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The Center of Healing Hearts

Round Valley Crisis Response Innovation Project Annual Report
January 15, 2018 - January 15, 2019

Mendocino County and Round Valley Indian Health Center Innovation Project



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This report was developed through a collaborative writing process with stakeholders. Round Valley Indian Health Center staff were the source of all data and for all stakeholder meetings. MHSA team members provided support. Photo Credits Gerrilyn Reeves and Mendocino County MHSA.

Prologue

Mendocino County was faced with many challenges in bringing our first Innovation Project to fruition. Mendocino County is small in population (approximately 89,000), but large in geographic area (3,878 square miles). Mendocino County's terrain is mostly mountainous with population centers scattered in valleys between the mountain ranges.



The Mendocino County Mental Health Services Act (MHSA) team started the Innovation community planning process for innovation with comprehensive education about the innovation process collecting input on priority project ideas. To prioritize the stakeholder proposed ideas, we held a county wide survey in 2014. Our stakeholders had a number of priority projects that did not meet the innovation criteria as the services are available elsewhere in the state or are available in the populous areas of the county.

An Innovation Taskforce Committee was developed in January 2014 to take the top stakeholder innovation priority, crisis respite services, and find innovative approaches to that service delivery. Over the subsequent year and a half, the task force members explored various innovative approaches to crisis, but continued to find that the stakeholder preference was for approaches that were not innovative in the state of California (for example the use of peer providers or tele-health to support crises).



The taskforce worked with the Mental Health Services Oversight and Accountability Commission (OAC) staff on how to adapt our stakeholder priority into an approvable innovation project. The OAC staff suggested we narrow our focus to one unique population, in particular an underserved ethnic population, and look for something that needs to be learned in that community. With that guidance the Taskforce selected the community of Round Valley as a unique population due to the combination of significant barriers to access from the remote nature of the community and the long history of culturally oriented trauma and institutional distrust.

The Round Valley Reservation was established originally as the Nome Cult Farm in 1856 and is one of the earliest examples of forced removal of Native people by the Federal government. Round Valley Native American people were subject to the same genocidal conditions as other California Indians, including the encouragement of killing men, women, and children, the use of boarding schools to separate families and eliminate passing on of culture, the impact of infectious diseases, and the kidnaping and enslavement of indigenous people.



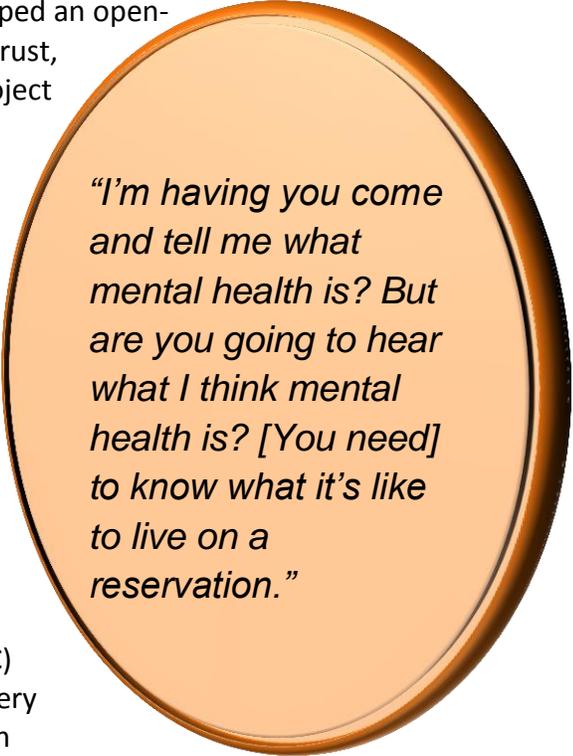
The Round Valley Tribal Government is comprised of six member tribes, most of whom were relocated from their home lands through forced marches into Round Valley. Traumas associated with forced

relocation and the devastation of the marches were compounded by the fact that the tribes forced to cohabitate in the Valley did not all have peaceful relationships. While these traumas are historical, many are within living memory.

Round Valley is located in a remote and isolated area of the county. Due to the location, community and county services are very limited. Travel in and out of the Valley is a 2-3 hour round trip over mountainous roads which can be treacherous in bad weather. While attempts to bring services into the Valley have been initiated, they are limited in scope, and unless the provider lives in or near Round Valley, there are often high turnover rates.

Round Valley continues to have institutional distrust. Contracts between Mendocino County and Round Valley Indian Health Center have been strained at times, continuing the established institutional distrust. Using the unique factors of historical trauma and institutional distrust as a focus, the Mendocino County Innovation Taskforce developed an open-ended project with a focus on crisis respite, institutional distrust, and historical trauma that would allow us to develop the project further as additional stakeholder input and feedback was obtained.

