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

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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

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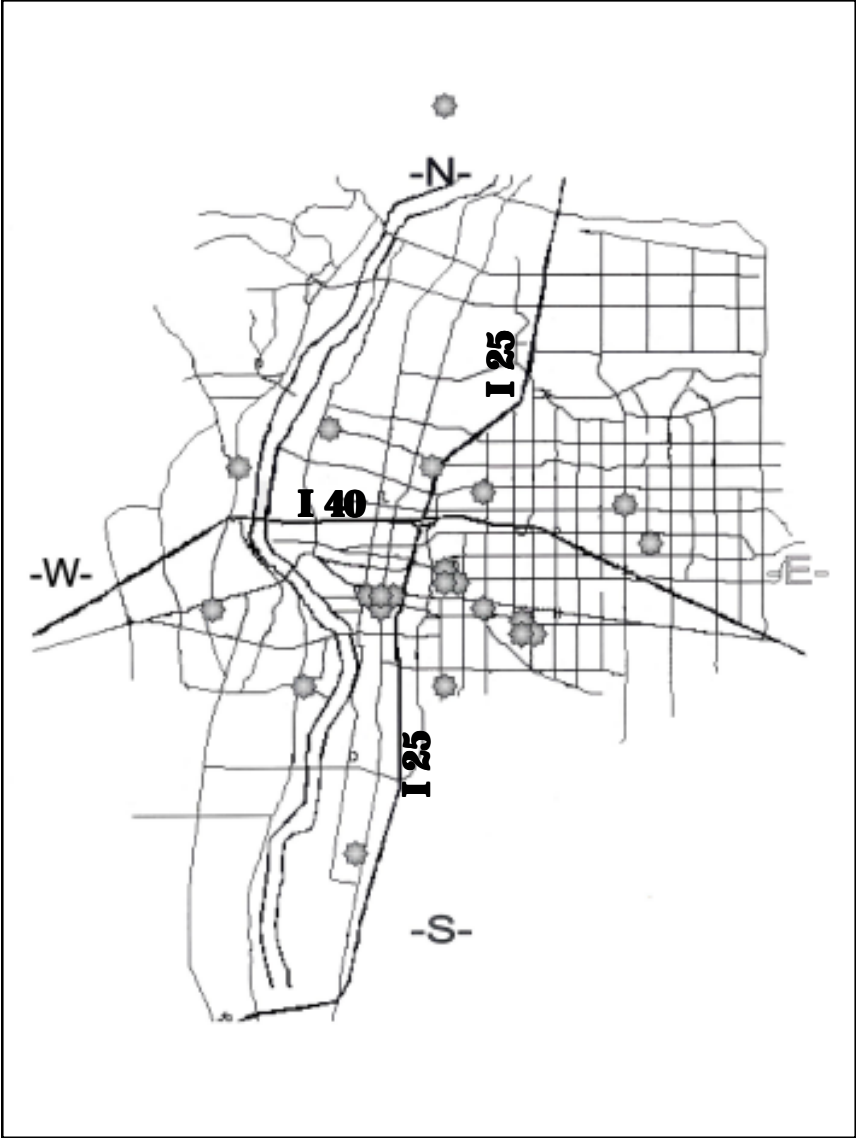
or lower right area). As can be seen in Figure 1 and 2, more than half of the organizations were located in the southeast quadrant. Through these maps, First Nations was also able to profile which potential collaborative organizations were best located in areas heavily populated by American Indians.

