Indian Education liaison, impacted by COVID and transition to virtual platform	2.5	2 Participation impacted by COVID-19 Shelter-at-Home
Cultural Intervention	Community Wellness Gatherings and Cultural Workshops	Y	Events/activities were implemented with frequency and duration as planned. As of March 2020, in-person events were cancelled and the required pivot to virtual took 2–6 months.	3	2.5 Participation impacted by COVID Shelter-at-Home
PHQ Depression Screening	Implementa-tion of screening	Y	Administered at every medical appointment	3	3

The most significant factor affecting program implementation fidelity was the COVID-19 pandemic and resulting Stay-at-Home public health order in March 2020. The inability to interact with community members in-person, combined with the need to follow pandemic public health precautions, caused an abrupt pause in program delivery. Prior to COVID SAH, program events were gaining visibility, momentum, and growth in attendance. Moving to a virtual platform was essentially starting over—attendance was sparse, and outreach and engagement was challenging. The TAY Cultural Wellness Series (Talking Circles) was the first event to launch in May 2020 with three participants. A four-day Gathering of Native Americans (GONA) in September 2020 was attended by six families. Although attendance was low, the quality of programming and value for participants remained high.

Statistical Analyses

Sampling Methods and Size

In total, data from 52 participants who completed both pre- and post-surveys were used in the analysis. These included 10 adults who were between 18 and 25 years of age and 42 youths who were between 12 and 17 years of age.

Measures for Pre-Post Changes

Participants were asked to complete the measures below both before the intervention and after the intervention.

Cultural Connectedness was measured in three subscales: *Cultural Connectedness, Cultural Protective Factors, and Cultural Risk Factors.* The first subscale *Cultural Connectedness* was measured using four items on a five-point Likert scale ranging from one as "strongly disagree" to five as "strongly agree." The sum of the four items was used as a composite index to indicate the level of cultural connectedness. A higher score means stronger cultural connectedness (20 as the highest index of cultural connectedness). *Cultural Protective Factors* was measured using two items on a five-point Likert scale ranging from one as "none of the time" to five as "all of the time." The sum of the two items was used as a composite index to indicate the level of cultural protective factors. A higher score is indicative of more protective factors. *Cultural Risk Factors* was measured using two items on the same five-point Likert scale as *Cultural Protective Factors*. However, in this scale, a higher score means more risk factors, implying that a lower score is indicative of a better outcome.

Psychological Distress was measured using six screening items in the Kessler 6 (K6) measure that ask about the frequency of negative emotions such as feeling nervous or worthless. Frequency was scaled from zero as "none of the time" to four as "all of the time." The items were summed to calculate the total raw scores. A higher score indicates a greater level of psychological distress. Participants were classified into three groups: low-level (0–4), moderate-level (5–12), and severe-level (13 or above) psychological distress. Both the total raw scores and the levels were used for analysis.

Psychological Functioning was measured using a set of items of the Sheehan Disability Scale (SDS). The adult version included four domains and the adolescent version included three domains. This measure asked the participants how often their negative emotions interrupted their normal daily functioning in those domains. The average of the items was used for further analysis.

Youth's Perceived External Support (pre- only) was asked to youth participants only to measure their levels of external support at school and at home using 13 items. A higher score means stronger feelings of external support. *Youth's Perceived External Support* was measured using 13 items on a four-point Likert scale ranging from one as "not at all true" to four as "very much true." This measure, adopted from the Annual Sonoma County Indian Health Project Needs Assessment (2017) was only asked before the intervention.

Program Satisfaction and Post-Intervention Adjustment (post- only) was asked after the intervention to evaluate their subjective satisfactions about the intervention and their adjustment in their life. Adults were asked to indicate their levels of agreement with 20 statements about their satisfaction with the services and staff. Youth were asked to indicate their levels of agreement with 11 statements about their satisfaction with the services and staff. Additionally, youth were asked to indicate their levels of agreement with 11 items about their adjustment in their life such as "I am better at handling daily life."

Data Analysis Plan Implemented

For further analysis, data from the 52 pre-post matched samples were used. For string variables such as the demographic variables or mental health needs, percentages were calculated and presented. For continuous variables such as the assessments above, composite scores (e.g., sums or means depending on the measure as written in the measures section) or the item averages were calculated and used for statistical testing. Repeated measures t-test (i.e., dependent t-test) was used to compare the pre-scores and the post-scores of Cultural Connectedness, Psychological Distress, and Psychological Functioning. For Psychological Distress, the discrete levels at pre and post (i.e., low, moderate, and severe) were compared using a McNemar test. All statistical tests were conducted using SPSS. Given the small size of matched samples, being marginally significant ($p<.10$) is also presented in the output as significant.

Qualitative Data Analysis

Qualitative data was primarily collected through participant focus groups, gathering subjective information aligned with the overarching evaluation questions. Three focus groups were held on February 26, 2021, March 10, 2021, and March 18, 2021. Two of the focus groups invited transitional-age youth (TAY), and the third focus group was for "Aunties" and "Uncles" supporting the program. Adhering to a community-based participatory research model, the Eagle Council members were very involved in the planning and development of the focus groups and the collection and analysis of the data. At their quarterly meetings, August 2020 through February 2021, the Eagle Council members developed the focus group protocols and corresponding questions (Appendix 6 and 7). Two Eagle Council members were trained and co-facilitated the TAY focus groups.

All focus groups were conducted on a virtual platform, *Zoom*, and recorded with consent. The focus groups were literally transcribed and reviewed by two independent evaluation team members for categorization and initial coding of key words. Furthermore, complete phrases were listed and reviewed by Eagle Council members who were instructed to volunteer descriptive themes through a cultural lens for Native Americans. With the Eagle Council's assistance, data was coded to identify preliminary themes. Themes were then refined and subject to a content analysis that examined patterns of frequency and correlation in themes. The inter-rater reliability was consistently high, using a correlation coefficient as a measure, as members of the analytic sessions were in consistent agreement with each other when identifying categories and themes.

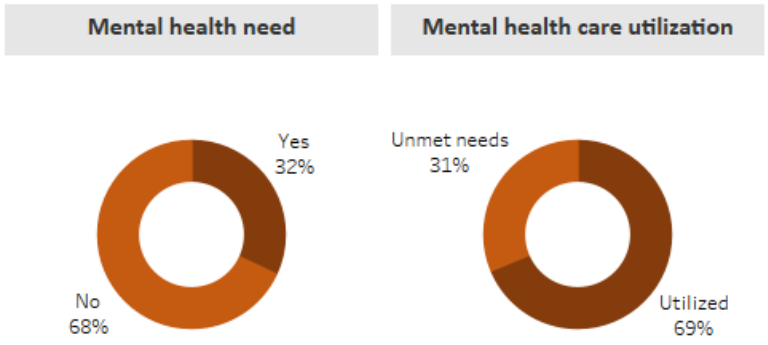
Each statement obtained from TAY and adult focus groups participants were then coded and summarized to identify the emerging and most important concepts and themes. Patterns of themes were mapped for repeated frequencies. The themes were then aligned under the six evaluation questions and analyzed in combination with the quantitative data findings.

In addition to focus group data, open ended questions in the local survey and the GONA Feedback Surveys were examined for additional insights to participant experiences, opinions, and beliefs. These additional data sources provided insight to the inquiry of changes in knowledge, attitudes and beliefs regarding mental health (Stigma); behaviors in seeking support, services and self-care; and perceived value and experiences in community and cultural connectedness.

Results

Quantitative Data Findings

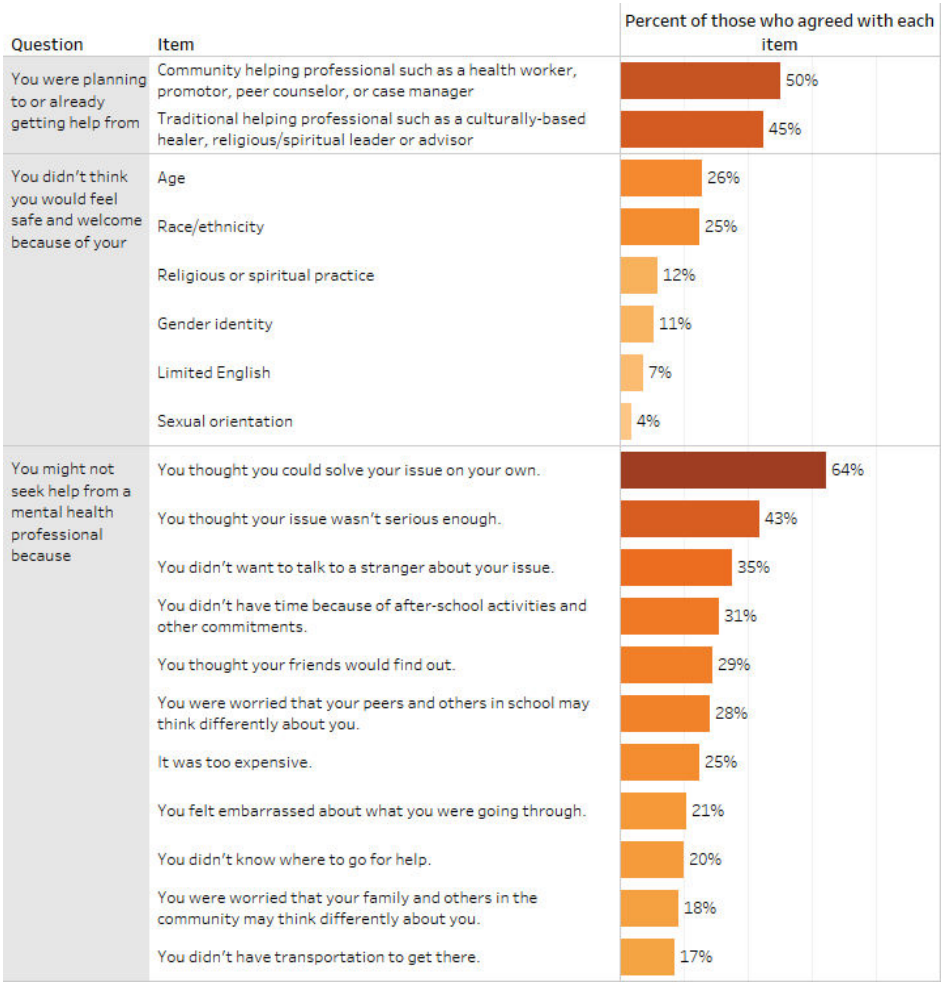
Mental Health Needs, Services, and Barriers



Among the 52 participants completing matched pre- and post-SWE core measures, 32% said they needed help for their mental health issues in the past 12 months. Of those 32% who stated they needed help; a high percentage (69%) had utilized mental health care.

(N=16-50)

Half of the total survey respondents indicated they were already getting help, or planned to, from a mental health provider, while 45% indicated they were, or were planning to get help from a traditional provider. These items were not mutually exclusive, so some respondents may have accessed both types of providers. When asked the reason why they might not seek help from a mental health professional, the most cited reasons for not seeking help were that survey respondents thought they could solve the issue themselves (64%) or that the issue was not serious (43%).



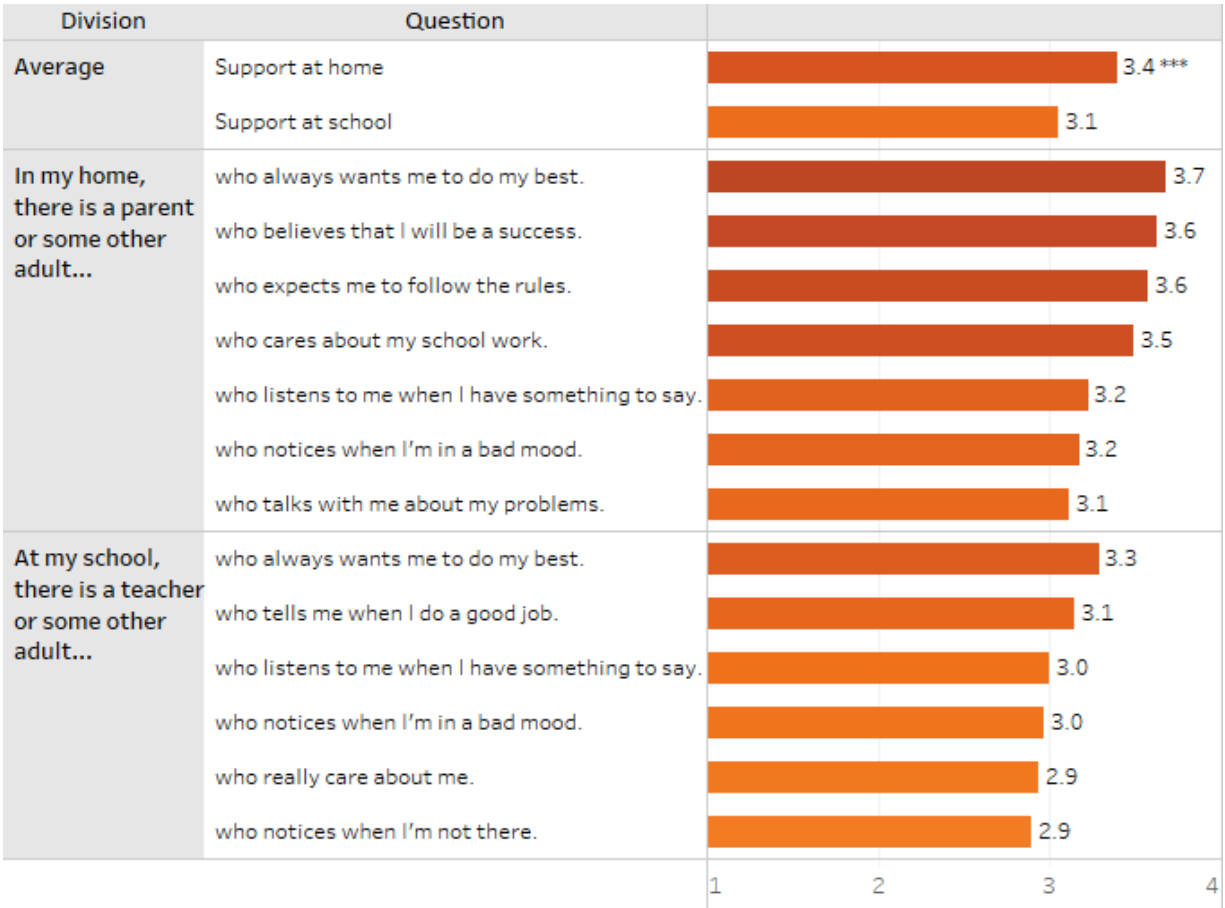
(N=20-32)

As survey participants could select multiple reasons, a quarter or more of the participants expressed concerns about not feeling safe or welcome due to age (26%) and race (25%), and not wanting to talk to a stranger (35%). Concerns about stigma, such as worrying that friends would find out (29%) or people would think differently about them (28%) were common. And there were logistical barriers, such as lack of time (31%), expense (25%), and not knowing where to go (20%).

Youth's Perceived External Support

The figure below shows the average scores of *External Support* youth felt at home and at school within a four-point scale. In general, youth felt significantly more support at home (3.4) than at school (3.1). Specifically, the highest score came from an item "In my home, there is a parent or some other adult who always wants me to do my best." Items with highest scores were about the adults' expectations about success or rules, whereas items with lowest items were about their emotions and communication. The overall scores on their support at school were lower than the scores on their support felt at home, although they were still high (around 3 "pretty much true"). Similarly, the highest scores came from the items about the adults' expectations about success and behaviors, whereas the lowest scores came from the items about the adults noticing their emotions and communication.

*(N=33-38). Asterisks indicate statistical significance at ***p<.001.*



In the local pre-survey, participants were asked who they would turn to for support when they feel stressed or upset and the top three responses were: Mom (49%), Friend (41%), and Cousin (35%). In the post-survey, the top three responses shifted to Friend (51%), Mom (47%) and Spouse/Partner (35%). Of note are the post-survey responses that included Grandparents and outside associations such as teachers, clergy, health professionals, and Native healers.

When you are upset or stressed, how often do you turn to the following people for support?

	Often/Very Often	
	Pre-survey (N=81)	Post-survey (N=52) *
Spouse/Partner	26%	35%
Friend	41%	51%
Cousin	35%	33%
Brother	25%	17%
Sister	26%	24%
Auntie	21%	12%
Uncle	18%	16%
Mom	49%	47%
Dad	29%	19%
Daughter	4%	0%
Son		6%
Grandma		27%
Grandpa		12%
Teacher		13%
Medical Provider		8%
Therapist		17%
Counselor		15%
Native traditional healer		15%
Church priest/minister		8%

** The post-survey had options not included on the pre-survey*

When asked why respondents turned to certain people, the main factor was a sense of feeling comfortable, trusting, and not feeling judged. In addition, many respondents reported that the people they talk to have known them for a long time and care about them. In some cases, they felt that the people they received support from understand their situations due to their own lived-experiences and can be helpful with resolving the issues.

"The reason I choose those people is because I have known them longer and I trust them."

"I chose them because they have more experience and understand what it was for them as a child, and they are very trustworthy."

"My spiritual leaders understand me when some of my other traditional family members don't understand what I am going through. ...if I didn't have them in my life, I would feel lost and would most likely be stressed, anxious, and possibly depressed."

Mental Health Stigma in the Community

In the local evaluation survey, TAY were asked about knowledge, attitudes, and beliefs regarding mental health in their community. Comparing pre- to post- responses indicated some significant changes and within the post-survey responses, there were differences between those who attended only one AUP event and those that attended 2 or more AUP events.

When survey participants were asked whether talking about emotions is important to the youth in the community, 68% agreed or strongly agreed in pre-survey results. In the post-survey there was a notable shift in that 90% felt that talking about emotions is important to youth. Within the post-survey group, 96% of those that attended 2 or more AUP events felt that talking about emotions is important to youth compared to 84% of those who only attended one AUP event.

Yet, when asked if adults in the community talk to youth about their emotions, only 58% agreed/strongly agreed with a small change from pre- to post-survey. When asked whether people in the community feel comfortable talking about suicide, only 29% agreed or strongly agreed in the pre-survey with a moderate increase to 35% agreed or strongly agreed in the post-survey.

There was a moderate increase in agreement from pre- to post-survey when asked if SCIHP staff ask about patients' emotions when they go to the clinic (61% to 69%), but 78% of those attending 2 or more events agreed or strongly agreed. Again, there was a slight increase from pre- to post survey when asked if participants felt there is a safe place for youth to go if they need to talk with someone (72% to 77%) with a higher percentage (85%) of the subgroup attending 2 or more AUP events agreeing or strongly agreeing with this statement.

Local Survey Q6	% of respondents that Agree or Strongly Agree			
Statement	Pre-survey N=81	Post-survey N=52	Post-survey N=25 *Respondents attended only one AUP event*	Post-survey N=27 *Respondents attended 2 or more AUP activities*
Talking about emotions is important to the youth in the community	68%	90%	84%	96%
Adults in the community talk to youth about their emotions	58%	57%	52%	62%
People in the community feel comfortable talking about suicide	29%	35%	40%	30%
There is a safe place for youth to go if they need to talk with someone	72%	77%	68%	85%
When people in the community go to the clinic, the staff ask patients about their emotions	61%	69%	60%	78%
I am satisfied with the suicide prevention activities in the community	55%	52%	44%	59%

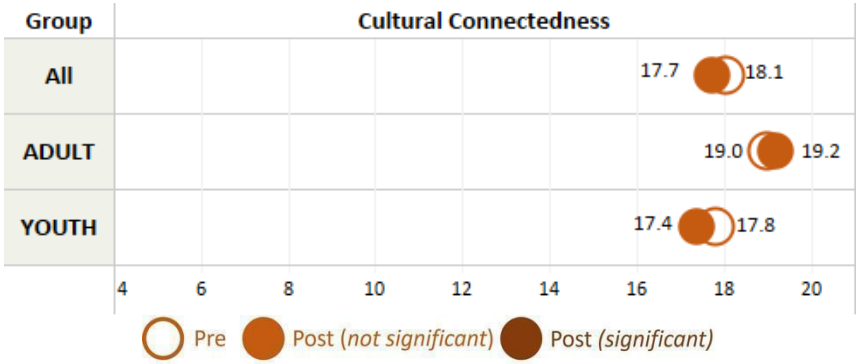
Knowledge and Awareness of Mental Health Wellness

Overall, participants in one or more event reported an increase in knowledge in suicide prevention, culture as a protective factor, self-care, resources, and ways to help others in emotional distress. Those who attended two or more events, reported additional increase in knowledge in self-care and resources for wellbeing.