One of our biggest challenges was staff turnover at the OAC resulting in inconsistent guidance as to the readiness of the project. We continued to submit drafts and refine project ideas seeking affirmation that the project would be “innovative enough” to obtain approval. In spring of 2017, we scheduled to present to the OAC in Sacramento, however the location was changed unexpectedly to Los Angeles. The team traveled to Los Angeles in order to avoid further delay in the approval of our project. This meant a smaller group of stakeholders was able to be present for OAC public comment. The team consisted of three Round Valley Indian Health Center (RVIHC) staff, three Mendocino County Behavioral Health and Recovery Services (BHRS) staff, and a member of the Behavioral Health Advisory Board. Our presentation was delivered jointly by RVIHC and BHRS on October 27, 2017.



“I’m having you come and tell me what mental health is? But are you going to hear what I think mental health is? [You need] to know what it’s like to live on a reservation.”

The proposed project was critically received by the commission. During the critique of the presentation, some presenters perceived some of the statements by commissioners as offensive and showing a lack of education about the Native American history. Our RVIHC presenters felt some of the questioning as dismissive of historical trauma. Group members later reported a sense of further traumatization of the individuals present, and those listening at home. The team discussed the event later both together and with OAC staff. The predominant feeling was that this was another instance of a government entity telling indigenous people that they are not qualified or correctly reporting on their own experience. There was a sense, as

one Elder put it, “of the State trying to put brown (round) people in a square hole,” and of the need for Native People to educate the government entity on how it continues to traumatize. The project ultimately was approved, with encouragement to accept further technical assistance to allow for more clear delineation of the learning process.

The experience nearly spelled doom for the project at the moment we had finally received approval to move forward. In the succeeding months, the community showed resiliency, as the core group rallied to begin the formal contract finalization and expand the stakeholder group.

Developing the Center of Healing Hearts

This project was envisioned to increase access to behavioral health services for those with behavioral health needs living in the Round Valley area of Mendocino County. In particular, the project aimed to serve those in crisis as well as the Native American community in Round Valley that hadn't been accessing existing behavioral health services through “institutional” County service modalities. Stakeholder input and feedback was consistent with data about service disparities related to historical trauma and institutional distrust.

The project was approved by the Board of Supervisors on July 12, 2016 and the Behavioral Health Advisory Board on December 21, 2016. The project consists of two parts and learning goals. First: How can the communication between county providers and tribal community be enhanced to be respectful and build trust in a way that helps heal historical trauma and reduces institutional distrust? Second: What resources are available in the community to develop a crisis response service that meets the needs identified by the community, builds on existing community resources, and incorporates natural helpers or other community/traditional healing practices?

Throughout 2018, trust was a topic regularly discussed at Innovation Project meetings. The biggest challenge faced was determining how to define trust in a way that could be measured. Eventually, stakeholder preference was to measure changes in trust as they relate to project progress, such as completion of formal documentation, beginning to offer and test crisis response, and increased community awareness and involvement. The definition of trust in the overall project will come from the creation of a meaningful, useful, and viable program, rather than from formal trust building activities. An ultimate goal in relation to trust building is that we develop the program through collaboration between County government, Round Valley Tribal Government, and the Round Valley Community.

Key Accomplishments

- Approved by Board of Supervisors July 12, 2016
- Plan Approved by Behavioral Health Advisory Board December 21, 2016
- Behavioral Health Advisory Board Letter of Support February 2017
- Approved by MHSOAC October, 27, 2017
- Start Up Contract finalized January 15, 2018
- Start Up payment to RVIHC written January 15, 2018

- Resolved challenges and hired project manager November 5, 2018
- Using Stakeholder input, named Facility, Announced December 4, 2018
- Soft Opening of Center December 4, 2018

The Center of Healing Hearts

The Center of Healing Hearts is housed at 23000 Henderson Road, Covelo in the former Transitional Living Center (TLC) for youth, which had been predominantly vacant since TLC closed. The building is a

single floor that consists of 5 bedrooms, 4 bathrooms, a kitchen, and two communal spaces. The space had been built and utilized as a Level 9 step down facility for 8 years. Renovations were made to the space prior to use for crisis response testing. The building is located on RVIHC land next to the Yuki Trails Human Resources Program building and community garden. The TLC experience provided a reference for stakeholders in the development of the innovation project.



The Center of Healing Hearts opened on December 4, 2018 with a ceremony and gathering. The gathering served as a “soft open” to begin the process of testing modalities. The initial testing was a drop in modality for a couple hours a day. This was met with success and positive response from clients and staff at Yuki Trails, so the hours were extended to five hours a day.



Proposed Learning Objectives

Round Valley Community Stakeholder Expansion and Involvement

The first priority and goal of the project was to expand the Taskforce planning group to a larger Stakeholder group to more precisely define the project. The objective was to answer the following questions: What are the barriers to Round Valley residents accessing crisis services or crisis prevention? What kind of crisis response is needed in Round Valley? What resources exist in the Valley to build crisis response services? What trainings are needed for Round Valley resources to help build capacity? What specialty mental health services are lacking or needed in Round Valley? Are there other services that are needed in Round Valley to address crisis response? What stakeholders are missing from the planning group and how do we best engage them?

