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

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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.

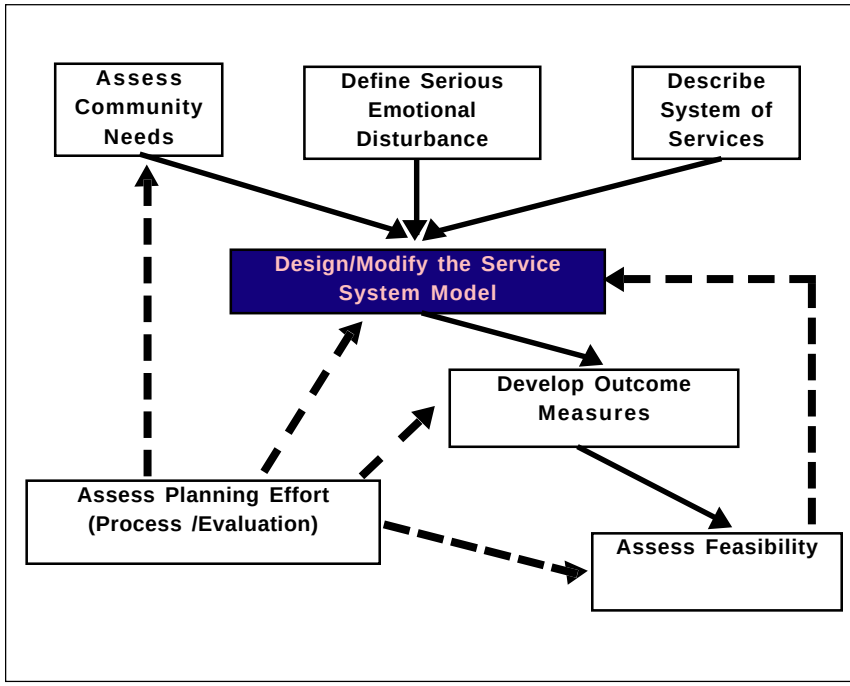
The Circles of Care Evaluation Effort

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.

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References

Aimee, L. F. (2001). Serving the public interest? Federal experiences with participation in strategic planning. *The American Review of Public Administration, 31*, 126-138.

Allen, J., LeMaster, P., & Deters, P. L. (2004). Mapping pathways to services: Description of local services for American Indian and Alaska Native children by Circles of Care. *American Indian and Alaska Native Mental Health Research: The Journal of the National Center, 11*(2), 65-87. Available at: http://www.uchsc.edu/ai/ncaianmhr/journal/11(2).pdf

Beiser, M., Sack, W., Manson, S., Redshirt, R., & Dion, R. (1998). Mental Health and the academic performance of first nations and majority-culture children. *Journal of the American Othopsychiatric Association*, 455-467.

Bess, G., Allen, J., & Deters, P. L. (2004). The evaluation lifecycle: A retrospective assessment of stages and phases of the Circles of Care initiative. *American Indian and Alaska Native Mental Health Research: The Journal of the National Center, 11*(2), 30-41. Available at: http://www.uchsc.edu/ai/ncaianmhr/journal/11(2).pdf

Bess, G., King, M., & LeMaster, P. L. (2004). Process evaluation: How it works. *American Indian and Alaska Native Mental Health Research: The Journal of the National Center, 11*(2), 109-120. Available at: http://www.uchsc.edu/ai/ncaianmhr/journal/11(2).pdf

Brookeman, C. (1990). *The Native American peoples of the United States: American Studies Today*, Liverpool, UK: Aldham Robarts.

Burns, B. J. (2001). Commentary of the special issue on the national evaluation of the comprehensive community mental health project. *Journal of Emotional & Behavioral Disorders, 9*, 6-14.

Coll, K. M., Mohatt, G., LeMaster, P. L. (2004). Feasibility assessment of the service delivery model. *American Indian and Alaska Native Mental Health Research: The Journal of the National Center, 11*(2), 99-108. Available at: http://www.uchsc.edu/ai/ncaianmhr/journal/11(2).pdf

d'Errico, P. (1998). *Sovereignty: A brief history in the context of U.S. "Indian law"*, American Political Landscape Series, Colorado Springs, CO: Oryx.

