American Indian and Alaska Native Mental Health Research

The Journal of the National Center

Volume 11, Number 2, 2004

PREFACE

Jill Shepard Erickson, M.S.W., A.C.S.W.

The story of the Circles of Care initiative is one that demonstrates the power of thoughtful collaboration for addressing critical health policy issues. Under Circles of Care, the Center for Mental Health Services (CMHS), part of the Substance Abuse and Mental Health Services Administration (SAMHSA), in partnership with Indian Health Service (IHS), the National Institute for Mental Health, (NIMH), and the Office of Juvenile Justice and Delinquency Prevention, Department of Justice (OJJDP) have provided critical funding and technical assistance to federally recognized tribes and urban American Indian and Alaska Native (AI/AN) communities to plan, design, and assess the feasibility of a culturally respectful mental health system of care for their children and families.

The initiative represents the collective vision of a large number of AI/AN tribal members, service providers, advocates, researchers, and federal agency representatives who met as an Advisory Board to CMHS regarding potential initiatives to address the unique mental health needs of American Indian and Alaska Native children, adolescents, and their families. Beginning in 1994, the Advisory Board met over a period of 4 years to develop consensus for the overall design of the project. Gary De Carolis, M.Ed, CMHS and Albert Hiat, Ph.D., of the IHS provided the initial vision and impetus for the Circles of Care. Nelba Chavez, Ph.D., Bernard Arons, M.D., Michael English, J.D., Diane Sondheimer, M.S.N., M.P.H., C.P.N.P., of CMHS, Douglas Dodge, J.D., of OJJDP, and Ann Hohmann, Ph.D., NIMH, provided support for the initiative. Expert testimony on the state of American Indian and Alaska Native mental health was provided for the series of meetings and led by Spero Manson, Ph.D., Director, National Center for American Indian and Alaska Native Mental Health Research, University of Colorado. The initiative builds upon the needs identified in the Congressional report of 1990, *Indian Adolescent Mental Health,* edited by Dr. Manson, and later described in a report commissioned by CMHS and compiled by Terry Cross, ACSW, and staff of the National Indian Child Welfare Association and Georgetown University: *American Indian Children's Mental Health Services: An Assessment of Tribal Access to Children's Mental Health Funding and a Review of Tribal Mental Health Programs,* 1996.

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We are grateful for the wisdom and direction provided for the initiative by the Advisory Board, in the series of discussions facilitated by Terry Cross, Executive Director, National Indian Child Welfare Association. Members included:

1.   Virginia Hill, MSW, Director of Social Services, Southern Indian Health Council, Alpine, California, National Congress of American Indians, Children's Committee.

2.   Dixie Jordan, (Eastern Cherokee) Families and Advocates Partnership for Education, Pacer Center, Minneapolis.

3.   Arliss Keckler, (Lakota) Health Director, (retired), Cheyenne River Sioux Tribe, South Dakota.

4.   Tracy King, (Assiniboine) To-ga-he-yo-he Youth Ranch, Harlem, Montana.

5.   Art Martinez, Ph.D., (Chumash) Washoe Tribe of Nevada and California.

6.   Penny McClellen, Ph.D., San Diego American Indian Health Center.

7.   Greer McSpadden, MSW, (Cherokee) First Nations Clinic, Albuquerque, NM.

8.   Gary Peterson, MSW, (Skokomish), Professor, Evergreen State College, Shelton WA.

9.   Jenny Rodgers, MPH (Navajo) Navajo Nation Center for the Prevention of Child Abuse and Neglect.

This Special Issue describes the process and outcomes of the unique program evaluation efforts conducted by the first seven grantees, funded from 1998 to 2001. A second set of grantees have been funded from 2001 to 2004. Given the enthusiastic support of the current SAMHSA (Charles Curie, A.C.S.W., Kathryn Power, M.Ed., Sybil Goldman, M.S.W.) and IHS (Jon Perez, Ph.D.) administrations, we anticipate awarding a third set of grants in 2005.

In line with priorities and objectives of the President's New Freedom Commission on Mental Health (President's New Freedom Commission on Mental Health, 2003), the Circles of Care initiative seeks to reduce mental health disparities and increase the cultural competence and effectiveness of systems of care for AI/AN children and families. The initiative bridges the gap from "service to science" by utilizing a community-based evaluation effort that identifies community needs, barriers to accessing services, service system gaps, local protocols for the inclusion of traditional healing, and the potential community and outside resources available to address mental health needs. This comprehensive evaluation effort enables Circles of Care grantees to develop model systems of care that are consistent with community needs

and values and feasible given community resources. The publication of this Special Issue fulfills one of the key goals of the Circles of Care initiative, "*to provide a blueprint that other tribal and urban Indian organizations or other agencies involved in service delivery to American Indian and Alaska Native children can use to guide implementation and/or modification and improvement of current service systems* (Federal Center for Mental Health Services, 1998, p. 6)." We hope this Special Issue proves to be a useful "blueprint" for similar efforts in both AI/AN communities.

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Jill Shepard Erickson, MSW, ACSW
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Suite 11-C-16
5600 Fishers Lane
Rockville, MD 20857

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EDITORIAL

Pamela B. Deters, Ph.D., Douglas K. Novins, M.D., and
Spero M. Manson, Ph.D.

The Circles of Care (CoC) initiative represents one of the most exciting and innovative initiatives in recent years for addressing mental health issues in American Indian and Alaska Native (AI/AN) communities. Funded by the Center for Mental Health Services (CMHS), the CoC initiative provides funding to plan, design, and assess the feasibility of implementing a culturally appropriate mental health service model for AI/AN children with serious emotional disturbances and their families. The two organizations that primarily assist in this effort are the National Indian Child Welfare Association (NICWA), which aids grantees in the program development component of CoC, and the CoC Evaluation Technical Assistance Center (CoCETAC), part of the American Indian and Alaska Native Programs at the University of Colorado Health Sciences Center, which aids grantees in the evaluation component of the initiative. The first cycle of CoC grantees were funded from 1998-2001. This publication represents the fulfillment of these grantees' firm commitment to disseminate the results of the CoC initiative, which gave so much to their communities and service systems.

This Special Issue is a compilation of the experiences and lessons learned described by grantees, administrators, and academicians involved in the first cycle of the CoC initiative during a planning meeting hosted by CoCETAC and supported by CMHS that took place in Denver in February 2002.[1] A companion to this volume will appear in the CMHS monograph series, which will make these issues more accessible to parents and community members interested in the CoC story, but less interested in some of the academic details presented here.

The core of this Special Issue are the six papers devoted to the components of the CoC evaluation effort: (a) Needs Assessment (Novins, LeMaster, Jumper Thurman, & Plested, 2004); (b) Serious Emotional Disturbance (SED) Definition (Simmons, Novins, & Allen, 2004); (c) Service System Description (Allen, LeMaster, & Deters, 2004); (d) Outcome Measurement Plan (Novins, King, & Stone, 2004); (e) Feasibility Assessment (Coll, Mohatt, & LeMaster, 2004); and (f) Process Evaluation (Bess, King, & LeMaster, 2004). Four additional papers provide the rich contextual nature of the initiative and evaluation: (a) an introductory paper (Freeman, Iron Cloud-Two Dogs, Novins, & LeMaster, 2004); (b) a paper describing the "life cycle" of evaluation (Bess, Allen, & Deters, 2004); (c) a paper describing outcomes (Duclos, Phillips, & LeMaster, 2004); and, (d) a final paper outlining conclusions and recommendations (Jumper-Thurman, Allen, & Deters, 2004). Data analyzed for this Special Issue were entirely secondary in nature, drawing on the reports of the grantees and the CoCETAC.

While a number of exciting aspects of the CoC evaluation effort are described throughout these papers, three deserve special mention here. First, the CoC evaluation effort showed strong evidence of a cyclical process as described by Bess, Allen, and Deters (2004, pp. 30-41). The life cycle of the evaluation initiative involved necessary, stage-specific dynamics that drove the process forward to completion. Distinct developmental levels emerged, including an understanding of prehistory relevant to participants, the definition and development of the evaluation effort, the transformation of data collection into policy and planning recommendations, and a final transition from planning to implementation.

Second, a critical aspect of the evaluation was assisting grantees to bridge the gap between AI/AN and non-AI/AN concepts of mental health and mental illness. This is clearly seen in Simmons, Novins, and Allen's (2004) paper on defining serious emotional disturbance (SED) for AI/AN children and their families (pp. 59-64). The authors highlight the fact that establishing a locally relevant definition of serious emotional disturbance (SED) was critical to the grantees' planning efforts. These definitions minimized stigmatization within grantee communities and allowed for the possibility of a strength-based conceptualization of need. This individualized characterization of each community's concept of SED also had significant implications for the design of a model system of care with, for example, a more broadly conceived definition of SED ultimately requiring a broader array of services.

Third, the CoC initiative produced tangible and intangible outcomes as described by Duclos, Phillips, and LeMaster (2004, pp. 121-138). A review of the overall outcomes of CoC was said to have included a "rippling effect." One efficacious outcome led to another, and so on. Ultimately this effect allowed grantees to identify tangible outcomes, such as written reports, programmatic changes, and funding for implementation of model systems of care, as well as intangible outcomes, such as the critical AI/AN focus of the evaluation, the energizing and mobilizing of AI/AN communities, and the establishment of long-lasting collaborations and partnerships as a direct result of the CoC initiative. The impact of CoC outcomes continues in these communities, noted most recently by the awarding of two more CMHS Children's Mental Health services grants to former CoC grantees.

We, the editors, thank all those involved in this endeavor for the hard work and tenacity evidenced throughout this process, including CMHS, which provided financial support for the 2002 planning meeting and completion of this publication. It was through their efforts that this Special Issue was conceived and took form. Their commitment and passion made this publication possible.

Finally, we believe that through this publication the participants in the CoC initiative have accomplished one of its primary goals: to disseminate the exciting and valuable information and experiences gathered through the

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CoC planning process. We hope that program planners, evaluators, and policymakers will use this Special Issue to assure that future planning efforts for all communities, including AI/ANs, benefit from the knowledge gained through the work of the CoC initiative.

Pamela B. Deters, Ph.D.
University of Alaska Fairbanks

Douglas K. Novins, M.D.
University of Colorado Health Sciences Center

Spero M. Manson, Ph.D.
University of Colorado Health Sciences Center

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Footnote

[1] A list of the participants in the planning meeting and the meeting agenda may be found on page 156 and 158 of this Special Issue.

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CONTEXTUAL ISSUES FOR STRATEGIC PLANNING AND EVALUATION OF SYSTEMS OF CARE FOR AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES: AN INTRODUCTION TO CIRCLES OF CARE

Brenda Freeman, Ph.D., Ethleen Iron Cloud-Two Dogs, M.S., Douglas K. Novins, M.D., and Pamela L. LeMaster, Ph.D.

Abstract: This introduction to the evaluation component of the Circles of Care initiative includes background on the nature of the initiative, Center for Mental Health Services support for developing systems of care for youth with emotional disturbances, and an overview of the systems of care approach. The prevalence, unique challenges, and the historical, political, and cultural context of health care delivery for American Indian and Alaska Native peoples are also discussed.

In September 1998, nine American Indian/Alaska Native (AI/AN) tribal grantees began a three-year journey to design culturally appropriate systems of care for children suffering from serious emotional disturbances. The project, called Circles of Care (CoC), was the joint effort of the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Indian Health Service (IHS), and the Office of Juvenile Justice and Delinquency Prevention, a collaboration that resulted in $2.55 million in grant funds and support from two technical assistance centers. The National Indian Child Welfare Association (NICWA) provided program level technical assistance, in collaboration with IHS. The University of Colorado Health Sciences Center provided evaluation technical assistance, in collaboration with the National Institute for Mental Health-sponsored National Center for American Indian and Alaska Native Mental Health Research.

The CoC initiative provided funding to *plan, design, and assess the feasibility of implementing a culturally appropriate mental health service model for AI/AN children with serious emotional disturbances and their families.*

The four goals of the CoC Guidance for Applicants (GFA) were to:

1. support the development of mental health service delivery models that are designed by AI/AN communities to achieve outcomes for their children that they choose for themselves;

2. position tribes, tribal groups, or villages advantageously for future service system implementation and development;

3. strengthen tribes', tribal groups, or villages capacity to evaluate their own service system's effectiveness, and

4. develop a body of knowledge to assist tribal, tribal group, village, and other policy-makers and program planners for all child-serving systems in improving systems of care for the AI/AN population overall (SAMHSA, 1998).

The nine grantees were: Cheyenne River Sioux Tribe, Eagle Butte, South Dakota; Choctaw Nation of Oklahoma, Talihina, Oklahoma; Fairbanks Native Association, Fairbanks, Alaska; Feather River Tribal Health, Oroville, California; First Nations Community HealthSource, Albuquerque, New Mexico; In-Care Network, Billings, Montana; Inter-Tribal Council of Michigan, Sault Ste. Marie, Michigan; Oglala Lakota Tribe, Porcupine, South Dakota; and the Urban Indian Health Board/Native American Health Center, Oakland, California. The nine grantees represent urban, rural, and reservation communities and are described in Figures 1 through 9.

Figure 1
Inter-Tribal Council of Michigan, Inc.

Project Name:	Nbwakawn
Project Goal:	To seek the good life and balance, "Mino-bimaadiziwin," for Anishnabek children, families and communities. The project was built on the premise that any new system of care could not be imposed but rather would evolve by and from the community. Using this principle of Respect, twenty-eight Talking Circles - Focus Groups - took place at 20 locations through out the 37 county service areas of the representative tribes. Community involvement included youth, parent and elder representation of the Three Fires people. Emphasis was on completing a Needs Assessment and developing possible solutions including a system of care modeled on the information gathered, refining the plan, assessing its feasibility and identifying resources for funding.
Population Served:	Anishnabek children age 0-22 years, with severe emotional and behavioral needs and their families
Geographic Description:	The three project sites in Michigan reflected 45% of the state's total Native child population. They were: the Hannahville Indian Community, the Little Traverse Bay Band of Odawa Indians and the Sault Ste. Marie Tribe of Chippewa Indians. The combined service area encompassed 37 of Michigan's 83 counties.

Statement of Purpose

The purpose of this special issue is to describe the program evaluation component of CoC, highlighting the stages of the evaluation life cycle (Bess, Allen, & Deters, 2004), the process of needs assessment (Novins, LeMaster, Jumper-Thurman, & Plested, 2004), the Serious Emotional Disturbance (SED) definition process and products (Simmons, Novins, & Allen, 2004), the service system description of the evaluation (Allen, LeMaster, & Deters, 2004), the outcome measurement plan (Novins, King, & Stone, 2004), feasibility assessment (Coll, Mohatt, & LeMaster, 2004), the process evaluation component (Bess, King, & LeMaster, 2004), the concrete as well as less tangible outcomes of the overall initiative (Duclos, Phillips, & LeMaster, 2004), and conclusions and recommendations gleaned from the initiative (Jumper-Thurman, Allen, & Deters, 2004). Rather than focusing on individual grantee evaluation stories, the common experiences across grantees have been woven into a framework that may prove informative for those evaluating similar projects. Since the sole focus of this special issue is to describe the results of the program evaluation component of CoC, the laying of the groundwork for the development of the models, community mobilization, galvanizing stake holders, the service delivery models, and the program development technical assistance activities are not included. Interested readers are referred to the companion CoC Program Development monograph authored by NICWA (which was still in preparation when this paper was written).

The overarching goal of this introductory chapter is to lay the groundwork for understanding the CoC initiative and to describe the contextual and theoretical background important to understanding the evaluation process. This chapter includes four sections: (a) a description of the background and need for the CoC initiative; (b) a broad view of the historical, cultural, and political contexts for the CoC initiative; (c) an introduction to the systems of care philosophy; and (d) a description and analysis of the CoC evaluation effort.

Background and Need for the Circles of Care Initiative

In addition to the political will to bring about the funding, the CoC initiative was essentially the result of the convergence of four forces. First, the initiative was part of a broader long-term effort on the part of CMHS to support the development of systems of care for children and adolescents with Serious Emotional Disturbances (SED). Second, the high prevalence of mental health problems of AI/AN children and adolescents was another distinct factor. Third, the lack of availability of mental health services to AI/AN communities and inadequate training of clinicians contributed to the need for the CoC initiative. The fourth and final force contributing to the implementation of the initiative was recognition by funding agencies of the difficulties AI/AN

communities had encountered in securing funding due to the unique challenges inherent in the planning and writing of competitive grant applications.

Figure 2
Choctaw Nation of Oklahoma

Project Name:	Chi Hullo Li/Choctaw Nation's C.A.R.E.S for Families (CARES - Cultural Assessment of Resources and Evaluation of Services)
Project Goal:	To improve and enhance the delivery of mental health services through a strategic planning process together with a feasibility assessment. The cultural context of the entire project was developed through the participation of tribal stakeholders and community members bringing their own traditional and cultural beliefs and values in the planning and assessment process. The project focused on four major areas: implementing a strategic planning process, performing a feasibility assessment of the program, developing a system of evaluation to produce measurable outcomes, and conducting a cost-benefit analysis of the program of service delivery to assure efficiency and effectiveness.
Population Served:	American Indian children and their families of the Choctaw Nation
Geographic Description:	The Choctaw Nation – a 10.5 rural country area in Southeast Oklahoma

CMHS Support for Developing Systems of Care for Children and Adolescents with Serious Emotional Disturbances (SED)

SEDs are typically defined as frequently occurring disruptive behaviors in children and adolescents leading to severe social, academic and psychological impairment (Quinn & Epstein, 1998). These disturbances are thought to impact 11 to 26% of the population of U.S. children and adolescents, with between 3 and 6% of this group categorized as SED (Kauffman, 1993). Over 50% of youth with SED drop out of school, and half of all those identified with SED are arrested within three to five years of leaving school (Quinn & Epstein, 1998). More than 70% of SED youth are referred to protective services annually to address issues of abuse or neglect (Trupin, Tarico, Low, Jemelka, & McCellan, 1993), and they account for a significant proportion of placements outside the home and community each year.

A 1969 report from the Joint Commission on the Mental Health of Children indicated that children with SED were being treated inappropriately, placed in excessively restrictive settings, and denied access to simultaneous multiple services. These findings were confirmed in other reports, including

Knitzer's (1982) Children's Defense Fund study, *Unclaimed Children*. Citing a lack of federal leadership, Knitzer documented that 2/3 of the nation's children with SED were not receiving needed services. As a result Congress appropriated funds and the National Institute of Mental Health (NIMH) initiated the Child and Adolescent Service System Program (CASSP), administered through the CMHS. Through the CMHS service demonstration project, Comprehensive Community Mental Health Services for Children and Their Families Program, over 460 million federal dollars have been invested in system of care efforts, encompassing partnerships across families, service providers, government agencies, policy-makers, and communities (Burns, 2001). The System of Care movement has also been enhanced by funding from the Robert Wood Johnson Foundation, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and the Annie E. Casey Foundation (Lourie, Stroul, & Friedman, 1998).

Figure 3
First Nations Community HealthSource, New Mexico

Project Name:	Circles of Care Project
Project Goal:	To plan, design, and evaluate the feasibility of a culturally appropriate mental health service model for American Indian children and families of Albuquerque. The proposed model was child-centered and family-focused, with need dictating services rather than vice versa. Child and family participation at all levels of planning was integrated into the process. Services, management, and decision-making were at the community level. The service system design was based on a "wrap around" model and was designed to be culturally competent and relevant to the urban Indian community of Albuquerque. Objectives of this project included the following: to define culturally specific outcomes for mental health services for children with serious emotional disturbances; to develop a feasible service system model; to provide this system design as a model to tribal and urban organizations; to contribute outcome data to a national database; to foster and enhance participation of families in planning and developing service systems and treatment options based on American Indian community values and principles, and to develop leadership capacity and knowledge about system design and assessment within the urban American Indian community.
Population Served:	Urban Indian children and young adults, ages 0-22 years. (Individuals from more than 250 tribes reside in Albuquerque.)
Geographic Description:	City of Albuquerque, New Mexico. 58,511 American Indians live in New Mexico. An estimated 35,000 urban American Indians reside in Albuquerque.

The CoC initiative was in part the result of the momentum of the system of care movement, a momentum that had been building for 20 years prior to its funding. The initiative is evidence of the efforts of CMHS, policy-makers, and foundations to improve the delivery of mental health services to children and adolescents struggling with SED.

Figure 4
Oglala Sioux Tribe

Project Name:	Wakanyeja Wape Tokeca
Project Goal:	To develop a comprehensive mental health service delivery model which integrated the principles of collaboration and Lakota philosophy in the healing of children, adolescents and their families affected by serious mental health disturbances. Critical in the development of the proposed service model was the involvement of traditional Lakota healers/interpreters to encourage families to develop positive outcomes. By retrieving traditional Lakota knowledge of healthy physical and emotional development, the project emphasized the notion of respect for every individual's role in society. Wakanyeja Wape Tokeca, a Lakota term for "children with a different way," will recognize and offer a conceptual foundation as a means for healing.
Population Served:	Tribal children and adolescents under the age of 22 years old with serious mental health disturbances.
Geographic Description:	Pine Ridge Reservation, South Dakota, with an approximate population of 30,000 people

High Prevalence of Mental Health Problems in AI/AN Children and Adolescents

Comparing mental health of AI/AN youth to that of other ethnic and cultural groups in U.S. is complex, particularly in light of the scarcity of empirically-based studies on the mental health of AI/AN children and adolescents. A complex set of interacting factors must be weighed, one of which is research methodology. Trimble (2000) asserts that social scientists overemphasize negative beliefs about AI/ANs, promoting the stereotype of the AI/AN as "sick" or "suicidal."

Despite the research complexities, evidence suggests that there is a high prevalence of a variety of mental health problems among AI/AN children and adolescents. McNevins and Shepard-Erickson (2001), citing the "American Indian Children's Mental Health Services: An Assessment of Tribal Access to Children's Mental Health Funding and a Review of Tribal Mental Health Programs" (SAMHSA, 1998), estimated that one in eleven AI//AN children suffer from a SED, a rate considerably higher than the national average. IHS estimates suggest that suicide rates for AI/ANs 10 to 24 years

of age are approximately 2.5 times higher than national averages (May, 1990). According to IHS, homicide is the second leading cause of death among AI/ANs 1 to 14 years of age and the third leading cause of death for those from ages 1 to 24. Beiser, Sack, Manson, Redshirt, & Dion (1998) found that at approximately 9 years of age, many AI children experience marked declines in academic performance and increases in depression and acting-out. Garrett (1999) posits the notion that AI children will face greater mental health issues because of the incongruity of the relational, cooperative, family-centered cultural value system with the much larger mainstream culture emphasizing individualism, competition, and achievement (U.S. Department of Health and Human Services, 2001).[1]

The mental health issues of AI/ANs are best understood in the context of historical wounding, the impact of historical events and social context on the multigenerational psychological and behavioral patterns of individuals. Moane (1994) notes "there are psychological patterns inherited from colonization which may be transmitted through family dynamics even while rapid social change is occurring" (p. 263). Though controlled research on historical wounding is elusive (Lee, 1994), Moane (1994) proposes that colonialism relies on mechanisms of control including physical coercion, sexual exploitation, economic exploitation, political exclusion, and control of ideology and culture. Moane (1994) further argues that these mechanisms bear a psychological legacy including dependency, fear, ambivalence toward the colonizer, suppression of anger and rage, a sense of inferiority, self-hatred, loss of identity, horizontal violence, and vulnerability to psychological distress. European colonization adversely affected the 50 million AI/AN people who lived in North America prior to contact, resulting in a 90% reduction in population by 1890, the year of the Wounded Knee Massacre (Takaki, 1993). The specific multigenerational, psychological impacts are largely unknown, though it is understood to be a root cause of the suffering of AI/AN families. In referring to the psychological and behavioral impact of the boarding school era on AI/ANs, Shelton (2001) writes, "The ripple effects of the boarding school system, like all assimilation policies, can still be seen today. Some of the tragic effects that have only recently come into light were a legacy of physical, emotional, and sexual abuse of children, as well as a lack of parenting, and historical grief from this trauma. These are commonly regarded as contributing factors for high rates of alcoholism, depression, suicide, and domestic abuse" (p. 17).

In short, one of the forces from which the CoC initiative grew was the recognition of the special mental health issues of indigenous people. Coexisting with the awareness of the high prevalence of a variety of mental health problems among AI/AN children and adolescents was an awareness of the considerable resiliency, strength, and vitality factors of the diverse AI/AN societies. This resiliency is not typically measured, nor is the impact of traditional spirituality, language, ceremonial participation, and the relational world-view of many tribes (Beiser, et al., 1998; Garrett, 1999). The CoC

initiative recognizes the mental health problems and the resiliencies among AI/AN youth, the latter being clearly articulated in the charge of the GFA that the systems of care be planned by and for AI/AN people, respecting the traditional beliefs and customs of the AI/AN tribes.

Figure 5
Fairbanks Native Association

Project Name:	Fairbanks Native Association Circles of Care
Project Goal:	To plan, design, and implement a culturally appropriate mental health service model.
	Key tasks included the following: 1) engagement of the Native community as well as severely emotionally disturbed children and their families; 2) needs assessment strategic planning including assessment of the environment, vision statement, development of support; 3) evaluation assessment; and 4) plan dissemination.
	The project envisioned the following three circles: 1 - the outer circle composed of the collaborating partners and child serving agencies (collaborators), Native and political leadership, and project staff; 2 - the middle circle of an all-Native Advisory Council which was the key planning and decision-making arm of the project; and 3 - the inner circle composed of Alaska Native children with serious emotional disturbances.
Population Served:	Alaska Native children with serious emotional disturbances and their families.
Geographic Description:	Urban Alaska Natives living in Fairbanks and Athabascan Indians living in the 43 villages of the Interior (Doyon Region). This is a 235,000 square mile region with an Alaska Native population of 9,748.

Lack of Availability of Mental Health Services to AI/AN Communities

The third force contributing to the funding of the CoC initiative was the long-standing concern regarding the lack of availability, accessibility, and acceptability of mental health services for AI/AN children and adolescents and their families. As indicated by McNevins and Shepard-Erickson (2001), the ratio of mental health service providers to AI/AN children was a dismal 1 to 25,000. Senator Daniel Inouye is said to have stated that AI/ANs have the "first pre-paid health plan" in existence, paid for by more than 400 million acres of land and contracted through a trust relationship with the federal government (Dixon, Mather, Shelton & Roubideaux, 2001). Yet, Congressional appropriations for IHS, the key federal agency responsible for the provision of mental health service to AI/ANs, on a per capita basis declined by 18% between fiscal years 1994 and 1998. Though in the fiscal year 2001 budget

IHS received a large increase ($213 million), this increase barely raised the spending power of the agency by 1% due to the rising costs of managed health care. This grossly inadequate funding enables IHS to address only 43% of the known need for mental health services in AI/AN populations (Dixon, Mather, Shelton & Roubideaux, 2001).

In addition, there is a disturbingly low level of child- and adolescent-trained mental health professionals working with AI/AN children, and significant questions regarding the cultural competence of the clinicians and programs providing mental health services remain. Other concerns include the cultural appropriateness of the services these clinicians and organizations provide, and the fragmentation of existing systems of services (Novins, Fleming, Beals, & Manson, 2000; WICHE, 1998).

Figure 6
Cheyenne River Sioux Tribe

Project Name:	Restoring the Balance
Project Goal:	To plan comprehensive mental health services for Cheyenne River youth and families with a particular focus on the needs of youth with reservation trauma. The project sought to develop a long-term and comprehensive Lakota and non-Lakota-based service system that is child-centered, family-focused, and culturally appropriate. The model service system included Lakota and non-Lakota consumers, family members, and service providers on boards, committees, and task forces that affect policy regarding service provider delivery systems. The parts of the logo of the Restoring the Balance Project represent the following: 1) the Tipi represents the physical and symbolic result of Lakota men and women working together to shelter and nurture the family; 2) the Sacred Pipe represents the family foundation of the Lakota people – the Red Road Way – the means of getting families back to traditional Lakota values; 3) the Circle represents the family circle, the circle of life, and the roundness of the Lakota universe and 4) the Seven Stars represent the Lakota seven generations.
Population Served:	Children and youth under the age of 22 who reside on the Cheyenne River Sioux Tribe reservation and who are experiencing lack of spirituality, identity loss, low self-worth, and physical/emotional needs are the target population.
Geographic Description:	The Cheyenne River Sioux Tribe Reservation in North Central South Dakota includes the Mnicoujou, Itazipco, Sihasapa, & Oohenumpa bands of the Lakota Nation. The population is approximately 14,000.

**Unique Challenges of AI/AN Communities in Developing Systems of
Care and Securing Funding for Implementation**

CMHS support for developing systems of care for children and
adolescents with SEDs in AI/AN communities is part of the recognition that
organizations providing services to AI/AN children and adolescents and their
families face a unique set of cultural, epidemiological, fiscal, jurisdictional,
and operational challenges in developing such systems. As noted in the GFA
(Federal Center for Mental Health Services, 1998), while service demonstration
grants issued under the Comprehensive Community Mental Health Services
for Children and their Families Program had funded three American Indian
tribal organizations, many more AI/AN organizations had submitted
unsuccessful applications under this initiative. It was the assessment of
CMHS, as well as a number of outside experts that served on an Advisory
Board to this agency that AI/AN communities would be more competitive for
grants under this and other initiatives if they were able to pursue a
community-based strategic planning effort that could form the foundation
for their applications.

Thus, the CoC initiative came about because of the convergence of
the systems of care movement, a heightened awareness of the prevalence
of SED and other mental health needs of AI/AN youth, a recognition of the
lack of funding for mental health services for AI/AN families, and the unique
challenges AI/AN organizations face in securing funding for mental health
services.

Figure 7
Feather River Tribal Health, Inc.

Project Name:	Community Circles of Care Project
Project Goal:	To design a system of care for American Indian children who suffer from severe mental illness. The purpose of this grant was to charge the health clinic with the task of organizing partnerships with non-Indian organizations in order to find solutions to the serious problems facing tribal communities. This project brought together all the stakeholders to develop a comprehensive system with case management and wrap-around services as the foundation and traditional values and spiritual traditions as the mortar.
Population Served:	Indian children and teens with mental health issues and their families.
Geographic Description:	Native Americans served by this grant are in Butte County in California. They are primarily Maidu, with other nations such as Wintu, Pomo and Miwok represented. The following four rancherias (reservations) reside in the county: the Berry Creek Rancheria, with 450 members; the Mooretown Rancheria, with 1,170 members; the Enterprise Rancheria, with 395 members; and the Chico (Mechoopda) Rancheria, with 321 members.

The Historical, Cultural, and Political Contexts

Federal AI/AN policy is complex, impacted by the judicial maze of AI/AN law, the continually swinging pendulum of sovereignty, and the variable outcomes of promises made to Indian people. All AI/AN life including types of services delivered, funding for services, relationships between tribal service providers and the states, definitions of who will and will not be served, control over the types of services delivered and the qualifications of those who deliver them, is influenced by a set of legal cornerstones. Dixon and Joseph-Fox (2001) maintain that the three basic foundations are: (a) tribal sovereignty, (b) the federal trust responsibility, and (c) the government-to-government relationship. A fourth has been added for the current purpose, (d) self-determination.

Sovereignty

Historically, Spain, Portugal, France, and England held that sovereignty was a political right of the colonizers based upon religious doctrines decreed by the Pope, who was considered the legitimate authority to grant portions of the earth for the purpose of Christian civilization (d'Errico, 1998). Colonists used European law to strip indigenous people of their independent status and of their right to land ownership. However, from a current international law perspective, no government (including the U.S.) has the legal right to mandate the terms or terminate the rights of another nation. At the time of colonization indigenous people easily satisfied the current international definition of a nation, having culture, language, organized societies, and the ability to make war, peace, and political alliances with other nations (Storbakken, 2001).

In AI/AN law, it has long been established that tribes have the inherent right of sovereignty and complete jurisdiction to rule AI/AN territory, and that these rights are inherent, not simply rights delegated to them by the U.S. government. The AI claim to sovereignty was supported in the Marshall court of the 1830s with a decision that AI tribes have the status of independent nations, a status held prior to the time of European arrival. Chief Justice John Marshall maintained that AI nations are unique political communities, having physical boundaries, within which their authority is exclusive, and their rights to all lands within these boundaries is both acknowledged and guaranteed by the United States. The Indian Reorganization Act, though rejected by some tribes, established tribal councils that are thought to be the vehicles of tribal sovereignty, acting as governments (Fowler, et al., 1996).

From a U.S. law perspective, the basic claim to sovereignty exists, but is subject to limitations that have developed over time in the relationship between the U.S. and the tribes. One of the primary limitations to sovereignty is the treaties between the tribal entities and the federal government. Yet, even as the treaties limit sovereignty, their mere existence is evidence of

government-to-government relationships. Thus, even treaties signed under duress are binding evidence of sovereignty. In an article for the Georgetown Public Policy Review, Steve Russell notes that abandoning the idea of AI/AN sovereignty would be to expose the treaties as legal fig leaves to cover ethnic cleansing (Storbakken, 2001).

Tribal sovereignty as a legal concept is a complex minefield of contradictions. Deloria, Jr. (1988) expressed a viewpoint that the Supreme Court "skips along spinning off inconsistencies like a new sun exploding comets as it tips its way out of the dawn of creation" (p. 139). Sovereignty might be summarized by noting that tribes are separate nations with inherent powers of self-government, but the independence of the tribes is subject to limitations on sovereignty and/or regulations by Congress, not by the states. Unlike other citizens of other sovereign nations, tribal members are dual citizens and tribes are to be protected by the federal government through a unique trust relationship.

Trust Relationship

In early treaties the U.S. pledged to protect the AI/AN tribes, a promise that serves as the basis for the trust relationship between them. Since the Marshall court, tribes have been understood to have a trust status, meaning that the federal government—the states are excluded unless Congress delegates power to them—is obligated to assist tribal self-sufficiency and protect the tribes from encroachments by the states and their citizens. In 1934 the Indian Reorganization Act (IRA) established the present tribal governments, the operationalizing structure for the trust relationship.