The proposal was designed to gather this information through regular stakeholder meetings and forums, obtaining feedback from stakeholders on how frequently to meet and what kind of meetings to have. After some initial experimentation we determined that a monthly meeting, held at a fixed time and date, facilitated by a local, respected, tribal member was preferred for stakeholder gatherings. Shortly after that was determined, it was agreed that food is essential as a cultural welcoming gesture, and that there should be a traditional blessing.

Defining and Measuring Trust

Once the stakeholder group was established, our second objective was to determine how we would measure trust and the improve trust over time. Our proposed questions for stakeholders related to trust were the following: What is the current rating of trust and respect of Round Valley members of outside agencies? How, where, to whom, and how frequently should communication occur to encourage trust? What measurement tools should we use to measure trust? What tools should we use to collect data on trust? How frequently, where, and who should participate in trust measurement?

In attempting to answer these questions, we came to the realization that we must define trust before we could measure it. The stakeholder group identified various concepts that reflect trust, such as commitment (including commitment at leadership levels), transparency, confidence, accountability, integrity, respect, and a sense of follow through. After initial attempts to measure trust through the proposed method of surveys, the group determined it would be more effective to measure trust through qualitative measures. Initial choices of qualitative measures include: tracking forward momentum and action items being completed (follow through), changes in content of minutes, and through qualitative word/phrase summaries of the meeting as opposed to quantitative survey checkmarks.

We continue to refine the concept of trust. While there is a qualitative sense of improved trust of the participants in the stakeholder group and some community members for the project, we have identified several aspects of trust that need to be addressed. These are levels of trust between RVIHC and BHRS, trust between individuals, community trust in the project,

“Daughters, mothers, aunties feeling overwhelmed/broken, come together as opposed to [seeing] a doctor for help. The different ways of healing create barriers between native people and facilitators. By learning more of healing practices, it can help with getting help - the sounding board - whether counselor or family.”

“Sharing experiences - you’re not alone. Especially among Native people - we are strong - you share and people know that you know how they are feeling.”

trust in the project by outside agencies, community trust of RVIHC, trust in the project by various Boards/Commissions, and trust by the community of the involved Boards and Commissions.

Since the project measures trust, we will continue to identify, refine, and test strategies to improve trust. Once we identified that forward momentum and follow through were the most consistently reported builders of trust among stakeholders, it was decided that we would begin focusing on crisis response strategies, while continuing to monitor and test trust strategies. There was a sense among various members that the focus on discussion of trust and establishing measurement was eroding community/stakeholder confidence that the crisis response component would ever be addressed.

“Our community, our native tribes are not the only ones experiencing this. All tribes - still here - pushing through this.

One person makes a difference. Don't give up. You have a voice. Even if you hit road blocks, don't give up.”

Identifying Crisis Resources and Preferred Modalities

The ultimate priority for the project is to identify successful and sustainable crisis response modalities that will address the needs of Round Valley with local Round Valley resources. In order to reach that goal, we proposed to answer the following questions: How do we define crisis in Round Valley/this project? What do we call the project that is both representative of the learning goals and is inviting to the community? How do we respond to “crisis” in Round Valley?

While we have just begun to explore these questions toward the end of our first year, we have identified starting points to test. Based on RVIHC’s prior experience running a Transitional Living Center for Youth, the RVIHC Board had concerns related to safety and liability. Stakeholders prioritized that modalities tested should start small and build from success. This strategy will guide crisis testing, build trust and community confidence, as well as ease concerns of RVIHC Board members.

Another significant early learning related to crisis response strategy is that calling any service “crisis” may likely be a barrier to utilization in this community. “Crisis” is associated with government and historical trauma. Modalities tested and what we call “crisis” response and prevention strategies will be developed with that in mind.

Addressing Historical Trauma

The unique history of Round Valley is a significant factor in what makes this learning project innovative. An essential component in our response to crisis needs in Round Valley must include addressing the historical trauma of Round Valley Indian Tribes. In the facilitation of early meetings, the initial project lead and meeting facilitator, Frank Tuttle, provided training to stakeholders to maintain awareness about historical trauma; this helped to keep the relevance present in the early planning processes.

Early learning related to historical trauma has included the importance of having a project manager and group facilitator who is from the local community. Having traditional practices that include blessings of food, smudging, and giving respect and preference to Elders during meetings has expanded participation by a larger group of stakeholders. As the project moves forward, trust continues to be built, and additional modalities are being tested. With this progress, more Elders have felt comfortable sharing their experiences in meetings, which include thoughts and suggestions for traditional paths to healing.