How much did your participation in AUP activities increase your knowledge in these areas? 1 = Not at all 2 = Somewhat 3 = A lot			
	Post-survey N=52	Post-survey N=25 *Respondents attended only one AUP event*	Post-survey N=27 *Respondents attended 2 or more AUP events*
Suicide prevention: listening techniques, community resources	2.5	2.5	2.5
How culture is a protective factor	3	3	3
Self-care for wellbeing	3	2.5	3
Resources and support for emotional wellbeing	2.5	2.5	3
Ways to help family, friends and other community members who suffer from emotional distress	2.5	2.5	2.5

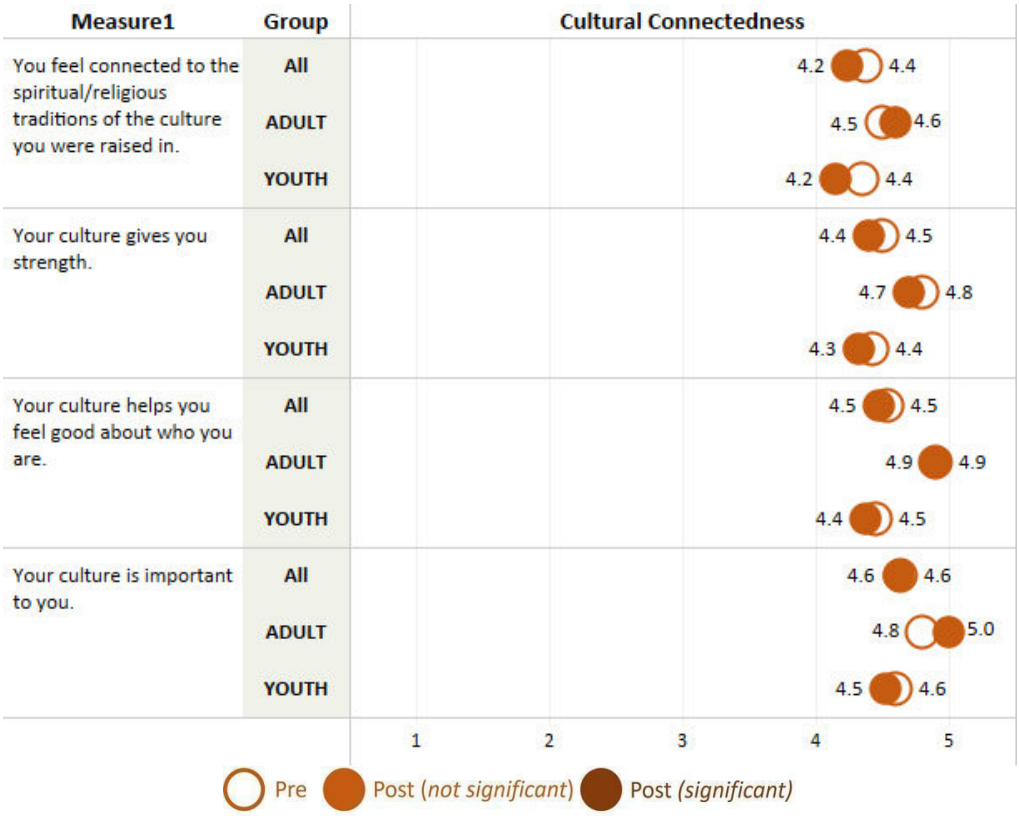
Cultural Connectedness

The levels of *Cultural Connectedness* before the intervention were very high (18.1 for all, 19.0 for adults, and 17.8 for youth). There was no statistically significant change in *Cultural Connectedness* comparing pre- to post-survey results (18.1→17.7).



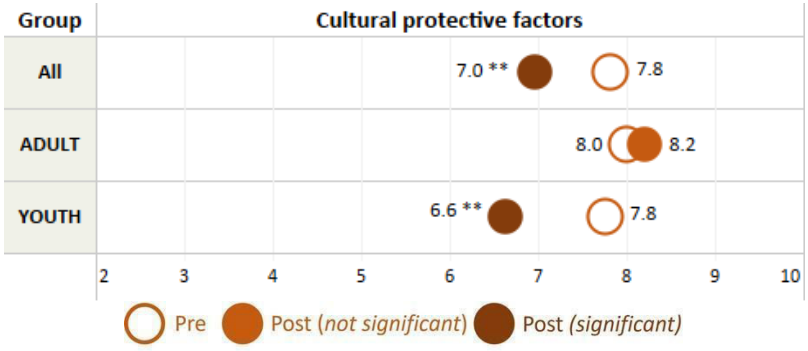
N=52 (Adult=10; Youth=42).

The four individual items in the *Cultural Connectedness* series pre- and post- were examined by age group. Results indicate that there were no significant changes pre- and post- in any of the items within the *Cultural Connectedness* series.



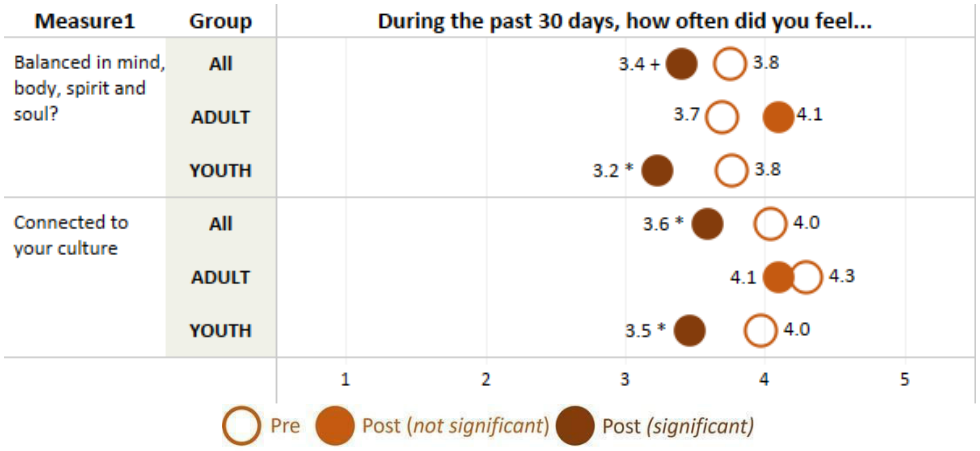
N=52 (Adult=10; Youth=42).

Overall, Youth respondents showed a significant <u>decrease</u> in *Cultural Protective Factors* after the intervention.



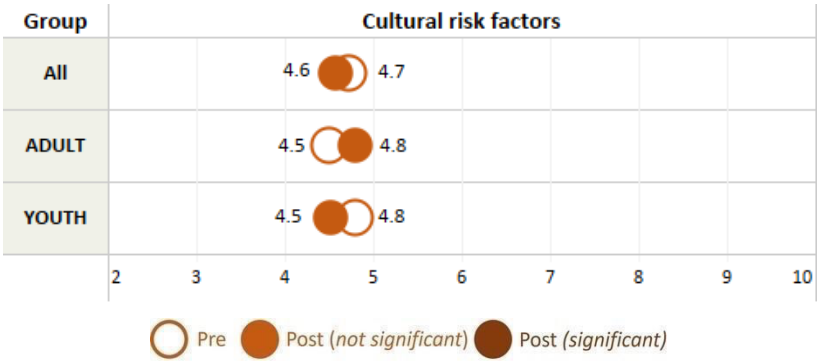
*N=48 (Adult=10; Youth=38). Asterisks and a plus sign indicate statistical significance at **p<.01.*

Cultural Protective Factors consists of two items below in the figure. Both items decreased. This implies that they felt less balanced in mind, body, spirit, and soul and they felt less connected to their culture after the intervention.

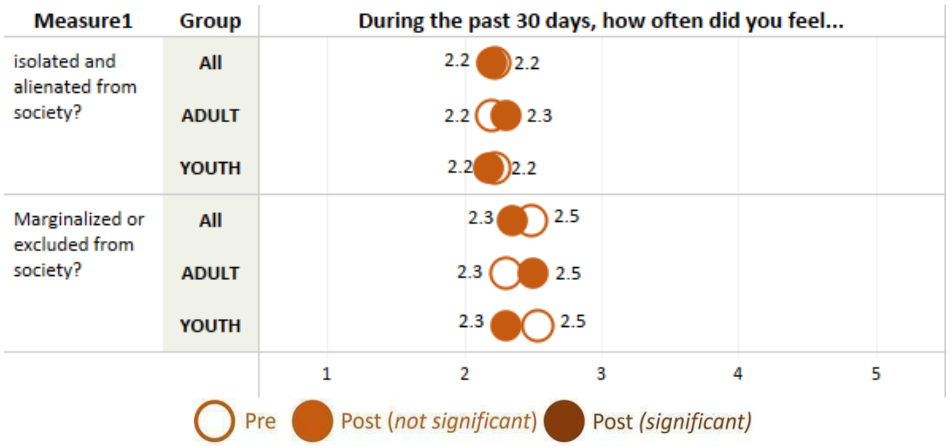


*N=49 (Adult=10; Youth=39). Asterisks and a plus sign indicate statistical significance at +p<.10. *p<.05.*

There were no significant changes in *Cultural Risk Factors* or the individual items belonging to *Cultural Risk Factors*.



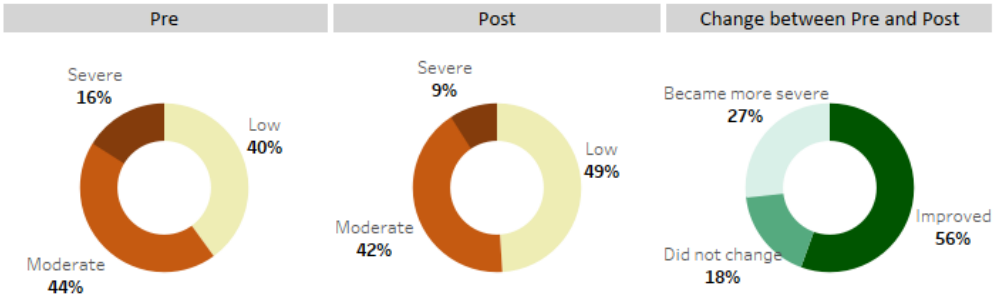
N=49 (Adult=10; Youth=39).



N=49-50 (Adult=10; Youth=39-40).

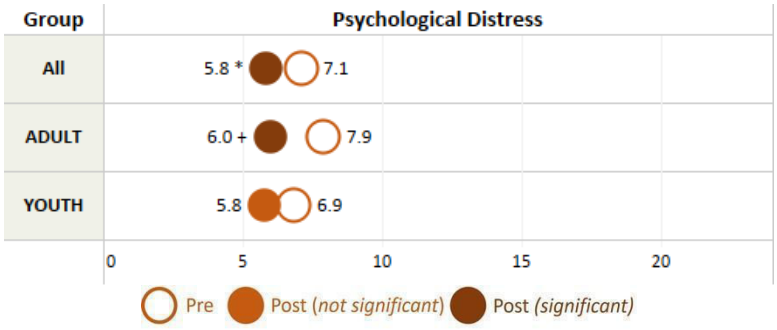
Psychological Distress

Out of the 45 participants responding before the intervention, 40% were classified with low-level symptoms, while 16% were classified with severe-level symptoms, and 44% were classified with moderate-level symptoms. After the intervention, 49% showed low-level symptoms, while 9% showed severe-level symptoms and 42% showed moderate-level symptoms. These changes were not statistically significant based on the McNemar test. However, calculation from the changes in the total raw scores indicated 56% showed improvements (that is, having lower scores of psychological distress).



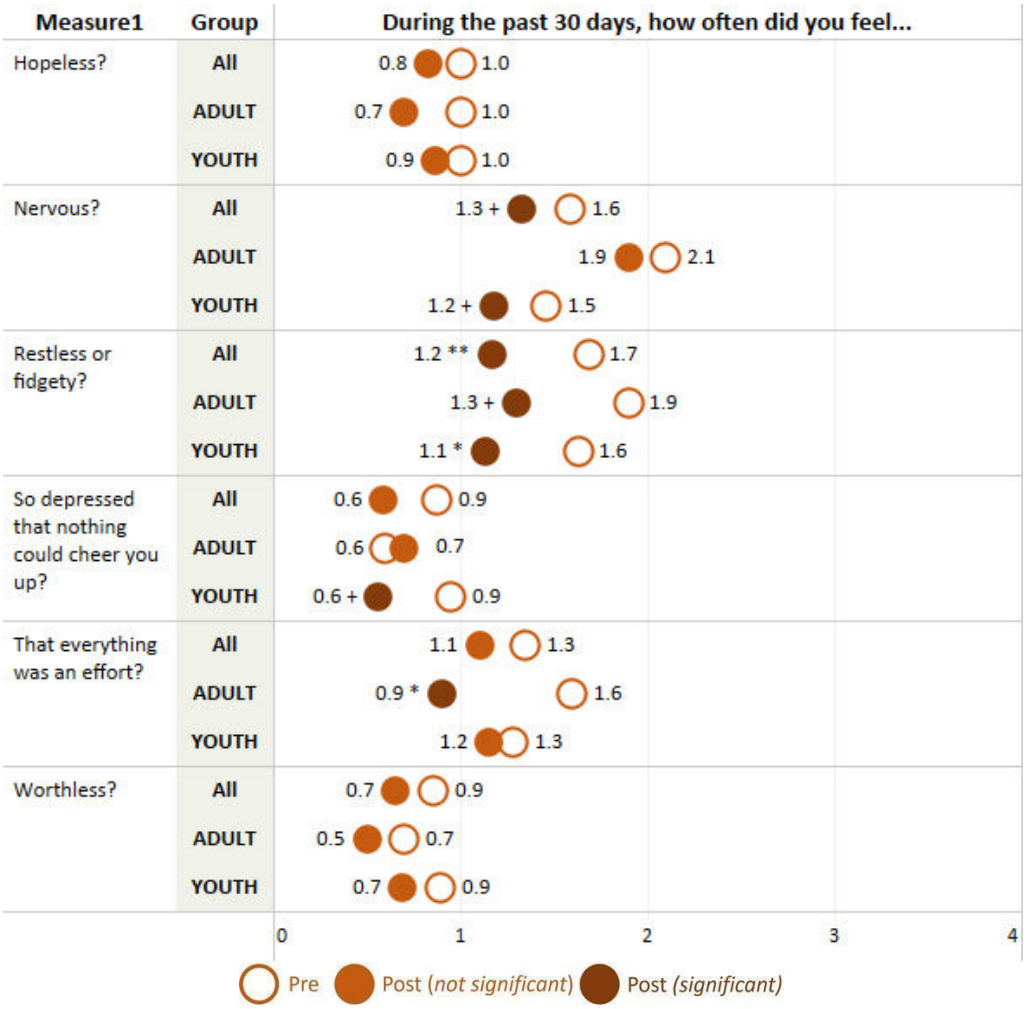
N=45.

When the total raw scores were compared between pre and post, participants showed significantly lower levels of psychological distress at post compared to pre (7.1→5.8).



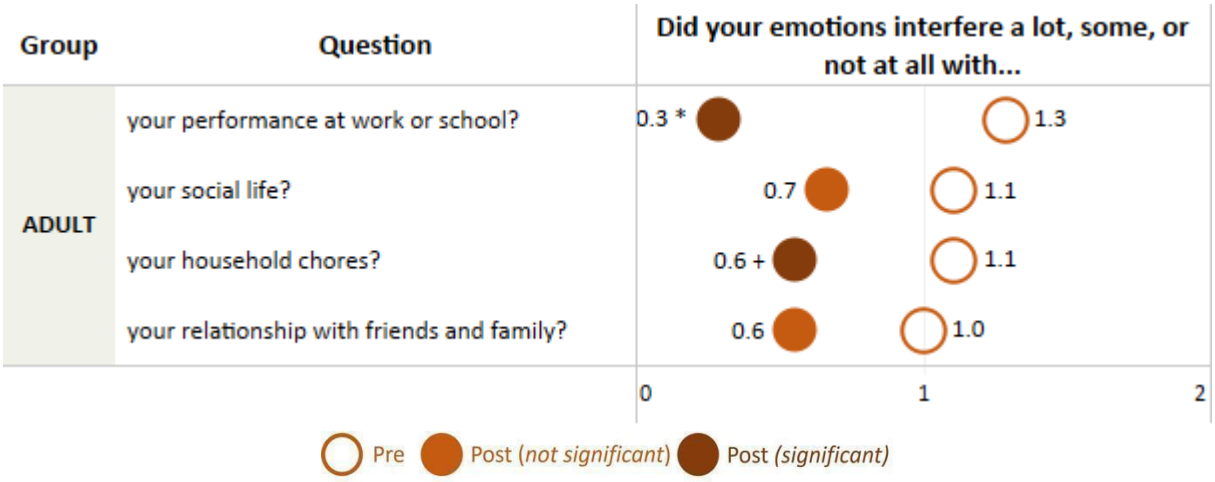
*N=45 (Adult=10; Youth=35). Asterisks and a plus sign indicate statistical significance at +p<.10. *p<.05.*

Results of analysis on individual items in *Psychological Distress* are presented in the figure below. Significant decreases in psychological distress are found in feeling nervous and feeling restless or fidgety. In addition, youth (12–17 years old) felt less depressed, and adults (18–25 years old) felt less that everything was an effort after the intervention.



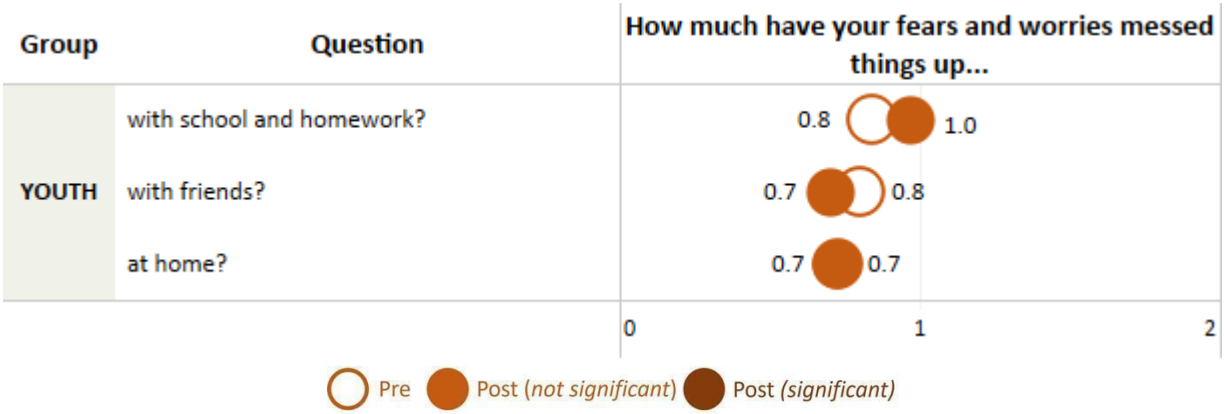
*N=47-49 (Adult=10; Youth=37-39). Asterisks and a plus sign indicate statistical significance at +p<.10. *p<.05. **p<.01.*

For *Psychological Functioning* there were different items for older TAY (adults) and younger TAY (youth). The older TAY were asked to complete the four items below. They reported a decrease in their emotions interfering with their household chores and their performance at work or school after the intervention.



*N=7-9. Asterisks and a plus sign indicate statistical significance at +p<.10. *p<.05.*

On the other hand, youth did not show any significant changes in their psychological functioning.

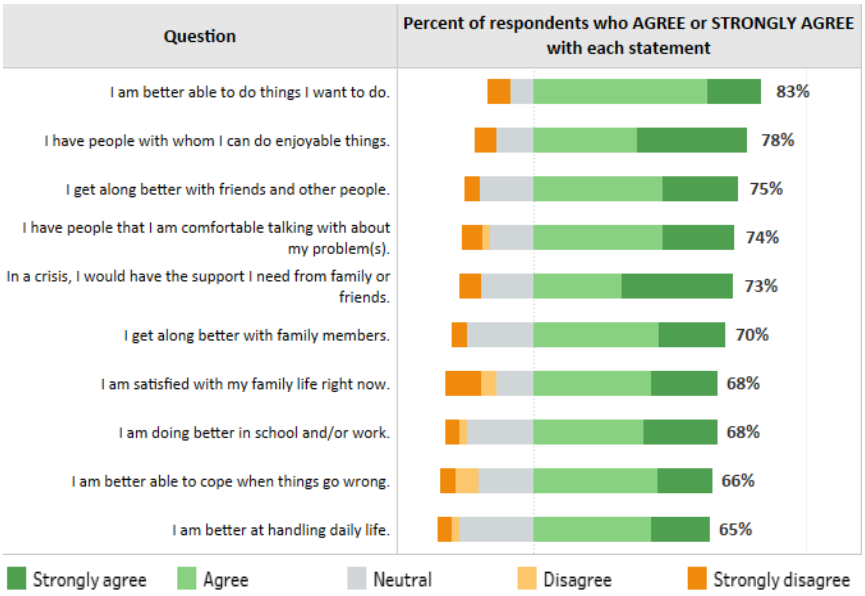


N=29-31.

Participant Satisfaction and Post-Intervention Adjustment

The SWE core measures for younger TAY (youth) and older TAY (adults) differed in the questions and/or language used, thus data analysis could not be combined. The youth survey had a set of questions about the impact of interventions and another set about satisfaction with staff. The adult survey combined questions about satisfaction with services and impact of services.

YOUTH POST-INTERVENTION ADJUSTMENT



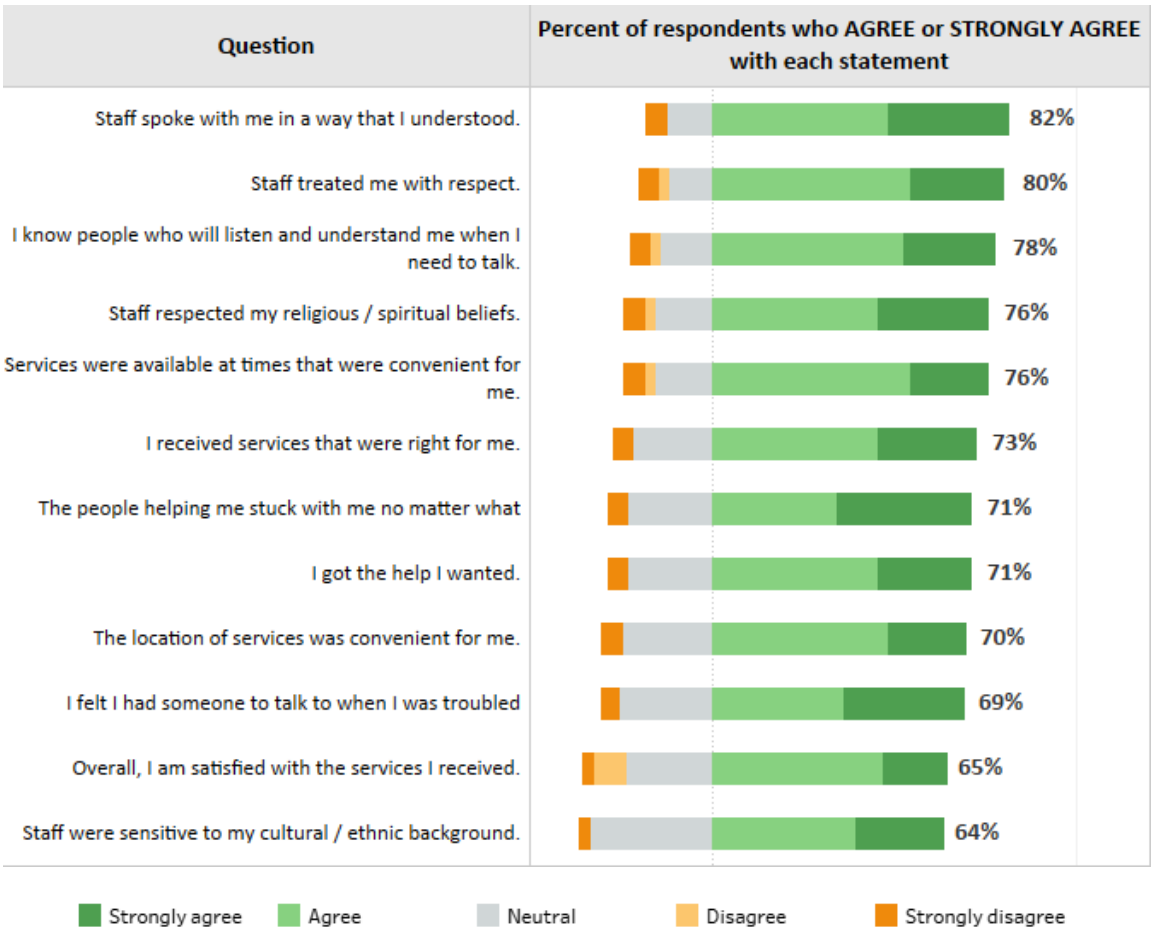
Youth showed moderately high levels of adjustment overall ranging from 65% to 83% across items. Most youth agreed that they were better able to do things they wanted to do (83%), and they had people with whom they could do enjoyable things (78%). Relatively lower agreement was shown on the items about handling their life (65%) and coping with problems (66%).