The balance between sovereignty and the trust relationship is at the heart of the uniqueness of the relationship between tribes and the federal government. It is also a source of tension. For example, AI/AN are citizens, not only of their tribes but also of the U.S. and the states in which they reside. Dual citizenship was a benign factor in the trust relationship until advent of gaming on AI/AN land. With the introduction of gaming, a few tribes have become political activists in non-tribal affairs and have wielded the power of economic self-determination, while the majority of tribes suffer in dire poverty, low educational attainment, poor health, and high rates of alcoholism and suicide. The full repercussions of political and economic extra-tribal political activism on the trust relationship has yet to unfold.

A potential undermining factor in the trust relationship is the shift toward block grants to state governments (called devolution, the transfer of resources and responsibilities to state, local, or tribal governments). The historic promise and the moral obligation to tribal nations are based upon the unique relationship between the tribal governments and the federal government, but state governments may feel no particular moral or historical

obligation. Though intended to assist the government in being more responsive to local need, the trend toward devolution of funds to states may leave tribal entitles unable to access funding that otherwise would be available to tribes if the federal government was administering the funds directly. This is particularly problematic in social service and support programs, such as the authorization to administer Medicaid, Medicare, and Children's Health Insurance Programs. Under the Social Security Act, only state governments are authorized to administer these programs, leaving tribal entities relatively powerless to impact the administration of funds important to the welfare of tribal peoples. In situations where tribes are authorized to administer programs, they are frequently subject to more oversight than state governments, as exemplified in the administration of welfare programs that require tribes to submit a tribal plan but holds no such mandate for states.

Though federal-to-state devolutionary policies may undermine the trust responsibility and reduce the federal responsiveness to tribal needs, federal-to-tribal devolution has been enormously successful in passing control and program management from the federal government to the tribal governments. With government-to-government negotiated agreements ideally suited for that specific tribal entity, the federal government is released of the responsibility to oversee the distribution of funds until an annual audit and the tribes assume the authority to regulate their own affairs.

Government-to-Government Relations

The government-to-government relationship is a natural outgrowth of sovereignty, which carries the promise that tribes should be able to receive funding and administer programs directly, equivalent to the states or counties. On April 29, 1994, President Bill Clinton held a historic meeting with tribal leaders in which he promoted the "unique legal relationship with Native American tribal government." Executive Order #13084 underscored and streamlined government-to-government relationships by directing government agencies to consult with AI/AN tribal governments before taking action on issues impacting tribes and by removing barriers to direct working relationships between individual tribal governments and federal agencies on issues affecting trust property or governmental rights (U.S. Department of Justice, 2002).

Tribal consultation, a process involving individual tribal governments in the setting of agendas and logistics for consultative sessions with state or federal agencies, is a natural outgrowth of several laws that have underscored the special status of tribes, and is the implementation of the government-to-government relationship (Dixon & Joseph-Fox, 2001). According to Dixon and Joseph-Fox (2001), in the tribal consultation process, individual tribes speak only for their own tribe, placing upon the states the responsibility of offering invitations to each individual tribe to participate in tribal consultation.

In describing ideal tribal consultation, Dixon and Joseph-Fox (2001) maintain that consultation should occur prior to the making of any decisions impacting the tribes, including decisions that relate to the administration of health programs. In addition, Dixon and Joseph Fox (2001) argue that state-to-tribal invitations to consult increase the higher likelihood of effective implementation of state health programs.

Self-Determination

Throughout the early history of tribal governments, the relationships between the tribes and the federal government were governed by an assumption of sovereignty and a trust relationship, with policies leaning toward self-determination. But the pendulum moved away from self-determination and sovereignty during the disastrous era of termination policies. The catalyst of the era to terminate tribes, relocate AI/ANs away from their homelands, and eliminate reservations was the 1949 Hoover Commission Report (Brookeman, 1990). The Hoover Report recognized the AI/AN loyalty in service to the country during the war and promoted the sentiment (shared by many in Congress) that AI/ANs should be assimilated into society. HCR-108 was a series of bills designed to free AI/AN from Bureau of Indian Affairs (BIA) oppression and to cease federal control. The result was that between 1954 and 1961, 109 bands and tribes were terminated, leaving tribal members unprotected from state taxation and basically ending their eligibility to access federal funds. To ease the transitional burden, Congress identified eight cities and assisted families to relocate to these cities principally for education, training, and work-related reasons, but also introduced urban poverty. The marked increase in the number of urban AI/ANs dispelled the message that "Indians are a folk people, whites are an urban people, and never the twain shall meet" (Deloria, 1988, p. 83). With the growing number of urban AI/ANs today, the distinction between the mental health needs of rural, reservation, and urban AI/ANs is important to investigate. This point is illustrated by Walrath's (2001) description of the system-of-care needs in two urban systems (New York and Baltimore), serving impoverished AI/AN children in small, densely populated areas.

Overall, relocation policies led to the imposition of state legislative and judicial authority, the sale of tribal lands, reduction or elimination of tax exemptions, and devastation as a result of urban poverty. One benefit to AI/AN people of the termination era was an improvement in AI/AN health care that had been managed by the BIA and was moved to the Department of Health, Education, and Welfare (now the Department of Health and Human Services-DHHS), IHS, in 1954 (Brookeman, 1990). This change brought about a significant increase in the health care of Indian peoples between 1955 and 1968, though AI/AN health problems remained severe relative to national averages.

The Nixon administration and the passage of the Indian Civil Rights Act of 1968 signaled the end of the termination policies. The Indian Civil Rights Act mirrored the U.S. Bill of Rights, except for the lack of separation of church and tribal government. President Nixon called for self-determination without termination, and in the mid 1970s several laws were passed to strengthen tribal sovereignty, and to restore tribes that had been terminated (Brookeman, 1990).

Three notable laws impacting the delivery of health and mental health services are the Indian Self-Determination and Education Assistance Act (P.L. 93-638), the Indian Health Care Improvement Act of 1976 (P.L. 94-437), and the Alaska Native Claims Settlement Act (P.L. 92-203; Dixon & Joseph-Fox, 2001). The Indian Self-Determination and Education Assistance Act directed DHHS and Department of Interior (DOI) to enter into self-determination contracts (called "638" contracts) with any tribe for the purpose of transferring administration of federal programs to the tribes. Title II expanded self-determination to all bureaus within the DOI. Title III, proposed by tribes, led to the participation of 20 tribes in a self-governance compact. Title III set the foundation for tribes to design their own contracts, shift funds between programs as needed, and redesign programs to better meet tribal needs. The Indian Health Care Improvement Act of 1976 addressed the lag beween IHS and national averages, by encouraging consolidation and authorization of funding for existing IHS programs, authorization for facilities construction, and authorization of health care for urban Indians. P.L. 93-437 also authorized Medicaid and Medicare reimbursement for services performed in IHS facilities. The Alaska Native Claims Settlement Act ("ANSCA") (P.L. 92-203) authorized 200 Alaska Native villages and 13 regional organizations to share profits related to land claims. Funds from these claims were held by Alaska Native corporations. In general, health and mental health care for Alaska Native people is provided by regional Alaska Native non-profit corporations, though in some cases it is provided by village governments, tribal governments, village corporations, and regional Alaska Native profit corporations (Dixon & Joseph-Fox, 2001).

Despite contradictory presidential actions in the mid-1980s, self-determination policies have continued to flourish since the 1970s. In 1988 Congress improved the streamlining of the contracting process, and the Demonstration Project was funded. The passing of permanent Self-Governance authority for the DHHS programs in 2000 was an important milestone in self-determination. This Indian Self-Determination Contra Reform Act; P.L. 103-413). PL 106-260, made self-governance a permanent program in the IHS, and was signed on August 18, 2000 (U.S. Department of Justice, 2002). Such promising developments provided momentum for the systems of care philosophy in tribal communities (Manson, 2001).

Figure 8
In-Care Network, Inc.

Project Name:	Circles of Care/A Shared Vision Project
Project Goal:	To design and assess implementation of a culturally appropriate mental health service model. An initial collection of baseline data and statistics provided a statewide profile of current system usage. The data also provided information on predominant issues of serious emotional disturbances that are unique to each of the seven reservations as well as common tribal factors of serious emotional disturbances of Indian children, adolescents, and their families. Profiles of each reservation were developed. Focus groups established on each of the seven Montana reservations provided feedback in the design of the models and acted as local resources in the ownership of the mental health service models. The database established at the beginning of the process was made available to all reservations throughout the planning grant. Cost-analyses and economic impact of the models were prepared with the assistance of the Native American Development Corporation, a multi-state Indian economic development organization.
Population Served:	Native American children in Montana with serious emotional disturbances and their families.
Geographic Description:	Seven Indian Reservations in Montana including Blackfeet, Crow, Flathead, Fort Peck, Fort Belknap, Northern Cheyenne, and Rocky Boy's. They make up approximately six percent of Montana's population.

The Systems of Care Philosophy

A brief description of the systems of care philosophy is provided to lay the groundwork for understanding some of the unique aspects of the CoC evaluation process. The system-of-care philosophy is just that—a philosophy. It does not prescribe a structure, a model, or an assembly approach to the delivery of services. Rather, it provides a meaningful set of core values and guiding principles developed by consensus from policymakers, parents, administrator advocates, researchers and other stakeholders.

Part of the Child and Adolescent Service System Program (CASSP) initiative was to create an interagency system that would ensure that the special needs of cultural and ethnic groups were addressed, inspire multi-agency planning in systems development, include families as an integral part of the planning process, and give numerous mental health agencies an equal footing in the process. These values and principles serve to guide service system development for a diverse set of communities. The CASSP program (later renamed the Planning and Systems Development Program) articulated

and enhanced the system of care concepts and presented their ideas in a 1986 monograph entitled, *A System of Care for Children and Adolescents with Severe Emotional Disturbance*s (Stroul & Friedman, 1986), which has been used as for other CMHS programs. The values and principles as articulated by Stroul and Friedman (1986) are as follows:

Core Values

1. The system of care should be child-centered and family focused, with the needs of the child and family dictating the types and mix of services provided.

2. The system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level.

3. The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

Guiding Principles

1. Children with emotional disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.

2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.

3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services

5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.

6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

These core values and guiding principles were then used to steer the strategic planning for systems of care in AI/AN communities (SAMHSA, 1998).

Figure 9
Native American Health Center

Project Name:	Urban Indian Health Board Circle of Care
Project Goal:	To create a culturally relevant, family-oriented and community-based plan to establish an innovative model that links treatment with prevention and integrates traditional Indian medicine with Western approaches. The program focused on planning a system of care addressing the needs of emotionally disturbed children and their families. Community Visioning Meetings (town hall meetings) were organized for public input, and a variety of Community Councils met to perform needs assessments, priority setting and preliminary planning. A Native American Community Cluster, Health Education Class, Youth Council, and Parenting Class served as a Family Council. The Indigenous Nations Family and Child Agency received a subcontract to coordinate planning activities with other child serving agencies. The Native American AIDS Prevention Center and Circles of Care staff performed the feasibility assessment analysis and evaluation.
Population Served:	Emotionally disturbed American Indian children and their families in the five counties of the San Francisco Bay area.
Geographic Description:	The San Francisco Bay Area Native American community in an urban environment with a Native American population of approximately 80,000.

Circles of Care: Strategic Planning for Systems of Care in American Indian and Alaska Native Communities

As indicated earlier, the CoC GFA provided grantees with a three-year opportunity to design a system of care, using a community-based approach to ensure that the care models would be specific to the needs of the grantee communities. The GFA was built on two beliefs: (a) the system of care philosophy would be valuable to AI/AN communities, and (b) time for strategic planning would position the participating grantees to be successful in securing funding for the implementation of the models.

One of the unique aspects of the CoC initiative was the way in which the values of AI/AN peoples were congruent with the systems of care philosophy and with the evaluation technical assistance approach. AI/AN self-determination was evident in the evaluator-as-participant approach, participatory design of the technical assistance for CoC, and local control over every aspect of the project, leading to new definitions of SED, non-

traditional methods of data collection, and unique solutions to challenges in evaluation. The relational worldview (McNevins & Shepard-Erickson, 2001) encompassed by many tribes was translated into an expectation that the community be central in the planning process. The high value that AI/AN people place on families was a cornerstone of the initiative, in synchrony with the systems of care philosophy and reflected by the presence of youths, family members, and elders at technical assistance meetings and at local gatherings sponsored by grantees. The importance of spirituality was evident in the prayers and spiritual activities at the technical assistance meetings and in the inclusion of ceremonial participation and traditional healing as part of the evaluation process. Reciprocity, a central AI/AN value of giving back to the community, was evidenced in the use of grant resources to reciprocate community members' generous gifts of time and knowledge through survey and focus group participation. The value of cultural competence and cultural appropriateness was directly reflected in data collection approaches that emphasized respect for formal protocol and tribal traditions and in the collection of information about the cultural competence of health care workers in the evaluation process. The article by Bess and Allen (2004) in this issue will illuminate these values further through a description of the developmental processes of the CoC evaluation.

The Circles of Care Evaluation Effort

Strategic planning efforts (encompassing the evaluation component) for the CoC initiative were supported by a unique technical assistance arrangement. The Child, Adolescent, and Family Branch of CMHS, in addition to supporting grant programs, has contracted a variety of technical assistance support centers, including funding of the National Technical Assistance Center for Children's Mental Health at Georgetown University, the Research and Training Center for Children's Mental Health at the University of South Florida, and the Research and Training Center on Family Support and Children's Mental Health at Portland State University. CMHS supported the Circles of Care Evaluation Technical Assistance Center (CoCETAC), based in the American Indian and Alaska Native Programs, Department of Psychiatry, at the University of Colorado Health Sciences Center. Under the leadership of Spero M. Manson, Ph.D. and Douglas K. Novins, M.D., CoCETAC was given the responsibility of providing technical assistance for the evaluation component of CoC, working in conjunction with NICWA, the project and family technical assistance provider for CoC, under the leadership of Terry Cross.

The CoCETAC designed evaluation activities for Circles of Care grantees to support the grantee communities in meeting the four goals of the GFA (stated above). The CoCETAC effort was designed to assure that the final service delivery models developed through the CoC initiative were

consistent with community needs, developed through community consensus building, and practical and feasible given the resources available. The flow of the evaluation process is shown in Figure 10.

Figure 10
Flow of Evaluation Process
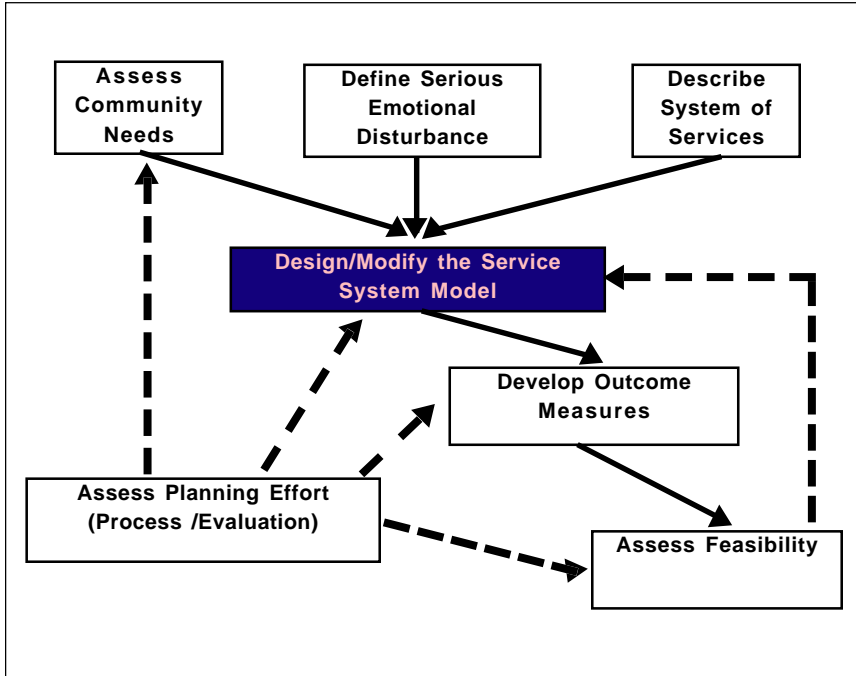
The six specific components of the CoC evaluation were:

1. *Assessment of Community Needs:* In this component of the evaluation, the CoC grantees attempted to answer questions such as "how many children suffer from SED? What specific types of difficulties do these children, youth, and families struggle with? What strengths do these children, youth, families, and the community at large possess that can be mobilized to address these difficulties" (Novins, LeMaster, Jumper-Thurman, & Plested, 2004)?

2. *Definition of Serious Emotional Disturbance:* Though the CoC GFA offered a definition of SED, grantees were allowed to define the kind and level of emotional, behavioral, or mental disability that would be required for eligibility for services under the strategic plans (Simmons, Novins, & Allen, 2004).

3. *Description and Assessment of the Current Service System:* In this component of the evaluation, grantees described the current components of the care system in terms of effectiveness, availability, accessibility, and acceptability of services. The Description of Services emphasized the gaps in the existing service system (Allen & LeMaster, 2004).

4. *Plan for Measuring Outcomes:* The model of the systems of care included a plan, and in some cases a description, of specific tools to be used in the measuring of outcomes. These plans were designed to identify key domains at the child/family, program, and systems levels, which would be impacted by the implementation of the model system of care and methods for measuring these domains (Novins, King, & Stone, 2004).

5. *Feasibility Assessment:* In this component of the evaluation, the CoC grantees assessed the feasibility of their model systems of care, with the overarching goals of assuring that each model was well designed with careful consideration of project goals, community resources, and measurable outcomes. Issues addressed in the Feasibility Assessment included the adequacy of resources to bring the plan to fruition, the strengths of the management system, the financial feasibility of the model, and the tightness of fit between the community needs and the model (Coll, Mohatt, & LeMaster, 2004).

6. *Process Evaluation - An Assessment of the Planning Effort:* The final component of the evaluation was a record and assessment of the planning effort itself. Grantees addressed the accomplishments of the CoC initiative in the community the steps to achieve the accomplishments, the barriers or obstacles, and the community satisfaction with the initiative (Bess, King, & LeMaster, 2004).

The CoCETAC developed an evaluation framework based on both the strategic vision described in the CoC GFA and upon the experience of the CoCETAC staff in working with AI/AN communities. The evaluation framework encompassed six goals that guided the evaluation technical assistance activities. The goals were:

1. To provide a clear framework for the grantees to use in designing their evaluation efforts.

2. To encourage the grantees to design an evaluation effort that was most consistent with the priorities of their communities.

3. To facilitate a process for identifying common domains for each of the evaluation components.

4. To assist the grantees in identifying locally relevant and feasible methodologies to use in their evaluations.

5. To provide a clear delineation of CoCETAC and grantee roles and responsibilities in the evaluation effort.

6. To provide consistently high quality technical assistance, through a specific set of activities, including grantee meetings, evaluator meetings, site visits, scheduled technical assistance conference calls, ad hoc conference calls and e-mail exchanges, and detailed reviews and critiques of evaluation reports.

As is evident from the description of the technical assistance goals above, CoCETAC imposed no single model of strategic planning upon the CoC grantees. The promotion of an engaged, self-determined strategic planning process was the evaluation technical assistance goal, encouraging systematic planning without forcing either a specific planning model or a specific planning process. Technical assistance provided a strategic planning structure and an expectation of strategic planning and evaluation products with associated deadlines. The structure consisted of an expectation that grantees would produce a description of the existing mental health and related services within their communities, a description of needs of the youth and families not addressed by existing services, and design a system of care model to fill the gap between the existing services and the desired services. Additional strategic planning and evaluation reports included a study of the practicality of implementing the model (feasibility study), a description of the processes used to accomplish the development of the model (process evaluation reports), and an expectation of the inclusion of outcome measurement plans.

If the CoC strategic planning process was to be categorized, it might be described as a postmodern approach with some elements of modern strategic planning. Approaches to strategic planning that are classified as modern assume that the leadership of the project can forecast the future, leading to the use of scientific methods to design future programs (Woods & Joyce, 2002). Federal agencies, required to do strategic planning through the Government Performance Results Act (GPRA) of 1993, have adopted a synoptic modern approach where key administrators use a rational planning process to formulate future goals and oversee the implementation of the goals, measuring progress and making adjustments as needed (Roberts, 2000). The strategic planning process that emerged in the CoC initiative reflected some elements of the modern approach, in that the system of care model is comprised of future goals designed on the basis of a snapshot of current needs.

Postmodern strategic planning approaches question the assumption that the future can be forecasted by strategic planners, embracing instead the concept that foresight (rather than forecasting) into the future occurs through interaction with the diversity of stakeholders and that foresight guides planning but does not hold future programming stagnant. Postmodern approaches stress flexibility as stakeholders shift positions and encourage

the recognition of the natural tensions that occur when a diversity of stakeholders are involved in the planning process. The CoC strategic planning process demonstrated postmodern planning in that listening to the voices of diverse and often conflicting stakeholders was at the heart of the planning process. For example, the natural tensions between service provider and parent perspectives were recognized and allowed to coexist. In the context of strategic planning with AI/AN communities, artificially homogenizing opposing viewpoints of key stakeholders would not be culturally appropriate and could in fact be viewed as an oppression strategy, given that consensus or recognition of differences is often valued more than compromise.

A set of basic strategic planning beliefs evolved naturally over the course of the CoC initiative. These were not explicitly stated to the grantees, but over the course of the evaluation technical assistance workshops and site visits, the following strategic planning/evaluation principles became evident:[2]

1. *Effective strategic planning requires the direct participation of key stakeholders.* Due to the Government Performance and Results Act of 1993, federal agencies are required to consult with stakeholders during strategic plan development. In the context of governmental agencies, this requirement might be thought of as a control mechanism to assure that governmental agencies are responsive to public interest, rather than to self-interest (Aimee, 2001). For systems of care planning, the value of stakeholder consultation is even more prominent, not as a control mechanism but as a means of integrating one of the basic principals of systems of care—that community input is crucial to effective service into the strategic planning process. Strategic planning for the Circles of Care project was designed to reflect the voices of youth and families as the driving force.

2. *In effective strategic planning the unique characteristics and needs of different tribal entities are recognized, including recognizing tensions among traditions, culture, and rural-urban-reservation factors.* In light of self-determination, stereotypes about AI/ANs, and the exclusion of the unique viewpoints and different tribal cultures in written historic accounts, AI/AN communities are particularly oriented toward understanding that a one-size-fits-all approach to strategic planning is inappropriate. The recognition of the tension between the general and the specific was best exemplified by the sometimes painful process of determining cross-site evaluation domains that honor the commonalities of the grantees, while acknowledging the uniqueness of individual tribes.

3. *Effective strategic planning encompasses an outcome-oriented approach, with outcomes determined by participatory action research methods.* Outcomes accountability in mental health strategic planning is not a new concept, having been required by PL 94-63 for Community Mental Health Centers in 1975. Yet the shift from funding based upon intrinsic good of the services toward a results-based accountability has been slow in becoming a reality (Hernandez & Hodges, 1998). Within AI/AN communities, top-down

outcomes may be thought of as a source of tension, perhaps due to the history of the misuse of AI/AN communities for research and the lack of recognition of self-determination policies when assessing outcomes. Yet, over the three years of the CoC process, the value of participatory, community-based outcomes emerged as a cornerstone of the planning process.

4. *Strategic planning processes need to be documented through process evaluation.* Telling the stories of the process of community involvement, the empowerment of parents, and the struggles to involve key stakeholders, while initially undervalued, was ultimately understood to be as valuable as the task of producing the model.

5. *Successful strategic planning necessitates establishing staff credibility.* Credibility is earned. It required staff and evaluators to be consistent in their behavior, following through on tasks in predictable ways over time. Predictability assured others of the trustworthiness of the staff and by association, the trustworthiness of the project. Credibility was also earned by allowing others to create expectations of staff that staff would then seek to fulfill.

6. *Effective strategic planning includes a central belief in change and change processes.* Although no change theory or logic model was imposed upon the planning process, grantees were encouraged to plan from the standpoint of understanding change processes. At a primary level, four understandings of change were implicit in the CoC planning process: (a) Change is possible; (b) it is important to identify the potential endpoints of the change process; (c) there are multiple paths leading to each identified endpoint; and (d) different programs and agencies move at various paces along these paths, and this is a part of the natural process of change.

7. *Effective strategic planning recognizes that cultural competence is not only a desired product, but also a crucial element of the strategic planning process itself.* Cultural competence as a product has long been expected, but the understanding of the implementation of cultural competence in the strategic planning process was not only complex, but also crucial to successful planning with AI/AN communities. Working within the culture of the community, respecting the community's readiness for change, promoting tribal self-determination in evaluation practice, and enacting the formal and informal protocols in relationships with groups, families and community members exemplified culturally competent strategic planning.

8. *In effective strategic planning processes, evaluation and project development are integrative, though each has a distinct set of responsibilities.* The symbiotic relationship between evaluation and project development occurred in part because the evaluator was not an observer. Evaluation forced project development to include multiple perspectives and elicited a commitment and a methodology to the process of valuing multiple perspectives. Evaluation also provided the information the project staff needed to plan effectively, and trained key stakeholders in the evaluation process. Project development informed evaluation by establishing relationships with key stakeholders who collaborated in the evaluation process and provided

information on culturally appropriate methods of approaching evaluation within the community context. In essence, evaluation challenged the assumptions of the planning process in order to create a broader, more comprehensive vision. Project development rendered that vision practical. In a symbiotic way, vision stretched practice even as practice rooted vision.

Conclusions

The evaluation model suggested by the integration of project and evaluation is a participatory action research (PAR) approach, wherein the evaluator is not simply in the auditor or observational role. Particularly for AI/AN communities, the potential tensions between the evaluation and project staff are part of a mosaic of top-down relationships with government projects and a history of negativity associated with AI agents (as representatives of the BIA). Referring to systems of care evaluators, Hernandez and Hodges (1998) cite several pitfalls of the traditional separation of evaluation and project development, including adversarial relationships, long-terms outcomes with little connection to actual practice, lack of communication between the project staff and the evaluator, detachment in measurement stemming from a position of scientific objectivity, and a lack of useful feedback from evaluation processes.

In keeping with the self-determination philosophy, the CoC project did not encompass a national evaluation plan. Holden, Friedman, and Santiago (2001) note that when a national evaluation plan exists a degree of tension and resistance are natural by-products of the top-down nature of national evaluation processes. However, without a national evaluation or the imposition of a specific strategic planning model, the CoC initiative experienced a natural void and a sense of ambiguity that at times was frustrating to grantees, yet is to be expected when self-determination is implemented. The void was eventually filled by nine unique and varied solutions to the evaluation and the strategic planning process, with the additional benefit of increased community and family involvement.

Brenda Freedman, Ph.D.
Northwest Nazarene University
Counselor Education Department
623 Holly St., Nampa, ID 83686

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Footnote

[1] See U.S. Department of Health and Human Services (2001) for a more complete review of the mental health characteristics of AI/AN children, adolescents, and adults.)
[2] This list is reiterated and expanded upon by Jumper-Thurman, Allen, and Deters (2004), pp. 148-152.

Author's Note

THE EVALUATION LIFE CYCLE: A RETROSPECTIVE ASSESSMENT OF STAGES AND PHASES OF THE CIRCLES OF CARE INITIATIVE

Gary Bess, Ph.D., James Allen, Ph.D., and Pamela B. Deters, Ph.D.

Abstract: A life cycle metaphor characterizes the evolving relationship between the evaluator and program staff. This framework suggests that common developmental dynamics occur in roughly the same order across groups and settings. There are stage-specific dynamics that begin with Pre-History, which characterize the relationship between the grantees and evaluator. The stages are: (a) Pre-History, (b) Process, (c) Development, (d) Action, (e) Findings/ Compilation, and (f) Transition. The common dynamics, expectations, and activities for each stage are discussed.

Life cycle metaphors have been used to explain the developmental process of task groups, treatment groups, and organizations (Cameron & Whetten, 1983; Hasenfeld & Schmid, 1989). Underlying this framework is the assumption that these groups move through developmental stages that are roughly akin to biological processes. This framework suggests that the same developmental dynamics occur in the same order across differing groups and settings.

The Circles of Care (CoC) experience suggests that the evaluation process can be conceptualized as life cycle. We have observed stage-specific dynamics that characterize the relationship between the CoC grantees and the evaluator. There are distinct developmental levels that help to explain the nature and content of each party's actions and concerns. Given that the evaluator's engagement in the CoC process is participatory (e.g., he or she is a critical member of the planning team), understanding the relational bond that is gradually formed and the stage-specific tasks that are undertaken can help future planners and evaluators to assess the process by which they and their projects develop (Rubin & Babbie, 1993). This understanding may also help groups to review their developmental pace and to troubleshoot common stage-specific issues that arise throughout the process.

Understanding the evaluator's relationship to the CoC initiative also necessitates consideration of the members' *pre-history*, which refers to their history before the creation of the setting (Sarason, 1971; 1996). There may be unique dynamics that distinguish the evaluation life cycle from other endeavors, based on historical experiences of the American Indian/Alaska Native (AI/AN) and the non-AI/AN status of many CoC evaluators.

The CoC initiative was born out of a history of conflict between AI/AN communities and federal and state governments, both broadly and specifically surrounding American Indian child welfare and health issues (for a thorough review of this history, see Freeman et al.'s paper in this Special Issue). These encounters have often been highly emotional and negative experiences for AI/AN communities which culminated with an important series of legislative innovations: the Indian Self-Determination and Education Assistance Act (1975), the Indian Health Care Improvement Act (1976), and Indian Child Welfare Act in (1978).

Furthermore, the experiences of AI/AN communities with regard to research, including evaluation research, reveals a history of practices and approaches that have alienated not only individual AI/AN people but entire AI/AN communities (Darou, Hum, & Kurtness, 1993; Manson, 1989; Norton & Manson, 1996). This history, which predated the creation of CoC, is thus important in formulating our understanding of the CoC planning process and its evaluation. It required CoC planners to initiate a process of discussing their various ideas and preferred agendas for the evaluation with a perceived *judgmental* outsider (i.e., the evaluator), and in addition, required working through the various tensions that were associated with this new relationship. In the end, this process created a shared sense of co-membership and a common base among the participants that allowed culturally diverse groups of AI/AN and non-AI/AN people to reflect upon their shared values, and to rise above a prehistory of conflict (Erickson, 1975; Hornby, 1993).

The Evaluation Life Cycle

With this pre-history as context, six developmental life cycle stages can be distinguished as separate and distinct evaluation phases. They are: (a) the Pre-history Stage, (b) the Process Stage, (c) the Development Stage, (d) the Action Stage, (e) the Findings/Compilation Stage, and (f) the Transition Stage. The common dynamics, expectations, and activities for each of these stages are discussed below, followed by concluding remarks intended to summarize the evaluation life cycle.

Pre-History Stage

This stage is characterized by relationship testing and building. In many instances, this is the first time that an outside contract evaluator has

been engaged to assess a particular agency-based AI/AN program. The notion of a non-AI/AN person involved in the evaluation, though a contract employee, can conjure feelings among the CoC program staff of prior adverse experiences within both professional and personal contexts. In many instances, the evaluator is unknown to the program staff prior to his or her engagement, having been recruited from a local university's psychology, sociology, or social work department, or *vis-à-vis* a recommendation provided by an allied service provider. In either instance, the evaluator and the program staff are unacquainted with one another, and each may have preconceived notions about the other.

The program staff may view the evaluator as an outsider, someone who is not part of the CoC team. In fact, the evaluator may be suspect for several reasons that include: (a) non-AI/AN heritage; (b) socio-demographic roots that differ from the local AI/AN community; (c) academic and research interests that may be perceived to be out of sync with the project's programmatic focus; and (d) the nature of the engagement itself, whereby the evaluator is compensated, as is the staff, and yet there is a perception that the evaluator's motivation is not derived from the same selfless commitment to helping the AI/AN community as is that of the program staff.

There is also distrust of the evaluator's judgment: that he or she will inaccurately interpret and report process and outcome domains, or demonstrate the insensitive qualities that all-to-often have been displayed by those charged with assessing AI/ANs. These feelings on the part of program staff often confront the evaluator as s/he enters the agency for the first time.

Similarly, the evaluator may have preconceptions that affect the work relationship. The evaluator may be concerned that he or she will not understand the specific context of AI/AN processes, needs, and services that will be evaluated. The evaluator may also be concerned s/he will not display or fully comprehend the cultural nuances that are an essential part of the assessment despite her/his technical competence. This latter point is especially critical as cultural context is an essential component of the evaluation process, affecting the form and substance of the assessment inquiry and influencing its interpretation.

Conversely, the evaluator may incorrectly assume knowledge or comprehension of ethnic and racial groups from prior experiences that do not conform to those of the AI/AN community. Spiritual awareness, non-verbal communication, talking circles, and reverence for elders are often part and parcel of the planning design and program implementation process. These cultural-specific dynamics can be confounding for the uninitiated evaluator, and consequently, may cause misrepresentation of events.

Furthermore, differing work approaches, reliance on a technical vocabulary and conflicting evaluation paradigms can create barriers between the evaluator and program staff. Some evaluators are not accustomed to working as part of a team, and, if they do participate, their involvement is

relegated to their expertise in evaluation. The evaluation design process can sometimes be a solitary one, where drafts are presented and input sought, with communication bi-directionally alternating (from program staff to evaluator and back again) without frequent face-to-face interactions. By contrast, AI/AN members of the team come from a tradition of conjoint planning and active participation that influence all facets of the CoC planning process. Thus, the expectation of the AI/AN participants is one of ongoing dialogue with the evaluator, their participation in the design of the process, data collection and interpretation.