Project Achievements

Milestones	Activity/Achievement	Target Date	Actual Date
0 – 3 Months January 2018 – April 2018	Consistent Stakeholder Participation – maintain core group, with expansion to new stakeholders Start-up Contract finalized and first expenditure of funds Full project contract finalized	April 2018	Ongoing thru January 2019 January 2018 April 2018
1 – 6 Months February 2018 – July 2018	Gathering of community support Community outreach for increased Stakeholders and potential Natural Helpers	July 2018	July 2018 & ongoing Nov 2018
	Recruitment of Natural Helper expertise: Informal efforts, soliciting interest Formal recruitment completed	July 2018	Nov 2018 May 2019
	Developing policies, job descriptions: Research, drafting and governing body review processes Policies, job descriptions approved by RVIHC board	July 2018	Beginning June 2018 April 2019
	Providing training, including culturally specific content, for natural helpers and community members:	July 2018	

	White Bison Mental Health First Aid White Bison Wellbriety		March 2018 Sept 2018 Jan 2019 Jan 2019
	Traditional Healer services offered	July 2018	Dec 2018 & Quarterly
1 – 18 Months February 2018 – July 2019	Monitoring for consistent positive response of collaboration Local collaboration of core stakeholders Improved trust responses Trust measurements taken at each meeting through June 2018 Began use of new trust measurements after stakeholder discussions at meetings Round Valley radio project KYBU Interview	July 2019	Every six months June 2018 June 2018 August 2018
1 – 18 Months February 2018 – July 2019	Planning, developing, and training for crisis-response plan models: Began discussing Project Manager job description Began discussing crisis respite parameters (safety, liability, level of acuity/capacity to respond, modalities to be tested, hours, start with existing resources and build) Continue process of finalizing Project Manager job description; begin formulating Policies and Procedures Suicide Prevention Week presentation RVIHC Oversight Committee establishing members Criteria for first crisis modality testing being developed	July 2019	Jan 2018 May 2018 June 2018 Sept 2018 Oct 2018 Oct 2018

	<p>Project Manager hired</p> <p>Community Survey of priority for Crisis Response – respite prioritized</p> <p>Began drafting brochure of initial resources</p> <p>Preparing the space, interior set-up and materials; final renovation and initial supplies purchased</p> <p>Outreach to expand stakeholders, identify potential Natural Helpers, inform medical providers of services and hours available</p> <p>“Soft open” and naming of Center of Healing Hearts, welcoming informal walk-ins, open house for community</p> <p>Established initial fixed hours for Center of Healing Hearts, distributed brochure, began accepting referrals from RVIHC and Yuki Trails</p>		<p>Nov 2018</p> <p>Nov 2018</p> <p>Nov 2018</p> <p>Nov 2018</p> <p>Nov 2018</p> <p>Dec 2018</p> <p>Jan 2019</p>
<p>6 – 36 Months July 2018 – January 2021</p>	<p>Implementation and testing of crisis response</p> <p>Began testing “Wellness Center + Natural Helper” modality of crisis response</p>	<p>January 2021</p>	<p>Dec 2018 & Ongoing</p> <p>Dec 2018</p>
<p>30 – 36 Months July 2020 – January 2021</p>	<p>Evaluation of crisis response sustainability</p>	<p>January 2021</p>	<p>N/A</p>
<p>30 – 36 Months July 2020 – January 2021</p>	<p>Evaluation of crisis response and suicide prevention Ongoing training and evaluation</p>	<p>January 2021</p>	<p>N/A</p>



Description of Changes During Our First Year

Changes in the project from the time of approval by the Oversight and Accountability Commission include changes to the timeline, anticipated changes to the budget, and changes in the scope and definition of crisis response.

The project has been impacted by some delays in full implementation that have impacted our overall timeline. The proposal was approved by the Oversight and Accountability Commission (OAC) in October of 2017, and contracts with Round Valley Indian Health Center were finalized in January 2018. This delay in making funding available to RVIHC, impacted meeting other timelines such as the completion of the space and the hiring of the project manager. Other document review and approval processes for policies, job descriptions, vision and mission statements, and brochures have also been delayed impacting the momentum of the project. Time spent coming to consensus on shared definitions of terms such as “trust” and “crisis” has impacted our timeline as well.

The definition of what we mean by crisis was not fixed at the time of the approval by the OAC, and we intended to collect additional stakeholder feedback on what modalities to test first. RVIHC prioritized starting small and building toward crisis due to concerns about failure, safety, and liability. Failure of an early test might lead to lack of trust in the community, so starting small and growing toward the higher levels of crisis response modalities seemed the best way to meet both community trust goals and crisis response development. Stakeholders have provided feedback that the use of the word “crisis” can be a deterrent as it usually implies law enforcement, hospitals, detentions, and removal from the Valley. Using words that imply healing and local supports was encouraged. The project is also starting with a more open door; drop in, wellness style of support.

By starting with lower level modalities, we have identified budget areas that were not initially anticipated. While a vehicle was anticipated in the original budget, the total cost will likely be inadequate, as there will need to be multiple transportation supports both within the valley, and outside to the larger service areas.

We identified additional stakeholders and resource agencies that have come to stakeholder meetings. This process has been slow, so waiting for input to obtain feedback slowed the timeline as well. Additional stakeholders have included Elders, caregivers, parents, local service providers, outside service providers, and Tribal Police. Not all of these additional providers are coming to stakeholder meetings on a regular basis yet, but we hope to improve on that in year two of the project.