N=35-38.

Percentages on the right side of the bars indicate the percentages of respondents who agree or strongly agree with each statement.

YOUTH SATISFACTION WITH SERVICES OVERALL

Nine items related to level of youth satisfaction with services overall. Strongest endorsements were given to the items "staff spoke with me in a way that I understood" (82%) and "staff treated me with respect" (80%). Fewer youth agreed with the statement that staff were sensitive to their cultural background (64%), but a greater percentage were neutral on this statement.

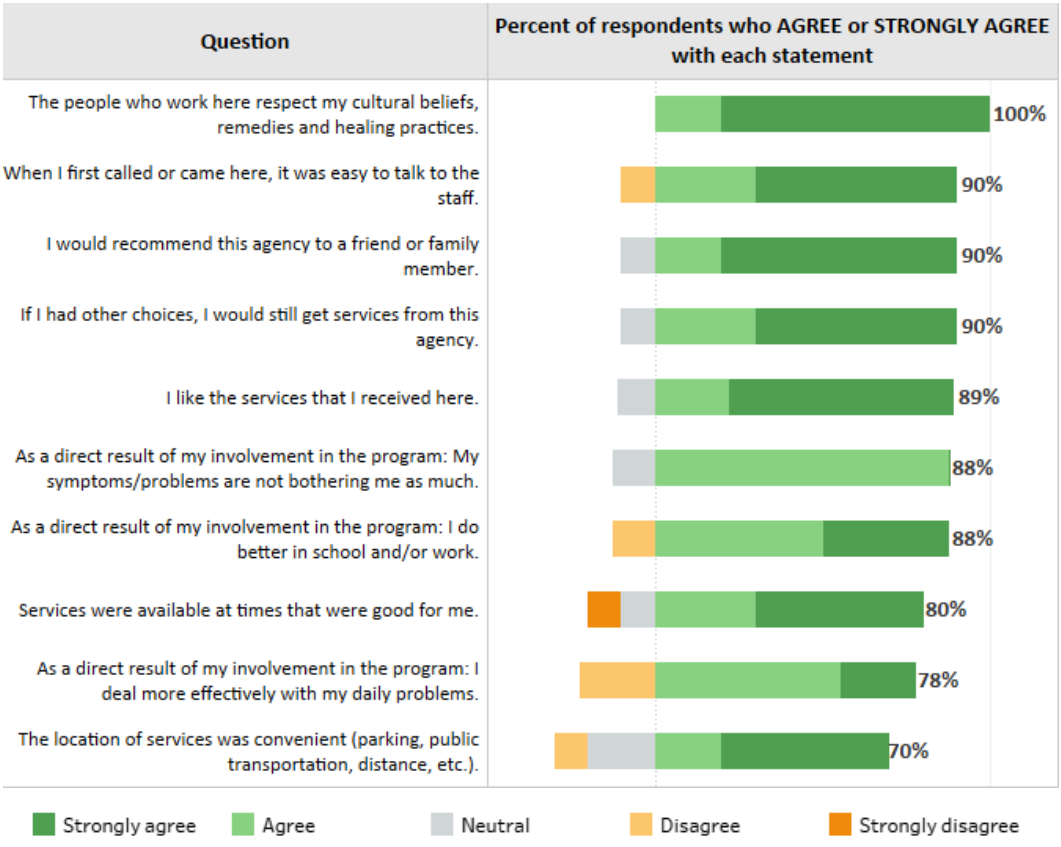


N=33-36. Percentages on the right side of the bars indicate the percentages of respondents who AGREE or STRONGLY AGREE with each statement.

> *"I found it (AUP event) to be beneficial to be able to sit with elders and other cultural people from my community to support me and the ideas I had for my future. It was comforting to hear stories from people I see in my community as leaders and to hear what they have gone through in their own journey. Those stories were reminders that we are all still people, regardless of the good and bad we go through. I believe that other Native youth could benefit from hearing these personal stories to help motivate each one of us to walk in a good way... to be humble and kind while staying true to our culture and traditions."* ***Survey Respondent***

ADULT SATISFACTION WITH SERVICES OVERALL

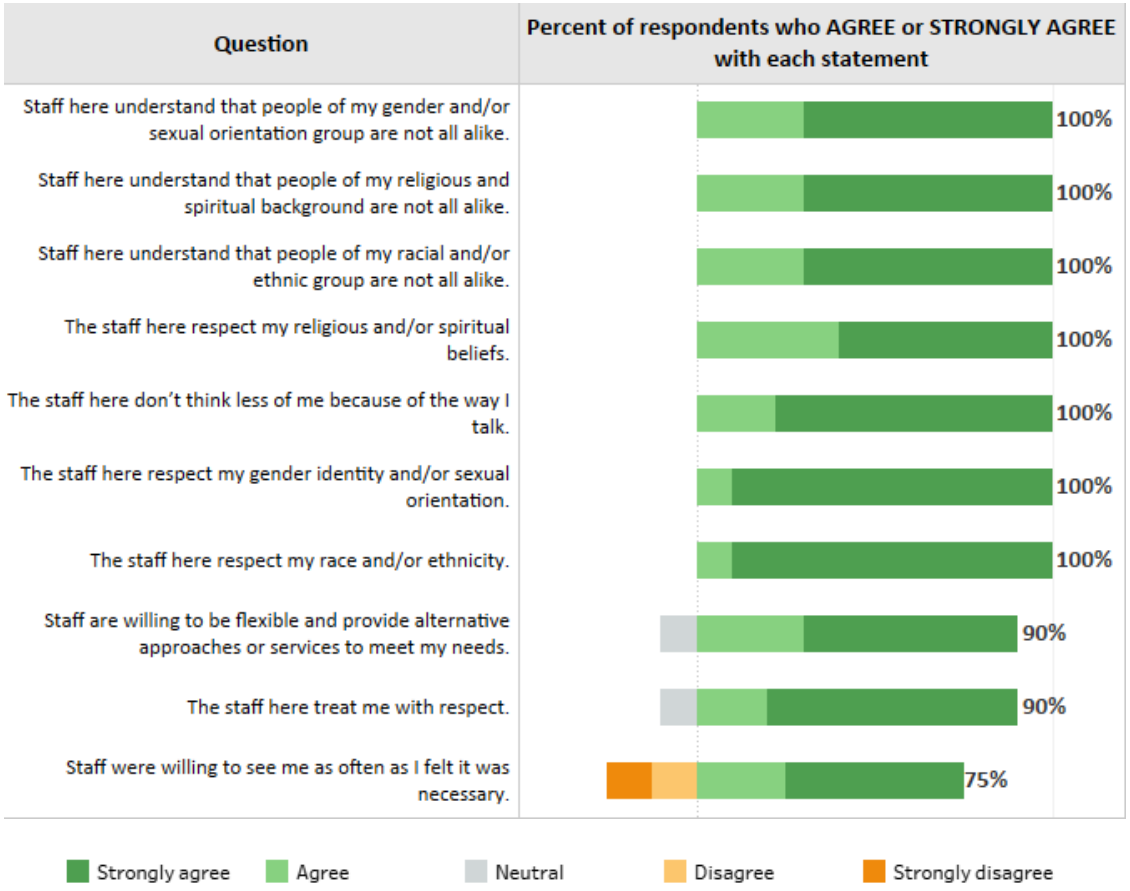
For all items, adult participants (ages 18–25) showed very high satisfaction. They strongly endorsed the staff's respect for their cultures and easy communication with staff. Further, 78% agreed that they were able to deal with their problems more effectively after the intervention.



N=8-10. Percentages on the right side of the bars indicate the percentages of respondents who AGREE or STRONGLY AGREE with each statement.

ADULT SATISFACTION WITH STAFF

Ten items related to level of satisfaction with their interactions with staff. The older TAY (adult) participants show very high levels of satisfaction for nearly all items. Yet, a few wished to see the staff more often.



N=8-10. Percentages on the right side of the bars indicate the percentages of respondents who AGREE or STRONGLY AGREE with each statement.

Focus Group Data Analysis

Three focus groups, two for TAY and one for "Aunties" and "Uncles," were conducted with questions focused on the value of AUP in supporting mental health wellness, supporting cultural identity and how the COVID-19 Stay-at-Home order affected participants. Eagle Council members were instrumental in developing the questions, co-facilitating the focus groups, coding data and identifying themes. Key themes are listed in the table below.

Recurring themes included connection, community and belonging, intergenerational interaction/teaching, and culture as prevention. Other themes that were complimentary included honoring self and others, resilience, trust, pride, inspiration, and motivation. The table below highlights the identified themes within the Youth (Y) focus groups and Adult (A) focus group.

Evaluation descriptor	Focus Group Themes				
Value of AUP	Community and Belonging (Y, A)	Family, Intergenerational Exchange (A)	Identity, Culture and Pride (Y, A)	Motivation, Participation (A)	
Value of being an Auntie/Uncle	Reciprocity (A)	Building and Finding Trust (A)	Inspiring (A)	Inclusion (A)	
Coping with stress and MH issues	Self-care (Y)	Taking Action, Change in Activity, Behavior (Y)			
Culture	Culture is Prevention (Y)	Teaching from Generation to Generation (Y)	Honoring Self and Others (Y)	Connection to Others, Connection to Culture (A)	Ease of Being with Community (A)
COVID	Disruption, Mental Health Challenges (Y)	Mental Health Challenges (A)	Resilience (Y)	Seeking Support (A)	

Participation

SCIHP projected to engage at least 100 TAY in AUP events and activities. For large events, sign-in sheets were not accurate, thus total TAY attendance was not tracked, but 106 TAY completed the SWE pre-surveys while attending an AUP event. Of those, 47 are recorded as attending more than one event. AUP also projected engaging at least 150 community members.

Participation of community members varied by location and whether the event was in-person or on-line virtually.

Participation in Prevention and Education Events ranged from five to 300. While some of those attending were TAY, the majority were not. Attendance at Wellness Gatherings varied by location and whether the event was held in person or virtually. In-person Memorial Gatherings drew more than 200 people to each event. In-person Family Fun Nights in the Santa Rosa area drew 60–137 participants, while on the coast they drew 30–40 participants. The in-person Natives Got Talent event drew 143 attendees, while the online event (due to COVID) recorded 15 attendees. A two-day Traditional Healing Gathering in person drew 141 participants, while the multi-day online Gathering of Native Americans (GONA) drew at most 36. Cultural Workshops, such as Basket Weaving, drew three to 13 participants each.

Over the course of the project evaluation period, seven Auntie and Uncle community members participated in the Eagle Council Advisory Board; 11 Aunties and Uncles provided support for cultural workshops and community events; six Aunties and Uncles provided support in the schools; and seven SCIHP staff provided support to the project.

AUP projected 15–20 students per school would participate in Talking Circles. Twenty-nine Talking Circles were conducted at five schools from January 2019 to March 2020. Attendance ranged from three to 23 students per meeting, with each school having between seven to 23 individual participants. High school sites included Ridgeway, Santa Rosa, Elsie Allen, Piner and Point Arena High Schools. Virtual Talking Circles were conducted with Santa Rosa High School students (ten sessions) and Point Arena High School students (two sessions) in late 2020 and early 2021, attended by one to eight participants.

The TAY Cultural Wellness Series, initiated in May 2020, met twice weekly for five months, but was reduced to weekly to accommodate participants' employment status. In total, 100 online Talking Circles were held in 14 months and were attended by one to three young adults at each session, primarily the same three TAY attending. (NB: At time of writing this report, attendance has doubled with seven participants regularly attending.) It was also estimated that 15–20 community members would participate in Talking Circles. Four Community Talking Circles were held at the Kashia Community Center, with six participants each. Six online sessions were held in late 2020 and early 2021, with two to four participants at each.

Event Attendance

Of the 50 TAY that completed a pre- and post-survey, 25 were recorded as having attended only one event. For those who attended only one event, over half attended a Wellness Gathering. The others attended a suicide prevention training, talking circle, or cultural workshop. For those that attended two or more events, almost all attended at least one Wellness Gathering and most attended at least one suicide prevention training, talking circle or cultural workshops.

EVENTS			
Type of Event	**Description**	**# of Events**	**Attendance**
Prevention and Education	AUP staff spoke about mental health, suicide prevention, and resources including AUP. These were cultural events or groups primarily hosted by other agencies. Three were held online after the Stay-at-Home order was issued. Examples: Community Wellness Fair, Native Arts Expo, presentations at High School Native Clubs.	38	Range: 5 – 300 Total: 2,346 Avg: 62*
Wellness Gatherings	These gatherings were community-wide events primarily organized by SCIHP/AUP. They were designed to increase wellness through Native practices and activities. Mental health information was woven in and linkages to services provided. Examples: Memorial Gatherings, Family Fun Nights, GONAs, and Natives Got Talent.	18	Range: 15-287 Total: 1,473 Avg: 82
Cultural Workshops	These were small workshops led by elders teaching the meaning of and skills for cultural practices. Mental health information was woven in and linkages to services provided. Examples: beading and basket weaving.	8	Range: 3-13 Total: 63 Avg: 7.9
Talking Circles for TAY	Talking Circles are a traditional method for identifying and solving problems. Ones for TAY were held at schools and online. Mental health information was woven in, monthly guest speakers were engaged and linkages to services provided.	129	Range: 1-23 Total: 477 Avg: 3.7

* Data not available for all events as host organization (Not an AUP event) did not provide information on attendees or numbers served.

A full list of attendance at each specific event can be found in **Appendix 2**: **Events Conducted and Attendance.**

Two four-day Gathering of Native Americans (GONA) events were conducted virtually emphasizing the themes of Belonging, Mastery, Interdependence and Generosity. Each participating family was asked to complete satisfaction surveys. A high level of satisfaction was reported for both GONA events and family representatives reported feeling more connected to family members, connected to community and cited greater optimism about their role in the community and in their future. The second GONA rated consistently higher in all elements of the survey with 100% of the respondents reporting being satisfied or very satisfied with their experience and that the teaching of GONA will help them to be a better person/community member and to achieve their goals. In addition, 88% of participants strongly agreed that they felt more connected to their family and community and are inspired to contribute more to others.

Questions from Feedback Survey	GONA - September 2020 (N=6)		GONA – March 2021 (N=8)	
	Satisfied	Very Satisfied	Satisfied	Very Satisfied
Overall, how was your experience participating in the GONA?	50%	50%	13%	87%
	Agree	Strongly Agree	Agree	Strongly Agree
I believe the lessons of the GONA will help me to be a better person/community member.	50%	50%	0%	100%
I will use the teaching of the GONA to help me achieve my goals.	67%	33%	0%	100%
I feel more connected to my family.	50%	50%	0%	88%
I want to learn more about my culture and community.	33%	67%	0%	100%
I am more inspired to contribute more to my community.	50%	33%	12%	88%
I feel more connected to my community.	33%	50%	12%	88%
I believe that I have something to contribute to my family and community.	50%	50%	12%	88%
I can be a role model to others in my community.	67%	33%	12%	88%
I feel more confident/optimistic about my future.	33%	33%	12%	88%

Herth Hope Index

The 12-item Herth Hope Index measures the multi-dimensional aspects of an individual's sense of hope. Overall, respondents scored well on the Herth Hope Index in the local pre-survey. In general, those survey respondents who participated in two or move events showed greater positivity and some improvement, while those who only attended one event showed no real change or showed a decline.

The elements that indicated a notable difference between the pre- and post-survey responses for those who attended two or more events or activities included the statements: "I have a positive outlook toward life," "I have short and/or long-range goals," "I believe each day has potential," and "I feel my life has value and worth." In contrast with the cohort that attended two events or more, the group attending only one event had a greater sense of feeling all alone (24%) and a greater feeling of being scared about their future (40%) as compared to 7% and 30% respectively.

Herth Hope Index	% of respondents that Agree or Strongly Agree			
Statement	Pre-survey N=81	Post-survey N=52	Post-survey N=25 *Respondents attended one AUP event*	Post-survey N=27 *Respondents attended 2+ AUP events*
I have a positive outlook toward life	73%	71%	56%	85%
I have short and/or long-range goals	70%	77%	72%	81%
I feel all alone	22%	15%	24%	7%
I can see possibilities in the midst of difficulties	64%	65%	64%	67%
I have a faith that gives me comfort	72%	63%	52%	74%
I feel scared about my future	44%	35%	40%	30%
I can recall happy/joyful times	87%	87%	80%	93%
I have deep inner strength	72%	71%	72%	70%
I am able to give and receive caring/love	92%	87%	88%	85%
I have a sense of direction	75%	79%	79%	78%
I believe that each day has potential	73%	85%	76%	93%
I feel my life has value and worth	86%	87%	76%	96%

Patient Health Questionnaire Screening and Referrals

Between June 30, 2018, and June 30, 2021, SCIHP clients were screened using the PHQ-2. If they scored two or above, they were offered the PHQ-9. Of 161 youth completing the PHQ-9, 58% (93) were referred to SCIHP's Behavioral Health Department. Of those referred, 69% attended a behavioral health appointment. For those aged 18-24, 44% were referred to services and 65% attended an appointment. Those 25 and older were referred at a rate of 38% and attended an appointment at a rate of 71%. Data tracking was through SCIHP's electronic medical records and aggregate data was provided to maintain confidentiality in compliance with HIPAA regulations.

PHQ-9	Duplicated	Unduplicated
14-17	306	161
18-24	886	304
25+	8422	1904
Referrals	Duplicated	Unduplicated
14-17	160	93
18-24	271	133
25+	1546	724
Referrals Kept	Duplicated	Unduplicated
14-17	91	64
18-24	145	87
25+	858	512

Evidence of Referrals to Services

In addition to the PHQ-9 screenings at medical appointments, there was evidence that community members attending AUP events would come forward and speak to the Community Outreach Specialist, a local Native, regarding their challenges and need for support. Data on frequency and outcome of these interventions were not recorded, but narrative data was obtained through the semi-annual reports provided to the statewide evaluator for the project. Below are sample stories highlighting the circumstances, referral, and outcome of the interaction.

A local Native family contacted the AUP Community Outreach Specialist, Dean, regarding concern for their son who has had a long history of substance abuse and mental health challenges. This family has known Dean for a while and trusted him with getting help for their son. Recently their son decided he's ready to enter treatment for his substance abuse and would like to go to a treatment center that includes his cultural practices. Prior to asking for help, their son was homeless and detached from the family. Dean contacted the director of a treatment program in San Francisco that includes Native practices in their treatment plans. Dean continued to work with SCIHP's substance abuse counselor to provide support to the family. The family plans to attend AUP's Adult Talking Circle scheduled in November to receive support while their son is in treatment.

While providing mental health resources and referrals in the community, staff are not always able to see the impact and results of their efforts. That was not the case regarding one family who attended the Memorial Gathering that was held at Ya-Ka-Ama Indian Education and Development Center in Forestville, California. This family, made up of a single mother, with four children ages six to 14. At the event the mother was able to meet two of SCIHP's Behavioral Health therapists and discussed her family's needs. She's now receiving therapy for herself and her children due to ongoing trauma and being impacted by the recent wildfires in Sonoma County. The mother also visited the Disability and Legal Services outreach table where she learned how to access services for one of her children. This mother was very overwhelmed with emotion, as she had shared that it has been a struggle to find support and assistance for her family and was on the verge of desperation, and even at times feeling hopeless. She believes that it was because of AUP hosting this gathering, she has renewed faith in others and that her family, specifically her children, will have the opportunity to pursue their goals and enjoy the good things to come.

Discussion

This section of the report revisits the six evaluation questions and considers SWE core measures, local survey data, focus group data and program documentation such as quarterly and semi-annual reports, attendance tracking and event logs to establish what impact, if any, the Aunties and Uncles Program had on transitional-age youth (TAY) 12–25 years and adults who had a key role in supporting the program as an "Auntie" or "Uncle."

As noted in the program description, the Aunties and Uncles Program did not have a fixed curriculum/intervention nor a cohort of participants that would receive a common intervention with the same content or exposure. AUP was a community inclusive, intergenerational mental health awareness and prevention program that invited community members of all ages to participate in large wellness gatherings, cultural workshops and talking circles to reduce mental health stigma, increase mental health wellness and resilience, and increase access to services.

Since the program participants exercised self-determination on whether to attend AUP events and activities, the limitations of this evaluation became apparent as encouraging consistent participation and tracking attendance of transitional-age youth was challenging. Thus, measuring and comparing dose and effect was not relevant within this study sample. There is evidence that a small core group of TAY were consistently participating, particularly during the TAY Cultural Wellness Series and other events offered during COVID Stay-at-Home. In the future, a program component that has stronger defined parameters and expectations of participation is recommended so that dose and effect can be examined.