The evaluator's technical vocabulary is also full of research jargon and methodological requirements that are little understood and perhaps even less trusted by program staff. Similar to the perception that federal, state and local laws are sometimes misapplied to AI/ANs is the concern among many AI/AN members of the program staff and community that the process of evaluation is not relevant or applicable. The evaluator may be seen as representing the values and beliefs of "the establishment" (i.e., the mainstream) that are incompatible with AI/AN ways. The program staff may grapple with the question, "Whose side is the evaluator on?" as they describe the importance of preparing an Institutional Review Board application, to be reviewed by an all-White panel of university or Indian Health Service researchers.

Since CoC requires an assessment of the planning process, an early decision must be made as to whether the evaluator's role is that of "participant observer" (Rubin & Babbie, 1993; Rossi & Freeman, 1993) or the more conventional "sidelines–objective" observer. For many evaluators, the latter is the more familiar, requiring a lesser level of engagement. Yet this approach, though methodologically valid, fulfills Pre-History notions of the evaluator as an outsider. The evaluator is seen as not being truly part of the team, but rather as a critical, unforgiving assessor of all that is deficient and that requires intervention. Though not congruent with the evaluator's intentions, these perceptions argue for participant observation, enabling the evaluator to be seen as a fully participating member of the team.

In light of these and other possible issues that may arise early in the process, discussion between CoC program staff and the evaluator concerning similarities and differences in style, approach, and expectations is encouraged at the Pre-History stage. Overall, a stronger foundation for the entire evaluation process can be built with the open expression and acknowledgement of these personal feelings and concerns. The three-year working relationship between program staff and evaluator is dependent on each party's trust of the other as well as commitment to working together as one united community enterprise. Though not instantly created, good will, acknowledgements of differences, and openness to learning, can each contribute to a solid beginning.

Process Stage

The work of evaluation truly begins in the Process Stage. During this stage, the evaluation process itself is defined. This definition includes how (a) the evaluation will relate to planning activities, (b) provide data to fulfill Center for Mental Health Services (CMHS) grant requirements, and (c) fuel the planning process itself. Program staff will likely feel somewhat unsure at this stage. That is, although they may have strong community-based program skills, they likely do not have formal planning experience and may have even less exposure to the process of evaluation.

The evaluator is still seen as a new, somewhat tangential, member of the group. Though the program staff may have worked together before, this is the first time that program staff and evaluator will meet to discuss project activities. Each may be silently questioning the process, as outlined in the following hypothetical questions.

> Program staff: How will we work together? How much explaining about my ideas and recommendations do I need to make? Should I ask for input from the evaluator, or am I asking for trouble? We haven't discussed the resource needs for the assessment process. Is it my responsibility, or that of the evaluator, to direct this component?

> Evaluator: How will we work together? How much explaining about my ideas and recommendations do I need to make? What do they expect of me? If I have an idea about their program, should I offer it or will I be considered ill-informed and pretentious? Is conducting the resource needs assessment, which relies on statistical compilation, a part of my responsibilities?

As is evidenced by these questions, getting to know one another and clarifying roles and expectations is an integral part of the Process Stage. While there may have been general philosophical discussions at the Pre-History Stage about how issues are approached and tasks undertaken, it is in the Process Stage that true interaction begins. This is the point at which the program staff and the evaluator begin to express themselves on substantive issues, where reasoning is explained, and where all begin to learn and to teach each other.

While program staff begin to determine an approach, mapping the community and its resources, as well as identifying potentially supportive and restraining forces, the evaluator undertakes the observation of the planning process. Given the newness of the evaluator's involvement, there may be a feeling of self-consciousness on the part of staff and evaluator

alike. Though participant-observation is a proven method for assessing the planning process, the likely perception among staff that the evaluator is not truly an integral part of the program inherently suggests that her/his participation is not fully accepted.

An important component of the Process Stage is the resource needs assessment. This assessment is a joint endeavor between program staff and the evaluator. It is an opportunity to meld the knowledges of program staff and evaluator and to test the developing relationship among its participants. Program staff members are most attuned to the community and its resources. They are familiar with the major institutions in the community, the formal and informal systems of care that exist, and where initial support and resistance to the CoC initiative may be present. Staff members are also responsible for collecting the needs assessment data. This includes requesting and cajoling health, human services, and educational personnel to provide detailed information on their services, programs, and beneficiaries.

The evaluator's role in the resource needs assessment is that of managing the data that is received. While some data are shared in raw form with the Circles of Care Technical Assistance Center (CoCETAC), the information also forms the foundation for community-based planning activities and for baseline assessment of the program's progress. Thus, the evaluator is responsible for the important task of organizing the needs assessment data into manageable and meaningful components.

At this point there is a convergence of interest. Program staff and evaluator alike are interested in the results of the needs assessment. The program staff have specific questions that they would like to have answered so they can confirm or disconfirm their knowledge of community needs based on the information that has been reported. For example, they may wish to know how many AI/AN youth are involved with the county's probation department? Or, what is the ratio of foster care placements by the child welfare agency for AI/AN youth relative to other youth in the service area? The evaluator is similarly interested in these and other questions, as they represent baseline information that is descriptive of the community that can be subsequently reassessed to determine whether positive change has occurred. This capacity to demonstrate the impacts of the CoC intervention is also of interest to the program staff.

Development Stage

Having successfully engineered the Process Stage, the program staff and evaluator proceed to the Development Stage. It is at this stage that the partnership between program staff and evaluator is cemented. Their initial work together during the Process Stage makes it easier to proceed into new domains of less prescriptive assessment and evaluation. Virtually every

planning meeting or programmatic undertaking (e.g., community picnic, newsletter, Gathering of Native Americans - GONA event) should have an associated evaluation component. In some instances the evaluation is part and parcel of the program's design, while at other times the evaluator's role as participant observer is most applicable. In either situation, however, trust and communication between staff and evaluator are essential.

Long-term perspectives on the planning process characterize the Development Stage. A master calendar of events and meetings is often established, whereby program staff and evaluator discuss incremental activities and timelines. While program staff focus on the preparation of materials, acquisition of event resources, and garnering support for specific events, the evaluator probes staff for relevant measures and consistently notes aspects of the planning process that may be informative to the overall evaluation process.

While program staff may have ideas about what measures are relevant for each undertaking, they will likely look to the evaluator for direction on specific instruments and their applicability. Whether it is a question of satisfaction with a planning meeting or the impact that a GONA or community picnic has had on participants' views, the evaluator is charged with developing questions and identifying or creating scales that will capture this information. Since a longitudinal perspective is available *vis-à-vis* the three-year planning process, care is taken to select measures that can be tested and retested over time. Changes in attitude and beliefs as well as knowledge about resources and regional AI/AN history, can be assessed and compared at periodic intervals.

A sample of standardized measures, including an explanation of instrument validity, can be obtained from the evaluator at this stage. However, determination as to the utility of each measure from a planning and program development perspective rests with the program staff. It should become clear at this stage that the evaluator and the evaluation process are in the service of the program, and that the program does not exist to serve the evaluation. From this perspective, each party's role and function on the team is clearly defined. Indeed, it is during the Development Stage that roles and responsibilities are clearly understood.

Consequently, though there may have been an orientation to the role of the evaluator at the Pre-History or Process Stage, this role bears repeating at the Development Stage. It is likely that with a clearer sense of their role and subsequent inclusion as a member of the team, the evaluator's contribution will be better understood, valued, and utilized. This experience may also prove to be cathartic in that early assumptions by program staff about the evaluation process and the evaluator can be explored and redefined in light of current roles and responsibilities. At the Development Stage, the CoC planning process is reaching its stride, and will be fully realized in the Action Stage.

Action Stage

Building on the Development Stage's solid planning, it is during the Action Stage that program staff and evaluator give meaning to the word "team." They are working in unison. Just as a GONA event requires meal planning, program planning, and recreational/social planning, so too does it require evaluation planning. And, just as members of the program staff assume responsibility for the first three activities, the evaluator as a team member is responsible for the latter component. Distinctions are no longer made between evaluation and program. Rather, it is now viewed as one process with several inter-related parts.

The collaboration among team members that characterizes the action stage is enhanced by the introduction of emerging evaluation findings. Though the evaluator is schooled in data coding, data entry, data manipulation, and data presentation, the interpretation of findings and the cross-tabulation of results based on planning assumptions and program-related questions come from the program staff. In line with the evaluator's role of furthering the planning process, findings need to be driven by planning and programmatic concerns. In other words, preliminary findings, which fuel a process of continued evaluation, are used to enrich program and planning activities.

Process evaluation also takes on new meaning during the Action Stage. Though process evaluation is an attempt to chronicle planning activities, seeking out distinct phases and benchmarking events that inform others who may attempt to replicate the planning effort, it also serves as a staff development tool. The evaluator is in a unique position to ask questions about the meaning of certain activities, and to query staff about their priorities and concerns. The dialogue that ensues between evaluator and program staff helps the latter to reflect on their immediate situation, to address specific issues that the evaluator has helped them to frame, and to view the planning process itself as a replicable and dynamic vehicle for producing change.

A shift has thus occurred in the relationship between program staff and evaluator. At an earlier stage the program staff likely perceived evaluation as an additional requirement, a non-negotiable add-on to contend with in the interest of receiving a CoC grant. However, by the Action Stage, evaluation is now an integral part of the overall effort, as is the evaluator. It is also during the Action Stage that the fruits of the planning effort begin to be seen, progress acknowledged, and an end-direction perceived.

Findings/Compilation Stage

CoC activities are in high gear during the Findings/Compilation Stage. Findings from the community engagement and evaluation process are contributing to policy and planning recommendations, and reports are being prepared to satisfy grant requirements. An abundance of primary and

secondary information is being obtained, catalogued, and interpreted. Program staff and the evaluator are interested in better understanding the meaning of the data that they have compiled, while also testing their tentative conclusions.

Meetings are convened with key informants and community members to review data and to confirm or disconfirm interpretations of findings. Program staff and the evaluator explore the meaning of the information obtained with these participative, community-based respondents. Possible programmatic and systemic solutions are discussed. In some instances, new and additional insights emerge from these sessions, as respondents explain subtleties in the data, and steps are considered that will transition CoC from planning to implementation.

Gaps in information also emerge at this stage. Program staff and the evaluator must decide whether additional surveys or interviews are necessary. Like earlier stage activities, survey or interview questions will be jointly developed by the team, with the evaluator responsible for assuring that the information obtained can be presented in a way that informs the planning process.

By the Findings/Compilation Stage, much has been written about aspects of the initiative that need to be compiled into a comprehensive report with recommendations. Though the evaluator or another team member with strong writing skills will ultimately pull the narrative together, conceptualization of the plan's elements is the responsibility of the entire team. If the evaluator is not the writer, the presentation of data is reviewed by the evaluator to assure accuracy.

As the implementation plan is developed, the program staff begin to explore funding opportunities that will support the introduction of services. The justification of need, an integral part of funded proposals, requires statistical and other proofs that the project is rooted in a clear understanding of the community and the intended beneficiaries of services. The abundance of evaluation data that has been amassed can be used to support this section of the proposal. In addition, should a separate evaluation be required as a condition of funding, the evaluator, who is familiar with the project plan, can be called upon to develop the evaluation design and possibly oversee its execution.

At the close of the Findings/Compilation Stage, a clear plan emerges with strategies and resource considerations that can lead to implementation. The seemingly unlikely marriage between program and evaluation, while consummated at the Action Stage, can now point to the progeny of its union: the creation of a developmental plan with specific recommendations for implementation. And, like doting parents, there is pride in the offspring and its potential, which begins to be realized at the Transition Stage.

Transition Stage

During the Transition Stage, the evaluator and program staff are at another juncture in the project's development and their evolving relationship. A choice point is reached as the planning phase ends and implementation begins. Will there be a role for the evaluator as the project moves from planning to implementation? Are resources sufficient to support this transition? If funding is limited what value is placed on the evaluation process? This question becomes particularly relevant when the funder does not require an independent assessment.

The Transition Stage thus may represent an end to the evaluation process through the preparation of the final report, the formal separation of the program staff and evaluator, and the contract termination. Alternatively, it may represent the beginning of a new work relationship, as the project moves toward implementation. There is also the possibility that individual program staff members or the evaluator may not be available beyond their initial three-year CoC commitment. Consequently, the project and its plan for evaluation, which are universally understood as an important part of program services, may continue with a revised agenda or a changed composition of program team members, each bringing to their new career assignments an enhanced understanding of roles and how the performance of their duties is dependent upon the expertise of other team members.

Even if a new team is assembled to carry on with the project, the continuity between planning and implementation is essential. Some would argue that these are different sides of the same coin, meaning that there is no currency unless planning and evaluation are united. And so, unlike the Pre-History Stage that began the evaluation process, at this transition it is likely that an evaluation component will be carried forward as an expected component of the Implementation Phase.

Several data elements on which the CoC evaluation rests also are important to the Transition Stage. They represent baseline information on which the impact of one or more interventions will be assessed. Evaluating complex data uncovered during the planning phase and subsequently designing interventions that address these issues are a fundamental and necessary part of this transition. Both program staff and evaluator at this stage are aware of the interdependence between the two phases, and having immersed themselves in an in-depth understanding of the problems facing the community, they are keenly interested in producing positive change.

Conclusion

With the Transition Stage complete, the Evaluation Life Cycle is ended and program implementation begins. Both parties now understand and appreciate the relationship between program staff and evaluator, which was once tentative. The success that characterizes the end of the evaluation process will likely carry forward into program implementation.

We have seen the nature of the work and the work relationships progressively change from the Pre-History Stage, to the Process Stage, to the sequential stages of Development, Action, Findings/Compilation, and Transition. The collective energies of the program staff and the evaluator have produced a series of outcome reports and a plan that addresses the unique mental health needs of AI/AN youths and their families. The three-year timeframe has afforded the planning process an opportunity to develop and mature across the six stages.

Though each stage has been described by key characteristics, including the evolving relationship between program staff and the evaluator, both the length of time that comprises each stage, and the confidence that all stages will be attained during the planning cycle, are uncertain. The planning and evaluation processes for each of the grantees encompass a different set of circumstances, and consequently, differing experiences and outcomes.

Gary Bess, Ph.D.
Gary Bess Associates
389 Wayland Road
Paradise, CA 95969
Phone: 530 877 3426
Fax: 530 877 3419
Email: bess@sunset.net

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DESCRIBING COMMUNITY NEEDS: EXAMPLES FROM THE CIRCLES OF CARE INITIATIVE

Douglas Novins, M.D., Pamela LeMaster, Ph.D., Pamela Jumper Thurman, Ph.D., and Barbara Plested, Ph.D.

Abstract: The assessment of community needs was one of the key foundations of the Circles of Care planning effort. Grantees identified a range of needs at the child, adolescent, family, programmatic, and community levels. This information, along with an emphasis on the importance of each community's history and culture, served as an important guide for each program as they developed their model systems of care.

As indicated in the *Circles of Care* Guidance for Applicants (GFA), the Circles of Care (CoC) grantees were instructed to include "a process for assessing the needs of the population consistent with the outcome expectations" as part of their plan and design of the model for a System of Care. Thus, one of the initial tasks undertaken by the grantees was an assessment of their community's needs. The overall goals for this assessment were to:

1. Describe the key community-wide historical, socioeconomic, and health contexts for the CoC strategic planning efforts.

2. Determine how many children and adolescents suffer from serious emotional disturbances (SED) in the community.

3. Describe the specific difficulties that these children, youth, and their families struggle with as well as the individual, family, and community strengths that can be mobilized to address these difficulties.

4. Depict community members' perceptions regarding the availability, accessibility, and acceptability of existing services within the community

Data for the Needs Assessment

The CoC grantees were confronted with the daunting prospect of conducting a needs assessment with limited funds and time. Because of these factors, grantees were unable to conduct scientifically rigorous assessments, pinpointing the prevalence and characteristics of the children and adolescents with SED in their communities. Instead, the grantees employed an often-elegant combination of targeted primary data collection, analysis of secondary data, and careful review of the existing scientific literature to depict their communities' needs.

Primary Data

Focus groups and community surveys were the key primary data collection methodologies utilized by the grantees, and were used to identify community perceptions of the difficulties with which children, adolescents, and their families struggle as well as community perceptions regarding the availability, accessibility, and acceptability of existing services. Two grantees used a series of case studies to better understand the characteristics of children and adolescents with SED as well as their service system's responses to these difficulties.

Secondary Data

Secondary data collection was used by most of the grantees to supplement their primary data collection efforts. Secondary data included information from the U.S. Census, service utilization figures from statewide programs such as Medicaid, and information from service organizations such as behavioral health programs, schools, social services agencies, and law enforcement.

Review of Previous Needs Assessments and Research

Because of significant limitations in time and resources, the grantees also turned to the existing scientific literature to develop a variety of estimates for their needs assessments. Several grantees were able to identify important research studies that had been conducted in their communities, and were thus highly relevant for their assessments.

Key Findings

Community Characteristics

The grantees developed rich descriptions of their communities. A number of themes consistently appeared in these assessments, and can be broken into three areas: (a) historical and cultural contexts, (b) sociodemographics, and (c) community health.

Historical and Cultural Contexts

All of the grantees felt strongly that in order to understand the needs of the children and adolescents with SED and their families, it was critical to appreciate the history of their communities and their cultures. While each community's history is unique, all share a history of the denigration of rich cultures through centuries of genocide and cultural oppression. As noted in one grantee report, "in the 500 years since the arrival of White people, American Indians and Alaska Natives have experienced genocide, sweeping epidemics, forced assimilation, boarding schools, involuntary relocations, and displacement."[1] Many grantees noted that this history has compromised the abilities of American Indian and Alaska Native (AI/AN) communities to maintain their cultural practices. In addition, some grantees described how members of their communities struggle both accepting and finding acceptance in the majority culture. As one grantee noted in their review of the results of their community survey, "…[Community members] feel tenuously connected to the Native American community – especially if they are unable to document their tribal affiliations. They also are keenly aware of being outside the majority culture – yet unable to embrace their Native heritage due to lack of understanding of cultural practices and loss of their Native language."[2] This tenuous sense of connectedness was a particular challenge noted by the grantees located in urban communities, where members of an extraordinary number of tribes with diverse histories, cultures, and healing traditions are attempting to build a shared vision for children's mental health services.[3]

Indeed, many grantees believe that their communities suffer from a form of "Historical Trauma" that explains many of the socioeconomic, health, substance abuse, and mental health problems that they believe are all too common among community members. Grantees used a variety of terms in addition to Historical Trauma to describe this belief, including "Intergenerational Post Traumatic Stress Disorder," "Internalized Oppression," and "Post-Traumatic Demoralization Syndrome."

> Cultural oppression, cumulative and unresolved trauma, [are] most frequently referred to [as] historical trauma and internalized oppression. 'The act of turning our rage upon ourselves, upon our families and our people through distress patterns and hurt that result from the racism and oppression of the majority society, with symptoms of Post-Traumatic Stress Disorder...[4]

Despite this history, ongoing oppression, and its impacts, all of the grantees emphasized the many cultural strengths that exist within their communities. Grantees saw evidence of this resiliency in a number of areas including population growth, efforts to increase the number of speakers of their AI/AN languages, and the richness of their cultures and networks of traditional healers. As one community member reported: "We keep coming back as a people, although we were conquered, through our spirituality and ceremonies. The buffalo and animals are also returning."[5] Others identified community strengths from which children, adolescents, and their families can draw support. These included rich traditional resources, extended kinship networks, and vibrant community organizations such as churches, recreational and educational programs. Several grantees noted substantial improvement in high school graduation rates as a sign of the strengthening of their communities: "Educationally, the numbers of Native children in the highest quartile for reading, math, and language arts in rural districts are approaching the statewide average. Educational supports such as the Alaska Native Knowledge Network and the Alaska Rural Systemic Initiative are working to more closely align indigenous knowledge and existing educational programs."[6]

Sociodemographics

A variety of sociodemographic characteristics were cited by the grantees as important for appreciating the contexts of their strategic planning efforts. High unemployment and poverty were the most frequently cited statistics by the grantees (see Table 1 for several examples). Grantees in rural areas also emphasized the geographic isolation of many of the families that they hoped to serve, and that limited transportation options and poor telephone services were significant obstacles to provision of services in their communities.[7] Others noted their rapidly growing populations and the relatively high percentage of their population 22 years of age and younger (see Table 2) as indicators of both the need for improved children's mental health services and significant potential for positive change in their communities.

As observed in the previous section, several grantees noted the educational gains that are occurring in their communities (although this was tempered by concerns regarding the high prevalence of youth dropping out of school in several grantee communities). Finally, two grantees identified the growth of gaming in their communities as an extraordinary economic

boon that is reshaping their communities and creating new opportunities for their children and adolescents. These opportunities include both direct effects such as employment as well as indirect effects such as improved housing, schools, and scholarships to pursue college and graduate education.[8]

Table 1
Employment, Income, and Poverty in Four Circles of Care Communities

Grantee	Employment Statistics	Income and Poverty Statistics
Cheyenne River Sioux Tribe	78% of workforce unemployed.	Income of 95% of employed fall below federal poverty guidelines.
Choctaw Nation of Oklahoma	7.8% unemployment rate for Oklahoma in 1997 (compared to a US unemployment rate of 4.0%.	35.3% of children living below federal poverty guidelines.
Feather River Tribal Health		29.6% of households in community survey reported an income of less than $10,000.
Urban Indian Health Board	9% unemployment rate for American Indians living in the San Francisco Bay Area.	15% of American Indians living in the San Francisco Bay area are living in poverty.

Community Health

As in the case of the sociodemographic characteristics reported above, many grantees identified a number of indicators of the health of their communities, and in particular the health of their children and adolescents. Grantees cited many troubling statistics that argue for a significant need for improving family-focused children's mental health services. These included high arrest, accident, and substance abuse rates for both adults and adolescents. Some grantees pointed to high rates of domestic violence and child abuse and neglect, as well as consequent foster care placements as another important indicator of community health. Several grantees raised concerns about high rates of teenage pregnancy in their communities. Examples of these statistics are displayed in Table 2.

Table 2
Selected Indicators of Community Health from the *Circles of Care* Communities

Grantee	Health Indicators
Cheyenne River Sioux Tribe	2,311 juvenile arrests in a population of 3,025 children and adolescents (1999-2000). 154 cases of child abuse, neglect, sexual abuse, and endangerment (1999-2000).
Choctaw Nation of Oklahoma	Teen birth rate of 75 per 1,000 (ages 15-19, 1999) compared to a state average of 63.3. 1,244 confirmed reports of child abuse and neglect (1997).
Fairbanks Native Association/ Tanana Chiefs Conference	Chart diagnosis of 3.6% for Fetal Alcohol Syndrome and Fetal Alcohol Effects but providers estimate the rate is closer to 34%. 1,213 substantiated reports of harm to children (1999).
Feather River Tribal Health	A community survey of Native American adults found that 33.2% of respondents had been in jail, prison, or juvenile hall at one time in their life.
First Nations Community HealthSource	Parent's focus group identified substance abuse by family members as a major community risk factor for the development of SED among their children and adolescents.
In-Care Network	2,600 Indian children were served by the State of Montana in 1999, representing 12% of all American Indians residing in this State. Of these 67% were in foster care and 25% are diagnosed with a SED.
Inter-Tribal Council of Michigan	Infant mortality rate of 11.81 per 1,000 (1996-1998) compared to a state average of 8.11. 76.2% of pregnant women received prenatal care (1996-1998) compared to a state average of 81.6%.
Oglala Lakota Nation	The planning committee noted a high prevalence of diabetes and a poor health care system as important indicators of community health.
Urban Indian Health Board	The planning committee noted the high prevalence of alcohol abuse, depression, and domestic violence in the San Francisco Bay Area Native American community.

Table 3
Estimates of American Indian/Alaska Native Population and Prevalence of SED

Grantee	Population Estimates		Children & Adolescents with or at highest risk for SED	
	AI/AN Population	AI/AN Children & Adolescents	Number	Percentage of AI/AN Adolescents in Community
Cheyenne River Sioux Tribe	10,589	3,038	517	17.0%
Choctaw Nation of Oklahoma	31,249	12,553	-	-
Fairbanks Native Association/ Tanana Chiefs Conference	9,748	3,823	500	13.1%
Feather River Tribal Health	8,000	2,080	520	25.0%
First Nations Community HealthSource	11,457	3,437	-	-
In-Care Network	56,068	22,083	-	-
Inter-Tribal Council of Michigan	12,354	6,913	2,007	29.0%
Oglala Lakota Nation	14,562	5,000	1,250	20.0%
Urban Indian Health Board	79,897	10,000	2,250	22.5%

Notes: Some grantees found the information available to them to be too conflicting to produce an estimate of the prevalence of SED among the children and adolescents in their communities. All those that did produce estimates saw them as only a rough guide to the level of need in their communities.

Prevalence of SED

The *Circles of Care* grantees took a variety of approaches in developing their estimates of the prevalence of SED among the children and adolescents residing in their communities, which are displayed in the right-hand columns of Table 3. Most started with federally generated estimates of SED, such as the *Surgeon General's Report on Mental Health* (U.S. Department of Health and Human Services, 1999), which estimated that 5 to 9% of children ages 9 to 17 could be classified as having a SED. Grantees also reviewed the existing research literature, but the studies cited focused on the prevalence of psychiatric diagnoses which would be expected to include some youths who did not meet the severe impairment criteria required for most definitions of SED (Beals et al., 1997; Costello, Farmer, Angold, Burns, & Erkanli, 1997). Grantees also conducted detailed analyses of data from local service agencies such as behavioral health programs, social welfare,

schools, and law enforcement. Several grantees used interviews with service providers to further inform their estimates.

The grantees struggled to develop a best estimate from these different sources. This was largely the result of the difficulty in successfully triangulating the conflicting estimates that emerged from different sources, particularly as the grantees questioned the reliability of the information they had gathered. For example, many grantees were concerned that the federal estimates would not be applicable to their communities and that many children and adolescents with SED were not receiving services in their community.

> Providers felt that the ... [project's calculated] estimate of 450 to 500 is too low to serve as an estimate of the number of Native children experiencing SED... Factors contributing to this underestimation... include: (a) the invisibility of many children in need, who do not show up for treatment; (b) provider discomfort with giving children severe diagnoses, on account of the resulting stigmatization...; and (c) the fact that the most severely disturbed children... are referred elsewhere for treatment and are thus not reflected in the... study.[9]

In the end, most grantees viewed their estimates as only a rough guide to the levels of need in their communities. Some grantees concluded that the information they gathered was so conflicting that any estimate would likely be too unreliable to be useful for their strategic planning. These grantees chose not to produce a final estimate, as reflected in Table 3.

In reviewing these estimates, it is particularly notable that all of the grantees settled on figures that were higher than that estimated by the Surgeon General. Whereas the Surgeon General arrived at an estimate of 5 to 9%, the CoC grantees arrived at estimates between 12.5 and 29%. There are several reasons that account for the differences in these estimates and their wide range. First, the Surgeon General's Report focused on children ages 9 to 17, whereas the CoC grantees included a wider age range: 0-22. Second, many of the grantees were uncomfortable focusing on children and adolescents whose difficulties met strict criteria for SED, and chose to include youth at "high risk" for SED. Third, many grantees concluded that the prevalence of children and adolescents suffering from SED in their communities was indeed higher than the available national estimates.

Children, Adolescents, and Families in Need

The CoC grantees developed detailed descriptions of children and adolescents in need. Grantees gathered information from community members and treatment providers as well as administrative and clinical

records. Some grantees also drew information from policy and research publications. Key findings are summarized below and in Table 4.

The grantee communities identified a number of common characteristics among the children and adolescents with SED in their communities. Suicide and related-behaviors as well as juvenile delinquency were identified by most of the grantees as symptoms and behaviors of particular concern. Posttraumatic Stress Disorder, Attention Deficit/ Hyperactivity Disorder, Major Depression, and Conduct Disorder were the most common diagnoses from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV); (American Psychiatric Association, 1994) identified by providers as being typical among children and adolescents with SED. Grantees also identified comorbid substance use as an important manifestation of SED among the children and adolescents in their communities.

In terms of families, many grantees indicated that children with SED come from single-parent families. They also identified substance abuse and mental health problems among parents of children and adolescents with SED as an all too common situation in their communities. A few grantees felt that families with children and adolescents with SED were often poorly connected with their communities and cultures.

While the above methods provided the grantees with information about the children and adolescents with SED and families as a group, the uniqueness of each child and family was lost in these groupings. To address this weakness, some grantees also conducted case studies to explore needs on a more individual basis. While the case study findings were consistent with the group data described above, the grantees gained a number of additional insights from this exercise. For example, one grantee's case studies documented poignantly the multiple layers of difficulties – health, mental health, substance abuse, domestic violence, and learning problems – that were characteristic of these children and adolescents. These findings reinforced the planning committee's commitment to creating coordinated, multi-sector, and multi-modal wrap-around services. [10] Another grantee community documented similar findings in its case studies, but also noted that serious emotional problems can emerge at very young ages and can persist and sometimes worsen through childhood and adolescence.[11]

Availability, Accessibility, and Acceptability of Services

In this component of the needs assessment, grantees developed a more complete understanding of the way services are perceived by people in the community. The grantees addressed three specific questions: (a) What services are available in the community?; (b) How accessible are they to children, adolescents, and families in the community?; and (c) How acceptable are they?[12] Key findings from this exercise are outlined in Table 5.

Table 4
Key Characteristics of Children and Adolescents with SED and their Families

Grantee	Key Findings
Cheyenne River Sioux Tribe	<u>From Mental health programs</u>: suicide ideation, attempts and gestures; attention deficit disorder, depressive disorders, family relational problems. <u>From youth interviews</u>: substance abuse, gangs/violence, behavioral incidents, no family guidance. <u>From parent interviews</u>: substance abuse, gangs, behavioral acting out, no role models, no cultural awareness.
Choctaw Nation of Oklahoma	<u>From focus groups</u>: A child may suffer from SED if they – attempt suicide; constantly lie or steal or get into troubles; are quiet, too clingy, and starved for love; are restless, can't concentrate, and don't pay attention; constantly cry, are nervous or uneasy, and unusually upset; are destructive towards others or objects; are unable to study.
Fairbanks Native Assoc./ Tanana Chiefs Conference	<u>From provider surveys</u>: *Most common DSM-IV disorders*: adjustment disorder, attention deficit/hyperactivity disorder, major depressive episode, alcohol dependence. <u>From community surveys</u>: *Problems in rural and urban households* – depression, stress, chronic fatigue/tiredness, anxiety/nervousness.
Feather River Tribal Health	<u>From provider surveys</u>: *Common reasons for entry into services* – substance use problems, social problems, family/support group problems, conduct problems. <u>From community surveys</u>: *Problems in families* – alcohol-related problems, domestic violence, post traumatic stress disorder and intergenerational stress, unemployment.
First Nations Community HealthSource	<u>Common themes across surveys and focus groups</u>: *Presenting problems of children and adolescents* – aggression, depression, substance abuse problems, anger management problems, acting out behaviors, suicidal tendencies, negative attitude. *Risk factors for development of SED* – substance abuse by family member, domestic violence, child abuse/neglect, disintegration of family unit, acculturation issues, peer pressure, lack of parental guidance/parents unable to parent their children, breakdown of family system, poverty, lack of finances.
In-Care Network	<u>From State of Montana administrative records</u>: *Most common DSM-IV diagnoses/ diagnostic groupings* – Attention Deficit/Hyperactivity Disorder, Disruptive Behavior Disorders, Mood Disorders, Adjustment Disorders, Anxiety Disorders, Substance Abuse.
Inter-Tribal Council of Michigan	<u>From community mental health service provider report</u>: *Diagnostic categories of children and adolescents with SED who received services* – attention deficit/ hyperactivity disorder; adjustment disorder, learning disorder, oppositional defiant disorder, conduct disorder, autistic disorder, depressive disorders, substance use disorder, psychotic disorders
Oglala Lakota Nation	<u>From parent surveys</u>: *The most pressing needs of their children* – problems with paying attention, flunking school, dropping out of school, not believing much in Creator or God, not interested in helping the community, family conflict, attachment (emotional bonding) problems, feeling nervous a lot. <u>From teacher surveys</u>: *Prevalent problems among the youth at their school* – behavioral and emotional problems (e.g., hitting, yelling, skipping class) and trouble with learning and connecting (e.g., disrespectful, not motivated)
Urban Indian Health Board	<u>Chart review</u>: *Most common problems among children and adolescents in treatment* – substance use disorders, anxiety disorders, mood disorders.

Table 5
**Circles of Care Community Perspectives of the Availability, Accessibility,
and Acceptability of Services**

Grantee	Key Findings
Cheyenne River Sioux Tribe	Availability: Youth recommended sports activities, counseling, substance abuse prevention and treatment services, and tutors be made more available. Parents recommended the development of youth/recreation center, more counseling services, and more programs to increase awareness regarding the negative consequences of substance abuse. Elders recommended that cultural practices should be added to the current system of services. Accessibility: Community focus groups identified transportation to the Agency town as a major barrier to accessing services for families in the outlying communities. Cancelled appointments and long waits for services were also cited as a barrier as was the lack of providers who speak and understand Lakota. Acceptability: "*While the Project did not specifically ask if... residents were completely satisfied with current services, the variety of problems or areas needing improvement by those surveyed... indicates there is a need to improve existing services.*"
Choctaw Nation of Oklahoma	Availability: "*The need for communities and individuals to have access to information on available services was the primary concern for many of the communities. Individuals did not always know where to start when seeking help.*" Accessibility: Barriers most often listed – poverty, lack of knowledge of services, lack of transportation. Acceptability: "*Many of the participants... [felt that] unless a... family member had special needs not much thought was given to services.*"
Fairbanks Native Assoc./ Tanana Chiefs Conference	Availability: "*There is not a mechanism in place to gather information or to find out what would work best...*" Accessibility: "*The system is extremely hard to access and obtain services... There is a reluctance to label the children in need within the school system.*" Acceptability: Stigma, concerns about lack of confidentiality, and inconsistencies within systems and across providers all raised questions regarding the acceptability of existing services.
Feather River Tribal Health	Availability and Accessibility: "*On the whole it appears that services are available, though they are difficult at times to access due to filled appointments and issues of transportation.*" Acceptability: "*There is also the issue of cultural competency on the part of agency staffs concerning their knowledge about the Native American community.*"
First Nations Community HealthSource	Availability: Need for more counseling, cultural and recreational activities, educational support programs, and parent education and parenting classes. Also noted that many families are unaware of the services available to them. Accessibility and Acceptability: Lack of transportation, inability to pay for services, managed care rules and regulations, scheduling difficulties, language and lack of cultural sensitivity were all identified as barriers to accessing care.