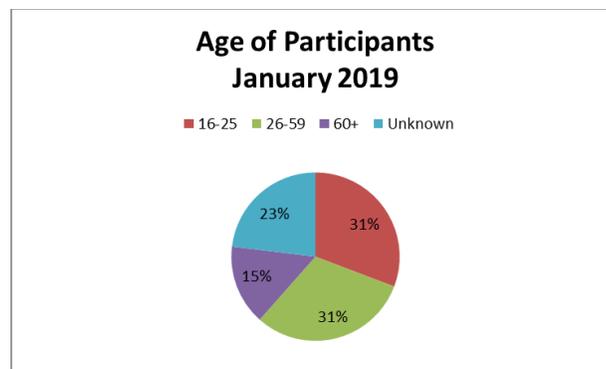
“Repeating same 20 questions you’ve already said; why do I have to keep explaining myself when I just need help for what is going on. I have had both kinds of help; I understand [you are] trying to help move forward, but these are some barriers - asking questions. Native people feel [like] ‘here we go again,’ can we get past that and get straight to what’s going on.”

Who We Served

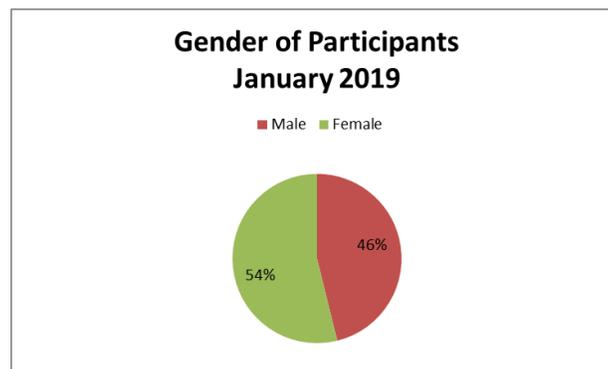
At the end of our first year of the project, we served a total of 13 participants at the Center of Healing Hearts.

“Age is an important category. Elders are important. I’m not going to ask a ‘young whippersnapper’ to help me, especially for mental health. Some have a lot of knowledge, but the way I was raised, I’m not going to go to you for help. Go to the Elders.”

Age



Gender



Ethnicity

All participants thus far have identified as Native American. There has been considerable discussion about the classifications for ethnicity not being relevant to the population. For example, we received the response, “Is this program for me, if I’m not on here?” in reference to the Innovation demographic criteria. Being asked for demographic information is a barrier to accessing services for this community, because the categories are chosen by governmental institutions and not how individuals self-identify. Stakeholders report that historically, data collected from the community has been used for government data or grants, but the information

doesn't come back to them or result in benefit to the community. At this time we are asking for demographic information after the support service has been offered.

Preferred Language

Language is another category that has not been completed by participants. The categories will likely need to be adapted from the MHSA/Innovation required categories to categories that are relevant to the community and include native languages.

Sexual Orientation, Disability, & Veteran's Status

Sexual Orientation is a category that has not been completed by participants. There has been strong stakeholder feedback that data and demographics are a barrier in particular among native communities where data has been collected but is not seen as benefiting the community or "used" to count the community but not benefit the community. Some of the statements we've heard related to data and demographics include: "Here we go again, repeating the same twenty questions you've already asked;" "Why do I have to keep explaining myself when I just need help for what is going on." At this time we are not collecting these demographics as a response to this feedback.

Types of service provided

At this time the services provided are in development. Services that may potentially be available or developed through the learning process include counseling, advocacy, assessment, respite, education, and/or case management. The project now has the project manager available at the center allowing for RVIHC staff to refer individuals that need extra support to talk and spend time. From that experience we have begun to expand the hours available and identify various other types of services needed/desired by the community.

The project intends to enable Natural Helpers, local community members who will use their own experiences and training to provide needed supports for individuals talk through their concerns.

In the first two months of services the predominant activities have been assistance with paperwork, providing wraparound supports for RVIHC service recipients, and integration with the Traditional Healer.

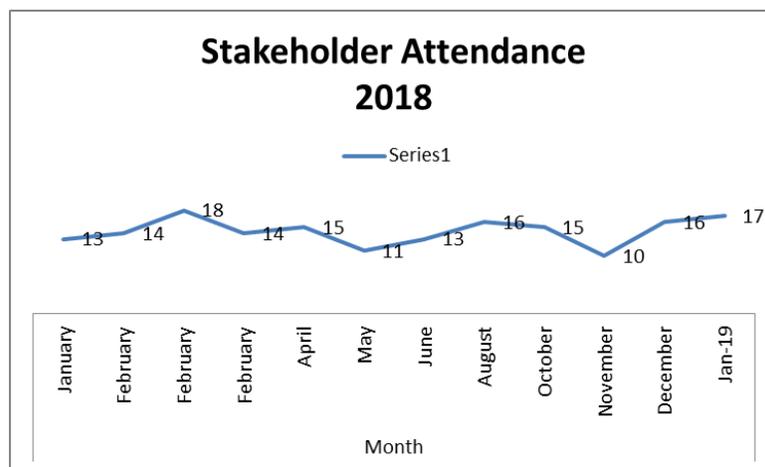


Yuki Trails Human Services Program

Lessons Learned (Outcomes & Measurements)

Trust Learning

Of the dominant lessons learned about building trust, foremost is that trust builds slowly. The most meaningful measurements of improved trust to our stakeholders is progress in the crisis response aspect of the project. We've learned that all our systems take longer to process than stakeholders would like (for example processing contracts and policy approval). This impacts public confidence that the project is moving forward. Early in the project, trust development was very person-specific. While individuals are still a significant factor in trust development, trust in the project seems to have grown between the BHRS and RVIHC agencies, as well as between the community and the project facilitators. We will continue to explore how various levels of trust (individual, community, participants, agency, systemic, internal, and between systems) improve and are impacted by progress in the project. We have seen recent growth in stakeholder participation.