A second limitation of the evaluation was obtaining the required parental consent for youth under 18 years participating in the Talking Circles that occurred at school sites. It was a logistical challenge to have consent forms sent home, provide adequate explanation of the program and evaluation, and to obtain signed consent forms for youth to participate in surveys or focus groups. This affected the study's ability to adequately respond to Evaluation Question 6: How participation in Talking Circles impact TAY. Conducting Talking Circles in the community and requiring a parent orientation to obtain consent or hosting Talking Circles for those 18 and older might be a solution in a future iteration of program implementation.

Evaluation Question 1

How did knowledge, attitudes, and beliefs (KAB) regarding mental illness change among TAY as a result of the AUP?

In the local evaluation survey, TAY were asked questions about their knowledge, attitudes, and beliefs regarding mental health. One key finding is that more youth stated that it is important to talk about mental health after exposure to AUP activities. In the post-survey there was a remarkable shift in that 90% felt that talking about emotions is important to youth compared to only 68% in the pre-survey results. Furthermore, although youth feel that adults are supportive and want the best for the youth's future but are more concerned about youth fulfilling responsibilities (school, chores, employment) that are related to success, rather than talking to youth about their emotions or challenges. This was evident in the series of questions regarding Youth's Perceived External Support and supported by their response to the statement "Adults in the community talk to youth about their emotions", where only 58% agreed or strongly agreed with this statement and there was almost no change from pre- to post-survey. When asked whether people in the community feel comfortable talking about suicide, only 29% agreed or strongly agreed in the pre-survey with a moderate increase to 35% agreed or strongly agreed in the post-survey indicating the perception that the community is reticent to talk about suicide.

Having a trusted confidant to talk to is important to youth and young adults. Youth declared that they felt more support at home than at school but felt that the adults both at home and at school are less likely to take notice of them when they are in a bad mood or listen to them when they have something to say. Responses to the survey question: "When you are upset or stressed, how often do you turn to the following people?" respondents most frequently mentioned their mom or a friend. The reasons given were that these people could be trusted, they were a good listener, someone who has had similar experiences, and someone who they respect and had wisdom. This sentiment was also found in the responses to the post-survey regarding feedback on program staff whereby 78% either agreed or strongly agreed with the statement "I know people who will listen and understand me when I need to talk".

Overall, survey respondents as a group had a high level of cultural connectedness and assigned value to culture prior to participating in AUP activities. When asked if participation in AUP activities increase knowledge that culture is a protective factor for mental health, all respondents unanimously stated that their participation increased their knowledge a lot. Furthermore, those participants who attended two or more events reported that AUP activities increased their knowledge in self-care and resources for wellbeing as well.

TAY responses to an open-ended question in the local survey indicated that participants learned not only about mental health, but about interpersonal relationships, being in community and what makes them feel good all within a cultural context. Specifically, the question was: "Thinking about the Aunties and Uncles activities you participated in, what did you like and how did it improve your knowledge about wellness and wellbeing?" A sample of responses are included below.

TAY participants' sense of accessing services and getting support for mental health challenges was strengthened post-AUP intervention. When survey participants attending two or more AUP events were asked if SCIHP staff ask about patients' emotions when they go to the clinic 61% agreed or strongly agreed in the pre-survey and 78% agreed or strongly agreed in the post-survey. There was a slight increase in pre-post survey results when asked if participants felt there is a safe place for youth to go if they need to talk with someone (72% to 77%), with a higher percentage (85%) of the subgroup attending two or more AUP events agreeing or strongly agreeing with this statement.

However, suicide is still perceived as a taboo subject and still carries stigma even as participants acknowledge the importance of preventing suicide in their community. In both the pre- and post-surveys, over 60% of the respondents did not agree with the statement that people in the community feel comfortable talking about suicide, indicating that suicide remains a difficult topic. A focus group participant acknowledged the difficulty in addressing suicide: "I knew it (AUP) was about suicide prevention and awareness especially among youth. In my family, I've had relatives who have committed suicide, so it was very intimidating to me when I first heard about this program. They asked me if I was interested in being a mentor. I said, 'I'm not a counselor.' I wouldn't know what to say to somebody who was in that position."

Evaluation Question 2

During the AUP implementation, did more community members (TAY and adults) seek help and support for mental health issues?

"Our program indirectly motivated a single mother in recovery to seek services on her own after participating in our virtual GONA and Family Fun Nights. We provided information on how to access our behavioral health services during those events. The single mother continues to attend our events with her child to support her recovery, wellness and connection to her cultural values." Dean Hoaglin, Community Outreach Specialist

Integrating the PHQ depression screening at every medical appointment within the Sonoma County Indian Health Project appeared to result in a greater number of community members being identified as needing mental health support resulting in a referral. In total, 2,369 unduplicated individuals (youth and adults) were given the PHQ-9. A greater percentage of youth ages 14–17 was identified as meeting a threshold for mental health services with 58% referred compared to 18–24-year-olds (44% referred) and 25+ years (38% referred). Specifically, of the 161 youth who were screened with the PHQ-9, 93 (58%) were referred to behavioral health services, of which 64 (69%) followed through with an appointment.

This is a significant finding as the SWE pre-survey measures cited that 32% of the youth survey participants self-identified as needing help for their mental health issues in the past 12 months, as compared to the 58% screened and referred for depression indicators at the clinic. Furthermore, 64% of the survey respondents stated they would not seek help from a mental health professional as they felt they could resolve the issue on their own and 45% felt their issue was not serious enough.

Of the 1904 adults who were screened with the PHQ-9, 724 (38%) received referrals to behavioral health services and 512 (71%) attended their first appointment. The adult group (25+ years) had the highest percentage follow-through with keeping an appointment based on PHQ-9 referral among all age groups. The practice of administering PHQ-9 depression screenings and tracking referrals and corresponding appointments demonstrate an effective process for supporting the mental health and wellbeing of the SCIHP patient community.

Focus group participants expressed gratitude for the formal and informal support they had received through the Aunties and Uncles Program. The recognition of trauma and common struggle helps reduce the stigma attached to mental health challenges.

"I do have MH disabilities, I have probably my whole life, from childhood trauma… So, when I was at SCIHP, I was seeing my counselor once a week through zoom/telehealth. The talking circle I go to every week helps me."

"I've been really isolated. And so being able to see other people on zoom and being able to interact at that level was neat."

"…reminded me of how strong our community is and how we don't always have to know each other to come together to uplift one another. I think for me, where I was dealing with something really hard, I knew that I had a really strong community to help me through that. I was really grateful for that event."

"It was just a few months after my Mom had passed away. We did a big prayer circle and they offered prayer to me and my family for the loss of my Mom."

Evaluation Question 3

How did the mental health status among TAY AUP participants change?

Based on the findings of the SWE core measures, Herth Hope Index in local survey and focus group data, AUP participants reported improvements in mental health status, specifically with depression and anxiety. Fifty-six percent of survey respondents (SWE core measures) showed improvement in their level of distress. The pre- and post-SWE core measures indicated that both older TAY (adult) and younger TAY (youth) reported significantly lower psychological distress after one year of AUP activities. Areas of particular significance for youth were a reduction in nervousness (1.5 → 1.2) and feeling so depressed where nothing could cheer them up (0.9 → 0.6). All TAY (adult and youth) reported improvements in feeling restless or fidgety. Adults reported a greater statistically significant improvement (1.9 → 1.3) compared to youth reporting (1.6 → 1.1). Finally, adults reported significant improvement in feeling that everything was an effort (1.6 → 0.9). Adult survey respondents between the ages of 18–25 reported significant improvement in their performance at work, school, and household chores, while youth did not have any significant changes in school/homework or in relations with family or friends (7.9 → 6.0).

The findings of the Herth Hope Index indicated survey participants who participated in two or more AUP activities had higher scores indicating optimism and hope for their future than their counterparts who only attended one AUP event. To be conclusive, this would require further study to assure the exposure to the intervention was clear and consistent. Of those attending two or more events, 85% reported they had a positive outlook for the future as compared to 56% of those who attended only one event. This is also reinforced by the finding that 24% of those who attend only one event reported feeling all alone compared to only 7% of those attending two or more AUP events.

Finally, focus group participants, a subset of those who took the surveys, reported a greater awareness of their mental health and an ability to practice self-care. Participation in talking circles for TAY and adults in the community were cited as having value, especially during COVID-19 and Stay-at-Home order.

"I participate in those adult talking circles too and I look forward to them. It's great to talk to other adults. Just to see them on zoom because we have been SIP (Shelter-in-Place) and can't go to too many places. The hard thing in the past year is just that, being cooped up. I do get the blues and it is a bit of depression that we're in this predicament that we are in."

"When I get stressed, I usually get mad, and I want to throw everything or just cry cause it's stressful. So, I usually take breaks, in between and usually try to find a way to calm me down. Like make friendship bracelets, paint or draw."

"The Wellness program is awesome too. Using that to talk about things, good things too, wellness that helps me a lot too."

"I'm a person who gets really overwhelmed pretty easily, so if I can find that healthy rhythm, a routine, it is definitely something that helps me keep my stress and mental health in check."

Evaluation Question 4

Does the AUP contribute to increased community involvement and community connectedness? Is increased community involvement and community connectedness associated with an increase in community wellness as reported by attendees?

The Aunties and Uncles Program provided opportunities for youth and adults to be more involved in their community and connected to their fellow Native American community members. During the evaluation period of three years, AUP offered 18 Wellness Gatherings (large community events), eight Cultural Workshops, and 129 Talking Circle sessions. Prior to the COVID-19 Stay-at-Home order, attendance at various events was growing, especially at large events with 200-300 individuals and family members attending (**Appendix 2**). Over 4,300 contacts were made in the course of the study period with interactions ranging from brief encounters during community fairs and wellness gatherings to more in-depth interactions during cultural workshops, GONA and talking circles.

Survey participants responding in the post-SWE core measures (no pre- for comparison) cited a high degree of community connectedness. When asked, "I have people with whom I can do enjoyable things," 78% agreed or strongly agreed with that statement. Three-quarters felt they get along better with friends and other people and 78% stated they know people who will listen and understand them when they need to talk.

Feedback surveys from participants of the GONA (Gathering of Native Americans) indicated a high level of community connectedness. 100% of participants reported feeling more connected to family and community and felt that they could be a role model and contribute more to the community. A great sense of optimism regarding the future was reported by 66% of attendees at the first GONA and 100% of attendees at the second GONA.

Participants in all three focus groups were asked to recall what AUP events they attended and what they found most valuable about those events. The most frequently mentioned comments were related to community (building), a sense of belonging, family, and intergenerational exchange/teaching.

"Meeting someone new and now we are in Wellness Group together. Come to have a good relationship with them and found out they are my cousin in one way or another. ...Discovering you belong to a larger community. Making connections, I like doing that."

"... just getting together to network and being with other parents to talk about how their kids are doing in school. Who to hook up your kids with, like if they were interested in dance, or wanting to learn how to sew or make regalia."

"Really building community, all of the things that AUP is doing are very valuable and significant to what our community really needs."

"I've been able to meet other really cool natives and role models that I wouldn't have met otherwise."

" I remember going to a FFN and the first thing I said to my Mom was, "My people!"

The participants of the adult focus group further shared the value of intergenerational relationships and the importance of tradition when asked, "What interactions have you had with other adults at the AUP community events that have been valuable to you, or even other participants?"

"There are some (youth) that don't have the connection with their own grandparents. When you have a Native around you that has pride to share the good, the many good things. Those kids sit there, and they are in awe. That is something I really feel we need to continue to keep there."

"I think for me, a lot of it is when I get to sit with those elders. You learn so much from those elders. They are a very, very big part of our community. Could I say that maybe we are losing some of that? Yea, we are. It's up to us, the 50-age group that gets more from our elders so we can continue that. The elders are a big part of it, for me. I love the youth and I know they are resilient, but when you learn from the elders you get to share part of that also."

"... and I do the honoring of graduates. The superintendent of schools was there, and I served her plate and gave a Native medallion. She felt so honored and thanked me when I brought her the food and when she spoke, she felt so honored. When I do something like that for an elder, I felt proud, right? Cause I was doing something that I was taught to do... is to be respectful to my elders, so I think that all that is happening with AUP, we are teaching and role models for the young people."

"I enjoy seeing not just the young people coming, but the elders coming too."

"Awesome networking time for me, cause I wasn't really raised knowing all the traditional things and I had a couple of foster children at the time who really wanted to dive into the culture more and so the FFN and networking really helped me to do that for them."

The large community events, such as Wellness Gatherings, Family Fun Night, Memorial Gathering, Native Wellness, and Natives Got Talent were designed to be all inclusive and family friendly. The strength of intergenerational relationships, passing traditions, honoring elders, celebrating culture, and belonging to community builds and maintains resilience as evidenced by this collective research. When people are connected, they develop a sense of purpose and pride. This resilience is a protective factor for both mental health and physical health. Within Native American families, resiliency is a particularly complex construct in part due to the importance and extent of family and kinship roles. Consisting of a larger social unit, Native American families are defined by how they provide for the youngest and oldest in the human life cycle. Extended family often includes blood relatives and those related by clan, informal adoption, spiritual ties, and other tribal community recognition processes. (Goodluck C 2009)

Evaluation Question 5

How did TAY participants' self-esteem and cultural identity change as a result of the AUP?

Examining TAY participants' change in cultural identity, the SWE survey data indicated that there was no significant change in cultural connectedness as levels were reported as very high in both the pre- and post-core measure results. Even when broken down by specific questions, the pre- and post- results were not statistically different. Furthermore, there was no change in the pre/post responses to cultural risk factors, albeit the responses indicated that the participants felt marginalized or excluded from society most of the time.

A surprising finding was the change in cultural protective factors from participants' pre-core measure responses to their post-core measure responses. Of significance, two questions "During the past 30 days, how often did you feel connected to your culture?" and "During the past 30 days, how often did you feel balance in mind, body, spirit and soul?" Both items demonstrated a decrease from pre to post. Participants felt less connected to their culture according to the data. One explanation is that participants who selectively decide to attend AUP events and activities already have an affinity and connection with their Native culture, and many were responding during the time of COVID-19 Stay-at-Home order. Another explanation may be that there was respondent bias in the pre-core measure responses where participants are reporting what they believe the "correct" answer is expected to be and are more honest in the post-reporting.

However, the GONA feedback surveys indicated a strong sense of cultural connectedness through community and family connections. Many participants expressed understanding the power of community connection, cultural identity and sense of self. Others stated the importance of intergenerational teaching of cultural practices and heritage. One hundred percent of GONA participants stated they wanted to learn more about their culture and that the lessons of the GONA would help them to be a better person/community member.

Focus group participants further elaborated on their increased understanding of how culture is prevention and that community connectedness, intergenerational relationships, and learning from elders was key to understanding their own identity and building self-esteem. Below are a few quotes from focus group participants:

"I think culture is really important to me, cause it represents who I am. Like traditional dancing, beadwork, basketry. ...my Mom does beadwork too, so my Mom teaches me that."

"Just by being a part of the cultural workshops, I didn't realize that that could be healing for somebody. A lot of the times the small things we do, is and can be big and huge for someone else. We just never know. When they say smile or hug someone, those things are really meaningful for somebody cause we never know who's going through a difficult time."

"I think the AUP goes a long way in helping facilitate an environment where you can embrace and look into, you get a better understanding of what culture can be in a healthy way, which is a really valuable opportunity considering that there is limited information out there and it can be really hard especially when you don't have direct access to it."

"T's mom is my auntie and I learned beadwork and sewing from her, I watched her pick materials for baskets and I'm grateful I have a lot of connections in my family to learn more about who I am."

Evaluation Question 6

How did participation in the AUP talking circles impact TAY and other community members?

Talking Circles for TAY were offered at six high schools and at the Sonoma County Indian Health Project Community Room. The Talking Circles at the high schools included Santa Rosa, Elsie Allen, Ridgeway, and Piner in central Sonoma County, and Point Arena/Kashia on the coast. Arrangements for all Talking Circles were coordinated with the schools through the assistance of the Indian Education Coordinator or Native Club advisor.

A total of 129 Talking Circles were offered in schools (39), community settings (2), and virtually (88). Attendance ranged from one to 23 TAY with an average of 3.7 participants. As noted in the Methods section, challenges in securing a consistent schedule influenced the program's ability to obtain consistent participation. However, in reviewing attendance records, there were six TAY who regularly participated. It should be noted that the break between in-person and virtual meetings influenced who attended, yet both methods of delivery were able to maintain a small cohort of participants.

The challenges in data collection from Talking Circle participants were significant and only four participants completed the pre- and post-core measures and local survey. Obtaining parental consent at school-based Talking Circles was logistically difficult in terms of sending paperwork home, connecting with the parent for an orientation to the project, and then getting the signed consent returned. Many survey participants that attended other in-person events, such as Wellness Gatherings, completed their pre- and post-surveys prior to, or very early in, the offering of virtual Talking Circles. Therefore, data pertaining to Talking Circles were included in very few pre- and post-surveys. Finally, the efforts to have Talking Circle participants attend the focus groups in early 2020 were met with minimal success. Only two focus group participants had attended Talking Circles with regularity. Thus, findings are inconclusive, at best, and are aligned with the sentiment of other focus group participants who did not attend Talking Circles.

A conclusion of the impact of Talking Circles is that, with consistency, trusting relationships can develop and a sense of individual strength can be found within the context of wellness and community.

"I think that as young people we have a lot of distractions around us, so it is really up to us to sit and listen and try to learn those things that they are trying to teach us."

"Meeting someone new and now we are in Wellness Group together. Come to have a good relationship with them…Making connections, I like doing that."

"The (Cultural) Wellness (Series) program is awesome too. Using that to talk about things, good things too, wellness that helps me a lot too."

"I've been able to meet other really cool natives and role models that I wouldn't have met otherwise."

"Understanding (my values) and Dean has shared it's OK to not be like everyone else."

Conclusion

Our healthcare system, in general, collects demographic data with race and ethnicity delineated with the intention of assessing cultural representation and utilization of health and mental health services. Often funding and policy development are aligned with this data. However, culture is much more diverse and impossible to capture via a checkbox. Culture can be found in groups of people of similar age, geographic location, experiences (e.g., Veterans), and race/ethnicity. These cultures are intersectional in various combinations. It is challenging to say that an evidence-based practice (EBP) program model is relevant to all groups of a similar nature, e.g., Caucasian men ages 35–55 years. If one group is located in an urban area and another is in a rural area, there may be cultural differences that may affect the effectiveness of the EBP.

On the other hand, CDEPs by their very nature are community defined. Inherent in that model, communities participate in the development, implementation, and evaluation of the program model. This is a very big paradigm shift for a system that has been built by a dominant culture through a singular lens.

CDEPs are localized. Cultural practices and opportunities to teach and learn within the local context are invaluable. Many Native Americans have been oppressed for generations, resulting in denied access to their culture. Native youth and young adults have rediscovered their culture, reclaimed their self-identity, and strengthened their resilience through the activities and community connections that the Aunties and Uncles Project provided.

The study findings are described in two sections: 1) significant evaluation findings relevant to stated evaluation questions and 2) key program elements relevant to the study of program process and implementation.

Significant Evaluation Findings Relevant to Evaluation Questions

1. How did knowledge, attitudes, and beliefs (KAB) regarding mental illness change among transitional-age youth (12-25) as a result of the Aunties and Uncles Program?
    a. Post-AUP intervention, 90% of survey respondents felt that talking about emotions is important to Native youth compared to only 68% in the pre-survey results.
    b. Native youth seek out those who they trust, who are non-judgmental, have lived experiences, and have wisdom. For the majority, Native youth feel supported by adults to succeed (school, career), but don't feel as strongly that adults listen or will talk to them when they are struggling emotionally.
    c. However, 78% of the participants reported that they knew someone who would listen to them and understand them if they needed to talk.
    d. Sixty percent of the participants stated that suicide remained a taboo subject that is difficult to talk about among community members.

2. During AUP implementation, did more community members (TAY and adults) seek help and support for mental health issues?

a. The practice of administering the PHQ-9 depression screening resulted in a high level of referrals made to mental health services and a significant percentage of youth (69%) and adults (71%) following up with an appointment to see a behavioral health specialist.

3. How did the mental health status among TAY Aunties and Uncles Program participants change?
    a. Over half of the AUP participants (56%) reported improvements in mental health status, specifically with depression and anxiety.
    b. Focus group participants, a subset of those who took the surveys, reported a greater awareness of their mental health and an ability to practice self-care.

4. Does the Aunties and Uncles Program contribute to increased community involvement and community connectedness? Is increased community involvement and community connectedness associated with an increase in community wellness as self-reported by attendees?
    a. Over three-quarters of the survey participants cited a high degree of community connectedness. Seventy-eight percent of the participants stated that they know others with whom they could do enjoyable things together and 78% also stated they know people who will listen and understand them when they need to talk.
    b. Focus group findings identified the themes of community and belonging as a valuable benefit of attending AUP activities. Direct quotes from the focus groups included sentiments of the importance of intergenerational and kinship (non-blood relatives) relationships in building mental health resilience.
    c. Participants in the Gathering of Native Americans (GONA) reported feeling more connected to family and community (100%) and believed they could be a role model to others in the community (100%).

5. How did TAY participants' self-esteem and cultural identity change as a result of the Aunties and Uncles Program?
    a. The value of cultural identity and recognition that culture is prevention was most apparent in the feedback surveys of GONA participants and focus group participants. Specifically, intergenerational relationships, learning from elders and being with other Native Americans were the most frequently repeated themes.
    b. The pre- and post-survey findings did not indicate cultural identity change in participants. The pre-survey results indicated a high level of cultural connectedness. A theory is that participants were self-selected already having an affinity for their heritage and Native American culture.
    c. Over two-thirds of TAY survey respondents stated feeling satisfied with their family life and stated they were doing better in school and/or work. In addition, two-thirds reported that they were better able to cope when things go wrong and that they were better at handling daily life.
    d. Respondents to the Herth Hope Index signified having a positive outlook toward life (85%) and having short and/or long-term goals (81%). Finally, over 95% reported feeling that their life has value and worth.