Table Continues

Table 5 Continued
Circles of Care Community Perspectives of the Availability, Accessibility,
and Acceptability of Services

Grantee	Key Findings
Inter-Tribal Council of Michigan	Availability: "*Community members reported that in many instances, they do not know what kinds of services their tribes are providing, let alone what state agency services are available.*" Accessibility and Acceptability: Barriers to accessing services included inability to pay for services, lack of transportation, lack of confidentiality, fear of stigma, racism, and lack of trust.
Oglala Lakota Nation	Availability: *Parent-identified service system gaps* – family counseling, mentoring, individual counseling, drug and alcohol education. Youth-identified service system gaps: individual counseling, violence/gang prevention, family counseling, drug and alcohol education. Accessibility: Long travel distances and lack of transportation was noted as the primary barrier to accessing services. Acceptability: "*Regarding the relationship between service providers and families, on a 1 to 5 scale with 1 representing 'highly included as empowered and full partner' and 5 representing disempowered and not given any chances to partner,' parents responses had a mean... of 2.74.*"
Urban Indian Health Board	Availability, Accessibility, and Acceptability: "*There are extensive mental health and substance abuse service systems in San Francisco and Alameda County. These services are available through a managed care system that is not well utilized by Native people. During the past year the California Legislature Joint Committee on Mental Health Reform held hearings on barriers that minority groups experienced in accessing services. They concluded that cultural competency is an unrealized goal and recommended that strategies be developed to achieve a cultural competent system of care' linking school, health, and social service agencies.*"

A common theme was that community members were largely unaware of what services are available in their community. The most common themes regarding the accessibility of services for grantees serving rural areas was the geographic isolation of many families and difficulties in securing transportation to access services. In urban areas, income, managed care, and administrative barriers such as difficulty scheduling appointments were most common. In terms of acceptability, the lack of cultural competency of service providers was the major concern with regard to the services available to community members in almost every grantee community.

Impact on the Planning Process

The results of the community needs assessment had a direct impact on the planning process, as grantees incorporated into their final models for a System of Care those elements that were identified by the community and

providers as lacking or desired services for their children as well as modifications in services currently available. In particular, they were able to address the availability, accessibility, and acceptability concerns that were identified through the community needs assessment, including such things as developing satellite clinics to address the lack of transportation and phones, special training programs to get more AI/AN providers trained and credentialed, and traditional support systems to focus on the strengths that the community has to offer the system. The process emphasized the very real differences between what the community saw as its needs and what providers felt were important components for a System of Care as well as the grantees' own ideas of what would best serve their community.

The Community Readiness Model, developed by a team of researchers at the Tri-Ethnic Center for Prevention Research (Donnermeyer, Plested, Edwards, Oetting, & Littlethunder, 1997; Jumper-Thurman, Plested, Edwards, Helm, & Oetting, 2001; Kumpfer, Whiteside, Wandersman, & Cardenas, 1997; Oetting, et al., 1995; Plested, Smitham, Jumper-Thurman, Oetting, & Edwards, 1999), was used by two of the grantee sites in their planning process. Specifically, it was used to assess the level of community readiness to accept and address the development of a service system plan as well as to assess the readiness for implementing pilot projects. Key informant surveys were used to assess readiness with community members (i.e., providers of services or users of the services available) responsible for the planning, funding and implementation of service systems and knowledgeable about their communities. The information gathered through this method was used to assist in providing knowledge about service gaps, service needs, the community's willingness to use the services, and established the priorities of the community. The model also assisted in generating community/tribal collaboration and investment so that the model for a System of Care was community specific and culturally appropriate.

The community needs assessment resulted in a number of challenges and opportunities that also had an impact on the planning process. One of the challenges the grantees faced was the timing of this task to be completed during the first year of the initiative. Grantees were asking for community input on often-sensitive information when trust had not yet been established. Trust, not only between community members but also providers and other agency personnel, was an essential element in this process, in order to obtain cooperation and be more assured that honest feelings were being shared about community needs. Trust also ensured the provision of accurate information.   The issue of trust was also a factor with regard to the competitiveness for funding that grantees observed between programs. Once trust had been established, the programs were more willing to work together and share resources. For these reasons, some grantees suggested that this task be initiated during the second year of the initiative, after rapport had been established.

Another challenge included an ethical dilemma: how does one garner community input and support for, and design a comprehensive System of Care to address their identified needs, when funding to implement such a system was not guaranteed? The need for immediate services was very great in many of the grantee communities, and it was difficult for some community members to understand that this initiative was only a planning effort. However, many did come to comprehend the importance of such an effort and became strong supporters. This initiative was developed, in part, to strategically place AI/AN communities in a position to apply for the SAMHSA-funded *Comprehensive Community Mental Health Services Program for Children and Their Families* initiative to implement their System of Care. Thus, many of the grantees focused on this necessary funding goal. In contrast, some communities did submit applications to fund various components of their System of Care as immediate needs and opportunities for funding were identified during the initiative. However, for the majority of grantees, the concerns regarding funding to implement and sustain such a system continued throughout the initiative.

Although some grantees found it a challenge to gather information from programs that might not be forthcoming with information, possibly due to the competition for funds and other resources, an opportunity was provided when the grantees were able to share information that was collected through their needs assessment. These programs and agencies then used the needs assessment information in submitting grant applications that in many cases were successfully funded, thereby bringing needed and desired services into the community. Thus, as a result of the efforts on this initiative, many agencies and programs came to realize the need to work together for the success of the new system. The community itself became more involved in the process, with members often volunteering to assist in the planning effort. In addition, the information gathered through the needs assessment was used to educate community members and providers about the prevalence of SED and other related mental health concerns in their community.

Conclusions and Implications

Overall, grantees found that there are many children and adolescents suffering from SED and subsequent difficulties often manifest themselves in complex ways. Grantees emphasized that these difficulties can only be understood by appreciating the history of their communities, both in terms of the historical trauma experienced by their peoples as well as their impressive resiliency. Grantees noted that community members feel that a variety of services are lacking in their communities, that they are difficult to access, and that many services fail to provide culturally competent services. For the communities, participation in the community needs assessment was an opportunity for their voice to be heard and to identify the needs that they felt were important to address as part of a comprehensive System of Care. The

initiative also reinforced the need for community support in undertaking such a planning effort and its eventual success within the community. For evaluators, this effort emphasized not only the need to listen to what the communities had to say but to involve them in the process as much as possible. The effort also demonstrated the utility of incorporating a variety of methods, such as those identified previously, to gather information on community needs from a variety of sources. For policymakers, it emphasized the need to address other complex economic and social issues (e.g., unemployment, poverty, historical trauma) as a mechanism for impacting the lives of youth and their families who experience a SED. The initiative also served as a basis for further planning and external funding. In conclusion, the CoC grantees conducted needs assessments that were impressively thorough given the limited time and resources available for this task. These needs assessments formed an important foundation for the grantees' strategic planning effort and provided the basic background information critical to securing community support, as well as external funding. Subsequent to the needs assessments, community support and external funding are essential elements in further planning, system development, and service delivery.

Douglas K. Novins, M.D.
Director, Circles of Care Evaluation Technical Assistance Center
American Indian and Alaska Native Programs
Nighthorse Campbell Native Health Building
P.O. Box 6508, Mail Stop F800
Aurora, CO 80045-0508
Phone: (303) 724-1414
Fax: (303) 724-1474
Email: douglas.novins@uchsc.edu

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Footnotes

[1]Urban Indian Health Board

[2]Feather River Tribal Health

[3]First Nations Community HealthSource

[4]Inter-Tribal Council of Michigan

[5]Cheyenne River Sioux Tribe

[6]Fairbanks Native Association/Tanana Chiefs Conference

[7]Cheyenne River Sioux Tribe

[8]Inter-Tribal Council of Michigan, Feather River Tribal Health

[9]Fairbanks Native Association/Tanana Chiefs Conference

[10]Inter-Tribal Council of Michigan

[11]Fairbanks Native Association/Tanana Chiefs Conference

[12]The grantees also conducted a detailed description of the services present in their communities. This is presented in a separate section of this Special Issue.

Author's Note

WORDS HAVE POWER: (RE)-DEFINING SERIOUS EMOTIONAL DISTURBANCE FOR AMERICAN INDIAN AND ALASKA NATIVE CHILDREN AND THEIR FAMILIES

Teisha M. Simmons, M.A., Douglas K. Novins, M.D., and James Allen, Ph.D.

Abstract: Circles of Care grantees were provided the opportunity to develop a locally relevant definition of serious emotional disturbance (SED) that would be used to define what type of emotional, behavioral, and mental disability would be required to receive services. After conducting detailed assessments of the definition in the guidance for applicants and the definitions used by others in their respective states, seven of the nine grantees developed their own local, project-specific definitions through the participation of community focus groups and Advisory Councils. The definitions for SED developed by rural grantees all included American Indian and Alaska Native concepts specific to each tribal community's culture; the urban grantee's definition was purposely focused for reaching out to non-professional members of the community. This opportunity for the communities to redefine SED not only provided each community with a definition which would be more culturally specific, but also proved to be an extraordinary exercise in empowerment and self-determination.

The second component of the Circles of Care (CoC) evaluation process was to develop a locally relevant definition of serious emotional disturbance (SED). The CoC guidance for applicants (GFA) allowed grantees to define what kind and level of emotional, behavioral, or mental disability would be required for eligibility for services under their strategic plans. This allowance was important for several reasons. First, the GFA anticipated that the term SED might be perceived as stigmatizing, and that some communities might be concerned that such labels could impact the future opportunities for children and families who would be served in these new systems of care. Second, some communities might prefer strength-based conceptualizations of need in place of the deficit-based concepts used in standard definitions of

SED. Third, it was anticipated that DSM-IV conceptualizations of dysfunction might map poorly onto local conceptualizations of health and illness. Fourth, it was also clear that the definition of the target population would have significant implications for the design of a model system of care. For example, a broadly defined target population would likely require greater capacity within the model systems of care and might require a broader array of services.

Because of the critical importance of characterizing each community's concept of SED, as well as that of defining the target population for the model system of care, each grantee developed a process for examining the standard definition of SED as described in the GFA and accepting, modifying, expanding, or replacing this definition as appropriate for the community to be served. Therefore, the grantees pursued a dual approach to defining SED for their programs. First, most grantees conducted detailed assessments of the CoC GFA definition as well as the definitions used within their communities by other health, education, and human service organizations. Evaluation staff researched and compiled these various definitions, and these assessments were conducted by CoC project staff, often in conjunction with each grantee's project Advisory Board (which for most grantees included representation by parents, youths, elders, treatment providers, and upon occasion, elected officials). Some grantees brought these definitions to focus groups or culturally appropriate alternatives such as Gatherings of Native Americans (GONA's) for further review. Second, seven of the grantees developed their own local, project-specific definitions of SED. These definitions were developed through the participation of community focus groups with substantial involvement from project staff and their Advisory Boards.

Assessment of Existing Definitions

Grantees gained a number of important insights through their detailed analyses of existing definitions of SED. For example, one grantee identified seven different SED definitions that were used by various service organizations within their community. These included two federal definitions (the Substance Abuse and Mental Health Services Administration as well as the Bureau of Indian Affairs), two state definitions (from mental health and education departments), as well as several definitions that were developed locally. Such a wide range of definitions would clearly raise challenges for developing a wrap-around approach to service delivery. Other challenges included the reliance on only a subset of DSM-IV diagnoses, or specific diagnostic categories. For example, the Fairbanks Native Association/Tanana Chiefs Conference group found that "the [state Department of Education definition] does not include children with Conduct Disorders, Substance Abuse, Fetal Alcohol Syndrome or Fetal Alcohol Effects, or Attention Deficit/Hyperactivity Disorder." Some grantees were also troubled by the impairment component of the standard definition of SED, finding it overly restrictive and precluding services

for youth at high risk for developing more severe emotional and behavioral problems. For instance, the Urban Indian Health Board community in Oakland felt strongly about avoiding the use of labels, including SED. Rather than focusing on treatment, this group preferred directing their efforts toward preventing at-risk youth from developing problems, and felt that the use of the term SED deterred them from this focus. As one Oakland community member said: "Let's just call them 'urban kids.'" As a result, the discussion surrounding the redefinition of SED was uneasy and focus group participants would either draw a blank or express their dislike for labels and redirect the discussion to another topic.

Perhaps most important was the common sentiment that the available definitions of SED did not incorporate traditional American Indian and Alaska Native (AI/AN) perspectives. For example, the existing SED definitions are deficit- rather than strength-based, fail to emphasize the important family and community contexts of emotional and behavioral difficulties, and fail to note that some of these difficulties may be part of an individual's and family's life path. For example, the In-Care Network in Billings, Montana stated, "There is a strong value in Native tribal cultures of the Northern Plains region that says every person, no matter what age – from infants to elders – has the right to follow their own path and that we all bring a gift to the whole community. That value does not allow room to dwell on deficits."

Decision to Pursue a Program-Specific Definition

Following their analyses of existing definitions of SED, the grantees were confronted with the decision of whether or not to develop their own, program-specific definition of SED. For seven of the grantees, the many concerns regarding existing definitions led them to pursue new, community and culturally appropriate definitions. For the other two grantees, including the need for a new definition was less clear. For example, the In-Care Network was concerned that the whole concept of SED was incompatible with the cultures of the tribes they served in predominately rural Montana settings.

An important urban-rural distinction emerged through this decision process regarding the development of a local, more culturally grounded SED definition. First Nations Community HealthSource, serving the urban AI/AN community in Albuquerque, did not think an additional definition would aid their efforts to serve children and adolescents with emotional problems and their families. This was particularly true of their setting because they had to communicate and interface with the existing and extensive urban system of care and its many non-Native organizations that were already using a confusing range of SED definitions. The Urban Indian Health Board, serving the urban AI/AN community in the San Francisco Bay area, came to a similar conclusion regarding a clinical definition, as they felt such a definition would interfere with their plan to serve all AI/AN children and adolescents through

a variety of funding streams, many of which would mandate their own definitions. As they noted,

> The Circles of Care has struggled with the definition and the usage of the term "severely emotionally disturbed" (SED). We prefer not to use this term when we don't have to. The Circles of Care is designed to serve all children, regardless of whether they are labeled SED according to appropriate state and federal definitions. Our system of care has many different funding streams. Service provided through funding that depends upon DSM-IV classifications will comply with legal definitions of SED.

Instead, the Urban Indian Health Board, in response to the serious community concerns regarding the labeling of their children noted earlier, replaced the term SED entirely in their community-focused work by instead saying the project would serve "our most needy and vulnerable children." At the same time, the Urban Indian Health Board worked within the existing clinical definitions of SED as they formed partnerships with other human services agencies and developed grant applications to expand their own services

Program-Specific Definitions of SED

The definitions of SED developed by the seven CoC grantees that chose to purse this effort are reproduced in Table 1. While each grantee took a different approach and arrived at unique definitions of SED, a number of characteristics are common to many of these definitions.

First, three of the grantees used words or phrases from their own languages, thus emphasizing the placement of their definition within the context of their community's culture. Second, most definitions emphasized the community context – that SED not only affects the individual but also affects the family and community. This emphasis was quite different from standard definitions of SED, which instead emphasize that SED is the illness of an individual that manifests itself through functional impairment within the family, at school, or in the greater community. Thus, consistent with the notion of the relational worldview (Cross, Earle, Echo-Hawke Solie, & Mannes, 2000), CoC grantee definitions served to emphasize the powerful interconnectedness of their community members.

A number of other characteristics of these definitions are particularly notable. All used AI/AN concepts such as disharmony, inability to maintain "balance," vulnerability, and the spiritual nature of these difficulties. The two grantees serving Lakota communities included in their definition that impacts of the outside world, both in historic and contemporary terms, are a major cause of SED among the children and adolescents in their communities. In

Table 1
Definitions of Serious Emotional Disturbance from Seven *Circles of Care* Communities

Grantee	Definition
Cheyenne River Sioux Tribe	*"The project has redefined SED as 'Unci Maka Ta Cinca' (Grandmother Earth's Children):* *1. Children who do not function well with family and community members. These children have strong mixed emotions.* *2. Children experience multiple emotional disturbances such as lack of capability to cope with love and hate caused by historical trauma, alcohol, abandonment, lack of spirituality, identity loss, physical abuse, spousal abuse, elderly abuse, child abuse, death, denial, teen pregnancy, parent/child conflict, parental neglect, dependence, low esteem, poor school performance/attendance, absent parent, poor romantic relationships, mental illness, dishonesty, depression, anxiety, stress, anger, fear, guilt, sorrow, greed, jealousy, ignorance, idleness, doubt, shame, and poverty. Also, SED comes from outside the realm of Lakota Culture."*
Choctaw Nation of Oklahoma	*Emotional disturbance is a temporary disharmony often involving the family, school, and community, which may affect the mental, physical, spiritual, and/or emotional well being of its members."*
Fairbanks Native Assoc./ Tanana Chiefs Conference	*"SED is a temporary disharmony involving the community, school, and family that affects the physical, emotional, spiritual, and intellectual well being of its members. The healing of our children, families, and communities is a flexible, evolving process that returns us to our most basic belief that children are precious (ch'eghutsen')."*
Feather River Tribal Health	*Severe emotional disturbance in Native American children can be an emotional, behavioral, or spiritual disorder. If a child is ignored, put-down, or does not otherwise feel valued, he or she may become depressed, have thought disorders, or engage in deleterious conduct or other harmful activities that adversely impact his or her health and well-being, that of the family and that of the Native American Community."*
Inter-Tribal Council of Michigan	*"Unable to maintain balance that enables a person to function within community context, mind, body, and spirit. Without intervention, this state of imbalance will continue for more than one (1) year."*
Oglala Lakota Nation	*"Children with SEDs are (Sacred) Children from families who have experienced trauma. Many of these children are victims of sexual abuse who feel unloved and disconnected from the community. They and their families suffer from the symptoms of historical wounding, such as shame and anger, and are in need of healing of the spirit. The shame and anger are acted out in behaviors such as chemical addiction, sexually acting out, disrespect toward elders and parents, deep sadness, suicide attempts and fighting, stealing, violent acts, nervousness, gang participation, and problems succeeding in school."*
Urban Indian Health Board	*"The most vulnerable and needy children in our community."*

addition, several grantees developed a list of specific difficulties that children with SED are likely to suffer. For example, the Fairbanks Native Association/Tanana Chiefs Conference identified the following as indicators of SED: suicide attempt, substance abuse, violence, fetal alcohol syndrome/fetal alcohol effects, and individual/collective generational trauma.

Conclusions

The analysis of existing definitions of SED and the new definitions that six of the grantees developed are among the most important products of the CoC initiative. What may be less clear, but is perhaps of more lasting importance, is the transforming nature that these exercises had on the grantee staff, their community partners, and the planning effort as a whole. The opportunity to discuss, analyze, and reconstruct the concept of SED was, for many grantee communities, an extraordinary exercise in empowerment and self-determination. In the end, rather than being governed by externally imposed, existing definitions, the grantees gained control of these definitions themselves. This was even true of those grantees that did not elect to develop definitions of their own, as they came away from these exercises with a greater understanding and appreciation of the nature of these definitions, their utilities and strengths, as well as their substantial weaknesses.

Examining the definition of SED energized communities to think in novel and creative ways. This exercise suggested alternative possibilities to existing services and Western understandings regarding children's problems. For many grantees, these new local definitions provided important guidance to their planning efforts, always grounding services within cultural understanding. Through this process, CoC communities became further empowered to envision how culturally appropriate services for AI/AN children and their families in their local communities might look, and further determined to make them a reality.

Teisha M. Simmons, M.A
UAF Project Director-ANPsych
P.O. Box 756480
Fairbanks, AK 99775-6480
Phone: (907) 474-5285
Fax: (907) 474-5781

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MAPPING PATHWAYS TO SERVICES: DESCRIPTION OF LOCAL SERVICE SYSTEMS FOR AMERICAN INDIAN AND ALASKA NATIVE CHILDREN BY CIRCLES OF CARE

James Allen, Ph.D., Pamela L. LeMaster, Ph.D., and Pamela B. Deters, Ph.D.

Abstract: The process of describing existing services for American Indian and Alaska Native children with serious emotional disturbance by the Circles of Care strategic planning initiative is overviewed. We explain why service system description is important and how it helped define the role of evaluation within the initiative. Primary goals and methodologies of the service system description are described. Key findings, challenges and opportunities presented by the findings, and impact on the planning process are described.

The first major assigned task for the Circles of Care (CoC) grantees in their strategic planning process was to develop a description of the existing services for American Indian and Alaska Native (AI/AN) children with serious emotional disturbance (SED). Requirements for this *service system description* were quite extensive. The Circles of Care Evaluation and Technical Assistance Center (CoCETAC) provided each site with a detailed evaluation template to guide the collection of comprehensive information regarding ten different types of services, termed *service sectors,* as articulated by Stroul and Friedman (1986). These sectors included Education/Schools, General Health, Developmental Disabilities, Mental Heath, Substance Abuse, Social Services, Juvenile Justice, Self-Help Groups, Recreational Services, and Vocational Services. In addition to these ten service system sector categories, CoC grantees were also encouraged to collect information on *traditional healing* services. In their descriptions, grantees attempted to answer the following questions: What components make up the System of Services? What are their characteristics? How do they interact? How accessible, acceptable, and effective are services? What are the gaps in the existing service system? Through these efforts, grantees mapped how existing services worked, or in some cases, did not work for AI/AN families and their children.

To provide a more complete picture of the service system description effort, this article will begin by answering the question - why is a service system description important? This will be followed by a discussion of how the service system description in CoC proved pivotal in defining the role of evaluation within the initiative. Then, the primary goals of the service system description will be described, along with the methodologies used in data collection. After this, selected key findings of the service system description will be overviewed across the various CoC grantee sites, along with challenges and opportunities presented by these findings, and ways in which they impacted the planning process. Finally, conclusions will be presented regarding what was learned through the service system description process, including the "lessons learned" that was particularly relevant to communities, evaluators, and policy makers.

Why is a Service System Description Important?

There were several reasons why documentation of the existing service system was important to the CoC process. First, documentation of the local system of care had obvious importance for planning at each site as each CoC program was engaged in a strategic planning process to devise services that would work with what already existed in the community. A second reason related to existing data on services for AI/AN children, which indicated these services are inadequate (U.S. Department of Health and Human Services, 2001). Funding for the Indian Health Service (IHS), the federal agency responsible for mental health services for AI/AN people, is sufficient to address only 43% of the known need for mental health services (Federal Center for Mental Health Services, 1998; Nelson, McCoy, Stetter, & Vanderwagen, 1992). Furthermore, while children's mental health services across the United States are inadequate (U.S. Department of Health and Human Services, 1999; New Freedom Commission on Mental Health, 2003), for AI/AN children and adolescents these shortages are further exacerbated by critical shortages of trained child and adolescent mental health professionals, concerns about the cultural competence of existing providers and the cultural appropriateness of existing services, and a high degree of fragmentation of existing service systems (Barlow & Walkup, 1998; Novins, Fleming, Beals, & Manson, 2000; U.S. Congress Office of Technology Assessment, 1990). Finally, because one of the overarching goals of CoC was to enable grantees to develop competitive federal, state, and foundation grant applications by the tribal entities, it was necessary to document service system inadequacies on the local level.

Defining the Role of Evaluation

One consequence of the placement of the service system description as the first task for the project was that from the start, evaluation played a

prominent role within the CoC initiative. This initial placement highlighted the important role that evaluation would play in the CoC planning efforts. The service system description research rapidly produced extensive and complex data sets. In some of the sites, this early prominent role for evaluation led to concerns that the project would become evaluation-driven, and dominated by evaluation "experts." Early on, many important discussions between evaluation staff and community leaders, service staff, and planning staff occurred concerning this issue. Foremost on many participants' minds was whether the CoC effort would become yet another initiative in AI/AN communities dominated by non-Native cultural values and methods? More specifically, could an extensive and rigorous evaluation embody AI/AN values and convictions? Or would the evaluation process co-opt CoC from the outset through the creation of a process communities would not feel comfortable or welcome within?

Evaluators needed to carefully listen to these vital community concerns, and address them directly through their actions. Most centrally, would evaluation be conducted in a participatory process that honored local expertise and engaged communities as co-researchers? Or would the evaluation instead work with limited community involvement and input? As will be seen, a place to start for the evaluators was in their presentation of this service system description data in ways that were clear and understandable to community members.

Goals of the Service System Description

CoC evaluators were charged with three primary goals for the service system description (Novins, LeMaster, Sharma, Jennings, & Manson, 2002). These included:

1.   Describe the components and characteristics of the current service system and how these components interact with each other.

2.   Determine the availability, accessibility, and acceptability of these services as well as their effectiveness.

3.   Identify the gaps in the existing service system.

Methods

To gather information for the service system description, the CoC grantees utilized both primary and secondary data sources within their communities. In addition, some grantees made use of geographic information mapping as a means to both present and interpret their data.

Primary Data

A series of data extraction forms developed by CoCETAC provided a template for the grantees. These forms can be found in Appendix A. Originally intended to guide data collection efforts in describing their current service system, it quickly became apparent to the grantees that these forms often required extensive modifications to fit local contexts, community norms, and community acceptance. To their credit, CoCETAC responded flexibly, and allowed grantees great latitude in the use and redesign of these forms to fit the data collection efforts for specific local contexts. In most cases, the grantees found that in-person interviews, either face-to-face or via phone, resulted in a better response rate and more complete information. Much of the information on programs came from these interviews with key agency contact persons. Information on informal helping systems proved more elusive, requiring local knowledge about communities and their informal helpers. Here involvement of consumers and local community members in the evaluation design and interpretation proved indispensable. This process was quite labor-intensive; one grantee site employed a team of eight graduate students who systematically interviewed agencies and tribal governments within the region over one summer. Other sources of data included focus groups and surveys with providers, traditional healers, community and family members, youth, and town and village meetings.

Secondary Data

Given the short time frame and limitations in the economic resources available to the evaluation, secondary data sources were identified to supplement the primary data. Grantees became quite skilled in locating and obtaining access to internal reports, grant reporting, and internal statistics collected by agencies within the various service sectors. In addition, public records associated with state agencies' functioning proved another rich source of secondary data. Some grantees were fortunate because they were able to make use of actual conference presentations and existing published research findings relevant to their communities.

Mapping

Geographic Information System (GIS) mapping is a set of procedures for geocoding, analyzing, and visually representing spatial information (Golledge, 2002). GIS is used increasingly in modeling behavioral health issues (Wieczorek & Hansen, 1997) and in social services planning (Queralt & Witte, 1998). It has been successful in widely varying behavioral health contexts, such as estimating need for alcohol services (Crook & Oei, 1998), understanding outcome at an adolescent residential facility (Esser, 1968),

understanding characteristics of rural child maltreatment (Fryer & Miyoshi, 1995), demonstrating economic links to teen pregnancy and sexually transmitted diseases (Hardwick & Patychuk, 1999), exploring patterns of assault in public housing (Holzman, Hyatt, & Dempster, 2001), examining intravenous drug use (Laktin, Glass, & Duncan, 1998), evaluating a homelessness prevention program (Wong & Hillier, 2000), and studying social stress and trauma (Harries, 1997). To describe and interpret data on existing services in their communities, several grantees made use of a variety of simple GIS mapping techniques. The types of GIS mapping of various service system characteristics that grantees used are presented in Table 1.

Visual representation of spatial information in the service system ecology and of provider, agency, and system characteristics allowed for analysis and understanding of these complex service system characteristics and their interrelations. The mapping allowed for the presentation of multiple, interrelated characteristics including: (a) provider characteristics such as training and ethnicity; (b) agency characteristics such as physical location of agencies, distances involved, and catchment area served; (c) cross-service sector characteristics such as differences in staffing levels, training, and turnover across sectors, and (d) congruencies and incongruencies in organization of services across sectors and regions.

Table 1
GIS Mapping of Grantee Services and Sectors

Fairbanks Native Association/Tanana Chiefs Conference	*Education:* School District Personnel, Prevention Programs; *Social Services*; *Mental Health*; *General Health Care System*, *Substance Abuse*: Inpatient/Residential/Detox Programs, Outpatient/ Continuing Care Programs, Prevention/Outreach Programs.
First Nations Community HealthSource	Albuquerque Public Elementary, Middle, High and Alternative Schools; Educational, Developmental Disabilities, Health, Mental Health and Substance Abuse, Social Services, Recreational, Vocational Sectors; Primary Native American Organizations.
Inter-Tribal Council of Michigan	Population Concentrations within Service Catchment Areas: County Unit Basis, Service Population by Age Group.
Oglala Lakota Nation	Secondary Services, Tertiary Services, and School Locations.

Key Findings, Challenges, and Opportunities

The resulting service system descriptions were quite extensive. These descriptions provided a comprehensive picture of many of the important supports used by AI/AN children and families within their community. At their best, the descriptions also created a map of the pathways by which families accessed needed services, or at times, were denied access. Grantee reports included descriptions of a broad array of service delivery modalities within a comprehensive set of service sectors, including Residential Services, Outpatient/Continuing Care Programs, Prevention/Outreach/Self-Help, and Informal and Natural Helper Networks. These descriptions were an attempt to portray as many as possible of the supports used by AI/AN families who had a child with SED, running a broad gamut from child immunization programs to home-heating assistance. From their descriptions, grantees arrived at several conclusions regarding characteristics of the service systems, important rural-urban service system differences, traditional and cultural resources, relationships between service sectors, and access to services (Novins, LeMaster, Sharma, Jennings, & Manson, 2002). In addition, key findings were obtained through the use of GIS mapping techniques.

General Service System Characteristics

Several general observations can be made from the CoC service system description data regarding the characteristics of services available to AI/AN families. The majority of services available were offered from within the education/schools and social services sectors for most of the grantee communities. Vocational, recreational, and self-help services were less prevalent. Most often, the services targeted children in middle childhood or adolescence. Comparatively fewer services were available for children in infancy and early childhood. Outpatient counseling services were the most frequently reported, and the majority of staff were in direct service and support staff positions. The majority of agencies identified their clients at medium to high risk for SED. Two disturbing trends were noted in much of the data. It was frequently reported that children often failed to access services until adolescence, by which time their mental health concerns had become quite severe. In addition, funding was repeatedly reported as problematic. In addition to a shortage of funds, many sites also reported difficulties associated with the manner of distribution of funds. In many cases, funding came from competitive federal and state sources that were, as a result, brief in nature and led to instability in the services offered.

Rural and Urban Service System Differences

Important differences were noted between rural and urban settings, along with a number of striking commonalities. Provider characteristics varied by rural and urban setting. In many of the sites, rural and reservation providers tended to have less training, though the providers were more likely to be AI/AN. In contrast, urban settings possessed greater numbers of clinicians who had more advanced degrees. However, these clinicians were less likely to possess cultural competence and AI/AN clinicians, particularly those with advanced degrees, were less available. Both rural and urban settings identified a need for mental health professionals, particularly licensed psychiatrists and psychologists as well as AI/AN professionals of all disciplines with advanced degrees. In fact, it was repeatedly noted across settings that as one progressed up the professional hierarchy of increasingly advanced training, fewer and fewer AI/AN professionals could be found.

Rural and urban funding streams also differed. Rural service systems were more reliant on federal grants as their primary source of funding, along with more limited state funding sources. Typically, Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA) were the primary resource for funding of rural services. Urban service systems accessed these sources, and in addition, appeared to leverage more opportunities for local (e.g., county, city) and state funding, along with foundation grants.

Though access to services was a problem for both rural and urban families, the reasons for difficulties in access differed. Rural settings among the CoC grantees typically covered large areas (e.g., a reservation of 2.8 million acres, a tribal consortium with a service area of 37 counties, a service region larger than the state of South Dakota). Geographic isolation, distance, communication interruptions, weather conditions, and transportation difficulties limited access to services in these rural communities. Existing rural services were typically located in more populated areas, away from many rural families' home communities. These families were required to travel significant distances for services, or relied on itinerant providers, who were only available for relatively brief periods at certain times of the month. Because of the lack of services, several of the rural grantee communities reported youth were often sent out of the community, or in some cases, sent out of state for services. In contrast, while more services were available in urban communities, the services were often reported as not culturally appropriate for the diverse urban AI/AN population, creating a different but equally challenging type of service accessibility issue for families.

Traditional and Cultural Resources

Several of the grantees described the rich traditional resources that are available within their communities. The traditional values of AI/AN cultures

embody reverence for their elders as a source of wisdom, guidance, and knowledge. The entire children's mental health system of care in each CoC setting has available to it the resources and traditional wisdom of the elders. The time and special relationships that elders can provide young people represent an untapped resource as advisors and members of children's mental health service system teams.

There was also evidence of an increasing recognition within the system of the strengths of traditional ways and practices in the participating communities. Examples of these resources are provided in Table 2. Inclusion of traditional healers and traditional practices was identified in the services system descriptions of many of the CoC grantees as a central component for their systems of care planning.

