# SYSTEMS OF CARE LITERATURE REVIEW

*CONNECTING COMMUNITIES TO KIDS*

JEFFERSON COUNTY DIVISION OF HUMAN SERVICES

SYSTEMS OF CARE PROJECT

*Produced by*
**Colorado Institute of Public Policy**

**103 University Services Center**
**Colorado State University**
**Fort Collins, CO 80523-2010**

**Phone: 970-491-2544**
**Fax: 970-491-3106**
**Email: Lyn.Kathlene@research.colostate.edu**

# SYSTEMS OF CARE LITERATURE REVIEW

## INTRODUCTION

Systems of Care (SOC) was developed for the delivery of children's mental health services (Stroul and Friedman, 1996). Given the complexity of services needed, the number of agencies involved in the child's life as well as the disarray of mental health service delivery in general (Grady, 2003), SOC provides a coherent framework upon which to better meet the needs of the child and family. The child and family focus and an emphasis on providing services that are comprehensive, coordinated, community-based, culturally competent and individualized (Stroul, 1996) are SOC principles that fit well with serving the needs of children in the welfare system.

## HISTORY

SOC has not emerged in a vacuum. The *PATCH program*, begun in the United Kingdom in 1970's, has some elements of the SOC, most notably a focus on community-based and community-oriented services via re-envisioning the role of social workers and recognizing that much social care is provided by informal sources (Barclay, 1982). PATCH made the link that communities have assets and individuals can benefit the most by receiving help in their communities. PATCH made the transatlantic trip to the U.S. via a pilot program in Iowa during the early 1990's ("Strengthening Families"). The *social service case-manager* concept, common in the 1980's, sought to have one case worker coordinate services across agencies for a client but without a systematic attempt to create interagency collaboration. Like other precursors to SOC, *cultural competency* arose out of a need. Cultural competency responds to the demographic shift in the U.S. population; it is estimated that by

2005, children and adolescents of color will comprise 40% of the U.S. population ("Embracing the Dynamics of Difference"). This cultural gap will increase service barriers for racial and ethnic populations. The *wraparound process* recognizes that informal community methods have historically supported individual and families (VanDenBerg, 1999). Wraparound seeks to create individualized service plans based upon the unique needs of the child and family including value differences arising out of a cultural context ("What is the Wraparound Process?"; Goldman, 1999). Rather than fitting the child to the system, the system is tailored to the child's needs and delivered as close to home as possible. It is a highly participatory process, with the child, family and formal (teachers, therapists) and informal (grandparents, neighbors) providers working together (Epstein, Nordness, Kutash, Duchnowski, Shrepf, Benner, & Nelson, 2003; Yoe et al., 1996; VanDenBerg, 1999). When properly utilized, the use of wraparound leads to reduced cost of care, less restrictive living conditions for youth, and improvement in system functioning (Burns & Goldman, 1999).

Some societal changes have also influenced the development of SOC. Most U.S. systems, including mental health, child welfare, juvenile justice, and social services, were created when two parent families were the norm, extended family were often involved in children's lives, and economically viable neighborhoods were common. As economic conditions deteriorate for many families, and single-parent families with little extended family support become more common, the design of these systems becomes outdated. Further, many children now display multiple needs, relegating these systems insufficient without considerable cooperation between services (Malysiak, 1997). Now, new approaches to care, such as SOC, are essential to meet family needs. Political stimuli, such as social services cost reduction, also served to motivate development of cooperative services like those in SOC (Malysiak, 1997).

## SYSTEMS OF CARE PRINCIPLES

SOC has proven successful to varying degrees in child and youth mental illness service delivery. Applying the lessons learned to the child welfare system is logical. The welfare system, like the youth mental health system, is comprised of a myriad of service providers, located in different public institutions, unevenly distributed around their counties, with different eligibility requirements. SOC, due to its bottom up approach, is likely to produce the best outcomes for children, families and communities.