6. How did participation in the Aunties and Uncles Program Talking Circles impact TAY and other community members?
    a. Talking circle participants, both youth and adults, expressed gratitude to have a safe place to express themselves, learn from others and build trust.
    b. The study was unable to quantify impact, however, attendance during the COVID-19 shelter at home was small but consistent, indicating importance and benefit to participants.

Overall, AUP program participants articulated the power of being connected to community and culture and that culture is prevention. Knowing one's culture strengthens identity and pride. Common ancestry and history between community members creates an initial bond and combined with shared understanding builds individual and community resilience. Culture is also seen as a way to carry forth traditions, honor elders and honor self. Native culture is rooted in spirituality and ritual. The Native youth participating in AUP stated they wanted to learn more about their culture, to know who they are, where they come from and to feel the wisdom and support from their ancestors.

Community building among Natives promotes a sense of belonging and supports resilience. AUP events were inclusive and intergenerationally focused. Elders were acknowledged and honored, children were given space to play and had arts and crafts activities, youth were engaged in a non-judgmental and safe space. Coming together as a community also allowed networking opportunities to meet new community members, for youth to meet other Natives, often elders/mentors, and for the exchange of resources that support family health and culture.

Post-evaluation, staff reported that two youth who participated in the Cultural Wellness Series (Talking Circle) facilitated break-out sessions at the third GONA held August 2021. This is a wonderful demonstration of youth leadership, an indirect outcome of AUP.

In the local Native community, there is still stigma associated with seeking support from behavioral health professionals. Some participants have expressed concern that their family or friends or other community members will find out about their seeking help for an emotional challenge. Talking about suicide is difficult and thus goes unaddressed within the community.

AUP youth participants acknowledged the importance of self-care in mental health wellness. They shared a range of activities and tools they used especially during the year of COVID-19 Stay-at-Home orders. Cultural practices and arts, such as beading, weaving baskets, dancing, drumming, land stewardship, and learning from elders were cited as activities to help keep them grounded, calm and centered when stressed, anxious or depressed.

Key Program Elements

1) Hiring staff from the community is an asset to the program's implementation and success. A local Native not only brings cultural knowledge and history, but also familiarity with practices, and pre-existing relationships with community members. The familial relationships go beyond immediate and blood relations. This is exemplified by the use of terms such as cousin, auntie and uncle used affectionately to relate to others

where close relationships have been built. The pre-existing relationships in the community are a strength, creating greater trust and connectivity, allowing staff to move into and throughout various tribes and Rancherias.

2) Sustained program activity and visibility is important to building trust and a sense of reliability in the community. Native Americans have experienced breakdowns in trust when offerings are made and then taken away, such as the breaking of historical treaties.

3) Listening and responding to tribal needs is foundational for programs that are culturally responsive. Ongoing communication and engagement with tribal councils, administrators and educators have been vital to addressing mental health disparities among local Native tribes.

4) Intergenerational events and activities honor the culture by including the whole family. Family is the foundation for community. The benefits of community building were supported by the evaluation findings.

In conclusion, the Aunties and Uncles Program integrated a number of culturally based interventions that have shown benefit, such as Gathering of Native Americans and community-cultural connectedness. (Masotti P 2020; Johnson C 2021) The traditional practices that are recognized as important components of healing including traditional healers, talking circles, ceremonies, storytelling, drumming, and basket weaving (California Reducing Disparities Project 2012) were specific activities and features in AUP events. For the participants of the Aunties and Uncles Program, the strength of intergenerational relationships, learning and sharing traditions, honoring elders, celebrating culture, and belonging to community built and supported resilience as evidenced by this collective research and others. (Morris SL 2021, Henson M 2017)

When people are connected to community and culture, they develop a sense of purpose and pride. This resilience is a protective factor for both mental health and physical health. Within Native American families, resiliency is a particularly complex construct in part due to the importance and extent of family and kinship roles. Consisting of a larger social unit, Native American families are defined by how they provide for the youngest and oldest in the human life cycle. Extended family often includes blood relatives and those related by clan, informal adoption, spiritual ties, and other tribal community recognition processes. (Goodluck C 2009)

Due to the cultural context that underlies inequities in mental health, cultural connectedness and cultural practices are important foundations for Native wellness. When interventions focus on the individual, they miss the importance of culture as a determinant of health, which for AI/AN cultures includes the risk factor of loss that can be addressed through strengthening connection with culture as a protective factor. (Masotti P 2020)

The opportunity to implement and evaluate the Aunties and Uncles Program, a Community-Defined Evidence Practice, was an outcome of community advocates and forward-thinking policy makers. For the ancestors and future generations, sustaining and expanding culture based community-wide mental health prevention, intervention, and treatment programs, such as Aunties and Uncles will address the disparities experienced by many generations. Policy makers,

funders and leaders need to keep their minds and hearts open to hear the stories of diversity and self-determination that are not in the traditional boxes built within our ivory towers. This report demonstrates the importance of supporting Native American communities as they draw from their own cultural beliefs and practices to define healing and wellness. Ultimately, the collective impact of this program is immeasurable, as it has supported and reinforced traditional Native American healing practices for the people in this community at a critical time in our history.

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Appendices

Appendix 1: Meta Analysis Data

Measure Name	Modified Y/N	Pre Score Mean	Pre Score SD	Pre N	Post Score Mean	Post Score SD	Post N	Correlation between pre and post	Age group
Cultural Connectedness	N	19	1.63	10	19.2	1.14	10	0.78	Adult
Cultural Connectedness	N	17.83	2.3	40	17.38	2.95	40	0.46	Youth
Cultural Protective Factors	N	8	1.05	10	8.2	1.55	10	0.41	Adult
Cultural Protective Factors	N	7.76	1.6	38	6.63	2.15	38	0.28	Youth
Cultural Risk Factors	N	4.5	2.32	10	4.8	2.25	10	0.32	Adult
Cultural Risk Factors	N	4.79	2.55	39	4.51	2.19	39	0	Youth
Psychological Distress	N	7.9	5.43	10	6	5.58	10	0.86	Adult
Psychological Distress	N	6.86	6.66	35	5.8	5.95	35	0.82	Youth
Psychological Functioning	N	1.11	0.67	9	0.53	0.44	9	0.12	Adult
Psychological Functioning	N	0.82	0.7	33	0.82	0.58	33	0.53	Youth
Cultural Connectedness	N	18.06	2.22	50	17.74	2.77	50	0.51	Combined
Cultural Protective Factors	N	7.81	1.5	48	6.96	2.12	48	0.3	Combined
Cultural Risk Factors	N	4.73	2.48	49	4.57	2.18	49	0.05	Combined
Psychological Distress	N	7.09	6.36	45	5.84	5.81	45	0.82	Combined
Psychological Functioning	N	0.87	0.7	42	0.76	0.56	42	0.4	Combined

Table B: Cultural Connectedness

Group	Pre Score Mean	Pre Score SD	Post Score Mean	Post Score SD	N	p-value	Cohen's D
All	18.06	2.22	17.74	2.77	50	n.s.	0.13
Adult	19.00	1.63	19.20	1.14	10	n.s.	-0.19
Youth	17.83	2.30	17.38	2.95	40	n.s.	0.16

n.s.: Not significant

Table C: Cultural Protective Factors

Group	Pre Score Mean	Pre Score SD	Post Score Mean	Post Score SD	N	p-value	Cohen's D
All	7.81	1.50	6.96	2.12	48	**	0.39
Adult	8.00	1.05	8.20	1.55	10	n.s.	-0.14
Youth	7.76	1.60	6.63	2.15	38	**	0.49

*n.s.: Not significant; **p<.01*

Table D: Cultural Risk Factors

Group	Pre Score Mean	Pre Score SD	Post Score Mean	Post Score SD	N	p-value	Cohen's D
All	4.73	2.48	4.57	2.18	49	n.s.	0.05
Adult	4.50	2.32	4.80	2.25	10	n.s.	-0.11
Youth	4.79	2.55	4.51	2.19	39	n.s.	0.08

n.s.: Not significant

Table E: Psychological Distress

Group	Pre Score Mean	Pre Score SD	Post Score Mean	Post Score SD	N	p-value	Cohen's D
All	7.09	6.36	5.84	5.81	45	*	0.34
Adult	7.90	5.43	6.00	5.58	10	+	0.65
Youth	6.86	6.66	5.80	5.95	35	n.s.	0.28

*n.s.: Not significant; +p<.10; *p<.05*

Table F: Psychological Functioning

Group	Pre Score Mean	Pre Score SD	Post Score Mean	Post Score SD	N	p-value	Cohen's D
All	0.87	0.70	0.76	0.56	42	n.s.	0.15
Adult	1.11	0.67	0.53	0.44	9	*	0.77
Youth	0.80	0.70	0.82	0.58	33	n.s.	-0.04

*n.s.: Not significant; *p<.05*

Appendix 2: Events Conducted and Attendance

Date	Event	Location	Attendance
PREVENTION AND EDUCATION EVENTS			
10/10/2018	Indigenous People's Day	Santa Rosa Jr College	Not available*
10/18/2018	Bioneers Conference	San Rafael	Not available*
10/27/2018	Native Arts Expo	Gualala Arts Center	Not available*
10/31/2018	Harvest Fair	Sonoma County Behavioral Health	Not available**
11/9/2018	Veterans Day Celebration	Sonoma County Indian Health Project (SCIHP) Community Room	62
11/17/2018	Men's Wellness Gathering	Ya-Ka-Ama	Not available*
11/26/2018	Native Club	Point Arena High School	Not available**
11/27/2018	Native Club	Montgomery High School	14
11/27/2018	Native Club	Santa Rosa High School	5
12/18/2018	Native Club	Comstock Middle School	Not available**
12/20/2018	Winter Wonderland Skate Night	Cal Skate, Rohnert Park	300
3/14/2019	Native American Cultural Awareness	Santa Rosa Jr College	100
5/10/2019	Gualala Community Wellness Fair	Gualala Community Center	50
5/20/2019	Mental Health Awareness	Memorial Hospital	50
5/21/2019	Native HS Graduation	Piner High School	100
5/30/2019	Native Motivation Day	Point Arena High School	60
6/2/2019	SCIHP Native Graduation	Friedman Center	200
6/7/2019	SCIHP Summer Health Fair	SCIHP Parking Lot	200
6/12/2019	ACORNS	Ya-Ka-Ama	40
6/17/2019	Native American Summer Bridge	Santa Rosa Junior College	14
6/25-27/2019	Dreams not Drugs	Ya-Ka-Ama	100
7/1/2019	Clinic Opening	SCIHP Manchester Point Arena Clinic	50
8/1/2019	MMIW Event	SCIHP Community Room	50
9/7/2019	CA Indian Celebration	California Indian Museum and Cultural Center	50
9/9/2019	Cultural Awareness Presentation	Santa Rosa High School	25
9/18/2019	Cultural Awareness Presentation	Sonoma State University	15
10/4/2019	Fall Health Fair	SCIHP Community Room	75
10/14/2019	Indigenous Peoples Day	Santa Rosa Junior College	50
10/14/2019	Cultural Awareness Presentation	Sonoma State University	20
10/16/2019	Health Fair	Point Arena High School	250
10/31/2019	Harvest Fair	SCIHP Community Room	150
11/7/2019	Buckelew Tabling Event	Sonoma Day School	100
2/28/2020	Native American Cultural Awareness	Santa Rosa Junior College	100
11/10/2020	Veterans Day Celebration Drive Thru	SCIHP Parking Lot/Outreach	25

11/19/2020	Indigenous Voice Panel	Virtual platform	13
1/21/2021	CIMCC Tobacco Listening Lesson	Virtual platform	18
3/30/2021	Men's Wellness Panel	Virtual platform	30
5/6/2021	Many Faces of Mental Health	Virtual platform	30
COMMUNITY WELLNESS GATHERINGS			
9/18/2018	Memorial Gathering	Ya-Ka-Ama	287
11/16/2018	Family Fun Night	SCIHP Community Room	81
2/22/2019	Family Fun Night	SCIHP Community Room	137
4/19/2019	PA Family Fun Night	Tribal Center	30
5/17-18/2019	Traditional Health Gathering	Ya-Ka-Ama	141
5/25/2019	Wellness Gathering	Spring Lake Park, Santa Rosa	30
6/21/2019	Natives Got Talent	Finley Community Center	143
7/12/2019	Wellness Gathering	Point Arena High School	43
8/31/2019	Memorial Gathering	Ya-Ka-Ama	222
9/20/2019	Family Fun Night	Piner High School	60
11/8/2019	Veteran's Day Celebration	SCIHP Community Center	50
11/15/2019	Family Fun Night	Kashia Community Center	40
2/21/2020	Family Fun Night	SCIHP Community Room	88
9/22-25/2020	Gathering of Native Americans (GONA)	Virtual platform	18
7/24/2020	Natives Got Talent	Virtual platform	15
12/18/2020	Family Fun Night	Virtual platform	18
2/19/2021	Family Fun Night	Virtual platform	34
3/23-26/2021	Gathering of Native Americans (GONA)	Virtual platform	36
CULTURAL WORKSHOPS			
2/28/2019	Basket Weaving Workshop	SCIHP Community Room	5
3/28/2019	Dreamcatcher Workshop	SCIHP Community Room	4
4/25/2019	Beading Workshop	SCIHP Community Room	3
1/30/2020	Basket Weaving Workshop	SCIHP Community Room	11
2/29/2020	Basket Weaving Workshop	Kashia Community Center	13
5/3/2021	MMIW Bandana Painting Workshop	Virtual platform	7
4/8/2021	Necklace Workshop	Virtual platform	7
6/30/2021	Medicine Bag Workshop	Virtual platform	13

*Data on attendance was not available since the event was not hosted by AUP. Host agency did not collect or provide sign-in sheet or attendance numbers.
**These events hosted by SCIHP or AUP did not collect attendance data. Program team and local evaluator identified the need to collect attendance data and developed Event Log to capture details on attendees and occurrence of event.

Appendix 3: AUP Local Pre/Post Surveys

AUP WELLNESS AND SUPPORT SURVEY

1) Participant ID *_____

Wellness and Support

2) When you are upset or stressed, how often do you turn to the following people for support? (Choose one response for each person)

	Never	Rarely	Sometimes	Often	Very Often	Not applicable
Spouse/Partner	( )	( )	( )	( )	( )	( )
Friend	( )	( )	( )	( )	( )	( )
Cousin	( )	( )	( )	( )	( )	( )
Brother	( )	( )	( )	( )	( )	( )
Sister	( )	( )	( )	( )	( )	( )
Auntie	( )	( )	( )	( )	( )	( )
Uncle	( )	( )	( )	( )	( )	( )
Mom	( )	( )	( )	( )	( )	( )
Dad	( )	( )	( )	( )	( )	( )
Daughter	( )	( )	( )	( )	( )	( )
Son	( )	( )	( )	( )	( )	( )
Grandma	( )	( )	( )	( )	( )	( )

Grandpa	( )	( )	( )	( )	( )	( )
Teacher	( )	( )	( )	( )	( )	( )
Medical provider	( )	( )	( )	( )	( )	( )
Therapist	( )	( )	( )	( )	( )	( )
Counselor	( )	( )	( )	( )	( )	( )
Native traditional healer	( )	( )	( )	( )	( )	( )
Church priest or minister	( )	( )	( )	( )	( )	( )

Shaded items were included in the post-survey, not the pre-survey

3) For those people you selected "often" or "very often," please share why they are someone you confide in for support.

4) Below are a number of statements. Read each statement and check which describes how much you agree with that statement right now.

	Strongly Disagree	**Disagree**	**Neither Agree Nor Disagree**	**Agree**	**Strongly Agree**
I have a positive outlook toward life	( )	( )	( )	( )	( )
I have short and/or long-range goals	( )	( )	( )	( )	( )
I feel all alone	( )	( )	( )	( )	( )

I can see possibilities in the midst of difficulties	( )	( )	( )	( )	( )
I have a faith that gives me comfort	( )	( )	( )	( )	( )
I feel scared about my future	( )	( )	( )	( )	( )
I can recall happy/joyful times	( )	( )	( )	( )	( )
I have deep inner strength	( )	( )	( )	( )	( )
I am able to give and receive caring/love	( )	( )	( )	( )	( )
I have a sense of direction	( )	( )	( )	( )	( )
I believe that each day has potential	( )	( )	( )	( )	( )
I feel my life has value and worth	( )	( )	( )	( )	( )

5) There are several ways members of the Sonoma County Native American community can help to prevent youth suicide. From the list below, please select which prevention methods you believe are most effective at preventing youth suicide. Please select all that apply.

[ ] Knowing the signs of suicide
[ ] Increased self-esteem
[ ] Traditional/cultural activities and events
[ ] Life skills classes
[ ] Helping family members get along
[ ] Talking Circles

6) Below are a number of statements. Please read each statement and check how much you agree with each.

	Strongly Disagree	**Disagree**	**Neither Agree Nor Disagree**	**Agree**	**Strongly Agree**
Talking about emotions is important to youth in the community	( )	( )	( )	( )	( )
Adults in the community talk to youth about their emotions	( )	( )	( )	( )	( )
People in the community feel comfortable talking about suicide	( )	( )	( )	( )	( )
There is a safe place for youth to go if they need to talk with someone	( )	( )	( )	( )	( )
When people in the community go to the clinic, the staff ask patients about their emotions	( )	( )	( )	( )	( )
I am satisfied with the suicide prevention activities in the community	( )	( )	( )	( )	( )

7) If you could design a wellness program that addresses behavioral health and well-being, what activities would it include? Please select all that apply.

[ ] Suicide Prevention
[ ] Trainings (please list types): _____
[ ] Community Gatherings
[ ] Group Counseling (Talking Circles, Support Groups)
[ ] Wellbriety/Red Road
[ ] Native American Cultural & Traditional Activities (i.e. gathering traditional foods, learning your language)
[ ] Any other things you would like to list, please specify here:
_____

Aunties and Uncles Activities

8) Have you ever taken part in any Aunties and Uncles activities?

( ) Yes
( ) No

9) What type of activity or activities? Please select all that apply.

[ ] Suicide Prevention Training
[ ] Other type of training (please list):_____
[ ] Friday Family Fun Night
[ ] Wellness Gathering
[ ] Memorial Gathering
[ ] Native Club at my school
[ ] Cultural Workshop(s) (please list):_____
[ ] Other (please list) _____

10) Thinking about the Aunties and Uncles activities you participated in, what did you like and how did it improve your knowledge about wellness and well-being?

11) Thinking about the Aunties and Uncles activities you participated in, was there anything that could be improved or added knowledge about wellness you would have liked to see?

Post-survey only:

12) Specifically, rate how your participation increased your knowledge in the following areas:

1= not at all, 2 = somewhat, 3 = a lot

	1	2	3
Suicide prevention: listening techniques, community resources			
How culture is a protective factor			
Self-care for wellbeing			
Resources and support for emotional wellbeing			
Ways to help family, friends and other community members who suffer from emotional distress			

Thank You!

Appendix 4: Statewide Evaluation IPP Pre/Post-Core Measures: Adolescent and Adult

ADOLESCENT VERSION PRE

ID:

__ __ - __ __ - __ __ __

Priority Pop Code *IPP Code* *CDEP Participant Code*

ADOLESCENT VERSION (12-17)

PRE

Culture means many different things to different people but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others, it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group. The next questions are about your culture.

At present…	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree
1. Your culture gives you strength.	☐	☐	☐	☐	☐
2. Your culture is important to you.	☐	☐	☐	☐	☐
3. Your culture helps you to feel good about who you are.	☐	☐	☐	☐	☐
4. You feel connected to the spiritual/religious traditions of the culture you were raised in.	☐	☐	☐	☐	☐

The next questions are about how you have been feeling during the past 30 days.

About how often during the past 30 days did you feel…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
5. …connected to your culture?	☐	☐	☐	☐	☐
6. …balanced in mind, body, spirit and soul?	☐	☐	☐	☐	☐
7. …marginalized or excluded from society? (*In other words, made to feel unimportant, or like your thoughts, feelings, or opinions don't matter.*)	☐	☐	☐	☐	☐
8. …isolated and alienated from society? (*In other words, feeling alone, separated from, cut off from the world beyond your family, school, and friends.)*	☐	☐	☐	☐	☐

	Yes	No	Refused	Don't Know
9. In the past 12 months did you <u>THINK YOU NEEDED HELP</u> for emotional or mental health problems, such as feeling sad, anxious, or nervous?	☐	☐	☐	☐

	Yes	No	Refused	Don't Know
10. In the past 12 months, have <u>YOU RECEIVED</u> any psychological or emotional counseling from any of the following…				
a. <u>Traditional helping professional</u> such as a culturally-based healer, religious/spiritual leader or advisor?	☐	☐	☐	☐
b. <u>Community helping professional</u> such as a health worker, *promotor*, or peer counselor?	☐	☐	☐	☐

	Yes	No	Refused	Don't Know
11. In the past 12 months, have <u>YOU RECEIVED</u> any psychological or emotional counseling from someone <u>AT SCHOOL</u>, such as a school counselor, school psychologist, school therapist, school social worker?	☐ GO TO Q12	☐ GO TO Q14	☐ GO TO Q14	☐ GO TO Q14
12. Are you still receiving psychological or emotional counseling from someone <u>AT SCHOOL</u>?	☐ GO TO Q14	☐ GO TO Q13	☐ GO TO Q14	☐ GO TO Q14

13. If not, what was the **MAIN REASON** you stopped psychological or emotional counseling AT SCHOOL? (Please select **ONE** main reason.)