Table 2
Examples of Traditional Resources Available in Six Circles of Care Communities

Choctaw Nation of Oklahoma	"Community and traditionally based services are not well known among the Choctaw people. Traditional practices have been lost through acculturation but have experienced a resurgence in the past few years with other tribes stepping in to help the Choctaw reinstate some of their traditions."
Fairbanks Native Association/Tanana Chiefs Conference	Traditional helping networks, including Talking Circles, Spirit Camps (teaching traditional and survival skills), natural helpers, peer helpers, and subsistence-based activities.
First Nations Community HealthSource	Traditional healing services available, although they reported that traditional healers are rarely hired by Native and non-Native agencies.
In-Care Network	*Available both on and off reservation in the state:* Healers, Spiritual Leaders, Herbalists, Medicine persons, Clan Aunts & Uncles, Vision Seekers, Horse Riding Projects and Services, and others.
Oglala Lakota Nation	"*The traditional healers believe that helping the Lakota people get back in touch with their spiritual traditions and ceremonies is central to restoring balance in youth.*"
Urban Indian Health Board	Agencies use traditional healers in programs, sometimes sending for the healer to come to their site or sending clients to healers. Traditional healers "passing through town" are invited to provide services. Talking Circles are also well utilized.

Relationships between Service Sectors

The majority of grantees indicated that children gain access to mental health services through referrals from other agencies. Consistent with ideas advanced in System of Care philosophy (Stroul & Friedman, 1986; Stroul, 1996), children and their families had needs for services from multiple service sectors, and typically utilized services from several sectors. However, relationships between agencies in the CoC grantee sites varied from strong, cooperative relationships to being unaware of each other's services. At some sites, Memorandums of Understanding (MOUs), Memorandums of Agreement (MOAs), and other forms of collaboration were in place between tribal entities and local service agencies. Relationships at other sites were characterized by agencies being protective of their "turf," a lack of trust among providers, a lack of knowledge of resources available from other agencies, and insufficient time allotted for adequate coordination of services. For many of the sites, the service system description quickly identified establishing interagency collaboration as a pressing area of need for system planning.

Access to Services

Probably the most important component of the service system description process was an assessment of access to services. Access to services includes an assessment not just of the existence and availability of needed services, but of equal importance, the acceptability of the services. Acceptability of services can be related to numerous factors; in the CoC grantee communities, acceptability was related to the quality of the services offered, including the cultural competence of the service delivery. Table 3 describes key findings on access to services from seven of the grantee sites. Three recurrent themes that appeared in the service system descriptions across sites were: (a) insufficient resources available to meet needs, (b) frustration over the need to travel outside of the community to obtain necessary services, and (c) consumer concerns that many service organizations were not culturally competent.

Findings from GIS Mapping

A number of grantees used GIS mapping to assist them in interpreting their service system description data, and as a tool to present complex information on the children's system of care to community audiences. To follow are selected maps from an urban (Albuquerque, NM) and a mixed rural-urban (Interior Alaska) grantee setting. These maps demonstrate some of the different uses that grantees found for GIS mapping in the service system description process.

Table 3
Access to Services in Seven Circles of Care Communities

Cheyenne River
Sioux Tribe

Availability: "*At the time of data collection, the local services included school-based, detention, outpatient, inpatient and residential services.*"
Accessibility and Acceptability: "*Geographical isolation of these communities creates problems in access and coordination of services... The understaffing of currently existing programs has also resulted in an inability to provide family-based services that are consistent with the spiritual and cultural practices of the Cheyenne River Sioux Tribe.*"

Choctaw Nation
of Oklahoma

Availability, Accessibility and Acceptability: "*There are not enough providers in the rural areas and resources are often shared and thus, stretched to the max... There is limited residential treatment available for children with SED's. What is available is in the urban areas and all have long waiting lists. None provide specific cultural treatment tracks or elements for Native people and managed health care has severely limited the care that can be provided.*"

Fairbanks Native
Association/
Tanana Chiefs
Conference

Availability: "*The system of service is composed of tribal, state, and private agencies and professionals... Significantly fewer resources are are available for children's mental health needs than those available in health, social services, juvenile justice, or education.*"
Accessibility: "*There is no residential treatment center (RTC), and there are few 'safe' houses or other residential opportunities for mental health service in the rural area. All such services require going to an Alaskan urban area or outside of Alaska.*"
Acceptability: "*Although all sectors serve children with SED, it is also clear that specific needs for identification and diagnosis, prevention, and early intervention, and treatment of Alaska Native children are not being met.*"

First Nations
Community
HealthSource

Availability: "*...A majority of mental health organizations not only provided mental health services, but also addressed other needs such as social services, substance abuse, juvenile justice, and educational issues. This trend suggests that the mental health issues among the Native American youth with SED are highly associated with other concerns such as crime, drugs, poverty, domestic violence and physical health problems.*"
Accessibility: "*More than half of the organizations...identified families being unaware of the need for services, transportation problems, being unaware that services exist, and language/cultural problems as major barriers for families when accessing services.*"
Acceptability: "*...Collaboration in the current service system with families and among service providers is limited.*"

Table Continues

Table 3 Continued
Access to Services in Seven Circles of Care Communities

In-Care Network	*Availability, Accessibility and Acceptability*: "...*Three types of services are presently available to American Indians residing within the State of Montana: (a) On-Reservation Services, consisting of services physically located on an Indian Reservation; (b) Service providers located Off-Reservation, but providing services On-Reservation; and, (c) Off-Reservation Services.*" Some services require several hundred miles round trip travel. Tansportation and waiting lists identified as problems.
Oglala Lakota Nation	*Availability*: "*The four most frequently provided mental health services are educational services, individual counseling, family counseling, and case management.*" *Accessibility*: "*While mental health services are not easily accessible to many reservation residents, educational services (schools) are well distributed across the reservation.*" Geographic distances, road conditions and weather identified as problems. *Acceptability*: "*On a 1 to 5 scale with 1 representing 'Very Satisfied' and 5 representing 'Very Dissatisfied', parents reported a 3.5 mean level of satisfaction with service providers. Youth were more satisfied than their parents, with a mean of 2.86.*"
Urban Indian Health Board	*Availability and Accessibility*: mainstream programs include mental health, educational, health care, social services, vocational and housing systems; "*...Indians tend to congregate at and seek help from the Native American service organizations...*" *Acceptability*: "T*he dominant culture systems are generally insensitive to the needs of Native Americans... People trust Native organizations because they can identify and feel safe.*"

First Nations Community Health Source of Albuquerque, New Mexico completed maps on all 10 service sectors. Figure 1 depicts the location of the 17 mental health (10 also provided substance abuse services) and four substance abuse organizations that participated in their service system description and their community needs assessment. Figure 2 depicts the location of the 19 social service organizations that participated in the service system description.

These maps allowed analysis of geographic accessibility of services and evaluation of the location of key organizations with which First Nations was contemplating collaboration. Albuquerque is 1,169 square miles with an estimated American Indian population of 35,000 (though this population figure is likely an undercount). The interstate highways I-40 and I-25 divide Albuquerque into four quadrants, which can be seen as the dark lines running north-south and east-west. First Nations assessed the geographic accessibility of services, determining the location of the organizations with respect to areas of the highest concentrations of Americans Indians (southeast quadrant

Figure 1
First Nations Community Health Source
Mental Health & Substance Abuse Organizations
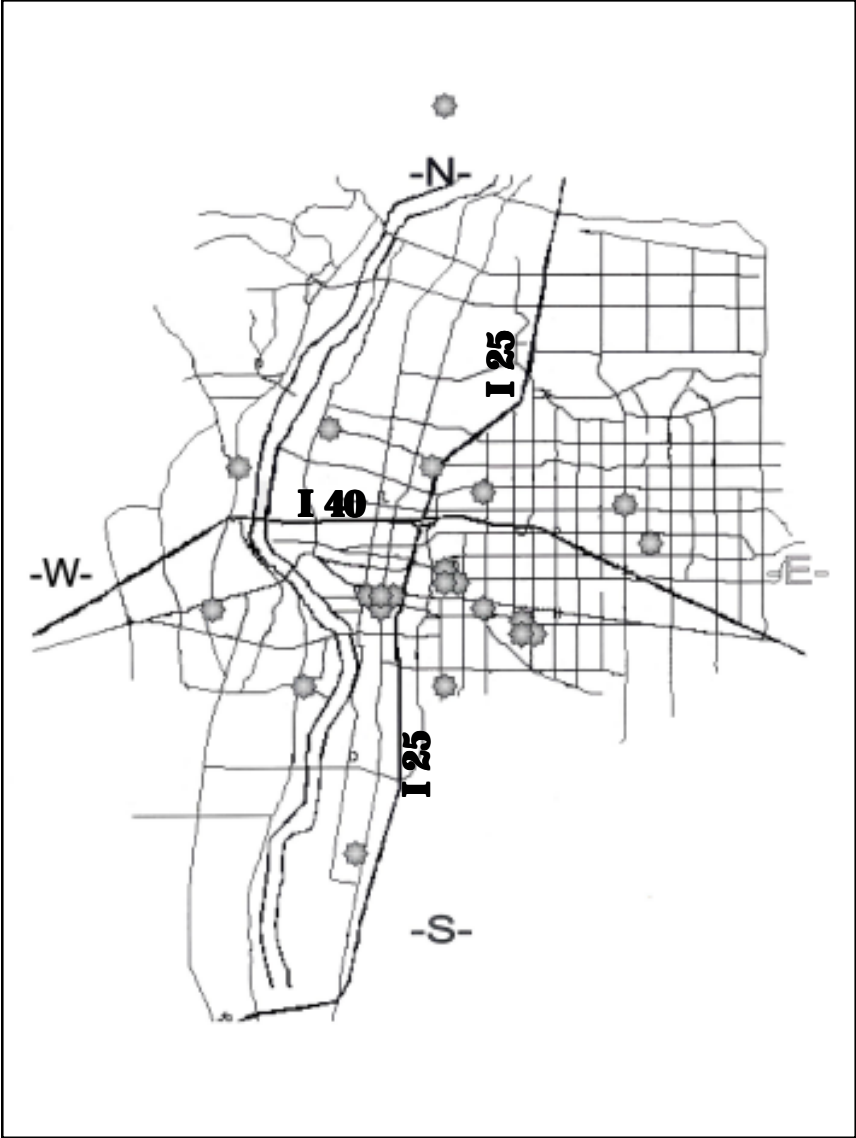
or lower right area). As can be seen in Figure 1 and 2, more than half of the organizations were located in the southeast quadrant. Through these maps, First Nations was also able to profile which potential collaborative organizations were best located in areas heavily populated by American Indians.

Figure 2
First Nations Community Health Source Service Region Social Services Organizations

The Fairbanks Native Association/Tanana Chiefs Conference service system description, also mapped all 10 service sectors. Figure 3 presents a map of the general health care system for Interior Alaska. This health care system uses an innovative mixture of community health aides, community health representatives, and other health professionals to extend the reach of the service system into areas without a medical doctor. More advanced degree health professionals are located in urban centers or regional "hubs," from which they service communities on an itinerant basis, or to which rural residents travel for services. The map shows the location of villages in the service catchment area, most of which are at great distances and off the road system, which is indicated by the black lines. Arrows show the direction and home base of itinerant providers. The human figures each describe an existing health care position in the service sector, along with important characteristics about the position and the individual filling it. This is all referenced through the key on the map. For example, the abbreviations next to the human figure describe the professional role and training of each staff person, and shading of a figure describes the ethnicity of that provider as Alaska Native. Figure 4 displays the mental health service system for the Interior Alaska region.

These maps allowed community members and the planning staff to assist the University of Alaska Fairbanks evaluators in interpreting the service system description data. One of the first things community members quickly noted in a comparison of Figures 3 and 4 was the service disparities between the general health care and behavioral health care service sectors. Significantly fewer staff were available for behavioral health care needs in the region. Other findings noted by community members included the following: (a) the majority of Alaska Native providers were located in rural Alaska; (b) the majority of providers with advanced degrees were in the urban center; (c) there was a significant shortage of doctoral-level psychologists and psychiatrists and few masters' level professionals; and (d) as one looked to providers with increasingly advanced degrees, fewer and fewer Alaska Native providers could be found. Other maps showed how different service sectors used different regional hub villages, posing problems for service integration, and how the disparities in Alaska Native professional staff were duplicated in all of the service sectors.

Figure 3
Fairbanks Native Association/Tanana Chiefs Conference Service Region
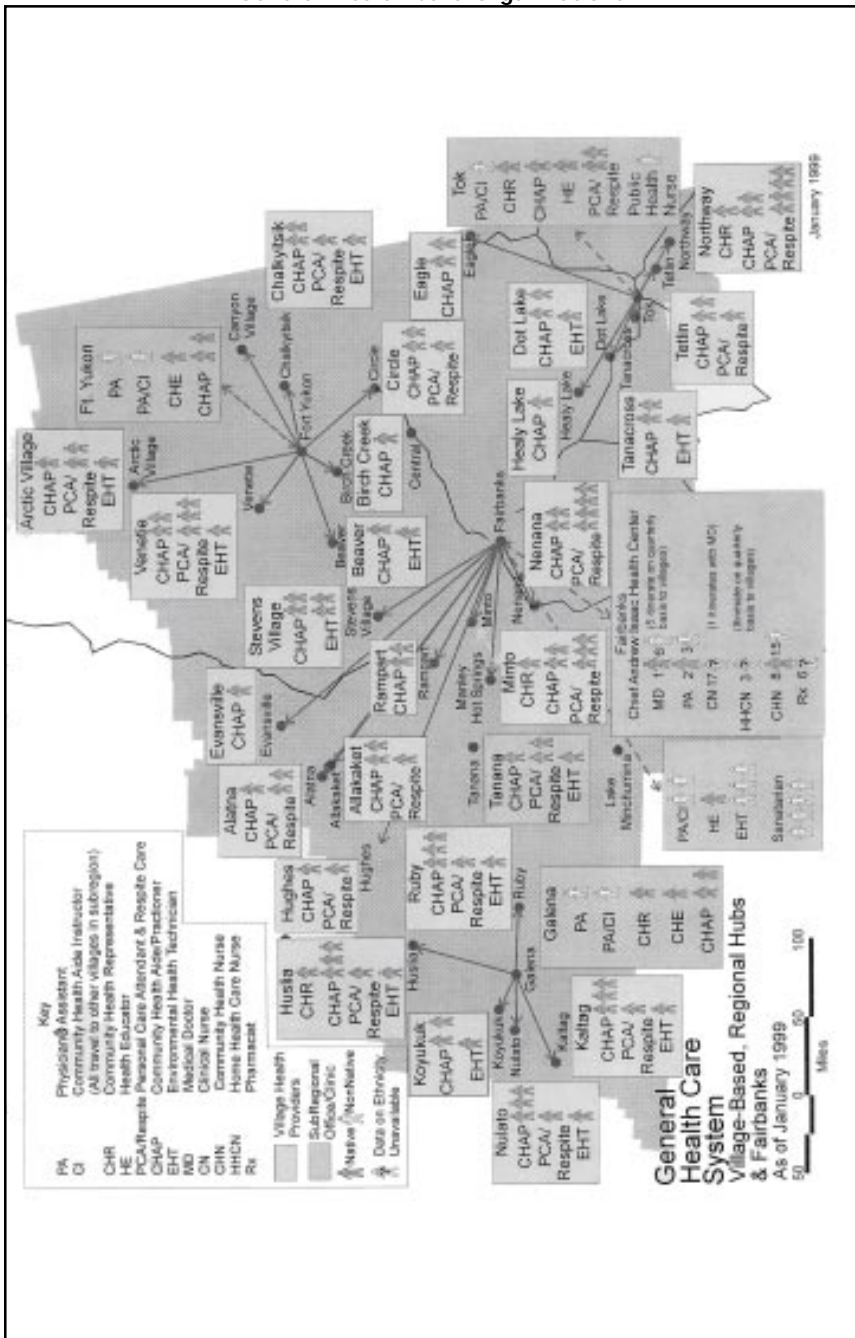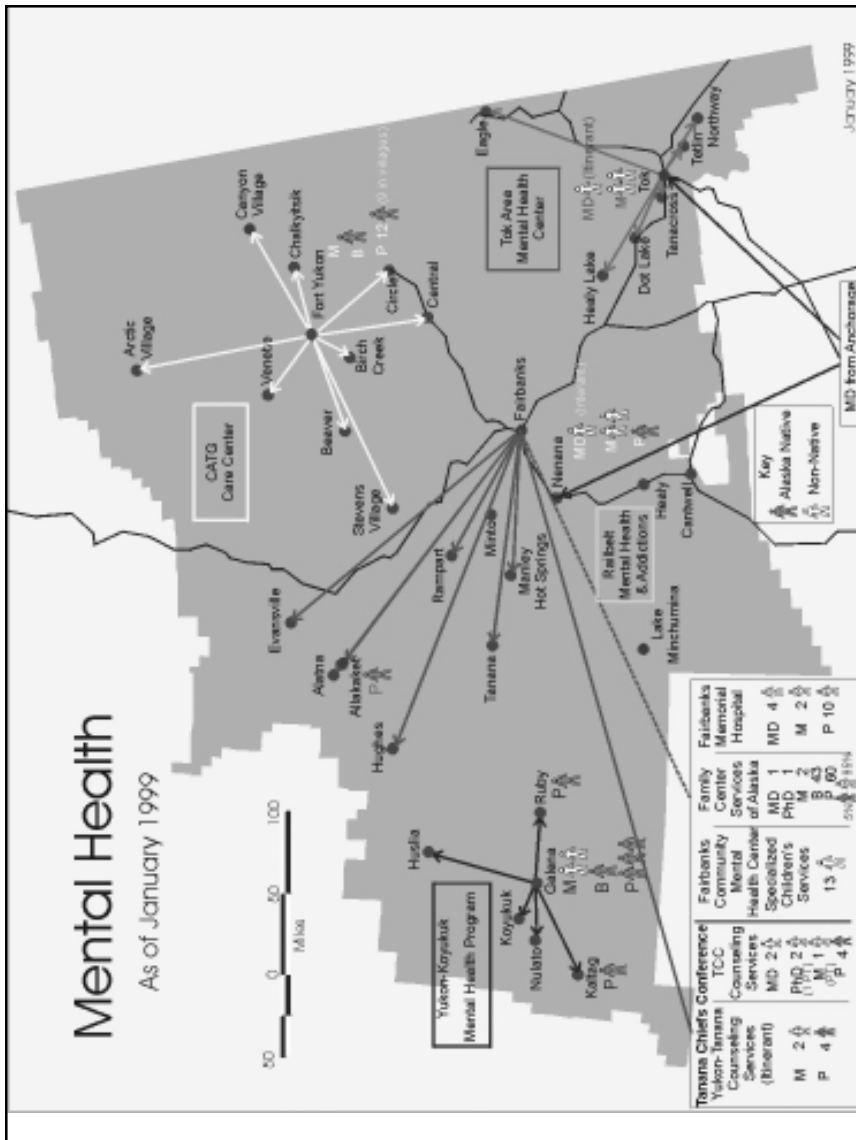**General Health Care Organizations**

Figure 4
Fairbanks Native Association/Tanana Chiefs Conference Service Region
Mental Health and Substance Abuse Oganizations

Gaps in Services: Impacts on the Planning Process

The CoC service system descriptions identified several critical gaps in services across sites. Identification of these gaps in the system of care impacted the planning process directly in that each of the CoC strategic plans specifically addressed many of the following core issues:

1. Insufficient resources available to address needs.

2. Current service systems not comprehensive.

3. Lack of qualified professionals, particularly psychiatrists and psychologists, along with need for training or certification of other service providers.

4. Lack of AI/AN providers, especially providers with advanced degrees.

5. Limited prevention, early intervention, and infant and early childhood services, which led to failures in addressing problems before they became severe.

6. Inadequate coordination both within and between service sectors, and between tribal and state entities, which impeded implementation of a system of care.

7. Cultural competence lacking among many providers.

8. High staff turnover due to lack of resources and high demands upon services providers.

9. Limited resources to collect systematic data on youth and services.

10. Need for improved information systems.

Strengths: Impacts on the Planning Process

In describing their current system of services, the CoC grantees also identified a number of significant strengths in their communities. All of the grantees acknowledged the valuable traditional resources available within their communities. These traditional resources emerged as an important component in all of the new Systems of Care models. In addition, many grantees recognized both the need for more collaborative relationships between service providers, and important parallels that existed between the collaborative models espoused by *wraparound* and *system of care* philosophies, and their traditional ways embedded within *relational* worldviews (Cross, Earle, Echo-Hawke, & Mannes, 2000). As the need for more culturally competent services was identified, local models of cultural competence invariably emerged among certain providers and agencies in each setting, providing models for the new system of care approaches. In this way, the map of services that the service system descriptions created also provided a map to direct strategic planning efforts for new, innovative service delivery pathways.

This process of discovery of local models of cultural competence was perhaps the most exciting part of the service system description work. Evaluators repeatedly discovered ways in which local providers, agencies, organizations, and communities had creatively adapted services or developed new ways of delivering services to fit AI/AN cultural contexts. Often, providers had gone quietly about this work without its documentation or acknowledgement.

One example of a local model was found in a small, geographically isolated AN village[1]. This village is home to about 250 people who live over 300 roadless miles from the nearest urban center of Fairbanks, Alaska, and who lead lives defined, in part, through their subsistence practices and the close, lifelong kinship based relationships in their village. Here, a group of dedicated AN community members had developed a model of child and family services for their local context, grounded in important elements of their Athabascan culture. Their work involved a team approach, which included village health aides, teachers, the village counselor, a Tribal Family Youth Specialist, a minister, and Head Start teachers. Often volunteers participated, as well as the parents of the child, if a child was being discussed.

Originally, the group formed out of the service providers' needs for mutual support to prevent burnout, but after about a year, the group started to also work together on children's issues in innovative, new ways. The team became quite involved on the community level, and recruited high school youth to carry out door-to-door surveying as part of regular community-wide child and family needs assessments, provided youth and family education/prevention activities, and offered activities and recreational outlets for youth. Because this is a small village of only a few hundred people, several roadless miles from its nearest neighbor, the status of all village children, including those who may be experiencing trouble, was known to the team. An individualized response to a problem, based on local knowledge of the child, the family, and their current circumstances was possible. Responses could range widely, from an invitation for the child to a special activity with an appropriate adult, such as trapping or beading, where help and problem-solving could then be offered in a more culturally-appropriate manner, all the way to referral to the Tribal Council, which might refer the child to formal children's services. The team took a proactive approach that developed local resources to prevent or treat children's problems in ways more in keeping with community standards and cultural practices.

A specific example of their clinical approach involved an early primary school age village child who had recently experienced trauma. The trauma event and the child's early responses to it quickly became known to a number of the team members. The team devised an intervention involving two AN members of the team, who had recently gone to a training on the therapeutic use of puppetry with young children. The two went to the child's classroom, and worked with the child's entire class in a group setting on the issue of trauma using the medium of puppets. Numerous components of this clinical

intervention are noteworthy, and contributed to the cultural competence of its approach: the child was not identified to those who carried out the classroom intervention, permission to intervene was sought from several involved individuals at multiple levels of involvement including the parents and school, and the child was not "spotlighted" as the focus of the intervention. Instead, the intervention was directed at this child's entire class, who comprised all the age mates in the village of this child, who all enjoyed close life long relationships with this child, and who all were being effected by their friend's trauma response on some level. The topics of the puppet work involved local context, local stories, and local manners of people relating; healing was understood to occur within the context of the group and the intervention took place entirely outside an office setting and a 'mental health' program.

Cultural competence in this particular intervention case was defined not just through the cultural content of the intervention, but equally important, through its process. Though many involved understood particulars of the intervention meaning and focus as members of a small close knit community, specific identity of the child and the traumatic event was not discussed at meetings of the entire village-based children's team of professionals and volunteers: the child was not even identified to the two service providers who intervened in the class room. In this way, special care was taken to protect confidentiality within the unique circumstances of this AN village; this proved an important element in the team's community credibility. Evaluators took this type of detailed description of local models back to planners in the various CoC initiatives, who in turn used them as specific, concrete examples for the types of culturally competent models and practices they wished implemented through their strategic plans.

Conclusions

Communities

The focus of the project's main energies on an extensive and detailed service system description early in the strategic planning process moved CoC in distinct ways. One positive outcome of this effort early in the strategic planning initiative was an enhanced appreciation of ways in which local existing children's services functioned as a System of Care (Stroul, 1996). The local community members quickly developed quite sophisticated understandings of the interrelation of service sectors, encompassing in their planning efforts important functions critical to families that are not always considered when people think of children's mental health services.

Evaluators

Two important lessons for evaluators can be drawn from the CoC experience with service system description in AI/AN communities. First, the process entails a lot of work, and to be done adequately, cannot rely on existing data and written materials. Much of the important work done by agencies in these settings is not written, and some of the most important services that AI/AN families come to rely upon exist in the informal network of services in communities. More often than not, this informal network of services is fertile ground for new models of service delivery and culturally competent modes of providing services. The fact that close collaboration with knowledgeable community members is required to locate and access information on these informal networks leads to the second conclusion: the need for participatory evaluation processes. Consumers, community members, and community leaders involved in the planning process need also be engaged in the design, data collection, and interpretation of the service system description data as co-researchers. Local knowledge often proved critical to the interpretation and understanding of the service system data.

Policymakers

Policymakers can draw three important lessons from the CoC service system description. First, planners quickly came to appreciate that the systems of care displayed enormous complexity in AI/AN communities, comprising a patchwork of overlapping tribal, state, and federal entities with different sets of policies, regulations, mandates, and requirements that often did not work in harmony with each other. A second outcome of the service system description efforts was an enhanced understanding among policymakers of areas of the system of care where things were working well, and where things were not working as well. A third outcome, beyond identification of gaps in existing services, was identification of the types of existing services for which AI/AN families and their children showed preference. Attention to these local successes within the system of care proved fertile models for innovation in design of a system of care that was both culturally competent and served the needs of AI/AN children, families, and communities.

James Allen, Ph.D.
Department of Psychology
University of Alaska Fairbanks
P.O. Box 756480
Fairbanks, AK 99775-6480
Phone: 907-474-6132
Fax: 907-474-5781
Email: Jim.Allen@uaf.edu

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Footnotes

[1] This children's services model for an Alaska Native village was developed by Ann Brantmeier, Violet Burnham, Anne Esmailka, Donna Esmailka, Fr. Joseph Hemmer, Beverly Madros, and Madeline Solomon.

Author's Note

DEVELOPING A PLAN FOR MEASURING OUTCOMES IN MODEL SYSTEMS OF CARE FOR AMERICAN INDIAN AND ALASKA NATIVE CHILDREN AND YOUTH

Douglas K. Novins, M.D., Michele King, and Linda Son Stone

Abstract: The Circles of Care initiative emphasized the importance of developing an outcomes measurement plan that was consonant with the model system of care as well as community values and priorities. This analysis suggests that the Circles of Care grantees achieved this key programmatic objective, but that a major constraint was the tendency of funders, including the Substance Abuse and Mental Health Services Administration (the funder of Circles of Care), to mandate their own outcomes measurement plans. Funders are encouraged to balance their needs for commonality of measures across programs for their own evaluation purposes with the needs of service providers to utilize measures that meet their unique programmatic and community contexts.

Mental health services are expected to demonstrate positive outcomes for the children, adolescents, families, and communities they serve (Nixon & Northrup, 1997). Indeed, the importance of demonstrating such positive outcomes for programs serving American Indian and Alaska Native (AI/AN) communities was emphasized by many of the parent and community participants in the Circles of Care (CoC) planning process, who advocated for services that improved the mental health of their children and adolescents.

However, parents, community members, program staff, and evaluators raised the following key questions throughout the CoC planning process: (a) what constitutes a positive outcome for AI/AN children, adolescents, and their families; and (b) how would these outcomes be measured? Underlying these questions was the concern that mainstream approaches to measuring outcomes for mental health services were inappropriate for programs serving AI/AN communities. The major weakness

of these mainstream approaches was their emphasis on clinical conceptualizations of mental health, with measurement focusing exclusively on problems rather than strengths.

Fortunately, these concerns were anticipated in the CoC Guidance for Applicants (GFA), which identified explicitly the development of a plan for measuring outcomes as a key goal of the initiative (SAMHSA, 1998a). Indeed, the introductory section of the GFA stated that "The program is intended to support tribes and urban Indian organizations in their efforts to develop service delivery models, *which will generate the outcomes selected by American Indians/Alaska Natives for their own children* [emphasis added]." Other sections of the GFA amplify this intention:

> The program is also intended to support the development of measures and processes that will be useful to tribal and urban Indian organizations in evaluating their service models against the outcomes they have selected.

Thus, the underlying message of the GFA was that strategic plans must include a plan for culturally and programmatically relevant approaches to measuring outcomes. Such a plan would assure that the model, once implemented, would be evaluated using the methods and measures consistent with its design, objectives, and values (SAMHSA, 1998a).

In this paper, we describe the framework, process, and products of this key component of the CoC evaluation. First, we describe the framework provided by the Circles of Care Evaluation Technical Assistance Center (CoCETAC) to the CoC grantees for developing their plan for measuring outcomes. Next, we describe the process the grantees used for developing their plans and a series of pragmatic issues that shaped this process. Then, using the framework provided by CoCETAC, we provide an overview of the grantees' plans for measuring outcomes. Finally, we analyze the process and products of this evaluation component and their implications for communities, evaluators, and policymakers.

The Circles of Care Framework for Developing a Plan for Measuring Outcomes

Grantees were presented with an idealized approach to develop a plan for measuring outcomes that reflected the values, objectives, and programmatic design of the strategic plan itself. CoCETAC identified the following five aspects of measurement for the grantees to consider as they developed their Outcome Measurement Plans: (a) "Domains of Measurement," (b) "Levels of Assessment," (c) "Assessment Approaches," (d) "Informants," and (e) "Timeline." To ensure that the outcome plans were not simply reflective of those measures that were most popular or expedient, grantees were encouraged to consider each of these aspects before choosing the

specific outcome measures they would employ. Each of these aspects of the Outcomes Measurement Plan is described in more detail below.

Domains of Measurement

First, the grantees identified areas or "domains" that would be impacted by their planned services. The following potential domains were identified by grantees and CoCETAC through the Needs Assessment activities described by Novins, LeMaster, Jumper Thurman, & Plested (2004) in another paper in this volume: local concepts of health and mental health, symptoms, indicators of health and dysfunction, resiliency and risk, tribal identities, spirituality, family profiles, availability of services, barriers to accessing services, and acceptability of services. Additionally, grantees were encouraged to develop other domains that were appropriate to their service area needs.

Levels of Assessment and Assessment Approaches

Next, the grantees determined the "levels of assessment" they would measure. Would they measure individual-based outcomes, family-based outcomes, and/or community-based outcomes? In addition, grantees were asked to choose specific approaches to their assessments. Would they concentrate on measuring outcomes from a problem-based perspective, typical of the measures used for programs serving non-Indian/American Indian and Alaska Native communities? Alternatively, would they also measure outcomes from a strength-based perspective, which was more consistent with AI/AN concepts of health and balance? Would they use some combination of these two approaches? The combination of these two aspects of the framework can be conceptualized as a 2 x 3 matrix as presented in Table 1.

Table 1
A Matrix of Levels of Assessment and Assessment Approaches

Assessment Approach	Assessment Level		
	Individual	Family	Community
Problem-Based	☐	☐	☐
Strength-Based	☐	☐	☐

Informants

Next the grantees identified the informants they would utilize in measuring their outcomes. CoCETAC and the grantees generated a working list of potential informants. Identified informants were the following: the child/adolescent themselves, their parents/caregivers, the extended family, elders, traditional healers, community members, project staff members, biomedical clinicians, and secondary data (e.g. county mental health, schools and juvenile probation). Project staff members were included in this list because of the multiple perspectives they bring, including that of parents, extended family members, and community members in addition to those of clinicians and planners.

Timeline

The grantees then produced a project timeline. Grantees were asked to consider when they would expect their programs to demonstrate a measurable difference in the domains they had identified and how long they would expect these impacts to last. For example, a baseline could be established as 'entry into the system' for measuring many aspects of problems and strengths at an individual or family level. Specific follow-up intervals could then be specified that matched the grantee expectations for meaningful changes. However, some outcomes might be difficult to match to an individual child or adolescent's entry into the System of Care. For example, information on school-wide test scores, suspensions, and rates of graduation would only be available on an annual basis consistent with school district or state reporting requirements.

Selecting Specific Measures

After specifying the aspects of the Outcomes Measurement Plan noted above, the final step for developing this plan was to select specific measures to employ. CoCETAC and the grantees developed a substantial library of potential measures which was revised several times as new measures were identified.

The rationale for this approach of identifying the specific aspects of their plans prior to selecting specific measures was that grantees would be able to evaluate and choose potential measures based on utility for their community contexts and specific service delivery models rather than popularity in non-AI/AN programs and usage in county, state, and federal funding efforts.

Factors Affecting the Development of the Plans

While the approach outlined above was considered ideal, three important logistical and political issues resulted in a more pragmatic approach for many of the grantees. First was the issue of time. The CoC evaluation effort is demanding and time-consuming. By the time the grantees reached this component of the evaluation (outcomes measurement), which was usually well into the third year of their grants, they needed to move expeditiously in order to meet their planning deadlines. Indeed, First Nations Community HealthSource wrote that the specific challenge met in completing this component of the evaluation was the "lack of time."

Second was the issue of potential funding sources for implementing their plan. Many funders, including CMHS, require specific outcomes measures as a part of their agreement to fund services. For example, CMHS' own Comprehensive Community Mental Health Services for Children and their Families Program, which was identified by many of the grantees as an important potential source of funding, mandates an extensive Outcomes Measurement Plan (SAMHSA, 1998b). Many grantees were reluctant to develop a plan that they would be unable to use under this and other initiatives. Third, many of the service organizations that would participate in the grantees' model systems of care had their own Outcomes Measurement Plans that would have to be incorporated into the grantees' plans as well. Many of these measures were mandated by federal, state, and third party funders of these programs.