One area where we still see person-specific impacts on trust is with the project manager. When Gerrilyn Reeves was hired as the project manager, we saw a change in stakeholder participation. She began to outreach and communicate about the program, adding personal social communication to the formal agency communication that had been done previously. New stakeholders that had not previously participated began to attend meetings. These were individuals that had a connection with Gerrilyn and trusted her, so came to learn more about the project. With new participants we have seen an increase in individuals willing to speak at meetings and have captured more quotes and statements from individuals, many of which we have included in this report.

Identifying how we measure improvement has been a primary focus in year one. With baseline measurement strategies identified, we will observe these over time in order to inform changes in the program. One of our qualitative measurements of trust is reviewing the content of minutes over time to monitor changes in confidence and follow through. For the first three months of the project there were several discussions around length of the contract approval process, the inability to spend money until the contract was finalized, the expectation/need for higher level

County and RVIHC staff participation in stakeholder meetings. These issues were perceived to impact trust levels among participating stakeholders. Following finalization of the start-up contract in January 2018, these issues subsided to some degree.

“There has been a communication gap for so long. There are things that are sacred in all cultures. But a lot of people don’t trust. After psychiatry and counseling, after everything do you check on people that you’ve helped? Need that said up front. Why can’t you check on people and do the follow up, even ‘how are you doing’ . . . ‘I’m glad you are doing better’ “

“ . . . feeling of not getting help sundown, sunup, when there is the need. No follow up calls to someone you’ve poured out your heart to. [For] this project, follow up will be very important. If you do that then you have done something, it is a success. “

As implementation planning proceeded, liability concerns were brought to the forefront. The importance of addressing safety and liability concerns slowed some approval processes, such as policies and procedures. Some of these issues were not resolved until after the hiring of the project manager in November 2018.

Stakeholder and project staff turnover was another factor that affected trust. In the beginning of the year, trust was very person-centered. Where there was trust in an individual, there was concern that change in individual staff members would disrupt progress of the whole project. The project lead who had contributed to the development of the project proposal left the project in July 2018 and the formal project manager was not hired for four more months. There was also turnover in the County of Mendocino liaison position, when Colleen Gorman became the MHSA Program Administrator in October 2018. The RVIHC governing board underwent changes in its membership, including some members assigned to the Innovation Project Oversight committee. These changes required additional time for incoming staff/stakeholders to become informed about the project and to develop baseline knowledge about the project that had been established by their predecessors. However, the project as a whole was not disrupted as greater agency level trust had been developed.

A final challenge related to trust outcomes was that the results from stakeholder surveys collected in the first several months of the project were lost with the departure of the former RVIHC project lead. By the time the project team realized that they were no longer available, the stakeholder group had decided not to use surveys to quantitatively measure trust outcomes.

Qualitatively, we identified fluctuations in trust and confidence over time between various project participants. We observed that OAC members did not

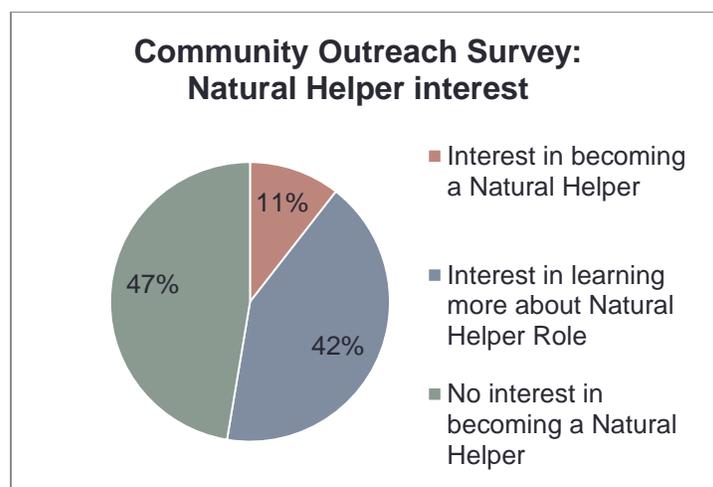
seem to trust that our project was fully organized and able to be completed based on the open-ended project proposal. We observed RVIHC lack of confidence in County contract processes when it took several months to complete, as opposed to several weeks. We observed lack of confidence by RVIHC leadership when County leadership was not present at stakeholder meetings. We observed concern for transparency related to budget outlines, administration, and evaluation costs. We observed community respect and increased participation when meetings were facilitated by a tribal member as opposed to a County staff person. We observed increase in project confidence by RVIHC staff when contracts were completed and funding was provided to RVIHC.