Core Values. Some principles are arguably more important than others and key to the implementation of the primary and secondary principles is a developmental process orientation (Hodges, Nesman, and Hernandez, 1999). According to Stroul and Friedman (1996, p.4-5), there are three core values in the SOC:

1. The SOC should be *child-centered and family-focused,* with the needs of the child and family dictating the types of mix of services provided.
2. The SOC should be *community-based*, with the locus of services as well as management and decision-making responsibility resting at the community level.
3. The SOC should be *culturally competent*, recognizing that culture and ethnicity are related to both system success with families and families' success within programs.

**Table 1: Core SOC values, rationale and implications**[1]

| SOC CORE VALUE | RATIONALE | IMPLICATIONS |
|---|---|---|
| *Child-centered and family-focused* | 1. Enhances personal dignity.<br><br>2. Maximizes opportunities for family involvement and self-determination. | 1. System of care commits to adapting processes and services to meet the family needs rather than having families conform to the system needs. |

[1] The table contains a sampling of the rationale and implications for each core principle.

| | | |
|---|---|---|
| | | 2. System of care recognizes and builds on the child and family strengths.<br><br>3. System of care commits to preserving the integrity of the family unit.<br><br>4. System of care involves families at all levels, from the planning stage through the evaluation stage. |
| *Community-based* | 1. Treatment within the community offers less restrictive and more normative environments.<br><br>2. The child and family have opportunities to join in community life. | 1. Case management is essential (Winters & Terrell, 2003).<br><br>2. Decisions about services are made at the community level.<br><br>3. Evaluation must include community actors and utilize multiple methods: qualitative and quantitative. |
| *Culturally competent* | 1. America's population continues to become more ethnically diverse (Hernandez et al., 1998).<br><br>2. There are structural barriers and value differences in social service systems that prevent effective treatment plans for the child and family. | 1. System of care involves affected populations in defining cultural elements.<br><br>2. Agency personnel – from administrators to front-line caseworkers receive yearly training.<br><br>3. Evaluation instruments reflect the cultural elements defined by affected populations. |

It is worthwhile to elucidate upon the third core value, *cultural competence*, an area that receives more attention in rhetoric than in practice. Culture can be defined as "ways of living or people's approaches to living and interpreting their environment," (Hernandez, Isaacs, Nesman, & Burns, 1998, pp. 1-2). It influences many aspects of life including

conceptualizations of illness, problems, needs, help-seeking behavior, and solutions. Some cultures may also have a fear or mistrust of government agencies or other sources of treatment (Huang, 2002). For an organization to be culturally competent, it needs "a set of congruent attitudes, behaviors, and policies that come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in cross cultural situations," (Cross, Bazron, Dennis, & Isaacs, 1989, p. 13). Hernandez et al. (1998) discuss five elements that are crucial to engendering cultural competence in organizations: valuing diversity (e.g., recognition and acceptance of different action, values, and ways of interrelating), cultural self-assessment (e.g., assessment and awareness of organizational culture to choose policies and practices to minimize cultural barriers), cross cultural dynamics (e.g., awareness of interactions; recognition of differences in communication styles, etiquette, and problem-solving methods), institutionalization of cultural knowledge (e.g., development of organizational responses to create culturally appropriate interactions; cross-cultural training of service providers), and adaptation to diversity (e.g., programs and services help not only individuals but culture group needs).

However, organizations may fall somewhere on a continuum of cultural competence, rather than being considered wholly competent or incompetent. A *culturally destructive* organization is totally incompetent, one which purposefully destroys other cultures. Or, an organization might be ignorant of other cultures and thus destructive toward them unconsciously, referred to as *cultural incapacity*. At the next level, organizations display cultural blindness, or a belief that all people are the same, which usually leads to dominance of the primary culture. *Culturally pre-competent* organizations recognize their weaknesses in serving minority populations and desire to do better. They are likely to hire diverse staff members, try new approaches to treating minority groups, or train staff members in cultural

competency. Unfortunately, these organizations often cease their efforts after taking some initial steps which they view as sufficient. Organizations displaying *basic cultural competence* accept and respect differences, continually assess their competence, provide ongoing training, adapt services to meet minority group needs, and seek output from communities of color. Those at the level of *advanced cultural competence* engage in all of the activities implying basic competence as well as developing new approaches to reach communities of color, conducting evaluation on success within these groups, and advocating system-wide competence (Cross, Bazron, Dennis, & Issacs, 1998).

