OUTCOMES AND ACCOMPLISHMENTS OF THE CIRCLES OF CARE PLANNING EFFORTS

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

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

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

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

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

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

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

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

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

Outcomes

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

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

Table 1
Circles Program and SAMSHA GPRA Goals

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

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

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

Tangible Outcomes

Written Products

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

System Infrastructure Change

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

Development and Implementation of New Programs and Services

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

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

Funding Toward Implementation

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

Intangible Outcomes

Integration of Culture

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

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

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

Capacity Building

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

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

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

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

Community Mobilization

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

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

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

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

Collaborations/Partnerships

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

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

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

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

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

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

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

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

Stages of Accomplishments

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

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

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

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

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

Barriers, Obstacles, and Overcoming Them

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

Table 3
Selected Barriers from Circles of Care Communities

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

Staffing Problems

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

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

Political Environment

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

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

Working Relationships with Partner Agencies/Providers

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

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

Perception of Evaluation

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

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

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

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

Community Satisfaction

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

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

Conclusions

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

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

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

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Author's Note

We would like to thank all participants and tribal groups in the Circles of Care program for their perseverance, hard work, and collaborative spirit that made these accomplishments possible. We hope this collaborative spirit continues and builds on the work of these first cycle grantees in improving systems of care for Indian youth.

Footnotes

[1] Original CoC GFA

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

[3] Oglala Lakota Nation

[4] Feather River Tribal Health

[5] Fairbanks Native Association

[6] Inter-Tribal Council of Michigan

[7] Feather River Tribal Health

[8] Cheyenne River Sioux Tribe

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

[10] Cheyenne River Sioux Tribe

Footnotes Continued

[11] Choctaw Nation of Oklahoma

[12] Cheyenne River Sioux Tribe

[13] Choctaw Nation of Oklahoma

[14] Fairbanks Native Association

[15] Cheyenne River Sioux Tribe

[16] Cheyenne River Sioux Tribe

[17] In-Care Network

[18] First Nations Community HealthSource

[19] Cheyenne River Sioux Tribe

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

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

[22] Oglala Lakota Nation

[23] Feather River Tribal Health

[24] Choctaw Nation of Oklahoma

[25] First Nations Community Health Source

[26] Inter-Tribal Council of Michigan

[27] Urban Indian Health Board

[28] Feather River Tribal Health

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

[30] Oglala Lakota Nation

[31] Fairbanks Native Association/Tanana Chiefs Conference

[32] Feather River Tribal Health

[33] Feather River Tribal Health

[34] Urban Indian Health Board, Inc.

[35] Feather River Tribal Health

[36] First Nations Community HealthSource

[37] First Nations Community HealthSource

[38] Feather River Tribal Health

[39] Cheyenne River Sioux Tribe

[40] First Nations Health Source

[41] Feather River Tribal Health

[42] First Nations Community Health Source

[43] Circles of Care GFA

[44] Oglala Lakota Nation