☐The counselor, therapist, psychologist, psychiatrist or social worker said I finished and/or met my goals	☐ Had bad experiences with counselor, therapist, psychologist, psychiatrist or social worker	☐The counselor, therapist, psychologist, psychiatrist or social worker did not understand my problem
☐ I ended it because I got better/I no longer needed services	☐Couldn't get appointment	☐I felt discriminated against
☐School ended	☐Not getting better	☐I did not want to go anymore
☐Hours not convenient	☐Didn't have time	☐Wanted to handle the problem on my own
☐I changed schools	☐Other (Specify) _____	

	Yes	No	Refused	Don't Know
14. In the past 12 months, have YOU RECEIVED any psychological or emotional counseling from someone OUTSIDE OF SCHOOL, like a counselor, therapist, psychologist, psychiatrist or social worker?	☐ **GO TO Q15**	☐ **GO TO Q17**	☐ **GO TO Q17**	☐ **GO TO Q17**

	Yes	No	Refused	Don't Know
15. Are you still receiving psychological or emotional counseling from someone OUTSIDE OF SCHOOL?	☐ **GO TO Q17**	☐ **GO TO Q16**	☐ **GO TO Q17**	☐ **GO TO Q17**

16. What was the **MAIN REASON** you stopped psychological or emotional counseling OUTSIDE OF SCHOOL? (Please select **ONE** main reason.)

☐The counselor, therapist, psychologist, psychiatrist or social worker said I finished and/or met my goals	☐Had bad experiences with counselor, therapist, psychologist, psychiatrist or social worker	☐The counselor, therapist, psychologist, psychiatrist or social worker did not understand my problem
☐ I ended it because I got better/I no longer needed services	☐Couldn't get appointment	☐Didn't have transportation
☐Insurance did not cover	☐Not getting better	☐I felt discriminated against
☐Too expensive	☐Didn't have time	☐I did not want to go anymore
☐School ended	☐I moved	☐Wanted to handle the problem on my own
☐Hours not convenient	☐Other (Specify) _____	

	Yes	No	Refused	Don't Know
17. In the past 12 months, did you receive any professional help for your use of alcohol or drugs?	☐	☐	☐	☐
18. During the past 12 months, have you take any medication because of difficulties with your emotions, concentration, or behavior?	☐	☐	☐	☐

Instructions: Here are some reasons youth/teens have for NOT seeking help from a mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker, even when they think they might need it. Even if you are receiving help now, do you agree or disagree with the following reasons why you might not seek help from a mental health professional?

	Agree	Disagree	Refused	Don't Know
19. You were planning to or are already getting help from…				
a. Traditional helping professional such as a culturally-based healer, religious/spiritual leader or advisor	☐	☐	☐	☐
b. Community helping professional such as a health worker, *promotor*, peer counselor, or case manager	☐	☐	☐	☐
20. You didn't know these types of mental health professionals existed.	☐ **GO TO Q34**	☐ **GO TO Q21**	☐ **GO TO Q21**	☐ **GO TO Q21**

	Agree	Disagree	Refused	Don't Know
21. You didn't feel comfortable talking with them about your personal problems.	☐	☐	☐	☐
22. You didn't think you would feel safe and welcome because of your…				
a. limited English	☐	☐	☐	☐
b. race/ethnicity	☐	☐	☐	☐
c. age	☐	☐	☐	☐
d. religious or spiritual practice	☐	☐	☐	☐
e. gender identity	☐	☐	☐	☐
f. sexual orientation	☐	☐	☐	☐
23. You thought you could solve your issue on your own.	☐	☐	☐	☐
24. You thought your issue wasn't serious enough.	☐	☐	☐	☐
25. You thought your friends would find out.	☐	☐	☐	☐
26. You didn't want to talk to a stranger about your issue.	☐	☐	☐	☐
27. You were worried that your family and others in the community may think differently about you.	☐	☐	☐	☐
28. You didn't know where to go for help.	☐	☐	☐	☐
29. You felt embarrassed about what you were going through.	☐	☐	☐	☐
30. You were worried that your peers and others in school may think differently about you.	☐	☐	☐	☐
31. You didn't have time because of after-school activities and other commitments.	☐	☐	☐	☐
32. It was too expensive.	☐	☐	☐	☐
33. You didn't have transportation to get there.	☐	☐	☐	☐

Instructions: The next questions are about how you have been feeling during the past 30 days.

During the past 30 days, how often did you feel…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
34. … nervous?	☐	☐	☐	☐	☐
35. … hopeless?	☐	☐	☐	☐	☐
36. … restless or fidgety?	☐	☐	☐	☐	☐
37. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
38. … feel that everything was an effort?	☐	☐	☐	☐	☐
39. … worthless?	☐	☐	☐	☐	☐

40. The above items are often used to describe experiences with mental or emotional distress. To what extent do the above questions (Q34-Q39) match how you would describe those experiences? (Check one)

☐ A Lot	☐ Somewhat	☐ Not At All

Okay, you just told me about how you have been feeling the past 30 days. Now I want to know how much your fears and worries have messed things up for you. In other words, how much have they stopped you from doing things you want to do?

How much have your fears and worries messed things up …	A Lot	Some	Not At All
41. …with school and homework?	☐	☐	☐
42. …with friends?	☐	☐	☐
43. …at home?	☐	☐	☐

44. The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q41-Q43) match how you would describe the negative effect of emotions on your life? (Check one)

☐ A Lot	☐ Somewhat	☐ Not At All

	Yes	No	Refused	Don't Know
45. In the past 6 months, have you done any volunteer work or community service that you have not been paid for?	☐	☐	☐	☐

46. How old are you? Write in age: _____

47. What is your race and ethnic origin? ***Select only one race category and specify your ethnic origin.***

☐ American Indian or Alaska Native
☐ Black or African American: Please specify your ethnic origin(s):_____
☐ Latino, Hispanic, or Spanish: Please specify your ethnic origin(s):_____
☐ Asian: Please specify your ethnic origin(s): _____
☐ Native Hawaiian or Other Pacific Islander: Please specify your ethnic origin(s): _____
☐ White: Please specify your ethnic origin(s):_____
☐ Other Race: Please specify your race and ethnic origin(s):_____
☐ Multi-Racial Please specify your origin(s):_____
☐ Refused
☐ Don't Know

48. How well can you speak the English language?

☐ Fluently
☐ Somewhat fluently; can make myself understood but have some problems with it
☐ Not very well; know a lot of words and phrases but have difficulties communicating
☐ Know some vocabulary, but can't speak in sentences
☐ Not at all

49. What is your preferred language?
☐ English
☐ Spanish
☐ Other _____

50. Were you born:
☐ Inside the U.S.
☐ Outside the U.S.
☐ Refused
☐ Don't Know

51. What are the first 3 digits of your ZIP Code? _ _ _ ☐Unstable housing/ no ZIP code ☐ Refused ☐ Don't Know

52. Have you ever spent time in a temporary settlement area for refugees or displaced persons or been held at ICE facilities?

☐ Not Applicable
☐ Yes
☐ No
☐ Refused
☐ Don't Know

53. About how many years have you lived in the United States? [*For less than a year, enter 1 year*]
Number of years_____ ☐ Not Applicable

54. My sex at birth was…

☐ Male/Boy ☐ I am not sure about my sex assigned at birth

☐ Female/Girl
☐ Intersex (they were unsure about my sex at birth)
☐ My assigned sex at birth (please specify):_____
☐ I do not wish to answer this question

Gender identity is how individuals perceive themselves and what they call themselves, whether male, female, a blend of both or neither. A person's gender identity can be the same or different from their sex assigned at birth.

55. When it comes to my gender identity, I think of myself as: Choose all that apply.

☐ Man/Male
☐ Woman/Female
☐ Transgender/Trans
☐ Trans man/Trans male
☐ Trans woman/Trans female
☐ Genderqueer/Gender non-conforming
☐ I do not wish to answer this question
☐ Non-binary (not exclusively male or female)
☐ Intersex (between male and female)
☐ Two Spirit
☐ Third Sex
☐ I am not sure about my gender identity
☐ I do not have a gender/ gender identity
☐ My gender identity is (please specify):_____

Sexual orientation is different from gender identity and is about whom you're attracted to and want to have romantic relationships with. Examples of sexual orientation are gay, lesbian, bisexual, asexual, and heterosexual. Some people are straight and are attracted to people of another gender. Other people are gay or lesbian and are attracted to people of the same gender.

56. What is your sexual orientation? Choose all that apply.

☐ Straight/heterosexual
☐ Gay
☐ Lesbian
☐ Bisexual
☐ Queer
☐ Pansexual/Non-monosexual (I am attracted to all genders)
☐ Asexual (I am not attracted to anyone sexually)
☐ I am not attracted to anyone romantically
☐ I am not sure who I am attracted to sexually
☐ I am not sure who I am attracted to romantically
☐ Something else: _____
☐ I do not wish to answer this question

Thank you for taking time to complete this questionnaire. Did any of the questions above upset you? Please check one.

☐ Yes
☐ No

If any of the above questions upset you and you want to talk to someone about it, here is a list of referrals for support services.

Instructions: How true do you feel the next statements are about your school and things you might do there?

At my school, there is a teacher or some other adult….

	Not at all true	A little true	Pretty much true	Very much true	Refused	Don't Know
…who really care about me.	☐	☐	☐	☐	☐	☐
…who notices when I'm not there.	☐	☐	☐	☐	☐	☐
…who listens to me when I have something to say.	☐	☐	☐	☐	☐	☐
…who tells me when I do a good job.	☐	☐	☐	☐	☐	☐
…who always wants me to do my best.	☐	☐	☐	☐	☐	☐
…who notices when I'm in a bad mood.	☐	☐	☐	☐	☐	☐

Instructions: How true do you feel the next statement are about your home?

ADOLESCENT VERSION **PRE**

In my home, there is a parent or some other adult…

	Not at all true	A little true	Pretty much true	Very much true	Refused	Don't Know
…who cares about my school work.	☐	☐	☐	☐	☐	☐
…who listens to me when I have something to say.	☐	☐	☐	☐	☐	☐
…who talks with me about my problems.	☐	☐	☐	☐	☐	☐
…who notices when I'm in a bad mood.	☐	☐	☐	☐	☐	☐
…who always wants me to do my best.	☐	☐	☐	☐	☐	☐
…who believes that I will be a success.	☐	☐	☐	☐	☐	☐
…who expects me to follow the rules.	☐	☐	☐	☐	☐	☐

ADOLESCENT VERSION POST

ID:

__ __ - __ __ - __ __ __

Priority Pop Code *IPP Code* *CDEP Participant Code*

ADOLESCENT VERSION (12-17)

POST

Culture means many different things to different people but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others, it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group. The next questions are about your culture.

At present…	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree
1. Your culture gives you strength.	☐	☐	☐	☐	☐
2. Your culture is important to you.	☐	☐	☐	☐	☐
3. Your culture helps you to feel good about who you are.	☐	☐	☐	☐	☐
4. You feel connected to the spiritual/religious traditions of the culture you were raised in.	☐	☐	☐	☐	☐

During the past 30 days, how often did you feel…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
5. …connected to your culture?	☐	☐	☐	☐	☐
6. …balanced in mind, body, spirit and soul?	☐	☐	☐	☐	☐
7. …marginalized or excluded from society? (*In other words, made to feel unimportant, or like your thoughts, feelings, or opinions don't matter.*)	☐	☐	☐	☐	☐
8. …isolated and alienated from society? (*In other words, feeling alone, separated from, cut off from the world beyond of your family, school, and friends.*)	☐	☐	☐	☐	☐

During the past 30 days, how often did you feel…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
9. … nervous?	☐	☐	☐	☐	☐
10. … hopeless?	☐	☐	☐	☐	☐
11. … restless or fidgety?	☐	☐	☐	☐	☐
12. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
13. … feel that everything was an effort?	☐	☐	☐	☐	☐
14. … worthless?	☐	☐	☐	☐	☐

15. The above items are often used to describe experiences with mental or emotional distress. To what extent do the above questions (Q9-Q14) match how you would describe those experiences? (Check one)

☐ **A Lot** ☐ **Somewhat** ☐ **Not At All**

Okay, you just told me about how you have been feeling during the past 30 days, Now I want to know how much your fears and worries have messed things up for you. In other words, how much have they stopped you from doing things you want to do?

How much have your fears and worries messed things up …	A Lot	Some	Not At All
16. …with school and homework?	☐	☐	☐
17. …with friends?	☐	☐	☐
18. …at home?	☐	☐	☐

19. The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q16-Q18) match how you would describe the negative effect of emotions on your life? (Check one)

☐ **A Lot** ☐ **Somewhat** ☐ **Not At All**

ADOLESCENT VERSION POST

Instructions: Please help our make our program better by answering some questions. Please answer the questions based on the services, program or activities connected to The Aunties and Uncles Program. Indicate if you Strongly Disagree, Disagree, are Undecided, Agree, or Strongly Agree with each of the statements below. If the statement is about something you have not experienced, check the box for Not Applicable to indicate that this item does not apply to you. Please note: the word "service" stands for any program activities or events connected to The Aunties and Uncles Program.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
20. Overall, I am satisfied with the services I received.	☐	☐	☐	☐	☐	☐
21. The people helping me stuck with me no matter what	☐	☐	☐	☐	☐	☐
22. I felt I had someone to talk to when I was troubled	☐	☐	☐	☐	☐	☐
23. I received services that were right for me.	☐	☐	☐	☐	☐	☐
24. The location of services was convenient for me.	☐	☐	☐	☐	☐	☐
25. Services were available at times that were convenient for me.	☐	☐	☐	☐	☐	☐
26. I got the help I wanted.	☐	☐	☐	☐	☐	☐
27. Staff treated me with respect.	☐	☐	☐	☐	☐	☐
28. Staff respected my religious / spiritual beliefs.	☐	☐	☐	☐	☐	☐
29. Staff spoke with me in a way that I understood.	☐	☐	☐	☐	☐	☐
30. Staff were sensitive to my cultural / ethnic background.	☐	☐	☐	☐	☐	☐
31. I am better at handling daily life.	☐	☐	☐	☐	☐	☐
32. I get along better with family members.	☐	☐	☐	☐	☐	☐
33. I get along better with friends and other people.	☐	☐	☐	☐	☐	☐
34. I am doing better in school and/or work.	☐	☐	☐	☐	☐	☐
35. I am better able to cope when things go wrong.	☐	☐	☐	☐	☐	☐
36. I am satisfied with my family life right now.	☐	☐	☐	☐	☐	☐
37. I am better able to do things I want to do.	☐	☐	☐	☐	☐	☐
38. I know people who will listen and understand me when I need to talk.	☐	☐	☐	☐	☐	☐
39. I have people that I am comfortable talking with about my problem(s).	☐	☐	☐	☐	☐	☐
40. In a crisis, I would have the support I need from family or friends.	☐	☐	☐	☐	☐	☐
41. I have people with whom I can do enjoyable things.	☐	☐	☐	☐	☐	☐

	Yes	No
42. Were the services you received here provided in the language you prefer?	☐	☐
43. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available in the language you prefer?	☐	☐

ADOLESCENT VERSION POST

Instructions: How true do you feel the next statements are about your school and things you might do there?

At my school, there is a teacher or some other adult….

	Not at all true	A little true	Pretty much true	Very much true	Refused	Don't Know
…who really care about me.	☐	☐	☐	☐	☐	☐
…who notices when I'm not there.	☐	☐	☐	☐	☐	☐
…who listens to me when I have something to say.	☐	☐	☐	☐	☐	☐
…who tells me when I do a good job.	☐	☐	☐	☐	☐	☐
…who always wants me to do my best.	☐	☐	☐	☐	☐	☐
…who notices when I'm in a bad mood.	☐	☐	☐	☐	☐	☐

Instructions: How true do you feel the next statement are about your home?

In my home, there is a parent or some other adult…

	Not at all true	A little true	Pretty much true	Very much true	Refused	Don't Know
…who cares about my school work.	☐	☐	☐	☐	☐	☐
…who listens to me when I have something to say.	☐	☐	☐	☐	☐	☐
…who talks with me about my problems.	☐	☐	☐	☐	☐	☐
…who notices when I'm in a bad mood.	☐	☐	☐	☐	☐	☐
…who always wants me to do my best.	☐	☐	☐	☐	☐	☐
…who believes that I will be a success.	☐	☐	☐	☐	☐	☐
…who expects me to follow the rules.	☐	☐	☐	☐	☐	☐

Thank you for taking time to complete this questionnaire. Did any of the questions above upset you? Please check one.

Yes ☐ **No** ☐

ADULT VERSION PRE

ID:

__ __ - __ __ - __ __ __

Priority Pop Code *IPP Code* *CDEP Participant Code*

ADULT VERSION (18+)

PRE

Culture means many different things to different people but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others, it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group. The next questions are about your culture.

At present…	**Strongly Agree**	**Agree**	**I am Neutral**	**Disagree**	**Strongly Disagree**
1. Your culture gives you strength.	☐	☐	☐	☐	☐
2. Your culture is important to you.	☐	☐	☐	☐	☐
3. Your culture helps you to feel good about who you are.	☐	☐	☐	☐	☐
4. You feel connected to the spiritual/religious traditions of the culture you were raised in.	☐	☐	☐	☐	☐

Instructions: The next questions are about how you have been feeling during the past 30 days

About how often during the past 30 days did you feel…	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
5. …connected to your culture?	☐	☐	☐	☐	☐
6. …balanced in mind, body, spirit and soul?	☐	☐	☐	☐	☐
7. …marginalized or excluded from society? (*In other words, made to feel unimportant, or like your thoughts, feelings, or opinions don't matter.*)	☐	☐	☐	☐	☐
8. …isolated and alienated from society? (*In other words, feeling alone, separated from, cut off from the world beyond your family, school, and friends.*)	☐	☐	☐	☐	☐

9. Do you currently have health insurance coverage? (check one)

☐ **Yes (GO to Q10)** ☐ **No (GO to Q11)** ☐ **Refused (Go to Q11)** ☐ **Don't Know (Go to Q11)**

→ *Did you have health insurance coverage in the past 12 months?*

☐ Yes ☐ No ☐ Refused ☐ Don't Know

	Yes	**No**	**Refused**	**Don't Know**
10. Does your insurance cover treatment for mental health problems, such as visits to a psychologist or psychiatrist?	☐	☐	☐	☐

	Yes	**No**	**Refused**	**Don't Know**
11. During the past 12 months, did you take any prescription medications, such as an antidepressant or an antianxiety medication, almost daily for two weeks or more, for an emotional or personal problem?	☐	☐	☐	☐

	Yes	**No**	**Refused**	**Don't Know**	**NA**
12. Because of problems with your mental health, emotions, nerves or your use of alcohol or drugs, was there ever a time during the past 12 months when you FELT LIKE YOU MIGHT NEED to see a…					
a. Traditional helping professional like a culturally-based healer, religious/spiritual leader or advisor	☐	☐	☐	☐	☐

b. Community helping professional such as a health worker, *promotor*, peer counselor, or case manager	☐	☐	☐	☐	☐
c. Primary care physician or general practitioner	☐	☐	☐	☐	☐
d. Mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker	☐	☐	☐	☐	☐

	Yes	No	Refused	Don't Know	NA
13. Because of problems with your mental health, emotions or your use of alcohol or drugs, HAVE YOU SEEN (or met with) any of the following helping professionals in the past 12 months?					
a. Traditional helping professional like a culturally-based healer, religious/spiritual leader or advisor	☐	☐	☐	☐	☐
b. Community helping professional such as a health worker, *promotor*, peer counselor, or case manager	☐	☐	☐	☐	☐
c. Primary care physician or general practitioner	☐	☐	☐	☐	☐
d. Mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker	☐	☐	☐	☐	☐

If YES to Q13c OR 13d, **GO TO Q14**
(otherwise **GO TO Q19**)

14. Did you seek help for your mental or emotional health or for an alcohol or drug problem? (*Circle one*)	*No* **GO TO Q19**	*Yes Mental/Emotional Health Problem* **GO TO Q15**	*Yes Alcohol-Drug Problem* **GO TO Q15**	*Yes Both Mental AND Alcohol-Drug Problems* **GO TO Q15**	*Refused* **GO TO Q19**	*Don't Know* **GO TO Q19**

15. In the past 12 months, how many visits did you make to a mental health professional (counselor, therapist, psychologist, psychiatrist or social worker) for problems with your mental or emotional health, alcohol-drug problem, or both? Do not count overnight hospital stays. _____ # of visits

	Yes	No	Refused	Don't Know
16. Are you still receiving treatment for these problems from one or more of these providers?	☐ **GO TO Q19**	☐ **GO TO Q17**	☐ **GO TO Q19**	☐ **GO TO Q19**
17. Did you complete the full course of treatment? In other words, you ended treatment when your counselor, therapist, psychologist, psychiatrist or social worker told you it was ok to end?	☐ **GO TO Q19**	☐ **GO TO Q18**	☐ **GO TO Q19**	☐ **GO TO Q19**

18. What is the **MAIN REASON** you are no longer receiving treatment? (Circle ONE only)

-Got better/No longer needed -Not getting better -Wanted to handle the problem on own
-Had bad experiences with treatment -Lack of time/transportation -Too expensive
-Insurance does not cover
-Other (Specify) _____
-Refused -Don't Know

Instructions: Here are some reasons people have for NOT seeking help from a mental health professional such as a counselor, therapist, psychologist, psychiatrist or social worker, even when they think they might need it. Even if you are receiving help now, do you agree or disagree with the following reasons why you might not seek help from a mental health professional?