It is important that organizations begin moving toward the higher levels of cultural competence and incorporating the five elements outlined by Hernandez at al. (1998) with great expediency. Soon children and adolescents of color are anticipated to comprise 40% of the youth population ("Embracing the Dynamics of Difference," 1997, as cited in Hernandez et al., 1998). The importance of culturally competent services is apparent when considering findings from a recent report from the U.S. Department of Health and Human Services (2001): minority populations have lower access to and availability of mental health services, are less likely receive the care they need, often receive lower quality care when they do seek treatment, and are less likely to be included in research (as cited in Huang, 2002). If these steps are not taken, minorities will continue to be over-represented in programs utilizing social control (e.g., punishment, incarceration, removal from the home) rather than proactive treatment, and African American children will continue to receive fewer services than Caucasian youth in the same situations (Coulter, 1996).

Cultural competency is not easily learned, in part because the relevant elements are not easily known. It is not as simple as "learning" about the "cultures" of Native Americans, Hispanics, or Asians. There is diversity within diversity; and the only effective way to tease

out these differences is to include the communities of color/ethnicity in the creation of cultural competency training materials. A case in point is the work done with American Indian tribes using the medicine wheel, which embodies context, mind, body and spirit, as the framework to understand overarching themes and tribe-specific values (Cross, Earle, Echo-Hawk Solie, & Manness, 2000). Table 2 provides examples of the cultural values common to the tribes in this study, yet uncommon in middle-class Caucasian communities in the U.S.

**Table 2: Cultural elements within the medicine wheel framework**[2]

| COMPONENT | ELEMENT |
|---|---|
| *Context* | ▪ Use of extended family and extended family concept<br>▪ Use of elders and intergenerational approaches<br>▪ Use of helping values from traditional teaching |
| *Mind* | ▪ Use of methods to promote healing of Indian identity and development of positive cultural self-esteem<br>▪ Use of methods that prepare children to live in two cultures<br>▪ Use of the native language |
| *Body* | ▪ Maintenance of an alcohol- and drug-free event policy<br>▪ Use of specific cultural approaches such as sweat lodges, feasts, etc. |
| *Spirit* | ▪ Use of traditional teachings<br>▪ Use of specific cultural approaches such as talking circles and ceremonies |

Despite the complexity of improving cultural competency, Huang (2002) suggests some concrete steps that might be taken to improve cultural competency of SOC. First, he suggests building services into education and primary health care so that minority children can be reached without seeking specific mental health care, which is unlikely given the biases toward mental health care held by some minority groups. Even if a family is referred by

[2] Table provides examples derived from Executive Summary of Cross, et al. (2000), p.3.

primary health care systems to specialty mental health providers, minorities are unlikely to follow-through. Second, he suggests restructuring of funding for mental health services to cover uninsured minority groups. Third, he emphasizes the importance of evaluating outcomes specifically for these groups and holding systems accountable for their improvement. Similarly, he considers it essential to increase the amount of research being done on the effectiveness of treatments for minority populations. Finally, he calls for the development of strategic plans to achieve cultural competence at state and local levels. These types of plans might include such elements as training in cultural competence, setting policy and program objectives, and reporting on achievement of these objectives at regular intervals.

Each of the core values presents a real challenge for areas moving toward a SOC. However, it is important to remember that each of these values is fundamental to the success of an integrated community-based systems of care. Further, each value must be adhered to in spirit rather than just being paid lip service by the system. Helpful in developing a SOC are the ten guiding principles discussed below.