Deloria, V., Jr. (1988). *Custer died for your sins*. Norman, OK: University of Oklahoma Press.

Dixon, M. & Joseph-Fox, Y. (2001). Federal and state policy to strengthen Indian health. In Dixon, M. & Roubideaux, Y. (Eds.), *Promises to Keep: Public Health Policy for American Indians & Alaska Natives in the 21st Century* (pp. 275-296). Washington, DC: APHA.

Dixon, M., Mather, D. T., Shelton, B. L., & Roubideaux, Y. (2001). Economic and organizational changes in health care systems. In Dixon, M. & Roubideaux, Y. (Eds.), *Promises to Keep: Public Health Policy for American Indians & Alaska Natives in the 21st Century* (pp. 89-121). Washington, DC: APHA.

Duclos, C., Phillips, M., & LeMaster, P. L. (2004). Outcomes and accomplishments of the Circles of Care planning efforts. *American Indian and Alaska Native Mental Health Research: The Journal of the National Center, 11*(2), 121-138. Available at: http://www.uchsc.edu/ai/ncaianmhr/journal/11(2).pdf

Federal Center for Mental Health Services. (1998). *Circles of Care: Planning, designing, and assessing mental health service system models for Native American Indian and Alaska Native children and their families* (guidance for applicants). Rockville, MD: U.S. Department of Health and Human Services.

Fowler, L., Dwyer, K., Brueckmann, S., Seekins, T., Clay, J., & Locust, C. (1996). *American Indian approaches to disability policy: Establishing legal protections for tribal members with disabilities*. Research and Training Center on Rural Rehabilitation, Missoula, MT: University of Montana.

Garrett, M. T. (1999). Soaring on the wings of the eagle: Wellness of Native American high school students. *Professional School Counseling, 3*, 57-64.

Hernandez, M. & Hodges, S. (1998). The ecology of outcomes: System accountability in children's mental health. *Journal of Behavioral Health Services & Research, 25*, 136-151.

Holden, W., Friedman R. M., & Santiago, R. (2001). Overview of the National Evaluation of the Comprehensive Community Mental Health Services for Children and their families program. *Journal of Emotional and Behavioral Disorders, 9,* 4-12.

Jumper-Thurman, P., Allen, J., & Deters, P. L. (2004). The Circles of Care evaluation: Doing participatory evaluation with American Indian and Alaska Native communities. *American Indian and Alaska Native Mental Health Research: The Journal of the National Center, 11*(2), 139-154. Available at: http://www.uchsc.edu/ai/ncaianmhr/journal/11(2).pdf

Kauffman, J. M. (1993). *Characteristics of behavior disorders of children and youth* (5th ed.). Columbus, OH: Merill.

Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services*. Washington, DC: Children's Defense Fund.

Lee, J. (1994). The Irish psyche: An historical perspective. *The Irish Journal of Psychology, 15*, 245-249.

Lourie, I. S., Stroul, B. A., & Friedman, R. M. (1998). Community-based systems of care: From advocacy to outcomes. In Epstein, M. H., Kutash, K., & Duchnowski, A. (Eds.), *Outcomes for Children and youth with behavioral and emotional disorders and their families* (pp. 3-21). Austin, TX: Pro-ed.

Manson, S. M. (2001). Behavioral health services for American Indians: Need, use, and barriers to effective care. In Dixon, M. & Roubideaux, Y. (Eds.), *Promises to Keep: Public Health Policy for American Indians & Alaska Natives in the 21st Century* (pp. 167-192). Washington, DC: APHA.

May, P. A. (1990). A bibliography on suicide and suicide attempts among American Indians and Alaska Natives: Omega. *Journal of Death & Dying, 21*, 199-214.

McNevins, M., & Shepard-Erickson, J. (2001, September, 3). Circles of care: An overview. *Pathways*.