	Agree	Disagree	Refused	Don't Know
19. You were planning to or already getting help from a…				
a. Traditional helping professional such as a culturally-based healer, religious/spiritual leader or advisor	☐	☐	☐	☐
b. Community helping professional such as a health worker, *promotor*, peer counselor, or case manager	☐	☐	☐	☐
20. You didn't know these types of professionals existed.	☐	☐	☐	☐
	GO TO Q34	**GO TO Q21**	**GO TO Q34**	**GO TO Q34**

	Agree	Disagree	Refused	Don't Know
21. You didn't feel comfortable talking with them about your personal problems.	☐	☐	☐	☐
22. You didn't think you would feel safe and welcome because of your…				
a. limited English	☐	☐	☐	☐
b. race/ethnicity	☐	☐	☐	☐
c. age	☐	☐	☐	☐
d. religious or spiritual practice	☐	☐	☐	☐
e. gender identity	☐	☐	☐	☐
f. sexual orientation	☐	☐	☐	☐
23. You were concerned about the cost of treatment.	☐	☐	☐	☐
24. You didn't have time (because of job, childcare, or other commitments).	☐	☐	☐	☐
25. You had no transportation, or the program was too far away, or the hours were not convenient.	☐	☐	☐	☐
26. You didn't think you needed mental health counseling or treatment at the time.	☐	☐	☐	☐
27. You thought you could handle the problem on your own.	☐	☐	☐	☐
28. You didn't think mental health counseling or treatment would help.	☐	☐	☐	☐
29. You were concerned that getting mental health treatment or counseling might cause your neighbors or community to have a negative opinion of you.	☐	☐	☐	☐
30. You were concerned that getting mental health treatment or counseling might have a negative effect on your job.	☐	☐	☐	☐
31. You were concerned that the information you gave the counselor might not be kept confidential.	☐	☐	☐	☐
32. You were concerned that you might be admitted to a psychiatric hospital.	☐	☐	☐	☐
33. You were concerned that you might have to take medicine.	☐	☐	☐	☐

Instructions: The next questions are about how you have been feeling during the past 30 days.

About how often during the past 30 days did you feel…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
34. … nervous?	☐	☐	☐	☐	☐
35. … hopeless?	☐	☐	☐	☐	☐
36. … restless or fidgety?	☐	☐	☐	☐	☐
37. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
38. … feel that everything was an effort?	☐	☐	☐	☐	☐
39. … worthless?	☐	☐	☐	☐	☐

40. The above items are often used to describe experiences with mental or emotional distress. To what extent do the above questions (Q34-Q39) match how you would describe those experiences? (Check one)

☐ A Lot	☐ Somewhat	☐ Not At All

NOW, think about the one month, within the past 12 months, when you were at your worst emotionally.

Did your emotions interfere a lot, some, or not at all with your…	**A Lot**	**Some**	**Not At All**	**Refused**	**Don't Know**
41. …performance at work or school?	☐	☐	☐	☐	☐
Check here if not working or not in school during the past 12 months ☐					
42. …household chores?	☐	☐	☐	☐	☐
43. …social life?	☐	☐	☐	☐	☐
44. …relationship with friends and family?	☐	☐	☐	☐	☐

45. The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q41-Q44) match how you would describe the negative effect of emotions on your life? (Check one)

☐ A Lot	☐ Somewhat	☐ Not At All

46. How old are you?

☐ between 18 and 29 years of age
☐ between 30 and 39 years of age
☐ between 40 and 44 years of age
☐ between 45 and 49 years of age
☐ between 50 and 64 years of age
☐ 65 or older years of age

47. What is your race and ethnic origin? ***Select only one race category and specify your ethnic origin.***

☐ American Indian or Alaska Native
☐ Black or African American**:** Please specify your ethnic origin(s):_____
☐ Latino, Hispanic, or Spanish: Please specify your ethnic origin(s):_____
☐ Asian: Please specify your ethnic origin(s): _____
☐ Native Hawaiian or Other Pacific Islander: Please specify your ethnic origin(s): _____
☐ White: Please specify your ethnic origin(s):_____
☐ Other Race: Please specify your race and ethnic origin(s):_____
☐ Multi-Racial: Please specify your origin(s):_____
☐ Refused
☐ Don't Know

48. How well can you speak the English language?

☐ Fluently
☐ Somewhat fluently; can make myself understood but have some problems with it
☐ Not very well; know a lot of words and phrases but have difficulties communicating
☐ Know some vocabulary, but can't speak in sentences
☐ Not at all

49. What is your preferred language?

☐ English
☐ Spanish
☐ Other _____

50. Were you born:

☐ Inside the U.S.
☐ Outside the U.S.
☐ Refused
☐ Don't Know

51. What are the first 3 digits of your ZIP Code? _ _ _ ☐Unstable housing/ no ZIP code ☐ Refused ☐ Don't Know

52. Have you ever spent time in a temporary settlement area for refugees or displaced persons or been held at ICE facilities?

☐ Not Applicable
☐ Yes
☐ No
☐ Refused
☐ Don't Know

53. About how many years have you lived in the United States? [*For less than a year, enter 1 year*]
Number of years_____ ☐ Not Applicable

54. My sex at birth was…

☐ Male/Boy
☐ Female/Girl
☐ Intersex (they were unsure about my sex at birth)
☐ I am not sure about my sex assigned at birth
☐ My assigned sex at birth (please specify):_____
☐ I do not wish to answer this question

Gender identity is how individuals perceive themselves and what they call themselves, whether male, female, a blend of both or neither. A person's gender identity can be the same or different from their sex assigned at birth.

55. When it comes to my gender identity, I think of myself as: Choose all that apply.

☐ Man/Male
☐ Woman/Female
☐ Transgender/Trans
☐ Trans man/Trans male
☐ Trans woman/Trans female
☐ Genderqueer/Gender non-conforming
☐ I do not wish to answer this question
☐ Non-binary (not exclusively male or female)
☐ Intersex (between male and female)
☐ Two Spirit
☐ Third Sex
☐ I am not sure about my gender identity
☐ I do not have a gender/ gender identity
☐ My gender identity is (please specify):_____

Sexual orientation is different from gender identity and is about whom you're attracted to and want to have romantic relationships with. Examples of sexual orientation are gay, lesbian, bisexual, asexual, and heterosexual. Some people are straight and are attracted to people of another gender. Other people are gay or lesbian and are attracted to people of the same gender.

56. What is your sexual orientation? Choose all that apply.

☐ Straight/heterosexual
☐ Gay
☐ Lesbian
☐ Bisexual
☐ Queer
☐ Pansexual/Non-monosexual (I am attracted to all genders)
☐ Asexual (I am not attracted to anyone sexually)
☐ I am not attracted to anyone romantically
☐ I am not sure who I am attracted to sexually
☐ I am not sure who I am attracted to romantically
☐ Something else: _____
☐ I do not wish to answer this question

ADULT VERSION POST

ID:

__ __ - __ __ - __ __ __

Priority Pop Code *IPP Code* *CDEP Participant Code*

ADULT VERSION (18+) POST

Culture means many different things to different people but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others, it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group. The next questions are about your culture.

At present…	**Strongly Agree**	**Agree**	**I am Neutral**	**Disagree**	**Strongly Disagree**
1. Your culture gives you strength.	☐	☐	☐	☐	☐
2. Your culture is important to you.	☐	☐	☐	☐	☐
3. Your culture helps you to feel good about who you are.	☐	☐	☐	☐	☐
4. You feel connected to the spiritual/religious traditions of the culture you were raised in.	☐	☐	☐	☐	☐

Instructions: The next questions are about how you have been feeling during the past 30 days.

About how often during the past 30 days did you feel…	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
5. …connected to your culture?	☐	☐	☐	☐	☐
6. …balanced in mind, body, spirit and soul?	☐	☐	☐	☐	☐
7. …marginalized or excluded from society? (*In other words, made to feel unimportant, or like your thoughts, feelings, or opinions don't matter.*)	☐	☐	☐	☐	☐
8. …isolated and alienated from society? (*In other words, feeling alone, separated from, cut off from the world beyond of your family, school, and friends.*)	☐	☐	☐	☐	☐

Instructions: During the past 30 days how often did you feel…

	All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
9. … nervous?	☐	☐	☐	☐	☐
10. … hopeless?	☐	☐	☐	☐	☐
11. … restless or fidgety?	☐	☐	☐	☐	☐
12. … so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
13. … feel that everything was an effort?	☐	☐	☐	☐	☐
14. … worthless?	☐	☐	☐	☐	☐

15. The above items are often used to describe experiences with mental or emotional distress. To what extent do the above questions (Q9-Q14) match how you would describe those experiences? (Check one)

☐ **A Lot** ☐ **Somewhat** ☐ **Not At All**

Think about the one week in the past 30 days when you were at your worst emotionally.

Did your emotions interfere a lot, some, or not at all with your…	**A Lot**	**Some**	**Not At All**	**Refused**	**Don't Know**
16. …performance at work or school?	☐	☐	☐	☐	☐
Check here if not working or in school during the past 12 months ☐					
17. …household chores?	☐	☐	☐	☐	☐
18. …social life?	☐	☐	☐	☐	☐
19. …relationship with friends and family?	☐	☐	☐	☐	☐

20. The above items are often used to describe how emotions affect people's lives. To what extent do the above questions (Q16-Q19) match how you would describe the negative effect of emotions on your life? (Check one)

☐ A Lot	☐ Somewhat	☐ Not At All

Instructions: Please answer the following questions based on the services you have received so far. Indicate if you Strongly Agree, Agree, are Neutral, Disagree, or Strongly Disagree with each of the statements below. If the question is about something you have not experienced, check the box for Not Applicable to indicate that this item does not apply to you. Please note: the word "service" stands for any program activities or events connected to the program.

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
21. I like the services that I received here.	☐	☐	☐	☐	☐	☐
22. If I had other choices, I would still get services from this agency.	☐	☐	☐	☐	☐	☐
23. I would recommend this agency to a friend or family member.	☐	☐	☐	☐	☐	☐
24. The location of services was convenient (parking, public transportation, distance, etc.).	☐	☐	☐	☐	☐	☐
25. Staff were willing to see me as often as I felt it was necessary.	☐	☐	☐	☐	☐	☐
26. Services were available at times that were good for me.	☐	☐	☐	☐	☐	☐
27. When I first called or came here, it was easy to talk to the staff.	☐	☐	☐	☐	☐	☐
28. The staff here treat me with respect.	☐	☐	☐	☐	☐	☐
29. The staff here don't think less of me because of the way I talk.	☐	☐	☐	☐	☐	☐
30. The staff here respect my race and/or ethnicity.	☐	☐	☐	☐	☐	☐
31. The staff here respect my religious and/or spiritual beliefs.	☐	☐	☐	☐	☐	☐
32. The staff here respect my gender identity and/or sexual orientation.	☐	☐	☐	☐	☐	☐
33. Staff are willing to be flexible and provide alternative approaches or services to meet my needs.	☐	☐	☐	☐	☐	☐
34. The people who work here respect my cultural beliefs, remedies and healing practices.	☐	☐	☐	☐	☐	☐
35. Staff here understand that people of my racial and/or ethnic group are not all alike.	☐	☐	☐	☐	☐	☐
36. Staff here understand that people of my gender and/or sexual orientation group are not all alike.	☐	☐	☐	☐	☐	☐
37. Staff here understand that people of my religious and spiritual background are not all alike.	☐	☐	☐	☐	☐	☐

As a direct result of my involvement in the program:

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
38. I deal more effectively with my daily problems.	☐	☐	☐	☐	☐	☐
39. I do better in school and/or work.	☐	☐	☐	☐	☐	☐
40. My symptoms/problems are not bothering me as much.	☐	☐	☐	☐	☐	☐

	Yes	No	Refused	Don't Know
41. Were the services you received here in the language you prefer?	☐	☐	☐	☐
42. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available in the language you prefer?	☐	☐	☐	☐

Appendix 5: Survey Administration Protocol

Sonoma County Indian Health Project
Pre-post Data Collection of Local and State surveys

Data Collection Process and Materials

Set-up

- AUP Program Coordinator will have possession of up to 6 electronic tablets that are secured with a password. Each laptop will require a Wi-Fi hook-up that can be secured through the AUP staff phone hotspot. Ask the Program Coordinator for the password for the laptops and for the phone. Boot up laptops, enter password and confirm Wi-Fi is active.
- In addition to the tablets, ample VISA gift cards, consent forms, participant log (names of youth who completed pre- and/or post-surveys, and contact sheet (for new youth taking pre-survey and are assigned a numerical ID) should be available.
- Ideally, there should be one Data Collector to three participants.
- Each station should have one table and three chairs for participants. The station should be in a location where the participant has the privacy to answer the survey without any distractions.
- **Materials**: Tablet, a copy of the SWE recruitment script; multiple copies of the SWE Parent Consent, Adult Consent, and Adolescent Assent forms; copy of the contact information sheet, Participant Log and VISA gift cards.

Participant Recruitment

- The assigned Data Collector(s) will greet the participant(s) and invite them to take a seat. Parents can accompany the youth/young adult for orientation but should be encouraged to excuse themselves during the survey administration. The consent/assent forms, participant log, contact sheet should be close at hand.
- The Data Collector confirms purpose of the survey with the participant(s) and confirms that the **youth is between 14 and 24 years of age**. Anyone younger or older than this age range will not meet the criteria to participate, however, if a youth is a couple of months away from turning 14, an exception can be made.
- Data collectors will read the Statewide Evaluation (SWE) Recruitment script to each participant (and their parent/guardian if necessary). Each data collector will have a copy of the recruitment script and will read it to the participant **verbatim**. After reading the script, the data collector will again confirm that the participant would like to participate.

Talking points for Data Collector: "Hi, I'm helping Sonoma County Indian Health collect some information about how they can improve their services to better address the needs of Native youth in Sonoma County. We're asking folks for approximately **30 minutes** of their time to complete two surveys about their health needs, their opinions on mental health among Sonoma County's Native community, and how Sonoma County Indian Health can create activities that Native youth would like to participate in. We're specifically asking folks between **14 and 24 years of age** to complete these surveys and ask that those that are under 18 years of age have their parent or guardian come by to give you permission to participate. For your time, we'll give you a **$25 Target gift card and an extra raffle ticket**. Would you like to participate?"

If participant is under 18: "For you to participate, we'll need your parent/guardian to give you written permission. Is your parent/guardian here with you and/or would they be able to come by to give you permission?"

Verifying Participant Status for Pre- or Post-survey Administration

- Ask participant for their full name and whether they have taken the pre-survey before.
- Data Collector should carefully reference the Participant Log to verify if the participant is eligible to take either the pre- or post-survey
    - If the participant name is not found on the Participant Log and they are 14 – 24 years old, identify as Native, they are eligible to take the pre-survey.
    - If the participant's name is listed on the Participant Log, they may be eligible to take the post-survey. The participant must have taken the pre-survey 9 to 15 months prior to taking the post-survey.
- If the participant has taken the pre-survey and is eligible to take the post-survey, use the three-digit numerical ID on the Participant Log for their post-survey administration.
- A new numeric ID is assigned to the participant(s) taking the pre-survey. (See below for Consent prior to assigning a new ID)

Consent and Contact Information

- Consent form is only necessary at pre-survey.
- To obtain consent, the Data Collector will confirm participant's age.
    - **If the participant is under 18 years of age**: The participant will need a parent's/guardian's consent in order to participate. If the participant's parent/guardian isn't present, greeter will ask them to come back with a parent/guardian to given them written consent.[1] In addition to the parent consent, the participant will need to sign the Youth Assent form.
    - The Data Collector will give the parent/guardian two copies of the Parent Consent form, and the participant two copies of the Youth Assent form and ask each to sign both copies. One copy will be retained for SCIHP's records, and the second copy will be given back to the participant as their copy.

    - **If the participant is over 18 years of age**: The Data Collector will give the participant two copies of the Adult consent form. One copy will be retained for SCIHP's records, and the second copy will be given back to the participant as their copy.

- Once the participant's parent/guardian completes the consent form, they are encouraged to leave. If they choose to stay, the Data Collector should let them know that for privacy reasons, the participant **must complete the survey independently**. An exception may be if their child has a learning or other disability that requires support in taking the survey.
- After completing the consent/assent forms, the Data Collector will ask the participant to complete the contact information sheet. The participant's information will be entered on the contact sheet beginning with the next available numerical ID (not highlighted). Participants are asked to provide a phone number and email. This will allow SCIHP to outreach to each participant in a year's time and ask them to take the post-survey. The Data Collector should check for legibility and note if the youth is under 18 (Y) or 18+ (A).

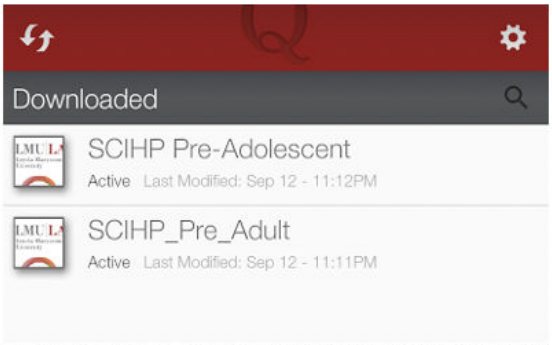
Talking points for data collector: "I'm asking for your contact information because SCIHP would like a way to get in touch with you to complete a follow-up survey mentioned in the consent/assent form. You **do not** have to give me your contact information in order to complete the survey and receive the gift card, but if you can share some contact information, I can give you an extra raffle ticket. Go ahead and give as much or as little information as you'd like to share and then I can get you started on the survey."

- The Data Collector should inform the participant that they are free to give as much or as little contact information as they feel comfortable. The contact sheet will ask for the participant's phone, email, and contact address, but they are not required to disclose information they're not comfortable disclosing. As an extra incentive, participants that do share their contact information will receive one raffle ticket.[2]
    - **If the participant declines giving their contact information**: If the participant would still like to participate, the Data Collector should continue to administer the survey.

[1] Under IRB guidelines, individuals under 18 years of age must have parent/guardian consent. Specifically, "one or both parents when the participant is a child (5 to 17 years of age); or in the absence of a parent, a person other than a parent authorized under applicable law to consent on behalf of the child or adolescent to participate in the SWE questionnaire."
[2] SCIHP team will provide extra raffle tickets that the Harder team will distribute to participants that share their contact information once they've completed the survey.

Data Collection

- While the participant is completing the consent/assent forms and/or while they are completing the contact sheet, the Data Collector will assure the tablet is on and connected to Wi-Fi. The data collector should make sure that the tablet is fully functional and charged before handing it over to the participant.
- The Data Collector should also take the SCIHP copies of the consent/assent forms, paper clip them together, and put them away in a sealable envelope. These copies will be kept at the SCIHP office for their records and will not be shared with anyone outside of SCIHP.
- The contact sheet will have a prepopulated, unique identification (ID) number for each participant. The data collector will enter the three-digit numerical ID number into the survey when prompted.
    - Even if the participant declined their contact information, the data collector will give them an ID number per the list given in the contact sheet.
- Participants also have the option of completing the survey via paper. Before handing them the tablet, confirm if they would like the option of pen and paper. Similar to the tablet, **please note their unique ID number at the top of the survey**.
- Each Data Collector will launch the SWE Core Measures instrument on their iPad by clicking on the Qualtrics Offline Survey icon on the home screen of the tablet. The Data Collector will then choose either the "Adult-pre", "Adult-post" survey or the "Adolescent-pre", "Adolescent-post" survey depending on the age of the participant and their status. The image below shows what the survey options will look like on the screen.
    - If the participant chooses the paper survey, please make sure you hand them the correct version of the instrument as indicated at the top.

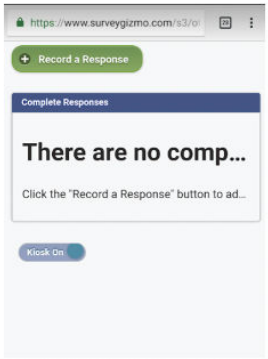


- Before handing the Participant the survey, the Data Collector will remind the participant that they can skip any question they don't feel comfortable answering.
- Once the Data Collector has given the Participant the survey, the Data Collector will step back and let the Participant complete the survey in privacy. However, the Data Collector should be attentive and be close at hand should the Participant have questions or need assistance in understanding the survey questions.

Talking points for data collector: "As a reminder, you can skip any question you don't feel comfortable answering. I'm going to step back to allow you to complete the survey, but I'll be close by if you have any questions about the survey or if you've having trouble with the tablet. The first survey is in front of you; please raise your hand or flag me down when you've completed the survey so I can give you the second survey."

- Once the Participant has indicated that they have completed the first survey, they should flag their Data Collector and hand the tablet back to them. The Data Collector should then make sure that the survey was submitted and launch the second survey via Safari and the app Survey Gizmo. (link found already bookmarked in left column on screen.

- The Local Evaluation survey is a link found on the home screen of the iPad. You should see a menu like the screenshot below. Click on the green "Record a response" button to launch the survey. **Both adults and adolescents will complete the same survey**.



- Hand the tablet back to the Participant with the new survey. Reiterate that you will be close at hand to answer questions and to flag you down should they have any questions.
    - Participants can also choose to complete this survey on paper. Hand the participant the paper copy and a pen.

Materials: Tablet(s); paper copies of the Adolescent and Adult Core Measures instruments; paper copies of the local evaluation survey; tablet charger cord; battery pack.

Incentives

- Once the participant has finished the survey, the Data Collector will confirm they submitted their final survey.
- Before letting the participant go, note the **last four digits of the gift card number** as written on the gift card envelope on the contact sheet under their name. This is necessary information for SCIHP's accounting records.
- Also make sure to give participants their extra raffle ticket if they shared their contact information.

Materials: Gift cards ›and raffle tickets.

Appendix 6: Focus Group Protocols

AUP FOCUS GROUP PROTOCOLS

I. Planning the Focus Groups

a. Create a planning group: Eagle Council Members, staff, and local evaluation team

b. Determine the purpose: Focus groups are used for generating information on collective views, and the meanings that lie behind those views. They are also useful in generating a rich understanding of participants' experiences and beliefs. The AUP focus groups will provide qualitative (narrative) data that will enhance, validate, or challenge the quantitative data (surveys) to tell the complete story. Specifically, focus groups will add more context through qualitative data from the community served, specifically on how they are interacting with the Aunties and Uncles Program, perceived value and benefit, and to gain more insight into how the community is responding/feeling about the current impact of the COVID pandemic, local threat of fires and the consequential evacuations and power outages.

c. Determine how many focus groups to run and ideal number of participants

Three focus groups

1**. Feb 26, 3:00–4:30p**: TAY (14–25 years) from Cultural Wellness Series and talking circles

2. **March 10, 3:00–4:30p**: TAY (14–25 years) who attended 2 or more events

3**. March 18, 4:00–5:30p**: Adults in the community with key role/participation in AUP (Eagle Council, Cultural Workshop teachers, attended 3 or more events)

Focus groups will be facilitated by two individuals, the Local Evaluator and either the Research Assistant or Eagle Council member. Suggested: no more than ten participants.

d. Determine the time to have focus groups

Focus groups will be hosted at a date and time convenient for participants, ideally, late afternoon or early evening.

e. Identify the participants

AUP Staff will assist in identifying and securing 6–8 participants. Each participant will be asked to complete a registration form with contact information for FAQ and reminder.