Guiding Principles. In addition to the three core principles, there are ten guiding principles (Stroul and Friedman, 1986, p.17), which are

1. Access to a comprehensive array of integrated services coordinated by a case manager;
2. Individualized plan of services (wraparound);
3. Least disruption of the child's environment (community-based);
4. Full participation by families;
5. Early identification of problems;
6. Rights of children are protected;

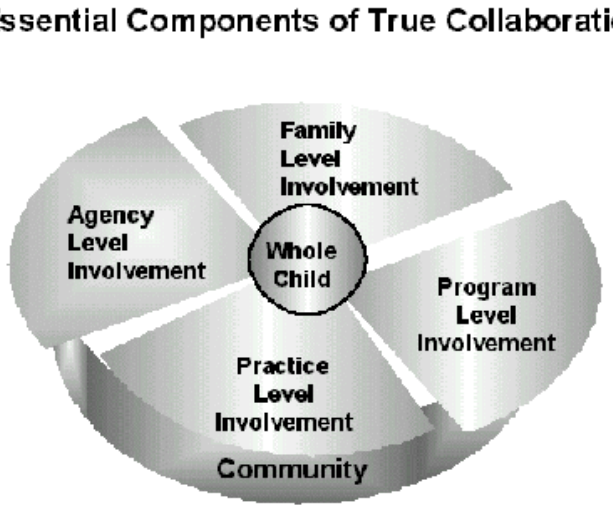
7. No disparity in service access based on cultural differences and other protected categories;
8. Case management to ensure multiple services are delivered;
9. Smooth transitions between juvenile and adult systems; and
10. Collaboration among the agencies and with the families.

Hodges, Nesman and Hernandez (1999) argue persuasively that the key to a well-functioning and sustainable SOC is *true collaboration*. It is possible for collaboration to be institutionalized in the rules of an organization, but without a reflective analysis of professional and organizational cultures (Cross et al., 1989) true collaboration is unlikely to occur. Ultimately, creating the process for true collaboration must be done from the onset and how we learn about each other matters. In this context, incorporating the "lived experiences" include not only families but personnel in the different agencies. According to Hodges, Nesman and Hernandez (1999, p.2), true collaboration embodies

- Role clarity for families and service providers;
- Interdependence and shared responsibility among collaborating partners;
- Striving for vision-driven solutions; and
- A focus on the whole child in the context of the child's family and community.

Only when the family becomes a full partner in the system will true collaboration arise. It ensures system legitimacy, consistency regardless of agency staffing, and system accountability. Figure 1 below illustrates the essential components of true collaboration.

**Figure 1: Essential Components of True Collaboration**[3]




*Family level involvement* is one important component of true collaboration that is frequently neglected. True collaboration between providers and family members can lead to services better able to meet specific needs of the community, a system strengthened by the expertise of all parties, and services that are more likely to be family-friendly (Simpson, Koroloff, Friesen, & Gac, 1999). Family involvement ensures that success is built upon family strengths rather than focusing exclusively on needs. Through this process families develop confidence and are better able to handle future challenges. (Malysiak, 1997). . Empowering parents puts them in a proactive situation of being able to seek out the help they need rather than a reactive stance of waiting for actions to be taken for them. Ideally, empowered parents will be able to pass this sense of efficacy on to other families in the system (Carpenter, 1997).

To increase family involvement to the appropriate level, family members should be engaged in several processes integral to SOC. These processes include planning, development, implementation, management, and evaluation of services in the SOC

[3] Taken from Hodges, Nesman & Hernandez. (1998), Executive Summary, p.5.

(Simpson, Koroloff, Friesen, & Gac, 1999). In some instances, parents are insisting upon and moving ahead with involvement in these processes with or without the sanction of the system (Carpenter, 1997).

Despite the promise of improved services through provider-family collaboration, barriers may prevent effective cooperation between these parties. Providers and others involved in service administration may not value or have sufficient commitment to family participation, or family members and providers may experience difficulty coming to agreement regarding the appropriate roles for each or how power should be shared. Key to resolving these issues is the development of trust and respect, treating parents with courtesy, opening and maintenance of communication channels, development of mutual commitment and respect, and reduction of suspicion within the relationship (Simpson et al., 1999; Epstein et al., 2003). Additionally, providers must be willing to relinquish some power, investing it instead in the parents (Carpenter, 1997). In a "family-driven" process the meetings welcome and involve families in active planning and this is best accomplished when parents are made to feel comfortable and welcomed, and meeting places and times are convenient for family members (Epstein et al., 2003). For true collaboration to be built, it is clear that mere presence does not constitute partnership.