Figure 2
First Nations Community Health Source Service Region Social Services
Organizations
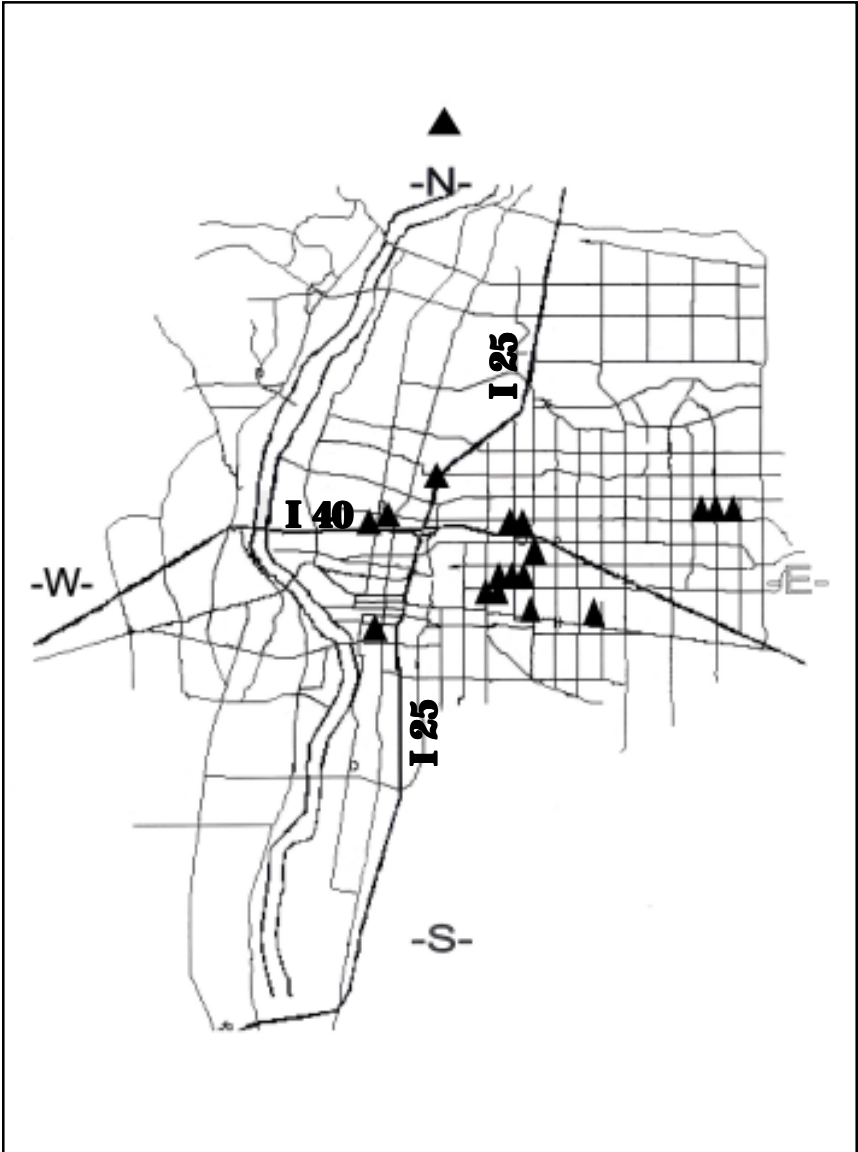
The Fairbanks Native Association/Tanana Chiefs Conference service system description, also mapped all 10 service sectors. Figure 3 presents a map of the general health care system for Interior Alaska. This health care system uses an innovative mixture of community health aides, community