Therefore, many of the grantees decided to simultaneously review these existing measures and slot them into the aspects of their Outcomes Measurement Plan identified above. This enabled them to identify those outcomes that would not be measured by mandated instruments, and consider whether additional measures were needed to 'cover' these outcomes. Again, a pragmatic issue the grantees faced here was participant burden. With extensive measurement plans already in place or mandated by potential funders, the grantees had to decide whether additional measures would create undo burden for participants in their systems of care.

We now review the characteristics of these plans.

Characteristics of the Outcomes Measurement Plans

Domains of Measurement

Table 2 displays the domains of measurement covered by the grantees' Outcomes Measurement Plans.[1] Indicators of Health and Dysfunction and Resiliency and Risk were covered by all eight of the grantees that submitted plans for analysis in this paper. The domain of Symptoms

was covered by seven grantees. Three grantees added the domain of Satisfaction with Services to the original list.

Table 2
Domains of Measurement Covered by the Circles of Care Outcomes Measurement Plans

Domains	Number of Grantees Including this Domain in their Plan
Indicators of Health and Dysfunction	8
Resiliency and Risk	8
Symptoms	7
Service System Needs (Availability)	6
Spirituality	5
Barriers to Accessing Services	5
Acceptability of Existing Services	5
Local Concepts of Health and Mental Health	4
Tribal Identities	4
Family Profiles	4
Satisfaction with Services	3
Acculturation (or Cultural Identity)	2

Notes: Only those domains identified by two or more grantees are included in this Table.

Levels of Assessment and Assessment Approaches

These two aspects of the grantees plans are summarized in Table 3. Grantees developed plans that were very balanced, both in terms of using problem- and strength-based approaches to measurement and in terms of assessing outcomes at individual, family, and community levels. Indeed, the emphasis on measuring community-level outcomes is unusual for mental health service systems, but consistent with the broad goals of the grantees' plans and the CoC initiative as a whole.

Table 3
Levels of Assessment and Assessment Approaches Included in the Circles of Care Outcomes Measurement Plans

Assessment Approach	Assessment Level		
	Individual	Family	Community
Problem-Based	6	6	5
Strength-Based	6	6	6

Informants

The list of informants included by the grantees in their plans is summarized in Table 4. All grantees included parents/caregivers as informants in their plans; seven included children/adolescents themselves; five included extended family members and elders. There was considerable divergence in informants beyond these three, fewer than half the grantees including informants such as biomedical clinicians, secondary data, and traditional healers.

Table 4
Key informants Included in the Circles of Care Outcomes Measurement Plans

Domains	Number of Grantees Including this Domain in their Plan
Parent/Caregiver	8
Child/Adolescent	7
Project Staff Member	6
Extended Family	5
Elder	5
Biomedical Clinician	3
Secondary Data	3
Community Member	3
Traditional Healer	2
Stakeholders	2

Notes: Only those informants identified by two or more grantees are included in this table.

Timeline

The timelines utilized by the grantees in their plans are summarized in Figure 1. Baseline, 6-month, and 12-month data collection points were the most commonly utilized by grantees in their timelines. In terms of number of intervals utilized in the plan, four of the grantees collected data at four points in time; one grantee collected data at two and one grantee at eight points. While most grantees (four) tied their plans to time since entry into the program, one grantee tied follow-up data collection to leaving the program.

Figure 1
Timelines for Measuring Outcomes
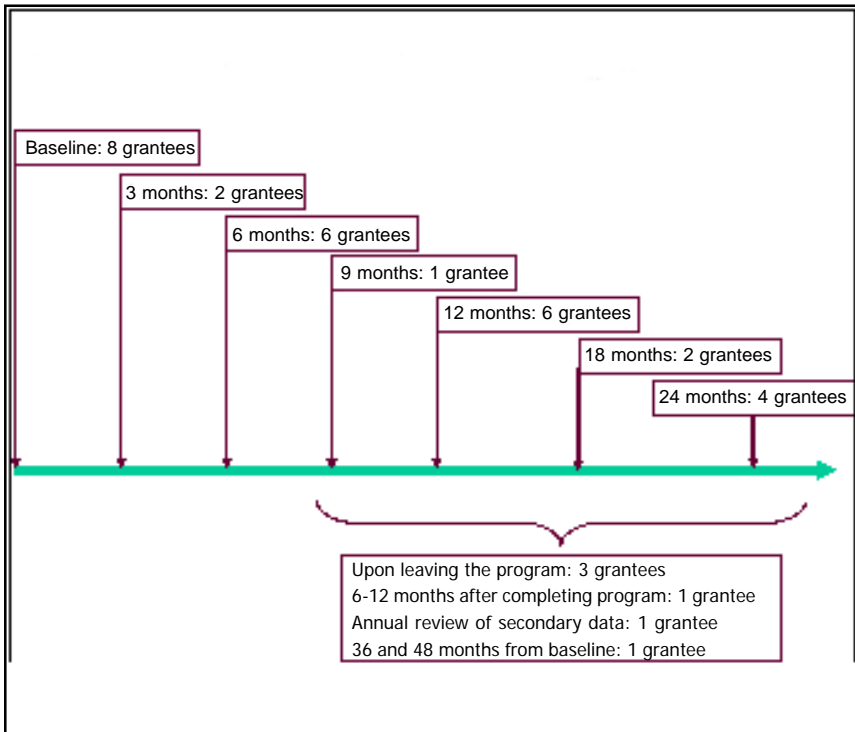
Specific Measures

The measures most commonly included in these plans are summarized in Table 5. Six of the eight grantees developed (or intended to develop) local instruments to use in their plans. These instruments were largely intended to measure outcomes not normally addressed in commonly used instruments (e.g., spirituality), tap into secondary data to measure community impacts (e.g., decreased domestic violence), or to measure domains from an AI/AN perspective. Only five commonly used individual/family-based measures were selected by more than one grantee: the Behavior and Emotional Rating Scale, the Child Behavior Checklist (and related measures such as the Youth Self-Report), the Child and Adolescent Functional Assessment Scale, Client Satisfaction Questionnaire, and the Family and Youth Satisfaction Questionnaire. The Voices of Indian Teens Survey was the only measure identified by more than one grantee that had been developed specifically for use with AI's. Community Readiness (Oetting, Jumper-Thurman, Plested, & Edwards, 2001) was the most common approach to examining community-level outcomes without relying on secondary data.

Also notable is that of the eight measures chosen by two or more grantees, four were measures included in the mandatory evaluation plan for the CMHS' Children's Mental Health Systems grants (SAMHSA, 1998b).

Table 5
Key Measures Included in the Circles of Care Outcomes Measurement Plans

Domains	Number of Grantees Including this Domain in their Plan
Locally-developed measures	6
Child Behavior Checklist and Related Measures	5
Behavior and Emotional Rating Scale	3
Child and Adolescent Functional Assessment Scale	3
Community Readiness Measures	3
Client Satisfaction Questionnaire - 8	2
Family and Youth Satisfaction Questionnaires	2
Voices of Indian Teens Survey	2

Conclusions and Implications

The CoC grantees developed outcomes measurement plans that, while affected by the demands of potential funding mechanisms, also incorporated instrumentation that would allow them to focus on the domains, assessment levels, assessment approaches, and timelines most appropriate to their strategic plans. Indeed, the process and products of the CoC plans for measuring outcomes have important implications for communities, clinical programs, evaluators, and policymakers.

For communities and the clinical programs that serve them, the CoC grantees demonstrated that Outcome Measurement Plans can focus on both individual and family strengths and problems. Indeed, as a group the CoC grantees identified a menu of measures that approached outcomes from these different perspectives. Such a balanced approach to measuring outcomes should provide a more complete assessment of the progress a child and family make while they are receiving services and afterwards, and should serve as a model for other systems of care.

Furthermore, these results underscore the importance community members place on measuring community level outcomes. Thus, there is an expectation among community members that mental health services will not only provide positive outcomes for children, adolescents, and families who receive these services, but that the impact of services will extend to the greater community as well. Not only should children and adolescents who receive mental health services be more likely to graduate from high school, but effective mental health services should raise the graduation rate for entire schools. Thus, an effective system of care was viewed by the CoC communities as a healing process not only for individuals and families, but for communities as well.

For evaluators, the Outcome Measurement Plans produced by the CoC grantees demonstrate the importance of a participatory approach to developing these plans. Given the constraints already placed on programs and communities by policymakers and funders, evaluators need to be particularly attuned to their program and community partners and work to identify existing measures that meet the community's visions of positive outcomes rather than relying on those problem-focused measures that are typically employed in mental health programs. Given the likely possibility that no existing measures will be completely consistent with this vision, evaluators should be prepared to work with their partners to develop measures and measurement approaches that fill in the gaps that will almost certainly exist. A full appreciation of the scope, strengths, and weaknesses of existing measures, the process involved in developing community-specific measures, and the use of implicit measurement techniques (Brook & Cleary, 1996) for particularly complex areas of assessment (e.g., whether an child, adolescent, and family are "in balance," and how they are "out of balance") is a particularly important ability for evaluators to possess.

There are two important lessons for policymakers in the Outcomes Measurement Plans produced by the CoC grantees. First, these plans serve as both a wonderful example of what communities are capable of when given the time and necessary fiscal and technical support to develop model programs. The resultant plans for measuring outcomes are particularly impressive in their comprehensiveness, the ways they reflect community values and beliefs, and their responsiveness to clinical perspectives of mental health service delivery. As such, the process for these developing plans, embodied in the CoC approach to strategic planning and program evaluation, are a model for similar efforts in both AI/AN and non-AI/AN communities alike.

Second, these plans also demonstrate the power the funders hold in shaping the entire discussion on measuring Outcomes. The more funders specify the use of specific outcomes measures, the less communities and clinical programs will pursue innovative approaches to measurement. Thus, funders must be thoughtful in balancing their need for commonality in outcome measurement in the programs they support and the need for communities and service systems to measure the outcomes that reflect the values and beliefs of the communities they serve.

Douglas K. Novins, M. D.
Director, Circles of Care Evaluation Technical Assistance Center
American Indian and Alaska Native Programs
Nighthorse Campbell Native Health Building
P.O. Box 6508, Mail Stop F800
Aurora, CO 80045-0508
Tele: (303) 724-1414
FAX: (303) 724-1474
Email: douglas.novins@uchsc.edu

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Footnote

[1] Eight of the Nine Circles of Care grantees provided Outcomes Measurement Plans for this report.

FEASIBILITY ASSESSMENT OF THE SERVICE DELIVERY MODEL

Kenneth M. Coll, Ph.D., Gerald Mohatt, Ed.D., and Pamela L. LeMaster, Ph.D.

Abstract: In this component of the evaluation, the Circles of Care grantees assessed the feasibility of their model systems of care. The goal of the Feasibility Assessment was to assure that each model system of care was well designed with careful consideration of project goals, community resources and readiness, cultural competence and measurable outcomes.

The Feasibility Assessment was designed to answer the following questions: Are the needs for services in the community matched with model systems of care? Are there adequate human and other resources to bring the plan to fruition? Is the management system appropriate to the service system design? Is the service system design financially sound? Is it economically justified?

Assessing the Feasibility of the Strategic Plan

Grantee Methodologies

One of the final steps required to accomplish the goals and objectives identified in the Circles of Care (CoC) Guidance for Applicants (GFA) was to complete an assessment of the feasibility of the new models. The GFA stated, "In order to add greater reliability to the service system design, grantees will perform a feasibility assessment of their preliminary design and complete the final design by making revisions consistent with the assessment." Prior to the implementation of a new System of Care, it is essential to determine if the system is fiscally and programmatically feasible, as noted from one grantee:

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This feasibility study and subsequent report is important to the program because it allows the project staff and evaluators to consider the question of cost effective programming. Determining if there are more efficient ways to accomplish the same outcome is part of fiscal responsibility. In addition, cost efficiency allows more youth and families to be served with available resources.

In order to guide them through this process, the Circles of Care Evaluation Technical Assistance Center (CoCETAC) conducted an orientation to feasibility assessments and provided the grantees with a comprehensive CoC Program Feasibility Assessment Checklist. This checklist included a number of components critical to conducting a feasibility assessment including a description of the strategic plan, their community needs assessment, as well as descriptions of human resources and material inputs, and management, financial, and economic analyses.

The overall goal of the CoC project was to plan the design of a family-focused, community-based, wrap-around service delivery model that is culturally appropriate *and* cost-effective for youth who are struggling with Serious Emotional Disturbances (SED). One of the steps in the strategic planning of any new service delivery model is to gather information about the feasibility (in terms of cost outlay) of developing certain programs currently missing in each community. The feasibility discussion among the grantees was framed by Wolff's (1998) "economic evaluation for measuring societal costs" (p. 385). Wolff noted, "...as policy makers have struggled to get the most out of each public dollar, economic evaluations of public-sector investments have become more important" (p. 386). A common form of such evaluation is the cost analysis study. The Government Accounting Office is increasingly using cost analysis to support public spending on children's programs (Wolff, 1998). The Substance Abuse and Mental Health Services Administration (SAMHSA) has now established well-specified "cost-bands" for the residential, intensive outpatient and regular outpatient services that its grants fund (S. M. Manson, personal communication, November 3, 2003).

A cost analysis worksheet was subsequently developed to provide the grantees with a standard procedure for calculating specific projections of costs related to proposed projects that emerged from their systems of care planning. Specifically, one grantee (in collaboration with community members and service providers) identified community-based residential treatment as a high programmatic need. It was noted that youth in this community needed the intensive services that residential treatment can provide, as well as on-going extended family support and readily accessible traditional healing services. As an illustrative example, a number of costs were identified by the grantee and plans were developed to address them in

the System of Care model (see Table 1). As asserted by Wolff (1998) and indicated in Table 1, cost analysis should include specific cost categories and provide a calculation of average cost per youth served.

Table 1
Cost Analysis Worksheet for Community Youth and Family Service Providers Source: Designing Economic Evaluations to Measure Societal Costs (Wolff, 1998)

EXAMPLE – Proposed ADOLESCENT RESIDENTIAL TREATMENT FACILITY
Cost categories (annual) and cost (in dollars)

1. Total <u>On- Budget Costs</u> - including:
    a. salaries, wages, benefits   500,000
    b. supplies (e.g., paper, cleaning, copying)   70,000
    c. equipment (e.g., new computers, new copier)   100,000
    d. utilities (heat, phone, electricity)   50,000
    e. building space (no rent; high maintenance)   100,000
    f. other (specify – vehicle maintenance)   40,000
    g. other (specify- horse maintenance)   10,000
    h. other (specify - food, kitchen maintenance)   20,000
    i. other (specify- school books, supplies)   10,000

2. Total <u>Off-Budget Costs</u> - resources paid (fully or partially by other agencies)
    a. grant funding (sources – State, Federal)   60,000
    b. foundation funding (source – Casey Foundation)   20,000
    c. donated labor (300 hours at $20 per hour)   6,000
    d. equipment (2 vehicles, 2 computers, 1 copier)   25,000
    e. land   - 0-
    f. building (one building)   - 0-
    g. administrative services (specify)   - 0-
    h. other off-budget funding?   - 0-

TOTAL GROSS RESOURCE COSTS (1 + 2) = $1,011,000

3. <u>Deducting</u> Unrelated Costs
    a. non-client services (estimated labor, transportation & materials)
            research   10,000
            community education   30,000
            training activities   30,000
    b. contracted-out specialized services (charity)   50,000
            (involves money transfer only)
    c. unrelated services   - 0 -
            (services not to adolescent/families)_____

NET RESOURCE COSTS = (1 + 2) – 3 = 1,011,000 - 120,000 = $891,000

Net resource costs divided by number served = Average Costs per person

891,000/400 = $2,227.50 per year ($185.62 per month)

CoCETAC suggested that grantees focus on assessing the feasibility of adding new services or programs included in their models as well as for any modifications of existing services or programs instead of trying to assess the feasibility of the entire plan. Much of this effort was completed among the program staff; however, several of the grantees indicated they brought the models back to the communities for review and comment. One grantee asked questions about the programmatic and fiscal feasibility of their model during meetings with leaders, Elders, community members, school professionals, and health care and special education providers.

Key Findings

Need for Services

In developing their Systems of Care, one of the primary tasks was to identify services or programs missing in the current service system and identified by the communities as something that they would like to see addressed in any new system. The grantees used their completed needs assessment and service system descriptions to determine what these components might include. Based on the needs that were identified by the communities, grantees included new services or modifications to existing services or programs and addressed these in their model. Overall, grantee communities observed a lack of mental health services or observed that existing services are under-funded and inadequate. A number of needs were identified by the grantees and plans were developed to address them in their System of Care model. Several examples serve to illustrate (and are included in Table 2). For instance, one of the grantees identified several needs in their current system as: (a) the need for trained, credentialed American Indian and Alaska Native (AI/AN) service providers with advanced degrees; (b) coordination or integration between certain sectors (e.g., substance abuse and mental health services); and (c) to address the isolation, burnout, and high turnover among service system staff. These needs were addressed by incorporating a new training model that included continuing education/training for providers in their System of Care. Another grantee addressed barriers to services, such as lack of access to funds, transportation, telephone, and physical access to services, by the development of satellite clinics in a number of their communities. Other grantees identified the need to involve the family and community support systems more formally into their service models and addressed this by including such things as a Family Support Circle and extended family (e.g., *Tiospaye*) support system.

Table 2
Selected Needs and Model in Four Circles of Care Communities

Grantee	Identified Need	Model Component
Cheyenne River Sioux Tribe	Barriers to services - lack of access to funds, transportation, telephone, physical access to services	Development of satellite clinics in communities
Fairbanks Native Association	Trained, credentialed AI/AN service providers & AI/AN providers with advanced degrees; coordination or integration between service sectors; isolation, burnout & high turnover among service system staff	Ch'eghutsen' training model - continuing education/training for all Ch'eghutsen' providers
Inter-Tribal Council of Michigan	Parent and family support	Family Support (F.S.) Services, with F.S. Coordinator, F.S. Circle, and Independent F.S. Organization
Oglala Lakota Nation	Community way of life patterned by Lakota rules	Tiospaye support system

Available Resources

Another component in the assessment of the feasibility of their service systems was an analysis of the resources each grantee community has available to them, including human and other material resources. One of the primary considerations was the availability and adequacy of human resources. All of the grantees indicated that they would need to hire additional staff in order to implement their new service systems. They identified specific positions with the desired educational level and experience in their Feasibility Assessment reports. As noted in their service system descriptions, the grantees concluded that these human resources are scarce. In particular, grantees residing in rural settings reported a lack of AI/AN providers who either possessed appropriate training and credentialing or had advanced degrees. In contrast, grantees located in urban settings noted that, while individuals with the desired background were more readily available, they often lacked cultural competence, and AI/AN professionals are not readily available. In spite of this, several grantee communities identified staff members from their CoC programs to assume a number of the identified positions within their Systems of Care.

Through the course of the grant, material needs were identified and budgeted by each grant community, including building space, office supplies, informational systems (e.g., computers, software), and utilities. This process allowed each grantee the opportunity to engage in specific planning so such material needs could be clearly articulated, as grant writing and other funding opportunities became available. Table 3 provides an illustration of needs for material supplies and utilities.

Table 3
Material Inputs/Supplies and Utilities

Cost categories (annual) and costs (in dollars)

1. Total <u>Material Inputs/Supplies and Utilities</u> - including:

a.	supplies (e.g., paper – 3000, cleaning – 5000, copying – 7000)	15,000
b.	equipment (e.g., computers, upgrades – 15,000, new copier, upgrades – 15,000)	30,000
c.	utilities (heat – 3,500, phone – 8,000, electricity – 3,500)	15,000
d.	building space (rented – 15,000; and maintenance – 5,000)	<u>20,000</u>
	Total	**$80,000**

Management System

Another essential element of the grantee feasibility assessments was an analysis of the local management system. As one might expect, the ownership and legal framework of the new Systems of Care range from tribal oversight to oversight by private non-profit organizations, with Executive Boards that have tribal, family, community, and/or service provider representation. One of the grantee communities planned a small program that would depend heavily upon other programs that currently exist to provide a new System of Care. Another grantee community expressed concern about the governance of their project, after a decrease in anticipated funding made it necessary to develop a scaled-back version of their model, which would be implemented in fewer communities. Because they hope eventually to fully implement the model, the grantee community identified the importance of outreach to these communities for their continued input and collaboration.

Justification for the System of Care

Other components of the grantee communities' assessment of the feasibility of their new service systems included financial and economic analyses. In general, the majority of grantees reported that their programs

were considered "financially feasible" (see Table 4) given that expected revenues were equal to or greater than expenses. However, a problem was identified in that most of the grantee communities were relying on local, state, and/or federal grant monies to fund a significant portion, if not all, of their programs, and they recognized that they would have to replace these funds when they completed these grants. As a result, several of the grantees acknowledged the need to investigate other funding options that would provide longevity for their programs. As one grantee noted, "The system of care needs to aggressively seek funding sources beyond federal grants to create a system that can be sustained over time. In addition to private foundations, Medicaid and third party reimbursement needs to be explored". Another option identified by one of the grantees was to have some of the costs absorbed by member agencies.

Table 4
Financial Feasibility Analysis

Source: Designing Economic Evaluations to Measure Societal Costs (Wolff, 1998).

Annual Estimates (in dollars)

1. Total <u>Investment Estimates</u> - including:
    a. donated labor and matching funds (see Appendix A)   30,000
    b. Volunteer services (extended families)   <u>80,000</u>

    Total investment estimates $120,000

2. Total <u>Revenue Estimates</u> – including:
    a. grant funding (source –Federal)   <u>600,000</u>

    Total: investments and revenue $720,000

3. Total <u>Operating Cost</u> Estimates – including:
    a. salaries, wages, benefits   300,000
    b. supplies (e.g., paper, cleaning, copying)   15,000
    c. equipment (e.g., new computers, new copier)   30,000
    d. utilities (heat, phone, electricity)   15,000
    e. building space (rented; and maintenance)   20,000
    f. other (specify – community, staff and service
        provider training –e.g., wraparound model,
        Cultural Mental Health training)   40,000
    g. other (specify- travel)   <u>80,000</u>

    Total operating costs $500,000

Financial Feasibility =

Total investments and revenue (720,000) less total operating costs (500,000) = $220,000

The financial feasibility for this program is adequate given that <u>revenue is greater than costs</u>. However, the federal grant subsidy will end in 2005. It will be important to begin now to cultivate more potential sponsors/donors for the continued viability of the program.

Wolff (1998) indicates that financial feasibility which addresses annual investments (e.g., volunteer, donated service) and revenue related to costs can provide sound justification to policy makers for continuing community-based children's services. Table 4 provides an example of a financial feasibility analysis used by one grantee to solicit additional funding from policy makers in their community and state. The cost effective focus on community-based, family-focused volunteer services enabled this grantee to successfully lobby its state and federal representatives for additional funding.

Cultural Competence and Community Readiness

All grantees worked in diverse tribal cultural settings. Given these contexts, a critical ethical and process element of the feasibility assessment was to determine if the plans were culturally appropriate and acceptable to the communities. Historically, either or both Indian Health Service (IHS) and state mental health units had served each of the communities. Needs assessments revealed that services were often delivered using personnel and methods that were alien to the communities. For example, the Alaska service system exported large numbers of children with SED to out-of-state placements in which their cultural background was not acknowledged, and aftercare considerations (often returning to a very remote and small village) were not part of the treatment modalities. Additionally, grantees discovered that communities associated SED with stigmatization and there was a reluctance to identify children early. Again historically many AI/AN children had been diagnosed (and misdiagnosed) with learning disabilities and placed in special education programs. In many grantee communities, this lead to suspicion and distrust of mental health professionals and programs. For example, in Alaska and South Dakota, such diagnoses have led AI/AN parents to believe that the state might take their children from them. Given these considerations, grantees had to assess the attitudes and awareness of the community for engaging in the programs that were developed.

Grantees dealt with this issue in a variety of ways but with some significant commonality. First, grantees involved the community in the development of the system of care models. Focus group methodology was utilized to elicit input on what the model should include. Significant for many of the grantees' process was the inclusion of Elders and Traditional Healers to insure that the model was grounded in the culture. Examples of how this shaped the program models were the culturally grounded definitions of SED. One program, in California, continued informing the community and providers throughout their process through a regular newsletter. This newsletter informed communities and developed awareness. Second, two of the grantees utilized the Community Readiness model developed at Colorado State University to structure their planning. One program in Oklahoma structured their entire planning process using this model while another program in

Alaska used it in the final stage of planning to assist in implementation of pilot projects. Third, at least one of the grantees returned to each community assessed during the needs assessment process to garner feedback related to the question of whether the assessment was feasible and culturally grounded. Many grantees held trainings and provider meetings to garner feedback on the models. Finally, this feedback from diverse sources was used to continually revise the systems of care models.

Conclusions

The feasibility assessment was reported to have a positive impact on the CoC planning process, as it proved to be quite valuable for practical planning. The most frequently reported challenges were related to getting accurate information, and the opportunities most mentioned were related to discovering new ways to make sustainability more of a reality. Ethical concerns consistently revolved around respect, cultural competence, and community ownership. However, in the end, all grantees reported high degrees of ethical practice related to feasibility assessment as outlined in the CoC GFA. Indeed, grantees overwhelmingly noted that evaluators and policy makers should make note of the process used in feasibility assessment (and other aspects of the CoC process) and use it as a participatory model for federal government and AI/AN collaboration. This issue is particularly important given the recent development of federal "cost-band" specifications for mental health (S. M. Manson, personal communication, November 3, 2003).

In conclusion, the CoC grantees considered a number of essential elements for feasibility assessment, including the needs of their communities, the resources available to them, the management system necessary for implementation, the financial and economic soundness of their plans, and cultural competence and community readiness in developing their Systems of Care. While optimistic that they would be able to successfully implement their systems with the revenues available to them, they were also realistic in acknowledging that they need to identify other funding options for the sustainability of their programs.

Kenneth M. Coll, Ph.D.
Boise State University
Counselor Education Department
1901 University Drive
Boise, ID 83725
Phone: 208-426-1821
Email: kcoll@boisestate.edu.

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PROCESS EVALUATION: HOW IT WORKS

Gary Bess, Ph.D., Michele King, and Pamela L. LeMaster, Ph.D.

Abstract: Process evaluation helps us to understand the planning process. This predominantly qualitative approach explains how and why decisions are made and activities undertaken. The focus includes feelings and perceptions of program staff. The evaluator's ability to interpret and longitudinally summarize the experience of program staff and community members is critical. Techniques discussed include participant observation, content analysis, situational analysis, in-house surveys, and interviews. By combining sources and methods, a fuller picture of the process is revealed.

What exactly is *process evaluation?* Is it really evaluation at all? The answers to these questions may be less straightforward than the questions themselves. Process evaluation, as an emerging area of evaluation research, is generally associated with qualitative research methods, though one might argue that a quantitative approach, as will be discussed, can also yield important insights.

We offer this definition of process evaluation developed by the Federal Bureau of Justice Administration:[1]

Process Evaluation focuses on how a program was implemented and operates. It identifies the procedures undertaken and the decisions made in developing the program. It describes how the program operates, the services it delivers, and the functions it carries out . . . However, *by additionally documenting the program's development and operation, process evaluation assesses reasons for successful or unsuccessful performance, and provides information for potential replication* [italics added].

The last sentence in this definition is at the heart of process evaluation's importance for Circles of Care (CoC). Process evaluation is a tool for recording and documenting salient ideas, concerns, activities, administrative and management structures, staffing patterns, products, and resources that emerge during three-year CoC planning grants. Unlike outcome evaluation, which often measures the results of a project's implementation against its programmatic projections, there are not necessarily *a priori* assumptions about what the planning process will look like.

Furthermore, as discussed in an earlier chapter on the life cycle of the evaluation process, there are stage-specific developmental activities occurring within the program. While the specific context will vary across projects, we may assume that there are common dynamics (e.g., Process, Development and Action Stages) that when understood can frame the experience and be helpful to participants and next generation planners.

In essence, process evaluation entails tracing the footsteps that CoC staff, as well as others involved in planning activities, have taken in order to understand the paths that have been traveled, as well as journeys started and later abandoned. This process is akin to the grounded theory approach of qualitative evaluation (Artinian, 1988; Strauss & Corbin, 1990). Process evaluation is an inductive method of theory construction, whereby observation can lead to identifying "strengths and weaknesses in program processes and recommending needed improvements" (Rubin & Babbie, 2001, p. 584).

To better understand process evaluation aligned with the qualitative tradition, we borrow from Rubin and Babbie (1993) for an operational definition of qualitative methods:

> Research methods that emphasize depth of understanding, that attempt to tap the deeper meaning of human experience, and that intend to generate theoretically richer, observations which are not easily reduced to numbers are generally termed qualitative methods. (p. 30).

We deduce from this definition the evaluator's unique role as the *tool* that synthesizes the "human (collective) experience" of CoC participants. Regardless of methods – participant or direct observation, unstructured or intensive interviewing – it is the evaluator who ultimately classifies, aggregates, or disaggregates themes that emerge as a result of the planning process.

As has been discussed elsewhere in this Special Issue, the evaluator's relationship with the CoC team is an integral part of the evaluation. It is especially paramount with regard to process evaluation, given the relative intimacy of interaction required by some of the data collection techniques. As may be expected, this "at your side" approach can intensify strained or suspicious relationships between the evaluator and program staff.

As one CoC program staff member explains:

When I think about these terms 'qualitative research' and 'participant observer,' I feel the abusive history of my people staring me in the face. Intense feelings of anger, hurt, and betrayal all come into play. Being in a fish bowl comes to mind, as do memories of 'tourists' who visited the 'mission,' which stood on my reservation, and took pictures of the 'Indian children,' and made comments like 'how poor' and 'uncivilized' we were.

As I understand the term 'participant observation,' I feel insulted. Feelings of betrayal, falsehoods, and sacrilege come to mind. Our culture and our way of processing is who we are as a people. It is all very intimate in nature. In Circles of Care we trusted to open ourselves up, to share ourselves, our culture, and to take the time to know those who were not of our culture. This was a big step and not one taken lightly. *Knowing that someone participated as one of us, yet in turn dissects the process, is not being true.*

Process evaluation thus requires vigilance on the part of the evaluator to respect the trust that has been afforded him or her by American Indian and Alaska Native (AI/AN) program staff. The evaluator's observations and comments should be made knowing that there are cultural and historic overtones and undercurrents that influence the interpretation of events, as well as the meaning that CoC program staff assign to the process evaluation description. Process evaluation, just like any other form of assessment, requires cultural sensitivity and awareness. It may be that certain techniques (e.g., participant observation) are not appropriate tools for evaluators that enter a program without prior relationships with the CoC program staff.

Having addressed at the onset the evaluator's role in process assessment, and mindful that working relationships will evolve during the life cycle of the project, the evaluator is ready to engage in the process evaluation. There are several conventional evaluation techniques that can be used to discern and describe the CoC planning process itself. They are: participant observation, content analysis, situational analysis, in-house surveys, and interviews. This multi-source approach is consistent with Marcus' (1988) recommendation that the collection of official documentation should be combined with the input of "key actors." Strauss and Corbin (1990) also support this approach by advocating for qualitative data collection from a grounded theory perspective. They point to the emergence of a *representativeness of concepts*, which is to say that themes can be generalized based on the similarities across the phenomena being studied.

With the exception of in-house surveys, these techniques are qualitative in nature, suggesting that Rubin and Babbie's (1993) definition of qualitative research's focus on understanding and the deeper meaning of human experience is most apt in the process evaluation domain. In his or her approach to qualitative assessment, the evaluator is interested in understanding the content and meaning of written and oral expressions. One helpful approach is to assess content based on manifest and latent themes (Rubin & Babbie, 1993). Manifest content refers to the frequency that certain words, phrases, or concepts appear in documents and oral expressions, such as recurring themes of specific resource needs and their sources, expressions of feelings (e.g., tired, excited, or fulfilled), categories of persons targeted for involvement as informants, or the kind of technical assistance requested. Latent level analysis entails the evaluator's overall assessment of the project activities or concerns, the input, its clarity of purpose and direction, and current level of development.

Process Evaluation Techniques

The following is a discussion of process evaluation techniques that are used by CoC grantees.

Participant Observation

Though there is a range of participatory roles that evaluators can play that run the gamut from fully immersed and *invisible* participant to *fly on the wall* sidelines observer, the common experience of CoC grantees is to have the evaluator in the *observer-as-participant* role (Gold, 1969). In this capacity, the evaluator's responsibilities and duties are clearly known to the planning and program staff, and to community members. There is no attempt to disguise the evaluator's role. Credibility and trust are of utmost importance.

Evaluators are present at key planning meetings involving CoC staff and community agencies. They listen at focus group sessions with families and youth, attend Gathering of Native Americans (GONA) events and community picnics, join in progress presentations to sponsoring agency boards of directors, and attend regional and national meetings with other staff members. When evaluators' roles are among the reasons for their participation, they fulfill these responsibilities by developing surveys, discussing data collection strategies, and reporting results. Regardless, however, of these assigned duties, evaluators also reflect on the content of each event, and attempt to categorize elements into thematic and descriptive domains. One evaluator's reflections are provided below:

The GONA provided important insights and a rich contextual understanding of tribal and community perspectives for participants. Several workgroups were formed during the GONA that were charged with identifying community strengths and needs, and participants provided examples from their personal experiences. The GONA experience, occurring within one year of the project's initiation, seems to have added new vitality and clarity about the project's purpose, and has increased support for the initiative among community leaders.

While participant observation is a primary source for uncovering themes and obtaining richer understanding of the process' context, secondary sources, such as content analysis, can be equally as informative.

Content Analysis

Content analysis refers to a systematic review of written documents produced by CoC staff, volunteers, and community members. Included are planning documents such as timelines, resource lists, and budgets, promotional materials such as flyers, letters to allied agencies and others explaining the initiative, minutes of meetings, proposals for funding and applications for special recognitions, as well as any other documents that capture features of the project.