To encourage a more appropriately involved role for family members, some more proactive measures have also been suggested. One proposal has been to employ a family member experienced in working within the SOC as a facilitator. This employee could help other families learn how to successfully navigate and participate in the system to obtain needed services. Another suggestion has been to employ family members to assist in training SOC employees by giving them the family perspective. These types of positions would be formally integrated within the system, and family employees would be

compensated based upon their level of responsibility within the SOC rather than their level of education or work experience. Other employees would also have to be willing to accept family members as essential to the functioning of the system despite probable disparities in formal education and training (Osher, de Fur, Nava, Spencer, & Toth-Dennis, 1999).

Some assistance in gaining parental participation has been provided by federal legislation. Public Law 99-457 supports the development of Individualized Family Service Programs (IFSPs), a move away from the Individualized Education Programs (IEPs) that have been commonly used to allow providers to share evaluative information, goals, and objectives with families. IFSPs, unlike IEPs, are to be designed by parents with their concerns and priorities integrated into the program (Carpenter, 1997). Only with this kind of provider-family partnership can true collaboration exist.

## THE ROLE OF INSTITUTIONS

National governments can have a large impact on the development of systems of care. If government policies are conducive to interagency collaboration, the development of systems of care is facilitated (Zachik, Heffron, Junek, Pumariega, & Russell, 2003). Efforts to establish systems of care in the United States have been supported nationally, in particular the Comprehensive Community Mental Health Services Program for Children and their Families (Holden et al., 2003). The program, administered by the Child, Adolescent, and Family Branch of the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services, funds efforts to develop systems of care in communities, states, territories, and Native American Tribes. The National Child Welfare Resource Center for Family-Centered Practice offers training to help state and Tribal child welfare agencies to

advance family-centered practices to promote the welfare of children and their families (Children's Bureau, 2003).

State governments also play a crucial role in the establishment of systems of care. State governments are influenced in part by federal initiatives, budget concerns, and parent and advocacy groups, among other factors (Pires & Ignelzi, 1996). State-level agencies have the power and resources to encourage collaboration and facilitate the cooperation necessary for system development. According to Pires and Ignelzi (1996), it "is clear from system change experiments that state leadership is a critical component" (p. 129).

Local governments have a role to play as well. A review of several sites in the process of developing systems of care reveal local efforts can achieve a measure of success, although there are difficulties that must be overcome (Stroul, 1996). These difficulties include funding and staffing programs, increasing family involvement, and gaining cultural competence. The review also brought to light several characteristics of successful efforts to build systems of care, such as negotiation, patience, and hard work (Stroul, 1996).

Various institutions, such as education systems, contribute to the development of systems of care. Schools are in a unique position to contribute because they are a large part of the lives of children and their families. Knitzer (1996) identified four key ways that schools, districts, and departments of education can contribute:

1. Develop collaborative child- and family-specific plans;
2. Participate in community-based governance structures;
3. Provide dollars; and
4. Develop new services.

The degree to which schools participate varies. For example, some have argued that children's mental health services should be provided through schools because it can be

delivered efficiently. (Ring-Kurtz, Sonnichsen, & Hoover-Dempsey, 1995), while others do not feel that mental health services belong in the school setting...

## EVALUATION

To determine whether programs have an impact as well as to identify areas for improvement, SOC programs need to be evaluated. Evaluation information can be used to improve service delivery, obtain public support for programs, validate decision-making, and maintain financial support for programs (Woodbridge & Huang, 2000). To conduct a useful evaluation, several preliminary questions must be asked. The evaluation team needs to consider what outcomes are truly of interest rather than just convenient to data collection, which indicators can most accurately reflect those outcomes, how the multicultural validity of the evaluation can be ensured, and what are the likely barriers to effective evaluation. Without careful initial consideration of these questions, evaluation data are likely to be of little use to inform decision making.