We observed an increase in participation by community members when the project manager was officially hired. This milestone increased community trust and confidence in RVIHC project momentum and follow through and also increased County staff confidence in RVIHC follow through. The loss of surveys during the transition from the first facilitator impacted County staff confidence in the progress of trust measurement.

Challenges finalizing Policies and Procedures were observed to decrease confidence in the RVIHC Board. We observed that as the trust between agencies has improved, attendance of RVIHC Board members has decreased. This has coincided with some changes in RVIHC Board members. Concerns of RVIHC staff and community members were raised about RVIHC Board commitment. We found it notable that while there were several discussions and some concerns around the dissemination of the initial project funds, delays in reimbursement of invoices related to providing supporting documentation has not created trust concerns.

We will continue to observe these qualitative impacts on trust and confidence to identify factors and strategies that impact trust.

Crisis Response Learning



One of Gerrilyn's first actions upon becoming project manager, was outreach to community members to collect data about the interest of individuals becoming Natural Helpers and in the priority of community members for types of crisis response. Survey results showed that respondents wanted a safe place to talk and get support. All 19 respondents (100%) indicated they would refer family members for support. The majority of respondents (15) indicated they would be willing to access the center themselves.

The project had originally proposed to build Natural Helpers from individuals in the community. The community survey and stakeholder feedback has supported utilizing local individuals. Of the survey respondents, almost half (8 respondents) expressed interest in becoming Natural Helpers. Two indicated active interest in becoming Natural Helpers and began early training.

One of the dominant lessons learned about crisis, is to avoid using the word "crisis." Individuals in the community associate "crisis" with governmental agencies and stigma, and are less likely to seek services labeled "crisis." Dr. Iyer, an RVIHC physician, called crisis a "time out," meaning taking a break, and community members preferred this phrasing. Individuals in the community want to be heard and helped. They have asked not to have data collected about them before they are helped, or even at all. Stakeholders and community members have asked for more narrative and story-based services, as opposed to data driven services. Community members asked for more follow up and follow through and more human connection. Suggestions for improving human connection include community education, use of traditional healers, further training of Natural Helpers, and including a role for Elders. Stakeholders recommend that services developed include cultural contexts of family, historical trauma, respect for elders, as well as an awareness of resource limitations in the Valley.

Of our 13 center participants, none have indicated they are in "crisis" when coming in for support. Upon intervention, several participants have been discovered to be in a pre-crisis state of distress. If their concerns were not addressed, they may have warranted higher levels of formal mental health intervention. Stakeholders have urged the use of wellness oriented, natural helper/peer driven support to learn more about individuals' needs and to serve more from a crisis prevention perspective. No participants have accepted referrals to Dr. Mack, RVIHC Behavioral Health program psychologist, for more intensive behavioral health services. Participants have been more likely to accept referrals to traditional medicine and the traditional

"Spirit moves at its own pace. [We need to] move from western pacing and agendas to allow for story to emerge and the spirit to move."



"We are a spiritual people, and we have a spiritual agenda."

healer, which are less stigmatizing than formal behavioral health services in this community.

Stakeholders have begun to provide more specific feedback about how services should be approached. The fact that Elders are trusted members of the community, and will be more respected by other Elders, has been raised as a reason to develop a role for Elders. Using individual's own words while collecting check-in information has been determined to be very important. Natural Helpers, like Elders, have lived experience. Their experiences of overcoming challenges and modeling self-help and coping strategies can be used as in other peer driven models of care. How to better incorporate Elders and Natural Helpers at the Center will be a focus in year two.

A traditional healer provides services at RVIHC and has offered traditional medicine at the Center of Healing Hearts. He has a very low no show rate, and is often sought by participants. Medicine offered by the traditional healer includes but is not limited to smudge, herbal medicine, and prayer. Ways to increase traditional medicine at the center will be explored in year two.

Concerns about safety and liability have contributed to starting slowly with drop-in and peer based modalities as opposed to 5150 level assessments at this time. Building from small successes will also build community confidence and help the project to grow and expand organically.

Recommendations Moving Forward

As we enter year two of the Center of Healing Hearts Innovation Project, we plan to continue to test wellness support (crisis prevention) modalities, building from the drop-in basis to include afterhours, on call and natural helper/peer based support modalities. We hope to build stakeholder participation from agency partners to add improved resource navigation and connection for individuals.

We have heard strong community feedback to support the importance of Elders in healing and modeling healthy supportive living, and plan to develop a role for Elders in our project.

The project timeline delays have been a significant part of our first years' learning. While these delays impacted confidence in follow through, we are aware of the cultural differences between Native American community sense of time and governmental/institutional project milestone/deadline sense of time. We would like to explore this further in year two, especially regarding how it relates to data collection and reporting needs. We expect we will further adapt how we collect and communicate data to respond to the cultural considerations of the community.