health representatives, 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
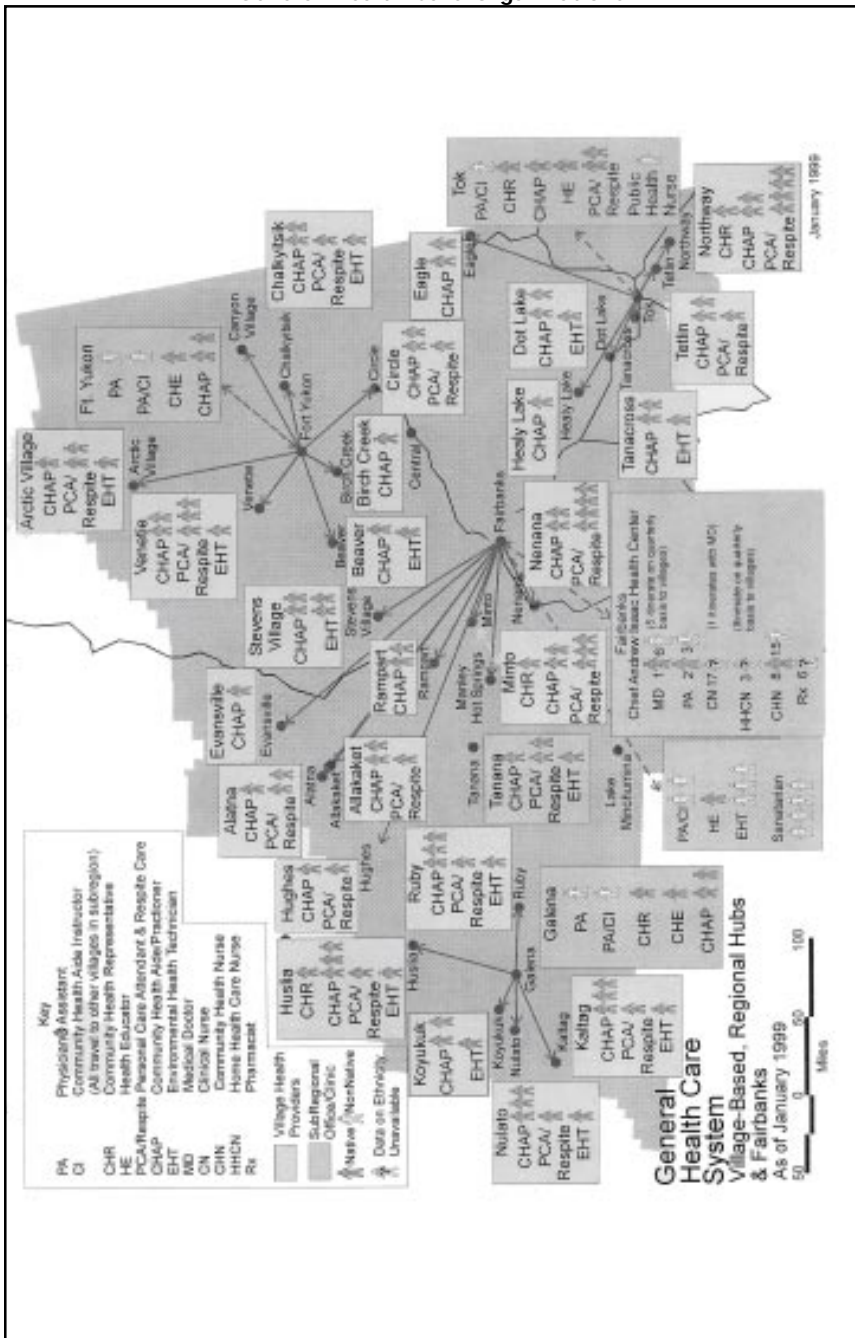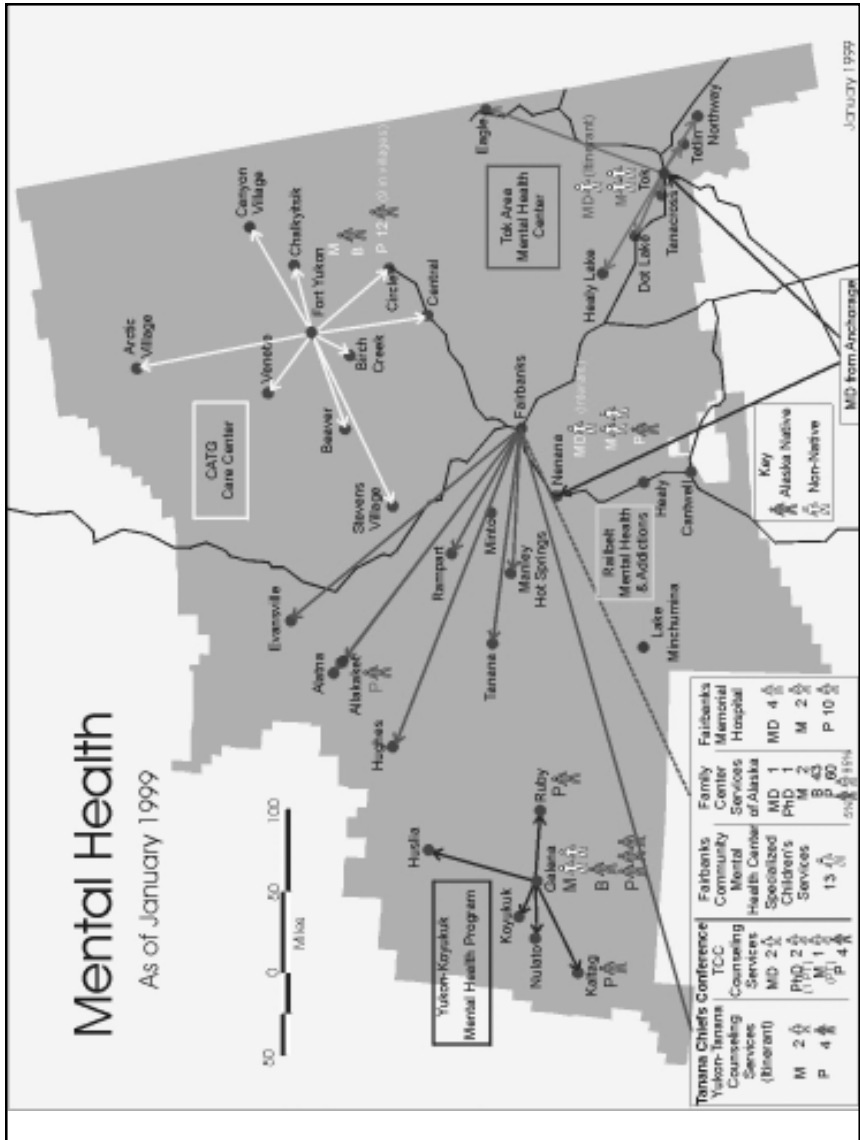**General Health Care Organizations**

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.

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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.

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