Too many possible outcomes exist for a system as complex as a SOC to measure each one; therefore, one of the first decisions to make is to determine which outcomes are of most importance to the success of SOCs. A starting place is to examine the organizational goals for the system change. Too often, outcomes are chosen with concern for compliance with rules or maintaining funding. These chosen outcomes are often number of persons served or variety of services provided rather than focusing on changes made for the families and children as a result of the SOC (Hernandez, Hodges, & Cascardi, 1998).

Involving members of all stakeholder groups is essential to produce useful information. Community members, program managers, and families all have an interest in how well the program is working. Families are likely to want outcomes related to the health

and safety, security and social stability, competence and independence, social interaction, educational growth, and eventual employment of their children. Community members want to know their time and efforts are creating positive changes in social service delivery (Osher, 1998).

Outcomes are often far from straight-forward, requiring evaluators to consider some complexities in designing their studies. Many outcomes are too encompassing or nebulous to allow direct measurement; therefore multiple specific indicators need to be developed. Context is important. If overall behavior change is important, indicators at school, in the home, *and* in the community should be utilized (Osher, 1998). The true influence of a program may be underestimated if only individual or group level outcomes are measured. Change in one outcome will almost certainly influence the level of change in others (Osher, 1998). Therefore, evaluation of a single outcome may indicate little change unless considered in the context of other changes. Moreover, incorporating community outcomes in evaluation may also provide information of greater use to policy makers.

Common indicators include intensity, duration, and frequency of services, location of services, variety and sequencing of services, integrity of services (e.g., consistency of services with values of the system) (Hernandez, Hodges, Cascardi, 1998), demographic description of clients, system costs, consumer satisfaction, and behavioral and emotional variables (Woodbridge & Huang, 2000). Despite a desire for quantitative data, important sources of information about family members and organizational change may be best tapped using qualitative methods. Some outcomes are going to be created by cooperation between multiple agencies. Measuring these outcomes will require interagency involvement in the evaluation, which may be difficult to obtain without prior planning (Rosenblatt & Woodbridge, 2003).

Finally, evaluation is an ongoing process with outcomes at various levels of complexity. Some evaluation occurs before a project even begins. At this point, the outcomes that are examined include existing baseline data. Accountability outcomes, usually assessed after the program has been in place for some time, ask questions about whether a program is used and the extent to which those in need have accessed it. Outcomes used for actual change of programs are likely to be more in-depth, asking questions such as under what conditions, for what children, in what types of families was the program effective (Barnes, Stein, & Rosenberg, 1999).

Several standardized means for assessing SOC outcomes have been developed. Most of these evaluate the degree to which wraparound, one aspect of SOC highly consistent with the core values mentioned earlier (Burns & Goldman, 1999), is being properly implemented within an SOC. For example, the Family Assessment and Planning Team Observation Form (FAPT) is a 42-item measure completed by observer(s) who rate the interaction between parents, youth, and providers during planning meetings on criteria like professional courtesy extended by the provider toward the parents (Singh, Curtis, & Wechsler et al, 1997).

From the FAPT, the Wraparound Observation Form (WOF) and Wraparound Observation Form-2 (WOF-2) were developed and validated. The 48-item WOF-2 asks observers to rate the planning team on items relating to the use of community-based services, the degree to which services are individualized, whether the processes are family driven, the presence of interagency collaboration, expression of unconditional care, the incorporation of measurable outcomes in the plan, team meeting management, and the efficacy of the care coordinator. In an initial implementation of the WOF-2 in Lancaster County, NE, it was found that informal supports were present at only 33% of meetings, and only 9% of the meetings had extended family members involved. This type of data can

suggest means for improving the implementation of key aspects of SOC, such as wraparound, as well as providing proof to stakeholders of which aspects are currently effective or ineffective (Singh, Curtis, & Wechsler et al, 1997).