In addition, we also intend to finalize projects that are in development. While we know they will be refined as the project develops, we hope to have Center policies finalized within the first few months of the year. We intend to finalize Natural Helper job descriptions and move forward with

“Are there resources at 8 pm? What if I don't have a car? We want the “real” 2 am needs, no car, [etc.] If people like me don't speak out, how will we learn?”

recruitment and hiring. The addition of Natural Helpers will allow for further expansion of hours. The community has expressed a desire for some sort of overnight response, and we would like to begin testing on-call response.

In year two of this innovation project, we hope to bring additional training to the community and Natural Helpers. Trainings in Crisis Intervention Teams are scheduled for February and April of 2019. Additional community discussion of historical trauma is being explored as an avenue to possible healing. We want to ensure the setting and context is appropriate. We hope that by developing a shared understanding of historical context, we may find a role for sharing family stories, history, and wisdom as a crisis prevention and intervention activity at the Center of Healing Hearts.

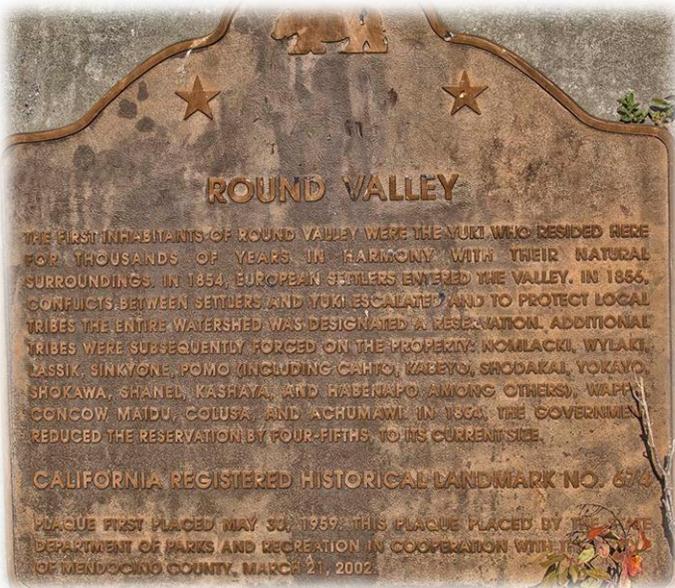
*“My Grandfather always told me move forward,
don’t go back . . . we need to move ahead.”*



Statement from a Community Member who visited the Center of Healing Hearts

“Before I first came I was depressed, and angry at my family, I felt shunned. I was helped by others in the community, I didn’t trust you Gerrilyn. I came, for a shower, food and I gave it a shot. Coming helped get my life together and your confidentiality is very important. We listened to each other, nothing was ever thrown back at me. This is for real, this is what I need, the confidentiality. The brochures, the chairs, sitting at the kitchen table is what I want again. I am treated with respect and welcomed. You go out to the community, you don’t discriminate. In your place we [clients] get along, even if we don’t normally. I don’t feel depressed anymore, I have goals now, I have my snow cone business back. You helped get my life back. Coming here helped me to hold my head up again.”

Gabriel Jon Patterson



Glossary of Terms

BHAB - Behavioral Health Advisory Board. Mendocino County has a 15 member board made up of three members of each county district including a consumer, a consumer family member, and a public interest seat.

BHRS - Behavioral Health and Recovery Services. A service unit of Mendocino County Health and Human Services Agency providing services to those that meet medical necessity for specialty mental health services or substance use treatment and those that qualify for Mental Health Services Act programs.

BOS - Board of Supervisors. Mendocino County has five districts each with a representative that make up the governing body of the County.

Crisis - This term is still being defined for the purposes of this project. Specialty mental health services define crisis as an individual at risk of danger to self, danger to others, or gravely disabled as a result of a mental disorder.

MHSOAC/OAC - Mental Health Services Oversight and Accountability Commission. A body that oversees the implementation of the Mental Health Services Act. This includes reviewing and evaluating MHSOAC programs; overseeing research, stakeholder contracts, and commission projects; and providing technical assistance and training. Responsible for approving Innovation Projects.

Natural Helper - Individuals with lived experience who will provide guidance and understanding from their own experience and training.

RVIHC - Round Valley Indian Health Center. A nonprofit primary health care clinic serving the Covelo and the adjacent Round Valley Indian Reservation. The clinic provides treatment, prevention and patient education including traditional Indian Medicine and holistic healing.

Smudge - Traditional medicine that involves burning sacred plants and prayer.

Traditional Healer - A practitioner of traditional Indian medicine and healing practices.

Trust - Trust was defined by stakeholders for the purpose of this project to convey commitment, belief, follow through, certainty, assurance, conviction, transparency, respect, something that is earned, confidence, honesty, accountability, and integrity.

Wellbriety - A Native American movement that emphasizes spiritual traditions as a means to break the cycle of hurt caused by alcoholism. Wellbriety incorporates both Native American spiritual practices and twelve step Anonymous practices.

White Bison - An American Indian nonprofit organization offering healing resources including Wellbriety. White Bison is a grassroots community based practice that includes culturally based practices along with 12 step principles for addiction recovery, sobriety, and recovery.