Develop FAQ sheet that contains consent form, confidentiality and privacy statement, date and time of focus group with link to zoom, and contact person for more information/questions.

$50 Gift certificates will be provided to those who attend for the duration of the group.

f. Generate the questions

Evaluation framework and areas to address with focus group – Appendix A

See draft questions below—Appendix B

g. Develop the script

See sample script—Appendix C

h. Outreach/Invitations

Registration with email/text to confirm and remind, mailing address for gift certificate. Send FAQ with date and time of focus group. Send reminders 3 days and 1 day prior.
Send consent forms on a secure link to all participants. Youth under 18 years will be required to obtain a parent consent and sign a youth assent form.

i. Logistics

A virtual platform will be used due to COVID and local shelter-in-place orders. Participants will be required to enter a password for security purposes.

II. Conducting the Focus Groups

a. Co-facilitator

When possible, two facilitators will conduct the focus group. Training will be provided to assure consistency in process, confidentiality, and protection of participants.

b. Cultural considerations and other considerations

- Opening prayer/blessing—ask if any of the participants would like to offer a prayer/blessing.
- Participants will be asked for permission to record a focus group session. All participants must give consent for recording to occur. The recording will be used for notes only and deleted after the written summary of the focus group is completed.
- A referral to a therapist can be made for those who experience any stress or emotional reaction to participating in the focus group.

c. Conduct the Session

- Introduction of facilitators and participants, set ground rules of confidentiality and anonymity
- Establish a positive tone, explain purpose, encourage everyone to participate and respect responses
- Monitor time
- At conclusion, express gratitude and explain distribution of gift certificates

III. Interpreting and Reporting the Results

a. Summarize each focus group

- Transcribe notes or audio recording of the focus group
- Note context and tone, emotional triggers
- If more than one facilitator, discuss impressions

b. Analyze the summaries

- Engage Eagle Council members to identify themes and trends, interpret the results for major findings and recommendations.
- No identifying information about participants will be shared.

c. Take action

- Incorporate into AUP evaluation report
- Distribute and discuss the report and next steps

Appendix 7: Focus Group Questions

AUP FOCUS GROUP QUESTIONS
TAY

Script:

- Purpose of the focus group
- What to expect in the next 1.5 hours
- Confidentiality, ground rules
- Incentives

Introductions: Put your "name" so it is visible to the group. Click on three dots in upper corner of your frame and edit your name.

Visualization: Think about your first time you participated in an Aunties and Uncles event. What was the event and when was that? Who came with you? How did you feel about that event? Now think, did you attend other events? (Aid: post up types of AUP events)

Share what events you have attended and what have you found most valuable in attending those events?

How has your ability to cope with stress and other mental health challenges changed in the past year? What specifically has changed? (Probe for self-care, knowledge gain, reduction in stigma, seeking support, other tools/resources that help with resiliency)

Now think about your cultural identity. What does cultural identity mean to you and what role does cultural identity play in your life? Who shapes and shares in your views of cultural identity?

a) How did the AUP activities support your cultural identity?
b) What interactions have you had with other adults at the AUP community events that have been valuable?
c) What other community events/activities have you participated in?
d) To what extent do you feel socially connected or disconnected to the larger community, beyond your immediate family and tribal community?

Given the recent crises with COVID-19, fires and floods, what has been hard and difficult in the past year? (Dig deep)

a) How has your mental health been affected?
b) Have you been able to find support and resources for challenges? What support and resources have you sought out? If you haven't, why did you decide not to seek out resources?

Are there additional challenges facing your community? (If there is time)

AUP FOCUS GROUP QUESTIONS
Aunties and Uncles Community Members

Script:

- Purpose of the focus group
- What to expect in the next 1.5 hours
- Confidentiality, ground rules
- Incentives

Introductions: Put your "name" so it is visible to the group. Click on three dots in the upper corner of your frame and edit your name.

Visualization: Think about your first time you participated in an AUP event. What was the event and when was that? Who did you come with? How did you feel about that event? Now think, did you attend other events? (Aid: post up types of AUP events) Share what events you have attended and what have you found most valuable in attending those events?

Describe your role as an Auntie or Uncle. **What was valuable about that experience?** (Eagle Council member, cultural workshop leader or facilitator, mentor, influencer)

Now think about your interaction with the youth, other adults, and families at AUP events.

e) How do you feel their sense of cultural identity was affected by AUP activities?
f) What interactions have you had with other adults in the AUP community events that have been valuable?

Given the recent crises with COVID-19 and the fires, what has been hard and difficult in the past year? (Dig deep)

a) How has your mental health been affected?
b) Have you been able to find support and resources for challenges? What support and resources have you sought out? If you haven't, why did you decide not to seek out resources?

What is the biggest challenge facing your community? (If there is time)

Sample Script

Introduction Text (Approx 15-20 minutes)
My name is _____ and I will be the moderator for today's Aunties and Uncles Program focus group. I am working with _____, who will be co-facilitating with me today. Today's discussion is to learn more about how the Aunties and Uncles program is affecting community members' attitudes, knowledge, and beliefs about mental health. In addition, we want to hear from you all about how this year has been for you and how COVID and the fires have affected your mental wellbeing.

All of you have been asked to participate because you (participated in the TAY Cultural Wellness Series, supported AUP as an Eagle Council member, teacher, advocate). It is our expectation that your opinions and experiences will help us learn more about the impact of Aunties and Uncles Program activities for our community. After the conclusion of the focus group, the information we discussed will be categorized into themes and topics before being shared anonymously with the AUP staff and Eagle Council. We will then take the focus group information and include it in a larger evaluation report.

Your personal information will not be connected to the results of this focus group. You all should have completed a consent form and a non-disclosure form. By signing these forms, you are agreeing to participate in the AUP focus group and to keep our discussion confidential. If you feel uncomfortable for any reason during the focus group and want to talk to a therapist, please send me a private message in the chat.

Before we begin, I would like to go over a few ground rules for the focus group. These are in place to ensure that all of you feel comfortable sharing your experiences and opinions.

Ground Rules:

1. *Confidentiality*—As per the non-disclosure form, please respect the confidentiality of your peers. The moderator will only be sharing the information anonymously with relevant staff members.

2. *One Speaker at a Time*—Only one person should speak at a time in order to make sure that we can all hear what everyone is saying.

3. *Use Respectful Language*—In order to facilitate an open discussion, please avoid any statements or words that may be offensive to other members of the group.

4. *Open Discussion*—This is a time for everyone to feel free to express their opinions and viewpoints. You will not be asked to reach consensus on the topics discussed. There are no right or wrong answers.

5. *Participation is Important*—It is important that everyone's voice is shared and heard in order to make this the most productive focus group possible. Please speak up if you have something to add to the conversation!

If it is alright with everyone, we would like to record the conversation. ___ will be taking notes but we want to make sure we get down everything you say correctly. Once the transcript notes are complete the audio recording will be erased. Is that ok, or does anyone object?
Do you have any questions before we begin? Before we get started, we'd like to start with an opening prayer. Would anyone like to lead the prayer?

Appendix 8: Consent and Assent Forms

LMU|LA
Bellarmine College of Liberal Arts

Psychology Applied Research Center

University Hall
1 LMU Drive, Suite 4725
Los Angeles, CA 90045-2659

Tel 310.568.6634
www.lmu.edu

INFORMED CONSENT FORM – 18+ Years of Age
California Reducing Disparities Project Phase 2 Statewide Evaluation
Principal Investigator: Dr. Cheryl Grills, Loyola Marymount University (LMU)

The California Reducing Disparities Project is a statewide project to improve mental health services. Aunties and Uncles Project is one of 35 programs funded by this project. The Psychology Applied Research Center in Los Angeles is doing a study of the project. The California Department of Public Health funds the study. The study will be used to report on the usefulness of programs like Aunties and Uncles Project. You can be in the study because you will be a part of Aunties and Uncles Project. If you take part in the study, you will be one of about 140 people for Aunties and Uncles Project and 9000 statewide.

If you say yes to the study, you will take two surveys. One survey when you start Aunties and Uncles Project. Another survey at the end of the program. The surveys ask about your mental health; services you have used or need for mental health, alcohol or drugs; and what you think about Aunties and Uncles Project. The survey also asks for details like your age, gender, and sexual orientation. One example of a question is, "Did you seek help for your mental or emotional health or for an alcohol or drug problem?" Another example is, "About how often during the past 30 days did you feel nervous?" The first survey should take 15 minutes. The second survey should take 10 to 15 minutes. Both surveys should take 25 to 30 minutes. Program staff can read questions and help you fill out the surveys.

Being in the study is optional. You will not be paid or receive any direct benefits. Saying no will not affect you being in Aunties and Uncles Project. If you say yes to the study, you will take two surveys. You can ask questions before you decide if you want to be in the study.

The surveys ask some questions that may cause discomfort. You can choose to not answer for any reason. You can also withdraw from the study at any time by saying, "I do not want to be in the study anymore." Nothing bad will happen if you withdraw. Withdrawing will not affect you being in Aunties and Uncles Project.

If you feel upset after you do the survey, the Sonoma County Indian Health Project can refer you to support services. If you want more support, you can contact Dr. Cheryl Grills at LMU, 310-338-3016.

To protect your data, paper surveys are stored in locked file cabinets and destroyed once put on computers. Computer data is stored on secure servers. However, there is a small chance of a data security breach that could cause loss of privacy. The law requires us to report child abuse, elder abuse, or plans to hurt yourself or others.

If you have any questions, you can contact Kurt Schweigman, MPH at the Sonoma County Indian Health Project at 707-521-4550. You can also contact Dr. Cheryl Grills at LMU, 310-338-3016 or cheryl.grills@lmu.edu. If you want to know more about your rights in research, contact the Committee for the Protection of Human Subjects, 916-326-3660 or cphs-mail@oshpd.ca.gov. You will also get a copy of the Participant's Bill of Rights for Non-Medical Research.

Signing below [or clicking the yes button below] means that:

- I understand all of the above information.
- I have received the Participant's Bill of Rights for Non-Medical Research.
- I consent to being in the study.

Signature: _____ Date: _____

Verbal Consent Obtained (if participant is unable to provide written consent): ☐Yes ☐No

Witness Signature if Verbal Consent was Obtained: _____ Date: _____

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INFORMED ASSENT FORM – 12-17 Years of Age

Principal Investigator: Dr. Cheryl Grills, Loyola Marymount University (LMU)
California Reducing Disparities Project Phase 2

This Aunties and Uncles Project is part of a statewide project to improve mental health services. Aunties and Uncles Project is one of 35 programs funded by this project. The Psychology Applied Research Center in Los Angeles is doing a study of the project. The California Department of Public Health funds the study, which it will use to report on the usefulness of programs like Aunties and Uncles Project. You can be in the study because you will be a part of Aunties and Uncles Project. If you take part in the study, you will be one of about 140 people for Aunties and Uncles Project and 9000 statewide.

If you say yes to the study, you will take two surveys. One survey when you start Aunties and Uncles Project. Another survey at the end of the program. The surveys ask about your mental health, services you have used or need for mental health, alcohol or drugs, and what you think about Aunties and Uncles Project. The survey also asks for details like your age, gender, and sexual orientation. One example of a question is, "In the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" Another example is, "About how often during the past 30 days did you feel nervous?" The first survey should take 15 minutes. The second survey should take 10 to 15 minutes. Both surveys should take 25 to 30 minutes. Program staff can read questions and help you fill out the surveys if you need help.

Being in the study is optional. You will not be paid or get any direct benefits. Saying no will not affect you being in Aunties and Uncles Project. If you say yes to the study, you will take two surveys. You can ask questions before you decide if you want to be in the study.

The surveys ask questions that may cause discomfort. You can choose to not answer. You can withdraw from the study at any time. You can withdraw by saying, "I do not want to be in the study anymore." Nothing bad will happen if you withdraw. Withdrawing will not affect you being in Aunties and Uncles Project.

If you feel upset after you do the survey, the Sonoma County Indian Health Project can refer you to support services. If you want more support, you can contact Dr. Cheryl Grills at LMU, 310-338-3016.

To protect your data, paper surveys are stored in locked file cabinets. Paper surveys are destroyed once put on computers. Computer data is stored on secure servers. However, there is a small chance of a data security break that could cause loss of privacy. The law requires us to report child abuse, elder abuse, or plans to hurt yourself or others.

If you have any questions, you can contact Kurt Schweigman, MPH at the Sonoma County Indian Health Project at 707-521-4550. You can also contact Dr. Cheryl Grills at LMU, 310-338-3016 or cheryl.grills@lmu.edu. If you want to know more about your rights in research, contact the Committee for the Protection of Human Subjects, 916-326-3660 or cphs-mail@oshpd.ca.gov. You will also get a copy of the Participant's Bill of Rights for Non-Medical Research.

Signing below [or clicking the yes button below] means that:

- I understand all of the above information.
- I have received the Participant's Bill of Rights.
- I agree to be in the study.

Your Signature: _____ Date: _____

Signature: _____ Date: _____

Adolescent Assent Form on File: • Yes • No

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PARENT CONSENT TO PARTICIPATE – 12 to 17 Years of Age

California Reducing Disparities Project Phase 2 Statewide Evaluation

Principal Investigator: Dr. Cheryl Grills, Loyola Marymount University (LMU)

The California Reducing Disparities Project is a statewide project to improve mental health services Aunties and Uncles Project is one of 35 programs funded by this project. The Psychology Applied Research Center in Los Angeles is doing a study of the project. The California Department of Public Health funds the study, which it will use to report on the usefulness of programs like Aunties and Uncles Project. Your child can be in the study because they will be in Aunties and Uncles Project. If your child takes part in the study, they will be one of about 140 people for Aunties and Uncles Project and 9000 statewide.

If you say yes to the study, your child will take two surveys. One survey when your child starts Aunties and Uncles Project. Another survey at the end of the program. The surveys ask about your child's mental health, services they have used or need for mental health, alcohol or drugs, and what your child thinks about Aunties and Uncles Project. The survey also asks for details like your child's age, gender, and sexual orientation. One example of a question is, "In the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" Another example is, "About how often during the past 30 days did you feel nervous?" The first survey should take 15 minutes. The second survey should take 10 to 15 minutes. Both surveys should take 25 to 30 minutes. Program staff can read questions and help your child fill out the surveys if they need help.

Being in the study is optional. You and your child will not be paid or receive any direct benefits. Saying no will not affect your child being in Aunties and Uncles Project. If you say yes to the study, your child will take two surveys. You can ask questions before you decide if you want your child to be in the study.

The surveys asks some questions that may cause discomfort. They can choose to not answer for any reason. Your child can withdraw from the study at any time by saying, "I do not want to be in the study anymore." Nothing bad will happen if your child withdraws. Withdrawing will not affect your child being in Aunties and Uncles Project.

If your child feels upset after they do the survey, the Sonoma County Indian Health Project can refer them to support services. If you want more support, you can contact Dr. Cheryl Grills at LMU, 310-338-3016.

To protect your child's data, paper surveys are stored in locked file cabinets and destroyed once put on computers. Computer data is stored on secure servers. However, there is a small chance of a data security break that could cause loss of privacy. The law requires us to report child abuse, elder abuse, or plans to for someone to hurt themselves or others.

If you have any questions, you can contact Kurt Schweigman, MPH at the Sonoma County Indian Health Project at 707-521-4550. You can also contact Dr. Cheryl Grills at LMU, 310-338-3016 or cheryl.grills@lmu.edu. If you want to know more about your rights in research, contact the Committee for the Protection of Human Subjects, 916-326-3660 or cphs-mail@oshpd.ca.gov. You will also get a copy of the Participant's Bill of Rights for Non-Medical Research.

Signing below [or clicking the yes button below] means that:

- I understand all of the above information.
- I have received the Participant's Bill of Rights for Non-Medical Research.
- I consent to my child being in the study.

Youth's Name: _____

Appendix 9: Remote Survey Administration Protocol

AUP EVALUATION PROTOCOL

Administration and Data Collection for SWE core-measures and AUP local survey

March 23, 2020

During the extraordinary times of shelter-in-place due to COVID-19 virus, Aunties and Uncles Program, Sonoma County Indian Health Project is unable to host in-person community events including Wellness Gatherings, Family Fun Nights, Cultural Workshops and Talking Circles. AUP staff and the local evaluator are adapting program and evaluation activities to be implemented remotely via electronic and social media platforms.

To engage Native American TAY in the AUP evaluation pre- and post-SWE core measures and pre- and post-AUP local survey will be administered remotely via links to Qualtrics and Survey Gizmo respectively. The following protocol outlines the process of obtaining consents/assents, administering pre- and post-instruments including a script for engaging and instructing the TAY.

Process to obtain consent/assent and administer pre-core measures and pre-local survey:

1) TAY who are engaged in an AUP activity such as remote facilitation of talking circles will be invited to participate in the AUP evaluation. If TAY is interested, contact information including email and phone will be obtained and logged into the TAY tracking form.
2) Individual appointments will be established with AUP staff or evaluator to explain the purpose of the evaluation, the voluntary nature and requirement for consent. Upon verbal agreement of interest, staff will determine the age of the TAY and take one of two actions:
    a. A TAY 14–17 years will be informed that they need to have parental consent and that two forms, parent consent and youth assent will need to be signed. Parents will be provided with an evaluation orientation to obtain an initial verbal consent. Once both TAY and parent verbally consent, an electronic parent consent and adolescent assent form will be emailed to the participant and parent. These forms will allow for electronic signature and secure record keeping through Adobe Sign.
    b. A TAY 18–24 years are eligible to sign their own consent as an adult. The adult consent form will be sent via email using Adobe Sign that allows for electronic signature and secure record keeping.

3) If a family or individual does not have good internet connectivity or proper hardware to receive, view and sign a consent form via Adobe Sign, a verbal consent may be obtained over the phone. Verbal consent will include a verbal acknowledgement that they have read the consent form contents, discussed the contents with AUP staff or evaluator, and have had their questions answered. The verbal consent will be documented on a consent/assent form, dated, and signed by the AUP staff/evaluator. A copy will be mailed via US Post or emailed to the participant/parent.

4) Once consent/assent forms are signed and secured, the TAY will be contacted by their preferred method of text or email. TAY will be asked to set aside up to 45 minutes to take both the pre-core measures and pre-local survey in a private uninterrupted environment. They are informed that once both surveys are completed and verified by staff, a $25 VISA gift card will be sent to their mailing address.
    a. The TAY will be given a unique ID number and instructed to use that number for both surveys.
    b. Staff will be available for any questions or support during the self-administered surveys.

Process for post-core measures and post-local survey administration:

1) Using the current tracking list of TAY who have taken the pre-SWE core measures and the pre-AUP local survey**, identify the eligible TAY to take the post-SWE core measure and post-AUP local survey.**
    a. Develop the list of TAY who have taken the pre-surveys eleven to thirteen months prior to the current date.
    b. Note whether TAY has a preferred method of contact (phone, text and/or email). Choose that method to contact TAY. Links for surveys can be sent either way.

2) Suggested script that can be sent either in text, email or spoken on the phone:

Hello (name of TAY). This is (your name). I am the (evaluator, program coordinator, community outreach specialist) for the Aunties and Uncles Project at SCIHP (Sonoma County Indian Health Project). Last year, you took two surveys for our project, and we would like to ask you to take it again so we can measure any change in knowledge, attitude, or status in mental health. All your responses are confidential and will not be tied to your identity.

We can send a link to the two surveys via email or text to your phone. You can complete them at home and it will take approximately 30-35 minutes for both. We are offering a $50 VISA card for those who finish both surveys. Are you interested in participating?

3) If yes, confirm method of participation
    a. Ask the TAY how they would like to complete surveys – on their phone via text link or on a computer via email link.
    b. Thank them and tell them to stand by as you'll prepare the text/email.
    c. Let them know they can call you if they have any questions or challenges with taking the surveys.

4) If no, thank them and tell them to be safe and stay healthy.
    a. Remind them they can go to the SCIHP page on Facebook to get program updates, health information and useful resources.

5) **Prepare the links**
    a. Consult the TAY tracking list to note if TAY is adolescent (Y) or adult (A). This is important because the SWE core measures are different for these two age groups.
    b. For adolescents, the link for the post-SWE core measure is http://mylmu.co1.qualtrics.com/jfe/form/SV_87JJhGctYnpcbA1
    c. For adults, the link for the post-SWE care measure is http://mylmu.co1.qualtrics.com/jfe/form/SV_38xcMPbXdh06lZH
    d. For all TAY, the second survey (AUP local survey) the link is https://www.surveygizmo.com/s3/5187770/Aunties-and-Uncles-Post-Wellness-Survey

6) **Note the unique identifier**
    a. Consult the TAY tracking list to note the TAY's unique identifier in the first column. You will need to provide this to the TAY.

7) **Email link and unique identifier to the TAY**
    a. Script: Hello (name of TAY). Here's a link to the state survey on an application called Qualtrics. Your identifier number is (xxx). (copy and paste the appropriate SWE core measure link (adolescent or adult).
    Here's a link to the second AUP survey that is on an application called SurveyGizmo. Your identifier number is the same (xxx). Confirm with me once you complete both. Feel free to call me at (xxx)xxx-xxxx if you have any questions or need help.

8) **Confirmation of completion**
    a. AUP staff/local evaluator can log on to confirm completion on Survey Gizmo by searching for the TAY identifier.
    b. SWE will send a confirmation to the Program Coordinator to confirm completion of post-SWE core measures.
    c. Once confirmation from both data sources has been obtained, contact TAY to see if they would like their gift certificate mailed by the US post. If so, obtain address and send out gift certificate, noting tracking number on log.