Content analysis focuses on the ideas being communicated. With the evaluator as the *instrument* for assessing the content of written materials, he or she lists or codes ideas, words, and phrases that capture salient elements of the program. Since the process evaluation has a longitudinal perspective (e.g., what issues, concerns, and strategies characterize the project at a given point in time), it is also necessary to note the temporal sequencing of events and to be clear about the units of analysis, which are the planning team and community members. Maintaining a macro focus is essential for content analysis to be helpful in supporting the process evaluation in that the inquiry pertains to replicable actions and stages, as well as any activities that have not proven to be productive or helpful.

One example of content analysis is a review of reports from newsletters produced by Feather River Tribal Health on their sponsorship of community picnics as a tool for community organizing and building awareness of resources for families. The first community picnic was held October 1, 1999. Below is the description of the event in the project's newsletter:

At our Wellness Retreat (GONA) last June, one message rang loud and clear: community togetherness. In these fast moving times of change, getting together with family, friends, and community members is often difficult to fit into one's schedule. The true community gatherings have become a thing of the past, becoming something we remember as "when I was younger . . ." Held at Durham Park, with a turn out of approximately 140 people . . .

A newsletter report on the second community picnic said:

On April 22, 2000, the Circles of Care staff . . . joined forces to put together a community picnic at Palermo Park. Approximately 350 adults and children attended this event . . . The heat from the grill was hot, but the day was cool and feelings of community belonging ran strong . . . Community events such as these are important to building and maintaining relationships within the community. In a time when it is easy to lose touch with family and loved ones, family and friend get-togethers are a perfect way of slowing down and touching base.

Aside from the large increase in the number of attendees between events, which in and of itself is instructive about the promotion and draw that such events can achieve, we observe manifest terms such as "community" and "family," and latent themes characterized by "slowing down" and "touching base." Values similar to those communicated in the newsletter emerged in other contexts, as well, as at provider meetings and focus group sessions, thus validating their importance to the project.

Situational Analysis

A technique that has been utilized by some projects to assess the CoC planning process involves periodic meetings of the planning staff facilitated by the evaluator to conduct what is referred to as a *SWOT* analysis. SWOT is an acronym standing for strengths, weaknesses, opportunities and threats (Barry, 1986). In a SWOT analysis, the following questions are sequentially asked:

1.   What are our organization's internal and external strengths?

2.   What are our organization's internal and external weaknesses?

3.   What opportunities are present, within our organization and in the environment that surrounds us?

4.   What threats exist – either internally or externally – that could adversely affect our efforts?

        The SWOT assessment is focused on both internal and external dynamics. Thus, the focus is divided between organization concerns, and community and environmental issues. Combined, these factors represent a full spectrum of issues and concerns facing the project at any given point in time. Utilizing this approach it is possible to longitudinally observe changes in staff perceptions as the planning effort evolves.

        For example, a SWOT assessment conducted at an early stage of a CoC grant reveals *strength*-based values such as teamwork, ability to network across cultures, and flexibility in program design and use of funds. *Weaknesses* pertain to misunderstandings about planning among segments of the community, lack of credibility as a planning entity, and concern that internal support is not adequate.   *Opportunities* at the early stage relate to complementary funding streams, new dialogues with public service providers, and descriptive data on resources and service levels that heretofore had not been available. Finally, *threats* relate to perceptions that CoC will be seen as a temporary project without lasting impact, and concern that public agencies, having low cultural competency in serving AI/ANs, will resent challenges to their methods of intervention.

        During the third and final year of the planning project, the SWOT reveals a different set of perceptions (see Table 1). Monitoring changes in perception through triangulation of sources, such as in-house survey discussed below, again enriches understanding and strengthens conclusions.

In-House Surveys

        Though we have characterized process evaluation as primarily a qualitative method, there are also opportunities to inform the process evaluation by relying on quantitative tools. For example, a variation of the situational analysis can be performed *vis-à-vis* an in-house survey, whereby staff and community members are asked to report their awareness of and satisfaction with the project at different points in time. A Likert-type scale can be developed, whereby respondents rate such variables as community awareness, provider cooperation, management support, timeline pace, or adequacy of resources on an ordinal scale ranging from "1"to "5".

        This approach can provide input into the planning process from a wider circle of respondents than core staff. It also provides a modicum of

anonymity for respondents, and allows those less reticent to be heard with equal voice. A mean score (average of responses) can be used to determine where the program is weak and strong, and where threats and opportunities are present.

Table 1
SWOT Assesment During the Third and Final Planning Year

Strengths	Weaknesses	Opportunities	Threats
Getting support from administration and medical	"Crankiness" – challenge to be seen as a professional when not feeling like one	Numerous funding opportunities	Potential loss of independence now that project is permanent and service focused.
Getting ready for transition (moving)	Transition to new facility – staff is uncertain about what changes will be made and how they will be affected by them	Classes available on computer training for Family Resource Center	Growth competition for limited space in new building.
Funding request submitted for outreach for workers, trainers, and others.	Long-term funding not identified	Family Resource Center regional conferences	Not enough staff to serve volume of anticipated clients

For example the following is an excerpt from a report on a CoC planning effort in which an evaluator conducted a survey of COC program staff to measure their assessment of the planning process to date:

> Using a five-point scale (1=Never; 2=Seldom; 3=Usually; 4=Frequently; and 5=Always), respondents were asked to rate the frequency at which they experience certain issues associated with the CoC program. See Table 2.

According to the survey, staff respondents reported that cooperation among community providers in data provision and activity promotion was low (mean = 1.91) – approaching the *seldom* level. They too indicate that there is presently modest community awareness (ranging somewhere between *seldom* and *usually*) of CoC's purpose (mean = 2.35). These responses suggest weaknesses in and threats to the program if not addressed. On the other hand, respondents identified three relative strengths and opportunities for the program. They reported that they *usually* felt that there was management support of CoC (mean = 2.97), and that the program's development was on track (mean = 3.27). Finally, they indicated that resources were quite adequate for the planning effort (mean = 3.82). It is sometimes possible to use these quantitative findings as a jumping off point to discuss with the planning staff the meaning of their aggregated responses. Interviewing is an effective technique for developing narrative commentary to accompany quantitative ratings.

Table 2
Circles of Care Concerns (*N=36*)

Issue	Mean Score	Experience Range
Cooperation among community providers in providing data and promoting activities.	1.91	Seldom
Community awareness of Circles of Care's purpose.	2.35	Seldom
Management support of Circles of Care.	2.97	Usually
Circles of Care is where we should be at this point in its development.	3.27	Usually
Resources are adequate to support the planning effort.	3.82	Frequently

Interviewing

To better understand the CoC process, evaluators employ different forms of interviewing. Patton (1990) identifies three forms of qualitative, open-ended interviews. They are: (a) informal conversational interviews, (b) general interviews using a guided approach, and (c) standardized opened-ended interviews. The first approach, informal conversational interviews, seems to work well as a process evaluation method.

Rubin and Babbie (2001) characterize informal conversational interviews as an "unplanned and unanticipated interaction between an interviewer and a respondent that occurs naturally during the course of field-work observation" (p. 404). This definition implies that spontaneity is important. The evaluator's focus is on maximizing his or her understanding of events in *real time,* by asking participants what they think about a situation as it unfolds. At the end of planning or finance meetings, after a long day of GONA activities, or following a special event like a community picnic, the evaluator can debrief with staff and other participants as to whether their expectations were met, and in what ways. The evaluator can inquire about the event's meaning to them as planners and as community members.

Though the activities and events will vary across the three years of planning, the evaluator's inquiry is consistent. He or she wants to know how the event or activity affects the planning process. Mental notes are made of each conversation that later are recorded. There is nothing secretive about this approach. The evaluator's role is known, and thus his or her questions are understood to be a part of the process evaluation.

A sample dialogue between the evaluator and a CoC staff member might go something like this:

> *EVAL*:   How do you feel about the Community Picnic now that it is over?

> *STAFF*: I'm glad that we had so many people. I'd estimate more than 300.

> *EVAL*:   What did you hope to accomplish?

> *STAFF*: Well we wanted to involve families that we hadn't seen before and to link them with community agencies.

> *EVAL*:   How do you think that it went? Were there new families and did the linkages with agencies work out?

> *STAFF*: On the whole I think that we were successful. I wish that there had been additional agencies, especially youth services providers. We'll need to reach out to them more aggressively next time.

As you can see, the dialogue is reflective and informal, and attempts are made to capture the experience through the eyes of a CoC staff member.

Conclusions

As we have seen, process evaluation is another tool on the evaluator's workbench. Like other evaluation techniques, it has its own specialized approaches, which are predominantly qualitative in nature. Like other evaluative endeavors, the evaluator's credibility with the CoC staff is an important part of the working relationship. The evaluator's ability to understand and summarize the experience of staff and community members is affected by their willingness to share their concerns and to trust the assessment process.

Since process evaluation utilizes a formative analytical approach, its benefits accrue to the CoC program itself in addition to new grantees. For example, in one CoC grantee program, manifest themes that emerged from the SWOT process, such as the compilation of rich descriptive data on the Native American community emerged as a *strength,* following its earlier identification as a *weakness* due to its previous lacking. The descriptive data also was seen as an *opportunity* to educate non-Native providers about the community through development of a PowerPoint presentation that was delivered to policymakers and human services administrators. Sole source contracts for mental health services to the CoC host agency that followed these encounters are attributable to its germination during the SWOT process.

A second example is the role that an evaluator of a CoC grant played as a participant observer. She worked with staff to develop a funding proposal for submission to a private foundation. Thorough documentation of the planning process that led to the project proposal was of special interest to the funder, which she drafted. This level of detail also portrayed the organization's capacity to continue to document its developmental processes as the proposed project unfolded. In essence, the evaluator, as participant observer, likely enhanced the content of the proposal, while also helping project staff to crystallize its implementation plan.

We have seen that participant observation, content analysis, situational analysis, in-house surveys, and interviews are each helpful techniques for conducting a process evaluation. Their usage, however, will depend on the evaluator's style and preferences. As we have shown, by combining data sources and methods, a more complete picture of the process evaluation emerges.

Gary Bess, Ph.D.
Gary Bess and Associates
389 Wayland Road
Paradise, CA 95969
Phone: 530 877 3426
Fax: 530 877 3419
Email: bess@sunet.net

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Footnote

[1] http://www.bja.evaluationwebsite.org/html/glossary/p.html

OUTCOMES AND ACCOMPLISHMENTS OF THE CIRCLES OF CARE PLANNING EFFORTS

Christine W. Duclos, Ph.D., Mary Phillips, B.A., and Pamela L. LeMaster, Ph.D.

Abstract: This paper presents outcomes and accomplishments of the first round of participating individuals, communities, and grantees of the Circles of Care program (CoC). While accomplishing all CoC program goals, the initiative supported grantees in developing individual service delivery system models and positioned each grantee advantageously for securing funds for future implementation. The process and products as described can now assist others in improving their own systems of care for Indian children, adolescents, and their families.

The Government Performance and Results Act of 1993 (GPRA) requires that federally funded agencies develop and implement an accountability system based on performance measurement, including setting goals and objectives and measuring progress toward achieving them. With this act, Congress has established a management tool that compels federal agencies and programs to focus on results and outcomes. This accounting is done through the integration of strategic planning, budgeting, and performance measurement. The broad intent of the legislation is to enhance the effectiveness, efficiency, and accountability of government programs by directing federal agencies to focus more singularly their management efforts on the results that are achieved, and away from such traditional concerns as staffing and activity levels. Under GPRA, agencies must set goals, measure performance, and report on their accomplishments. They must also ask and answer some basic questions: What is our mission? What are our goals and how will we achieve them? How can we measure performance? How will we use that information to make improvements?

In response to GPRA, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed four precepts that now guide the agency, precepts that reflect the benchmarks under GPRA requirements:

1. Assuring Services Availability (by implementing and promoting systems improvement).

2. Meeting Unmet and Emerging Needs (by implementing proven strategies and interventions, coupled with increasing utilization).

3. Bridging the Gap between Knowledge and Practice (by generating new evidence-based information and facilitating adoption of evidence-based strategies).

4. Strengthening Data Collection to Improve Quality and Enhance Accountability (by ensuring that data are available for the most critical areas of need and that the data are both timely and useful.

The Circles of Care initiative (CoC) of the Federal Center for Mental Health Services (CMHS, part of SAMSHA), with additional support from the Indian Health Service (IHS), the Office of Juvenile Justice and Delinquency Prevention, and the National Institute of Mental Health (NIMH) is a good example of the positive impacts of SAMHSA's response to GPRA requirements. This first Guidance for Applicants (GFA) of the Circles initiative outlined the initiative's aims which cut across the above-mentioned SAMSHA GPRA goals (see Table 1).

In this paper, we present outcomes and accomplishments that have been described by the participating individuals, communities, and grantees. In assessing these outcomes, we attempted to answer the following question: How are the tribes and organizations different after participating in CoC? We were also interested in assessing change in the participating grantee communities. For our purposes, "outcome" will be defined as a change in the population that the intervention targets (Pietrzak, Ramler, Renner, Ford, & Gilbert, 1990).

Outcomes

In our analysis of outcomes and participants recollections of them, we were impressed by a powerful "rippling effect" across grantee organizations and communities. One outcome led to another outcome, and so on. When asked to identify their own outcomes, the grantees identified both "tangible" or product-oriented accomplishments as well as more "intangible" or process-oriented outcomes. While the grantees identified a number of unique outcomes and accomplishments from their individual efforts on this initiative, several were identified as major accomplishments across the sites, including written products, system changes, new programming, and funding toward implementation, and less tangible products such as

integration of culture, capacity building, community mobilization, and collaborations/partnerships. See Table 2 for a list of examples of selected grantee accomplishments.

Table 1
Circles Program and SAMSHA GPRA Goals

CIRCLES PROGRAM GOALS	SAMHSA GPRA GOALS			
	Assuring services availability	Meeting unmet & emerging needs	Bridging the gap between knowledge & practice	Strengthening data collection to improve quality & enhance accountability
1. To support the development of mental health service delivery models that are designed by AI/AN communities to achieve outcomes for their children that they chose for themselves.	V	V		
2. To position tribal & urban AI/AN organizations advantageously for future service system implementation & development.	V	V		
3. To strengthen tribal & service system's effectiveness.	V		V	V
4. To develop a body of knowledge to assist tribal & urban AI/AN organizations, & systems in improving systems of care for the American Indian/Alaska Native population overall.			V	V

Table 2
Selected Accomplishments of the *Circles of Care* Communities

Grantee	Accomplishments
Cheyenne River Sioux Tribe	Organizational change; working relationships between service providers; cultural competency and awareness; parental and community involvement in services, planning, and training; technical assistance provided.
Choctaw Nation of Oklahoma	Community made aware of the project, which is well known and respected; stable staff; staff interaction with community in volunteer projects and tribal gatherings; Community Readiness.
Fairbanks Native Association/ Tanana Chiefs Conference	Changes to the organization; changes in working relationships between service providers/agencies; coordination of services; parent involvement in services, planning and training; tribal/ community empowerment; learning how to do evaluation of planning process.
Feather River Tribal Health	GONA (i.e., Gathering of Native Americans) event; CoC newsletter; funding commitments; participation on community committees and task forces; cultural competency training; leadership development; steps toward implementation.
First Nations Community HealthSource	Service system changes; increased awareness of CoC project among other organizations; parent and youth involvement in services, planning and trainings; changes in cultural competency standards or cultural awareness; technical assistance to partner organizations; tribal/community empowerment.
In-Care Network	Formation of statewide Advisory Committee; seminars on mental health issues; cultural competency training seminars; analysis of In-Care Network data and Foster Parents Survey; improved public relations efforts.
Inter-Tribal Council of Michigan	Networking & contacts made within service delivery areas; committed groups of community members, consumers and service providers; key stakeholder buy-in; evaluation plan.
Oglala Lakota Nation	Leadership team; liaisons with traditional healers, families, providers and other organizations; development and implementation of Lakota Mental Health Assessment Manual; MOU's/MOA's with all major mental health service providers on Pine Ridge Reservation.
Urban Indian Health Board	Identification of principles for System of Care; outcomes of resource development; MOU's with other agencies and local governments; maintenance of community family-strengthening activities; development of culturally competent and certified staff.

Tangible Outcomes

Written Products

The CoC GFA overall aim was for participating communities to create service system designs that were feasible and reflect the service outcome expectations unique to the tribe or region served by each project.[1] Thus it is not surprising that all grantees felt that their written products were one of the more important outcomes of their participation. In particular, they identified the Needs Assessment, Service System Description, and final System of Care Plan as especially significant. The results and data from these efforts were used within the projects and by other agencies to assist in developing a number of grant applications, most of which were funded. Three of the grantees indicated that changes were made to the current service system as a direct result of gaps in existing services and identified through their needs assessments and service system descriptions.[2] Additionally, the final service system plan provides a "roadmap" for subsequent plans for implementation. This was a key factor in allowing culturally centered approaches to be seen by other non-Native service providers in strategic planning efforts.

System Infrastructure Change

Some grantees mentioned that agency infrastructure was changed to more effectively and efficiently provide data to the CoC initiative. These changes ranged from the simple (e.g., agency administrators, realizing the importance of data, began to systematically maintain it) to the more moderate (e.g., agencies that purchased new computer hardware and software to store data more efficiently). Some programs identified their problem areas in collection and improved their processes, raising organizational information output standards. It should be acknowledged many community programs do not have the infrastructure or resources to take advantage of state-of-the-art dissemination approaches; innovative approaches need to be developed to address this problem (SAMHSA/CSAT, 2000).

Development and Implementation of New Programs and Services

The planning process for some tribes and organizations resulted in the concurrent development and implementation of new programs as funding opportunities arose. These communities were able to carve out resources for integrated services for children and families, linking treatment and prevention, mental health, physical health, and substance abuse. The additional grant monies procured during the CoC initiative were then able to increase overall treatment capacity and accountability, as well as provide additional needed resources. For example, the Inter-tribal Council of Michigan

identified the need for a senior van, and then was able to secure funds to purchase one.

Funding Toward Implementation

All grantees anticipated seeking funding that would allow them to implement their final models, with many focusing on the CMHS services grant (*Comprehensive Community Mental Health Services for Children and Their Families*). Indeed, several of the grantees were successful in obtaining funds for implementation of the model or components of their models. One grantee successfully applied for the CMHS services grant;[3] others successfully applied for private, local, state, and other federal grants. As a result of their efforts, one of the grantees received unsolicited offers of financial support.[4] Several grantees were able to use the data collected from their needs assessment and service system description to assist other departments, programs, or agencies to successfully apply for federal and other grants. Grantees also worked with other agencies to position their programs to bring model collaborations to pursue funding venues when necessary. While anticipation is high for the CMHS services grants to implement their models, many of the grantees are already moving forward with implementation based on the funds that have been received to date, and will continue to identify and pursue a variety of funding opportunities as they move forward with implementing all components of their models.

Intangible Outcomes

Integration of Culture

The past experience of many of the grantee service systems was fragmented and based on the western medical model. Including community members, traditional healers, and Elders in the planning of the new system of care emphasized the importance of integrating cultural or traditional ways and resources. The prevention of mental illness is defined by a disease-oriented model of care. Professionals are encouraged by American Indian and Alaska Native (AI/AN) people to move beyond the exclusive concern with disease models and the separation of mind, body, and spirit, to consider individual as well as collective strengths and means in the promotion of mental health (U.S. DHHS/PHS, 2001). The need for this integration was mentioned throughout data collection for all grantees and documented in final needs assessments. The needs assessments conducted by AI/AN staff, in some cases, made working in the community and the exchange of information easier. The level of acculturation was different in each grantee site. Many grantees provided service agency cultural training, even to service providers based on the reservations. Thus, the planning process for a new system of care based on traditional culture influenced how current care was

delivered. It was also recognized that culturally congruent mental health services must not merely consider such things as client belief systems and spiritual practices, but rather, must be directly derived from the cultural base of the community it serves. For many of the CoC grantees, the inclusion of traditional healers and Elders in the design development resulted in traditional practices as the central component of their new system of care.

> The entire children's mental health system has available to it the resources and traditional wisdom of the Elders...The time and special relationships that they can provide young people as well as their guidance and wisdom, represent an untapped resource as advisors and members of children's mental health service system teams. There is an increasing recognition within the system of the strengths of traditional ways and practices.[5]

Capacity Building

The majority of grantees reported that the opportunity for personal and professional growth for project staff and service providers, as well as parents and youth grew from this initiative. "Skill-building for the communities has been identified...as a way for 'giving back,' and also as a way of empowering people to continue to articulate their own, grassroots model of what a healthy...community should look like."[6]   This growth occurred in a number of ways. Many of the grantees received training or provided training to others in their communities on topics such as cultural competence,[7] strategic planning,[8] research methods (including conducting surveys, facilitating focus groups, and managing the resultant data),[9] and wrap around services.[10]

While the evaluation portion of this initiative consumed a significant amount of staff resources and was initially viewed with some suspicion (in part due to previous experiences with research and evaluation), many grantees came to see the significance of data collection and how the resulting products could be used to greatly benefit their communities. The evaluation process in effect proposed a new level of capacity in monitoring project progress. Evaluation became part of the community by helping to develop program expansion and betterment. In essence, the evaluation process generated the information for all outcomes mentioned. Additionally, the consultant evaluators in some cases were eventually seen as valuable resources. This process was most effective when evaluators worked integrally with program staff in face--to--face meetings and open discussions of evaluation areas. Evaluators were then asked to assess the community or assist the community in other programming.[11,12]   In a few cases, evaluators were able to give expertise across grantee sites.[13,14]

The evaluation process involves staff and other capacity building by learning evaluation logic and skills, for example, goal setting, establishing priorities, focusing questions, inputting and interpreting data, data-based decision-making, and connecting process to outcomes.[15]

In addition, grantees provided education, such as cultural education for service providers, community members, youth, and project staff,[16] a seminar series on mental health issues to service providers,[17] and brown bag luncheons for providers and parents on various topics.[18] Technical assistance was another activity geared toward capacity building, provided to partner and other agencies, including coordinating and hiring staff from community programs,[19] and assistance with grant writing.[20] Educational curricula were developed by several of the grantees[21] and were associated with a certification program for one of the grantees.[22]

Community Mobilization

Another major accomplishment identified by the grantees was the impact the initiative has had on their communities. "Circles of Care substantially heightened awareness of mental health issues and their impact on American Indian children..."[23] In fact, one of the grantees showed an increase in community readiness to address the needs of youth with severe emotional disturbances through the data collected from Community Readiness surveys.[24] The community became involved in developing and designing the final service plan. "Our CoC Project provided opportunities for community members to come together, talk about common problems, and find solutions."[25] As a result of this heightened awareness and interest, grantees witnessed the development of core community groups that evolved from CoC focus groups and other project activities. For instance, in one community, a group of community members formed a "*Circles of Care* Parent Group" for the purposes of planning, support, and advocacy.[26]

Advisory boards were formed early in the planning process. These boards, which included a number of community members, were critical in assisting the CoC staff obtain better representation from certain segments of the community (e.g., males, youth, Elders). Many of the grantees identified a significant increase in tribal and community empowerment as a result of the CoC initiative, this empowerment then lead to advocacy. This organized advocacy was influential in securing additional funding for systems of care implementation, as well as making the communities powerful forces in policymaking decisions.

Over the years we have nurtured the growth of the American Indian community, and now we have a vision that provides us with direction in which to grow. Our community has grown emotionally and psychologically, and embraced both who we are and where we came from. We have been healed of the spiritual disease such as anger and jealousy that held us back 10 to 15 years ago.[27]

In the spirit of a holistic approach, the community developed the seeds that lead to the formation of a Native American Family Resource Center. Here individuals and families have a safe place to address a variety of life issues and is the stepping stone to other more specific services available through Feather River Tribal Health such as medical, dental and, outreach in addition to behavioral health services.[28]

Collaborations/Partnerships

Grantee efforts on this initiative provided the opportunity to develop or strengthen partnership on many levels. A system that can address the entire spectrum of knowledge development, transfer, and application would create opportunities to multiply the effect of various efforts by individual agencies or groups (SAMHSA/CSAT 2000). Improved relationships were developed with families, other agencies and service providers in their communities, and other state agencies, as well as other agencies and grantees nationally. AI/AN and non-AI/AN agency communication improved. CoC projects enabled all relevant service providers to meet and collaborate.

Networking and contacts made within the service delivery areas opened up opportunities. Many collaborative agreements as well as formal MOU's (i.e., Memorandum of Understanding) and MOA's (i.e., Memorandum of Agreement) with other local agencies were secured by the grantees. A number of grantees participated in local and state councils and task forces on children's mental health and other policy issues, as well as in committees of other agencies.[29] Several of the grantees also obtained letters of support or tribal resolutions from participating tribes, and in the case of one grantee, they received a charter from the tribe to oversee their System of Care.[30] These partnerships with providers and community members were seen as essential to the planning and eventual implementation of new service systems. Partnerships were sustained and even utilized as resources to address other community, county, and state issues. Some of the involved Native communities have become an active voice on decision-making boards and committees.

> In order for strategic planning to be successful in initiating a process of systemic change in mental health services for Alaska Native children, CoC must develop strong relationships with the existing system and with the communities of concern.[31]

> Our county behavioral health department applied for a SAMHSA services grant last month and came to us asking that we be their partner and that the proposal would focus on Indian children. How much better could it get![32]

Involving families from the beginning of the initiative led to successful outcomes. Families became true partners in all the grantee activities. The process allowed for safety and permission to talk and be involved. Through the redefinition activities of SED, community members and families became more trustful of the planning process and of the agencies involved. These activities created the mutual understanding, respect, and caring associated with trust. The moment SED was redefined and made relevant by the community, SED became less stigmatizing, and thus able to be discussed. This development of respect and trust also saw more people seeking care and services.

Many of the grantees utilized outside evaluators, that is, evaluators outside of the community and/or outside the AI/AN culture. The presence of outside non-AI/AN researchers can still bring concern stemming from past history of intrusive and insensitive research. The CoC process and community ownership allowed tribal leadership and CoC staff to choose whom they wanted to work with. The majority chose evaluators who had worked with their programs in the past, and thus had established positive working relationships with the community. However, the very nature of the strong evaluation component of this initiative produced stronger team approaches between staff and evaluator. Effective teamwork was based on trust and a common goal - helping Indian children and families. "He is non-Native, but has been an ally for many years. He participated in activities with community members and wasn't rigid in his approach. He became a part of our process and was not just an objective bystander." [33] "The evaluator created effective ways for the staff and administrators to bring together the components needed to document and show our impact in the community."[34] "The evaluator got to know many community members. It really helped that he participated in the GONAs."[35]

The Project Evaluator maintained a positive working relationship with Project staff. She was perceived by staff as being effective for the following reasons: (a) extensive evaluation experience with the state, (b) prior experience in working on large-scale projects, (c) geographically accessible [i.e., phone, email, or in person], (d) willing to assist and support staff in all aspects of the projects, and (e) successfully fulfilled her contractual obligations. [36]

The opportunity to meet other grantees from across the nation was often cited by the projects as a highlight of the initiative. Grantees were helpful to each other and became a very cohesive group that now can move health services and knowledge forward nationally. "Attending and participating in the grantee meetings [was a standout moment]. These meetings were particularly instrumental in helping us develop our evaluation efforts. Listening to other grantees' accomplishments, trials, and obstacles were positive learning experiences."[37]

Stages of Accomplishments

A number of stages or steps in the process were identified by the grantees as leading to their many accomplishments. Indeed, many of these steps were accomplishments in their own right. Although major change takes time, "staying the course" must provide evidence that the effort is paying off in short-term wins. Short-term wins have at least three characteristics: (a) they are visible, (b) they are unambiguous, and (c) they are clearly related to the change initiative (Kotter, 1996). Short-term wins give the effort needed reinforcement. They show people that the activities are paying off, that the effort is getting stronger. For a major change initiative such as this, many short-term wins were needed and subsequently noted by the grantees. For instance, data collection activities provided an opportunity for grantees to inform providers and community members about the initiative and to start to develop essential relationships. Once these relationships were established, additional data collection was greatly facilitated.

Visibility of the project in the communities was a necessary step identified by the grantees. This was done through a number of methods, including media coverage (e.g., radio, cable television, newspapers, and other publications), hosting community events and open houses, participation in the events of other agencies and the community, distributing project brochures and other informational material, presentations to local and state groups, and identifying key stakeholders in the communities to interview.

As indicated above, many of the grantees were asked to sit on committees and task forces. This not only increased visibility in the community but also served to strengthen partnerships through this collaborative effort. Data sharing and collaboration on grant writing further strengthened these partnerships. One of the grantees[38] saw much success with the distribution

of a newsletter that featured updates from their evaluator on the results from surveys and other assessments, articles on the region's history, reports on past and upcoming events, and biographical sketches of tribal leaders and others in the communities. The same grantee also held a Gathering of Native Americans (GONA), which was identified as a "watershed event" for them. This event combined awareness of AI/AN culture, values, and history, while planning for improved services for youth and their families affected by severe emotional disturbances. It served as a catalyst for the planning process by increasing the initiative's prominence among AI/AN and non-AI/AN agencies and community leaders, and strengthened relationships among participants. In areas where there has been little inclusion from state and local governments, and where strategic planning efforts begin in small conference rooms, AI/AN communities are now positioned to bring vital information to help guide bureaucratic policies in understanding culture.

The on-going evaluation activities became integral parts of the planning process, from beginning to end. The integration of evaluation within all project efforts established and maintained a culture of information. "We need to know where we came from, where we are, before we can move forward."[39] A change from a non-research to a pro-research paradigm was noted among all grantees. Though the process of data gathering was arduous, the information from this data proved to be invaluable. The results of evaluation activities proved to be an effective navigational tool for the planned change.

Barriers, Obstacles, and Overcoming Them

The grantees identified a number of barriers or obstacles to the planning process (see Table 3). Challenges that were identified by the majority of grantees included: (a) staffing problems, (b) the political environment, (c) working relationships with other agencies/providers, and (d) perceptions of the evaluation activities.

Table 3
Selected Barriers from Circles of Care Communities

Barriers	Number of Grantees Identifying These Barriers to Their Planning Effort
Staffing Problems	9
Political Environment	9
Working Relationships with Partner	8
Agencies/Providers	8
Perception of Evaluation	7
Geographic Distances	8
Time & Effort for Evaluation Activities	9
Expectations for Service	3
Visibility in Communities	3

Staffing Problems

All of the grantees experienced changes in staffing during the three years of this initiative. Staff turnover affected all of the sites, with the majority of grantees losing key staff members such as the Project Director, Coordinator, and/or Evaluator. Staff turnover had a serious impact on the grantees' progress, as new people needed to be educated about the project and brought "up to speed" on its activities. If this attrition happened early in the initiative, new people were hired to fill these positions. If it happened later in the process, the current staff of the project often assumed many of the responsibilities of the departing staff. Another challenge faced by several of the grantees was the lack of adequate staff who could dedicate their time to this effort. These grantees either did not have adequate numbers of staff to undertake all the activities or did not have staff whom were adequately prepared for all of their responsibilities. In these cases, certain staff members were overworked and/or project activities were greatly delayed. For some grantees, staff turnover was a problem that recurred throughout the initiative. Clearly, a project of this magnitude requires the commitment of a stable full-time staff, who have the support and resources needed to fulfill a set of ambitious goals and objectives.

> Project staff departures were special standout moments that forced us to rethink the course of the Project and to mobilize our efforts to meet project requirements.[40]

Political Environment

The political environment, as identified by the grantees, encompassed both the tribal and agency level. A change in tribal leadership had a significant impact on several of the grantees, as it then became necessary for them to reestablish rapport with and support from a new administration. In addition, many changes occurred among the staff of partner agencies. Changes in agency leadership also necessitated the reestablishment of support from new administration. In both cases, significant delays of project activities occurred. The political environment at the agency level produced barriers for some grantees.

Several expressed frustrations when the umbrella organization for their projects did not see the value in CoC as a planning grant and therefore did not dedicate the resources necessary to complete the required work for the initiative. In some cases, this situation improved as the organization came to realize some of the accomplishments in the communities. However, the situation did not change for others and was something they dealt with routinely throughout the three years of the initiative.

Working Relationships with Partner Agencies/Providers

A significant challenge faced by many of the grantees was the lack of commitment by service providers to the time and effort necessary to complete their surveys and interviews. This lack of commitment was a problem, especially early in the initiative, before the grantees were able to establish strong relationships with these providers. Many of the grantees also encountered agencies or providers who did not have a good working relationship with each other. For instance, long-standing conflicts regarding funding and caseload caused tensions between agencies that affected planning session meetings. The grantees used group planning sessions, individual appointments, and a variety of feedback mechanisms (e.g., newsletters) informing them of the purpose of CoC to increase partner agency investment in the planning process. For example, the previously mentioned GONA was particularly successful in bringing together providers who did not have good working relationships with each other, enabling them to overcome these past histories and thus move forward with the planning effort.

Working with non-tribal entities that do not understand tribal ways can be frustrating and time consuming. "The only ethical issue was trying to maintain our cultural integrity while trying to collaborate with non-tribal entities such as the county behavioral health program. We did a lot of cultural competency training for outside agencies."[41] Continual interaction and education was used to overcome this obstacle.

Perception of Evaluation

As previously mentioned, there was some initial skepticism and mistrust of the evaluation component of the CoC initiative among the grantees. This did not come as a surprise, given the history of many tribes who had been exploited by many non-AI/AN individuals who had come to do "research" in their communities. In addition, the complexity of the evaluation component for this initiative, which required a considerable amount of knowledge (or willingness to learn) and resources to be directed toward evaluation activities (especially early in the initiative) added to the perceived burden of the grantees and their apprehension about how the data they collected would be used.