Moane, G. (1994). A psychological analysis of colonialism in an Irish context. *The Irish Journal of Psychology, 15*, 250-265.

Novins, D. K., Fleming, C. M., Beals, J., & Manson, S. M. (2000). Quality of alcohol, drug, and mental health services for American Indian children and adolescents. *American Journal of Medical Quality, 15*(4), 148-156.

Novins, D. K., King, M., & Stone, L. S. (2004). Developing a plan for outcomes in model systems of care for American Indian and Alaska Native children and youth. *American Indian and Alaska Native Mental Health Research: The Journal of the National Center, 11*(2), 88-98. Available at: http://www.uchsc.edu/ai/ncaianmhr/journal/11(2).pdf

Novins, D. K., LeMaster, P., Jumper-Thurman, P., & Plested, B. (2004). Describing community needs – Examples from the Circles of Care initiative. *American Indian and Alaska Native Mental Health Research: The Journal of the National Center, 11*(2), 42-58. Available at: http://www.uchsc.edu/ai/ncaianmhr/journal/11(2).pdf

Quinn, K. P. & Epstein, M. H. (1998). *Characteristics of children, youth, and families served by local interagency systems of care in Outcomes for Children & Youth with behavioral and emotional disorders and their families*, Austin, TX: Pro-Ed.

Roberts, N. (2000). The synoptic model of strategic planning and the GPRA: Lacking a good fit with the political context. *Public Productivity and Management Review, 23,* 297-311.

SAMHSA. (1998). *Circles of Care: Planning, designing, and assessing mental health service system models for Native American Indian and Alaska Native children and their families*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Shelton, B. L. (2001). Legal and Historical Basis of Indian Health Care. In Dixon, M. & Roubideaux, Y. (Eds.), *Promises to Keep: Public Health Policy for American Indians & Alaska Natives in the 21st Century* (pp. 1-30). Washington, DC: APHA.

Simmons, T. M., Novins, D. K., & Allen, J. R. (2004). Words have power: (Re)-defining serious emotional disturbance for American Indian and Alaska Native children and their families. *American Indian and Alaska Native Mental Health Research: The Journal of the National Center, 11*(2), 59-64. Available at: http://www.uchsc.edu/ai/ncaianmhr/journal/11(2).pdf

Storbakken, W. W. (2001). Indigenous rights: An argument for independence as a necessity for development. *Master's Thesis*, Public Policy, Hubert H. Humphrey Institute of Public Affairs, University of Minnesota.

Stroul, B. A., & Friedman, R. M. (1986). *A system of care for severely emotionally disturbed children and youth (Rev. ed.).* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Takaki, R. (1993). *A Different Mirror: A history of multicultural America*. New York: Little, Brown & Co.

Trimble, J. E. (2000). Social psychological perspectives on changing self-identification among American Indians/Alaska Natives. In R. H. Dana (Ed.), *Handbook of cross-cultural and multicultural personality assessment* (pp. 197-222). Hillsdale, NJ: Erlbaum.

Trupin, E. W., Tarico, V. S., Low, B. P., Jemelka, R., & McCellan, J. (1993). Children on child protective service caseloads: Prevalence and nature of serious emotional disturbance. *Child Abuse & Neglect, 17*, 345-355.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

U.S. Department of Justice. (2002). Department of Justice policy on Indian sovereignty and government-to-government relations with Indian tribes. Available at: www.usdog.gov/otj/sovtrb.htm

Walrath, C. M. (2001). Serving children with SED in urban systems of care. *Journal of Emotional & Behavioral Disorders, 9*, 94-106.

WICHE (June, 1998). *Cultural competence guidelines in managed care mental health services for Native American populations*. Final report of the Native American Managed Care Panel of the Western Interstate Commission for Higher Education (WICHE) Mental Health Program.

Woods, A., & Joyce, P. (2002). The arrival of postmodernist strategic theory: Its academic manifestation and the development of a new modernist perspective. *Journal of Strategic Change, 11*, 71-80.

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.

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