However, an exciting change came about as the grantees immersed themselves in the evaluation activities and began to see benefits from their efforts. As already mentioned, many of the grantees were able to use the information they had collected to successfully apply for other grants or to assist others in doing so. As information was disseminated within the communities, the heightened awareness of mental health issues mobilized many community members to advocate for better provision of services for their children. In addition, because of the major role that data collection played in this initiative, many staff and community members were either

trained in or educated about evaluation and research and how it could benefit their communities. Evaluation represented the facilitation of data and the collection process that could lead to funding and approval from observers from the "outside." This process was identified by many of the grantees as a major accomplishment toward capacity building in their communities. As the CoC initiative came to its conclusion, many of the grantees who had expressed apprehension about doing evaluations became vocal advocates for the process.

> The evaluation was important in the program development and planning process. The evaluation was effective for prioritizing program goals and objectives, ensuring adherence to project deadlines, developing timelines for project activities, troubleshooting for problems, problem solving, and creating project reports. The evaluation also informed the project design through modifications of project activities due to unanticipated complications (e.g., low focus group participation rates among parents and youth during the first three months).[42]

Community Satisfaction

The CoC grantees faced a formidable task in seeking support and gaining participation from community members for a planning initiative when these communities had an immediate need for services. Community participation and support were essential for each site to meet the goal of the initiative "...to support the development of mental health service delivery models that are designed by AI/AN communities to achieve outcomes for their children that they chose for themselves."[43] Overall, the grantees reported that their communities were satisfied with the initiative and the work completed by project staff. Indicators of this satisfaction included the increase in participation of family, youth, providers, and other community members in CoC activities, which now stand as a model for the communities to use in addressing other issues, and the commitment and/or seeking of funds for system implementation. An added result of this initiative is the efforts which continue to prosper in the many communities involved with CoC. These are ongoing programs that promote, research, and pursue collaborative activities that benefit services and development for AI/ANs to better address our nation's indigenous people's health disparities.

...A growing number of parents, grandparents, and other family members are on-board as participants and volunteers for the project. Their perspective is from the inside, since over the course of the project they became increasingly integral to the project. This group does not represent all the parents on the reservation, but their active participation in the project is a strong indicator that the parents are feeling more ownership and a greater depth of understanding related to the mental health services provided to their children.[44]

Conclusions

While the overarching goal of the CoC initiative was the development of a culturally appropriate mental health service model for AI/AN youth experiencing severe emotional disturbances and their families, this initiative provided the grantee communities with other opportunities to achieve a number of important accomplishments that benefited their communities. Although faced with significant challenges, the grantees found ways to overcome them and often changed them into an opportunity for progress. Did the grantees and communities change? Yes, they changed tremendously.

On reflection, all CoC program goals as outlined in the beginning of this chapter were met. The CoC initiative supported grantees in developing service delivery systems as evidenced by the final nine community-specific systems of care models. This major accomplishment positioned each tribe or urban agency advantageously for future implementation and development. In fact, some grantees have already secured funds and begun the implementation process of proposed service systems. Each current service system was mentioned as being strengthened by the planning process. This process and its products, as described in this publication, can now be used to assist other tribes and urban AI/AN organizations in improving their own systems of care. Meeting the goals of CoC also means meeting the SAMSHA GPRA requirements.

Short-term achievements as described above provided the momentum and means for the overall successful outcomes of the program. A sensible and feasible vision and strategies to achieve this vision have been developed by each of the grantees. These outcomes can now serve as a foundation and play a key role in the continual efforts of producing much needed service system change for AI/AN children, adolescents, and their families by helping to direct, align, and inspire further actions on the part of all the communities and people involved.

Christine W. Duclos, Ph.D.
John Snow, Inc.
1860 Blake Street, Suite 320
Denver, CO 80202
Phone: 303-262-4312
Fax: 303-262-4395
Email: cduclos@jsi.com

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Author's Note

Footnotes

[1] Original CoC GFA

[2] Oglala Lakota Nation, Choctaw Nation of Oklahoma, First Nations Community HealthSource

[3] Oglala Lakota Nation

[4] Feather River Tribal Health

[5] Fairbanks Native Association

[6] Inter-Tribal Council of Michigan

[7] Feather River Tribal Health

[8] Cheyenne River Sioux Tribe

[9] Cheyenne River Sioux Tribe, Oglala Lakota Nation, In-Care Network

[10] Cheyenne River Sioux Tribe

Footnotes Continued

[11] Choctaw Nation of Oklahoma

[12] Cheyenne River Sioux Tribe

[13] Choctaw Nation of Oklahoma

[14] Fairbanks Native Association

[15] Cheyenne River Sioux Tribe

[16] Cheyenne River Sioux Tribe

[17] In-Care Network

[18] First Nations Community HealthSource

[19] Cheyenne River Sioux Tribe

[20] Cheyenne River Sioux Tribe, First Nations Community HealthSource

[21] Urban Indian Health Board, Oglala Lakota Nation, Cheyenne River Sioux Tribe

[22] Oglala Lakota Nation

[23] Feather River Tribal Health

[24] Choctaw Nation of Oklahoma

[25] First Nations Community Health Source

[26] Inter-Tribal Council of Michigan

[27] Urban Indian Health Board

[28] Feather River Tribal Health

[29] First Nations Community HealthSource, Inter-Tribal Council of Michigan, Feather River Tribal Health, Oglala Lakota Nation

[30] Oglala Lakota Nation

[31] Fairbanks Native Association/Tanana Chiefs Conference

[32] Feather River Tribal Health

[33] Feather River Tribal Health

[34] Urban Indian Health Board, Inc.

[35] Feather River Tribal Health

[36] First Nations Community HealthSource

[37] First Nations Community HealthSource

[38] Feather River Tribal Health

[39] Cheyenne River Sioux Tribe

[40] First Nations Health Source

[41] Feather River Tribal Health

[42] First Nations Community Health Source

[43] Circles of Care GFA

[44] Oglala Lakota Nation

THE CIRCLES OF CARE EVALUATION: DOING PARTICIPATORY EVALUATION WITH AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES

Pamela Jumper Thurman, Ph.D., James Allen, Ph.D., and
Pamela B. Deters, Ph.D.

Abstract: Little information exists regarding mental health and special needs related to American Indian and Alaska Native (AI/AN) families. In this article we emphasize the use of oral tradition during the Circles of Care initiative, which was essential in understanding cultural history and historical trauma of AI/ANs while giving a greater understanding of an AI/AN-based definition of serious emotional disturbance. The success of these methods serves as a template for improving systems of care and may be useful in evaluation among a wide range of ethnic communities.

You have noticed that everything an Indian does is in a circle, and that is because the Power of the World always works in circles, and everything tries to be round.... The Sky is round, and I have heard that the earth is round like a ball, and so are all the stars. The wind, in its greatest power, whirls. Birds make their nest in circles, for theirs is the same religion as ours... Even the seasons form a great circle in their changing, and always come back again to where they were. The life of a man is a circle from childhood to childhood, and so it is in everything where power moves. – Black Elk, Oglala Sioux Holy Man

Clearly there is great diversity among American Indian and Alaska Native (AI/AN) communities in both pre-colonial and postcolonial contexts, and this diversity was evident in the broad range of cultural, organizational, and geographic settings of the Circles of Care (CoC) grantee communities. How mental health and other special needs are understood and have impacted

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AI/AN families is an area of limited literature. Historically, diagnosis and treatment of AI/AN people has been influenced by the interpretations of non-AI/AN peoples. The CoC initiative represented one of the first opportunities for AI/AN families and their communities to have substantial input into the design of services to address the needs of their children, from their own understandings of these needs. This fact alone makes the contributions of this special issue invaluable.

In addition to presenting an overview of the evaluation research findings, this special issue describes the CoC evaluation process, and presents practical planning ideas for groups considering evaluation of similar projects that are culturally based and culturally driven. The diversity of tribes and the community milieu that AI/AN families live in today must be viewed within each unique and local tribal community context. Often, there is the tendency to look for and to pose solutions that apply across tribes and regions. In the CoC experience, understanding and working within the community context, it became apparent through both the evaluation findings and the diversity of planning effort solutions (documented in the monograph produced by the National Indian Child Welfare Association which was still in preparation at the time this paper was written) that solutions to challenges in AI/AN communities must be specific to local needs and service system ecologies and be culturally relevant.

In the understanding and search for community-based solutions to any issue in AI/AN communities, a discussion of history and trauma is important. Historically, one very important factor that must be considered is the legacy of mistrust that AI/AN people have for government, public health officials, and the intentions of Western health and mental health providers. Sadly, this mistrust is well founded and examples can be found in each of the tribal histories, from the "gifts" of blankets infected with smallpox to the sterilization abuses of the seventies (Jennings & Asetoyer, 1996; Talvi, 1997). This mistrust extends to health and mental health services, where issues of confidentiality have been questioned, quality of care has been debated, discrimination found, and depersonalization issues prominent. These are particularly important factors to consider for providers in tight-knit communities, where rumors and innuendo are common. Clearly, this history of distrust prevents many AI/AN families from seeking diagnosis, assistance, and mental health services.

Certainly, AI/AN communities have experienced a wide variety of community problems and challenges, including the impact of intergenerational trauma. Although the construct of intergenerational trauma has long been known to healers and Elders in AI/AN communities, and has been reported in clinical studies of Jewish Holocaust survivors (Yehuda, Schmeidler, Giller, Siever, & Binder-Brynes, 1998; Yehuda, Schmeidler, Wainberg, Binder-Brynes, & Duvdevani, 1998), it is new to many disciplines and should therefore be discussed briefly.

Historical trauma is recognized in AI/AN circles as a result of colonization that brought oppressive federal policy, forced change, and disparate treatment of AI/ANs. Historical trauma or intergenerational trauma, then, is offered as a paradigm to explain, in part, many of the contemporary social issues that have plagued AI/AN communities (Brave Heart & DeBruyn, 1998; Weaver & Brave Heart, 1999).   These historical factors must be considered when planning services for AI/AN communities. Indeed, these factors were a major consideration throughout the CoC initiative.

Similarly, these factors were incorporated into the content of this Special Issue, which has sought to provide an in-depth description of the program evaluation component of the CoC initiative. For example, the Special Issue's second paper introduces the concept of the life cycle of the evaluation process (Bess & Allen, 2004). Certainly evaluation is not new to AI/AN people. Rather, evaluation is simply the accurate telling of a very important story. AI/AN groups have relied on the oral tradition of story telling for centuries. The stories were used to teach, to provide guidance and direction to tribal members, to maintain and perpetuate tribal stories, legends, customs and values, to keep an accurate accounting of the tribe's life cycle and history, and to shape the future of the tribe. In 1964, Helen Cordero of the Cochiti Pueblo created the first contemporary storyteller clay figure in honor of her grandfather, Santiago Quintana, a storyteller and one of the first people from the Pueblo to work extensively with both researchers and ethnographers. Thus evaluation, like storytelling, is used to teach, to provide guidance and direction to key stakeholders, to maintain and perpetuate program stories, customs and values, and to keep an accurate accounting of the program's life cycle, history, and to shape its future.

It was the hope of the numerous authors of this Special Issue to accurately tell the story of the life cycle of the CoC evaluation, beginning with the recognition that planning was necessary, through the process of the needs assessment, service system description, outcome assessment, and feasibility assessment process. The outcomes realized through this process were very rich and led some tribal groups to pursue the SAMHSA Comprehensive Community Mental Health Services for Children and their Families grant, as well as other grant mechanisms. This funding enabled CoC grantees to implement a system of care that came out of their carefully developed planning process, or to pursue the new beginnings of separate service components.

It was also important, and specific to this initiative, to recognize tribal needs for more culturally grounded definitions for the label of serious emotional disturbance (SED). While both federal and state governments have specific defining terminology to describe SED, there was some difficulty in accepting the terminology on the part of AI/AN communities in the CoC initiative. Out of this discomfort, some grantee communities created their own definitions that reflected higher levels of cultural congruence.

Vignette: An emotional disturbance is a temporary disharmony, often involving the family, school, and community, which may affect the mental, physical, spiritual, and/or emotional well-being of its members. Healing the disharmony returns us to the basic belief that... "VLLA VLTHLEHA VT HOLITOPA" Children are Precious. – Choctaw Nation of Oklahoma's definition for children with serious emotional disturbances.

Throughout this paper as well as this Special Issue, we have focused on the common experiences reflected in all of the grantee sites, rather than individual grantee stories. In keeping with this spirit, we offer conclusions and recommendations that arise from the collective CoC experience in the hope that telling this story will be useful in the evaluation of similar projects in AI/AN communities. We believe that the participatory approach chosen by those who administered the CoC initiative allowed grantees to learn from their communities of concern, from one another, and to gain support both from their communities and their shared experiences. Recommendations will be offered that we hope will be practical to use in evaluation work with other ethnic minority communities. In order to provide a clear context for understanding the recommendations offered, it would be helpful to first review the original goals of the CoC initiative.

The Goals of the Circles of Care Initiative

The CoC initiative offered funding to *plan, design, and assess* the feasibility of implementing a culturally appropriate mental health service model for AI/AN children with SED and their families. The four goals of the CoC Guidance for Applicants (GFA) were to:

1. Support the development of mental health service delivery models that are designed by AI/AN communities to achieve outcomes for their children that they choose for themselves;

2. Position tribes, tribal groups, or villages advantageously for future service system implementation and development;

3. Strengthen tribes', tribal groups, or villages capacity to evaluate their own service system's effectiveness, and

4. Develop a body of knowledge to assist tribal, tribal group, village, and other policy-makers and program planners for all child-serving systems in improving systems of care for the AI/AN population overall (CoC GFA, p.9).

By way of summary, we discuss below how the evaluation effort contributed to each of these goals.

Support the Development of Mental Health Service Delivery

This concept, which provided for the creation of this initiative, was really quite innovative in its approach. Generally, GFAs are by nature quite specific in structuring what is appropriate for funding and exactly what types of activities are allowable. However, this GFA allowed tribes to actively identify a definition for SED, to develop the strategic planning approach as locally appropriate in the development of a practical system of care model and to examine the feasibility of this model; all conducted within the context of the culture of the participating tribes. It allowed latitude in selecting the types of outcome that AI/AN families and providers wanted for their children. It called for community involvement and included families and important AI/AN community and tribal leaders in the planning, as well as in grantee workshops and conferences. Although the GFA provided a specific structure for applicants, many of the decisions for the content and context of a service model were in the hands of each tribal grantee.

Position Grantees Advantageously for Future Service System Implementation

In implementing CoC, the Substance Abuse and Mental Health Services Administration and its partner agencies (the Indian Health Service, the Department of Justice, and the National Institute of Mental Health) were invested in the success of both the initiative and in the tribal grantees. Thus, a key factor in the success of CoC was the administration of the overall initiative. The partner agencies experienced challenges in pulling such diverse tribal groups together, and yet the leadership was strong and the direction clear. For example, the National contractual evaluation requirements were substantive and difficult for tribes to implement initially. Understanding on the part of the contractor was helpful in overcoming this situation. Many tribes were not aware of the types of technical assistance that were available by the technical assistance contractor and it was the second or third year before this information was utilized by many tribes. However, the one on one assignment of a technical assistance specialist for each tribe met this challenge very well. Both contractors worked diligently to make this partnership a success. These funding agencies, their representatives, and the leadership of the initiative demonstrated a great deal of support and involvement throughout the life of the initiative.

Grantee meetings were held two to four times a year. These periodic meetings provided a strong networking environment wherein grantees could share experiences and ideas, learn from one another, and gather strength not only from the leadership of the initiative, but from other grantees as well. This communication and support generated like behavior for grantees and their individual sties. Results of the planning process included requirements for community involvement, evaluation methods for gathering

data (including the use of focus groups, surveys and interviews), community dissemination of data, and often, community and consumer involvement in the interpretation and reporting of the evaluation data. Tribes were then allowed to place these results into more culturally relevant contexts. For example, some tribes gathered information during GONA's (Gathering of Native Americans), allowing them to develop strategies consistent with each tribal culture. In addition, Healing Circles, rather than focus groups, allowed community members a safe environment for discussion of frustrations with the current system and needs for a future system. Finally, dissemination of evaluation data often occurred through cultural venues, such as tribal newspapers, tribal radio stations, tribal councils, and community-wide meetings.

These types of culturally-based activities fostered high levels of communication and information exchange within many of the grantee sites, resulting in strong community investment in the planning process and the eventual outcome of services to families. Moreover, the evaluation gathered significant amounts of information on need, service disparity, feasibility of their strategic plan, and locally defined outcomes. This information gave grantees many important tools, for use in developing competitive grant proposals for service system implementation. It also ensured that strategies were based on local needs, and community involvement was a key factor in development and ownership of the strategies. The combination of data, community involvement, and local investment in the strategic plan positioned many of the CoC grantees quite advantageously for the development of competitive grant proposals for future service system implementation and development. Even more importantly, these factors contributed to the development of strategic plans that actually fit the needs of the AI/AN communities, and were acceptable because they were grounded in the local contexts and culture of the participating tribes and urban communities.

Strengthen Tribal Capacity for Evaluation of Service Systems

A decision was made prior to release of the GFA to provide funding for two technical assistance teams to be utilized by the CoC grantees. This proved to be a wise decision because these technical assistance teams provided an informed and valuable body of information to the grantees. Technical assistance for the evaluation process was provided by the CoC Evaluation Technical Assistance Center (CoCETAC), National Center for American Indian and Alaska Native Mental Health Research, University of Colorado Health Sciences Center. Although at times this was a challenging process, grantee groups were provided training opportunities at each conference and in addition, met with experienced consultants who advised and taught methods of evaluation. Most importantly, these consultants, who truly served as partners in the evaluation process, provided grantees with a model for evaluation that was practical, useful, and culturally appropriate.

The technical assistance partners emphasized frequently that they were learning from the grantees, just as the grantees were learning from them. Their peer review of efforts and products set standards for quality control that greatly benefited the grantees. While reviewing work, CoCETAC staff were timely in offering support, feedback, and vital information to grantees. Importantly, they listened thoughtfully to grantee comments and concerns about evaluation. This reciprocity resulted in a rich transfer of contextually relevant skills that strengthened tribal capacity to evaluate their own service systems in a culturally congruent manner.

Development of Knowledge to Improve Tribal Systems of Care

The sustained efforts of the evaluation process developed extensive data sets, and subsequently a significant body of knowledge within each grantee community on children's services. Overviews of these resulting data have appeared in this Special Issue. Perhaps unique to CoC was the extent of the sharing of knowledge between multiple grantee sites, administrative leadership and grantees, and technical assistance teams and grantees. This information sharing provided an even broader and stronger knowledge base from which to build systems of care within the context of each tribal community. The emerging knowledge base that resulted from the evaluation work was crucial to the planning process and provided a model of supportive advocacy for future efforts.

The outcomes from these four goals culminated in the overall goal of CoC: to plan, design, and assess the feasibility of implementing a culturally appropriate mental health service model for AI/AN children with SED and their families. The planning effort, informed by the evaluation process, resulted in the development of a very unique, culturally grounded, and extensive body of knowledge within each community and across tribal entities. This body of knowledge will continue to assist tribes, villages, and other policy-makers and program planners of child-serving systems in improving systems of care for AI/AN populations. Moreover, these tribal communities now possess an evaluative product and accompanying knowledge base from which they can draw in the exercise of self-determination. Tribal communities who participated in CoC can respond to new competitive initiatives with comprehensive data sets to support their vision, and conversely, can respond to inappropriately posed solutions, models of services, and outcomes with quite sophisticated data to the contrary.

Rural/Urban Differences

It seems imperative to make certain that the recommendations generated differentiate between rural/reservation, village, and urban tribal communities. Strategies, methodologies and levels of resources varied considerably within these groups. Three and possibly four separate systems

exist within tribal systems of care, based upon geography, population dispersion, and political organization (urban, village, rural and reservation). Though they shared a similar goal within CoC for using evaluation data as part of the planning process, the evaluation and planning processes functioned quite differently across these different types of settings.

As described in Allen and LeMaster (2004) of this special issue, urban and rural settings often had different levels of professional and traditional resources. We wish to emphasize here that we are not implying that one is better than another, rather that there are important differences in the nature and access to resources between settings.

Finally, rural and urban planning and evaluation also organized in relation to government entities, as outlined below:

1. Urban programs had to recognize spheres of influence of various state, county, city, and nonprofit programs that served AI/AN children and families both the planning process and the evaluation process.

2. Rural programs had fewer programmatic resources; however rural government is smaller and closer to home, and therefore potentially more responsive to local community planning and evaluation processes.

3. Though reservations are generally sovereign, they are compelled to collaborate with the state and county governments; however, federally recognized tribes seem to have more control over resources.

4. The element of self-determination reverberates throughout both rural and urban settings.

Rural and urban differences also directly impacted the process of evaluation. Almost all of the urban, rural, reservation, and village areas utilized evaluation teams generally associated with university systems, increasing the number and type of resources available to them. However, the planning process for collection of data varied immensely. Travel between villages in roadless rural Alaska is costly and time consuming, and thus, attending a tribal or village community meeting was typically a two- or three-day process. Under these circumstances, conference calls, electronic mail, and planning for visits became a key factor in the planning process. Travel in rural and reservation areas was a similar challenge for many of the grantees. For example, it sometimes took an entire day to travel to a focus group or healing circle, conduct the circle and return to home base. Urban areas may not have faced the same challenges, but mobility of families and transitional relationships increased the challenge of planning for consistent services to families in different ways across urban settings.

Importance of the Three-Year Grant Process

There have been past and current attempts by the Substance Abuse and Mental Health Services Administration and the Indian Health Service to conduct this type of planning process within two years or even one, yet considering all of the elements, politics, and collaboration that must occur, a three-year time frame appears more appropriate. Looking back, a full three years was required for the planning and evaluation process to occur and in some cases agencies requested a fourth year through no-cost extensions. The time allotted in this GFA allowed for building of trust and collaboration, as well as for consideration of the complexity of the relationships between agencies and governments in the system of care within AI/AN communities. A three-year time frame also allowed for sharing data, community involvement, and the extensive data collection required by the evaluation. These were all necessary elements for program success.   As noted in the previous chapter this special issue on outcomes, there was a rippling effect found in the overall outcome review (i.e., one outcome leading to another), and the element of time was essential to this process. When one looks back over the accomplishments of this initiative (see Table 2, p. 124 in Duclos, Phillips, & LeMaster, 2004), it becomes clearer why three full years were needed to achieve this degree of success. The primary goal of the CoC planning process was to develop or change a system of care to make it more culturally competent and culturally responsive, and to build enduring collaborations within the service system. To accomplish this feat, even within a three-year time frame, was a formidable task.

Participatory Process and Group Cohesion

A key factor contributing to the success of this initiative was its participatory process. Evaluators, program directors, and community stakeholders typically found themselves working together as a close-knit team. Much of the planning process was integrated with evaluation, to the extent that often one could not really tell which issues were specific to planning and which were specific to evaluation. This integration of tasks contributed to an open style of communication that in turn enhanced the collaboration of evaluation and program staff, consumers, families, and communities in the design of the evaluation, data collection activities, and interpretation of evaluation results. In many of the settings, there existed an environment of sharing and listening; the willingness to listen and hear was evident, even though at times the stories may have been heartbreaking or even invoked anger. Often asking the questions was a difficult process because the answers were hard to hear. They outlined our failures as a system and were presented with a great deal of emotion, since they involved the families' frustration with the system and its failure to provide access to needed services.

The level of communication and sharing that permeated the CoC initiative, from beginning to end, resulted in a group cohesion rarely seen in other initiatives: from the funders and administrators to the key stakeholders and tribal members in the communities. Participants in many of the sites found themselves bound by a single goal - to improve services and ultimately the welfare of AI/AN children and families. Evaluators were most successful when they were not only open and willing to listen, but more importantly, were able to engage communities of concern as co-investigators and allow the community planning process to lead in the interpretation and understanding of the information collected throughout the initiative.

Conclusions and Recommendations

A set of basic strategic planning beliefs and recommendations evolved naturally over the course of the CoC initiative. These were not explicitly stated to the grantees, but over the course of the evaluation technical assistance workshops and site visits, the following strategic planning/ evaluation principles became evident:[1]

1. *Effective evaluation requires the direct participation of key stakeholders.*

As part of the Government Performance and Results Act of 1993, federal agencies are required to consult with stakeholders during strategic plan development. In the context of governmental agencies, this requirement might be thought of as a control mechanism to assure that governmental agencies are responsive to public interest, rather than to self-interest (Aimee, 2001). For systems of care planning, the value of stakeholder consultation is even more prominent, not as a control mechanism, but as a means of integrating one of the basic principals of systems of care—that community input is crucial to effective service—into the strategic planning process. Strategic planning for the CoC project was designed to reflect the voices of youth, Elders, and families as the driving force.

2. *In effective evaluation, the unique characteristics and needs of different tribal entities are recognized, including recognizing tensions between traditions, culture, and rural-urban-reservation factors.*

In light of self-determination, stereotypes about AI/ANs, and the exclusion of the unique viewpoints and different tribal cultures in written historic accounts, AI/AN communities are particularly oriented toward understanding that a one-size-fits-all approach to strategic planning or to evaluation is inappropriate. The recognition of the tension between the general and the specific was best exemplified by the sometimes painful process of determining cross-site evaluation domains in CoC that honored the commonalities of the grantees, while acknowledging the uniqueness of individual tribes. This important consideration will surface in the evaluation of any large project across multiple tribal settings.

3. Effective evaluation contributions to strategic planning encompass an outcome-oriented approach, with outcomes determined by culturally appropriate and participatory action research methods.

Outcomes accountability in mental health strategic planning is not a new concept, having been required by PL 94-63 for Community Mental Health Centers in 1975. Yet the shift from funding based upon intrinsic good of the services toward a results-based accountability has been slow in becoming a reality (Hernandez & Hodges, 1998). Within AI/AN communities, top-down outcomes, particularly when they originate outside of tribal settings, may be thought of as a source of tension, perhaps due to the history of the misuse of AI/AN communities for research and the lack of recognition of self-determination policies. Yet, over the three years of the CoC process, the value of participatory development of outcomes and community-based outcomes emerged as a cornerstone of the planning process. This process showed how locally developed outcomes could allow for the inclusion of culturally appropriate strategies and assist in the development of culturally congruent models of care.

4. Strategic planning processes need to be documented through process evaluation.

Descriptive methodology that fostered the telling of stories of the process of community involvement, the empowerment of parents, and the struggles to involve key stakeholders emerged as an important effort in the task of producing the model, and as a valuable effort in its own right.

5. Successful evaluation requires the development of evaluator credibility.

Credibility is earned. It requires the collaborative efforts of staff and evaluators to be consistent in their behavior, respectful of communities, and to follow through on tasks in predictable ways over time. Predictability assured others of the trustworthiness of the staff and evaluators, and by association, the trustworthiness of the project. Credibility was also earned by allowing others to create expectations of evaluators that evaluators would then seek to fulfill.

6. Effective evaluation of strategic planning includes a central belief in change and change processes.

Although no change theory or logic model was imposed upon the planning process, grantees were encouraged to plan from the standpoint of understanding change processes. Community Readiness Assessment (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000) was one model that was a successful tool in several CoC programs. Community Readiness and methods employed by other grantees provided important baseline information and measures of change. Equally important, these processes fostered community involvement, provided valuable qualitative information for development of the model, and facilitated the development of a structure for intervention and development of action plans. At a primary

level, four understandings of change were implicit in the CoC evaluation *process:*

(a) Change is possible.

(b) It is important to identify the potential endpoints of the change process.

(c) There are multiple paths leading to each identified endpoint.

(d) Different programs and agencies move at various paces along these paths, and this *is a part of the natural process of change.*

7. Effective evaluation in AI/AN communities recognizes that cultural competence is not only a desired product of the planning effort, but is also a crucial element of the evaluation process itself.

Cultural competence as a product has long been expected, but the understanding and implementation of cultural competence in the evaluation process was not only complex but also crucial to successful works with AI/AN communities. Working within the culture of the community, respecting the community's readiness for change, promoting tribal self-determination in evaluation practice, and enacting the formal and informal protocols in relationships with groups, families and community members exemplified culturally competent evaluation practices.

8. In effective strategic planning processes, evaluation and project development must integrate, though each has a distinct set of responsibilities.

The symbiotic relationship between evaluation and planning that occurred to great benefit within CoC was facilitated, in part, when evaluators became not only observers, but also active participants in the process. This required flexibility among evaluators, close attention to evaluation ethics, and careful and ongoing examination and self-scrutiny regarding roles within the project. Evaluation assisted the planning process to the extent that it included and valued multiple perspectives through participatory methodologies and a commitment to valuing multiple perspectives. Evaluation was successful in CoC to the extent that it provided the information the project staff needed to plan effectively; and this was facilitated by the extent to which it trained key stakeholders in the evaluation process and involved them as co-investigators in the design, execution, and data interpretation of the evaluation

The planning effort informed evaluation by establishing relationships with key stakeholders who collaborated in the evaluation process and provided information on culturally appropriate methods of approaching evaluation within the community context. At its best, evaluation in turn challenged the planning process to create a broader, more comprehensive vision of their system of care. The planning effort then rendered that vision practical. In a symbiotic way, vision stretched practice, even as practice rooted vision.

The evaluation model suggested by the integration of project and evaluation, and community as co-researcher is a participatory action research

approach (Reason & Bradbury, 2001), wherein the evaluator is not simply in the auditor or observational role. Particularly for AI/AN communities, the potential tensions between the evaluation and project staff are part of a mosaic of top-down relationships with government projects and a history of negativity associated with agents representing governmental organizations such as the Bureau of Indian Affairs. Referring to systems of care evaluators, Hernandez and Hodges (1998) cite several pitfalls of the traditional separation of evaluation and project development, including adversarial relationships, long-terms outcomes with little connection to actual practice, lack of communication between the project staff and the evaluator, detachment in measurement stemming from a position of scientific objectivity, and a lack of useful feedback from evaluation processes. Due to the careful design of CoC, these pitfalls were less problematic across the three years of this initiative.

9. *In the reporting of evaluation results, consensus or recognition of differences may be valued more than compromise in many AI/AN communities.*

        Given the historical issues related to tribes, it is important to note that in the context of strategic planning with AI/AN communities, artificially homogenizing opposing viewpoints of key stakeholders may not be culturally appropriate, and could in fact be viewed as an oppression strategy, given that consensus or recognition of differences is often valued more than compromise. This is an important overarching recommendation for both evaluators and planners to bear in mind in their work.

10. *Evaluation occurs within a wider socio-political context in AI/AN communities.*

        Evaluators will be most successful to the degree that their work fosters, rather than hinders tribal self-determination and sovereignty. Evaluators need to recognize they work within the context of a history of research that has not served AI/AN communities well; hence, credibility must be earned.

11. *The process of engagement for the evaluation is defined by a common set of AI/AN values that include the establishment of trust, flexibility, reciprocity, suspending judgment, inclusion, and bravery.*

        The process of engagement for evaluation first required the establishment of trusting relationships between evaluators and participants, and could not successfully proceed until this occurred. The process required flexibility on the part of evaluators in their approach, methods, and ability to adapt to changing circumstances through things learned, including approaches that did not work. Reciprocity or the giving back to the community was an important requirement for evaluators. They could not be seen as taking information from the community without giving back to it. Successful evaluation also required suspending judgment and inclusion, which required the

acceptance of multiple perspectives. Finally, the process of engagement in AI/AN communities included bravery. Bravery surfaced in a willingness and trust on the part of consumers to tell their story at no small risk or pain to themselves, a willingness of evaluators to do things in a different way and to acknowledge publicly their limitations, as well as a willingness on the part of policy makers to take on an enormous risk for thinking outside the box, in hopes it would better serve AI/AN children and families.

12. *As in other aspects of AI/AN life, spiritual values become an important part of the evaluation process and how the evaluation is conducted.*

The spirituality of AI/AN people surfaced in specific ways in the evaluation process, through the commitment to a superordinate goal. Most concretely, this meant that people involved could have lower levels of disagreement on specific issues, yet they remained focused and committed to the larger task embodied in CoC. Meetings and gatherings began and ended with prayer, singing with the drum, circle dancing and asking the Creator for guidance. Finally, the presence of family members at the grantee meetings, talking about the pain in their hearts, brought spirituality to the forefront as well.

Conclusion

To its credit, in keeping with the self-determination philosophy of CoC, the initiative did not impose a rigid national evaluation plan. Holden, Friedman, and Santiago (2001) note that when a national evaluation plan exists, a degree of tension and resistance are natural by-products of its top-down nature. However, in the absence of a national evaluation or an imposed specific strategic planning model, the CoC initiative at times experienced a natural void and a sense of ambiguity. This led to some frustration on the part of grantees, yet this is to be expected when self-determination is implemented. This void was eventually filled by nine unique and varied local solutions to the evaluation and the strategic planning process, with the additional benefit of increased community and family involvement, and enhanced cultural competence in the approaches.

The CoC initiative resulted in nine community-specific systems of care models for AI/AN children, as evidence of the initiative's strong support of grantees in their development of culturally driven service delivery systems. Several of the CoC grantees went on to successfully apply for implementation of their strategic plans through various grant mechanisms, including the SAMHSA Comprehensive Community Mental Health Services for Children and their Families initiative that were previously out of reach of the planning infrastructures of their communities.

The process of these major accomplishments positioned each tribe or urban agency advantageously for future implementation and development through other funding sources as well. Each grantee's existing service system reported being strengthened by the planning process. It is our hope that the

CoC evaluation process and resulting products described in this publication can now be used to assist other tribes and urban AI/AN organizations in improving their own systems of care and further, that its methods and approaches may be of use in evaluation among other ethnic minority communities.

> In our every deliberation we must consider the impact of our decision on the next seven generations – Great Law of the Six Nations Iroquois Confederacy.

Pamela Jumper Thurman, Ph.D.
Senior Research Scientist
Tri Ethnic Center for Prevention Research
Colorado State University
Sage Hall
Ft. Collins, Colorado 80523
Phone: 800 835-8091
Email: pjthurman@aol.com

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Footnote

[1]This list is a reiterated and expanded version of the one initially presented by Freeman, Iron Cloud - Two Dogs, Novins, and LeMaster (2004), p. 17.

Author's Note