Another example, the Wraparound Fidelity Index (WFI), is a survey completed by youth, parents, and service providers to determine which of the elements of wraparound are being implemented. Findings during validation studies for the WFI have suggested that some SOC claiming to utilize wraparound are actually failing to adhere to its key principles. Commonly excluded elements were collaboration with families in developing care plans, not including family and informal supports, and not using a strength-based approach in care plan development (Bruns, Bruchard, & Ermold, 2001, as cited in Epstein et al., 2003). Although 88% of states and territories report use of wraparound, it is likely that many exclude qualities essential to the concept.

These "off-the-shelf" instruments might be good options for organizations that lack the resources to develop their own evaluation tools; however, with borrowed tools, careful consideration should be given to determining whether the data can answer essential questions for the particular SOC being implemented.

Whatever outcomes or indicators are chosen, the *multicultural validity* of the entire evaluation system needs to be carefully considered. Multicultural validity is "the accuracy, correctness, genuineness, or authenticity of understandings (and ultimately evaluative judgments) across dimensions of cultural difference" (Conner & Kirkhart (2003), p. 1, as cited in Conner, 2004). In another definition, cultural competence in evaluation is defined as "a systematic, responsive inquiry that is actively cognizant, understanding, and appreciative of the cultural context in which the evaluation takes place; that frames and articulates the epistemology of the evaluative endeavor; that employs culturally and contextually

appropriate methodology; and that uses stakeholder-generated, interpretive means to arrive at the results and further use of the findings" (SenGupta, Hopson, & Thompson-Robinson (2004), p. 13). Like all types of validity, multicultural validity has to do with the usefulness of data for making the desired inferences. From two case studies, Conner (2004) suggests five factors that increase multicultural validity of evaluative data:

1. Involving participants in the evaluation study planning;
2. Speaking the literal language of the participants;
3. Speaking the figurative language (i.e., content and style of language) of the participants;
4. Working collaboratively with participants during implementation; and
5. Sharing the benefits with all of the evaluation partners.

A good example is Conner's case study with the Tres Hombres sin Fronteras (Three Men without Borders) HIV/AIDS prevention program for Latino farm workers. Based on input from the farm workers, the administrators used an oral-and-written survey with picture icons to accommodate those unable to read and conducted all activities in Spanish at a grade-level accessible to all participants. Farm workers were able to participate comfortably and the likelihood of accurate and honest responses was increased.

When striving for multicultural validity, it is important to understand that there is diversity within diversity (e.g., diversity is complex rather than definable by national boundaries), cultural meanings are dynamic and require constant re-calibration and training, and differences should not automatically be interpreted as weakness (Symonette, 2004). The latter is difficult given the strong bias toward viewing our own values, perspectives, and behaviors as correct and all others as deviant (SenGupta, Hopson, & Thompson-Robinson, 2004). Such awareness is not likely to come without significant training and maintenance.

Several barriers, in addition to cultural complexity, may stand in the way of conducting an effective evaluation. Often, the staff in charge of evaluation is a different group than those responsible for implementation, leading to an uncooperative relationship between them. Another barrier may be a desire for scientific objective data, which may prevent gathering useful qualitative information. As another example, data may not be fed back to the program implementers efficiently so that it can be utilized as soon as possible. Overcoming these obstacles requires strong leadership as well as a supportive political climate. Effective planning before beginning evaluation may also help to avoid some of these barriers. Before beginning, a vision for the evaluation, a starting place to begin work, and an assessment of the personnel and technology resources available should be complete to avoid later problems (Hernandez, Hodges, & Cascardi, 1998).

## SYSTEMS OF CARE OUTSIDE MENTAL HEALTH

Due to its comprehensiveness and focus on the whole family, the systems of care approach can be beneficial in areas other than children's mental health. There are various child welfare issues, such as homeless and runaway youth, that can be effectively addressed using SOC. Children who are homeless are particularly hard to serve, especially if they do not seek help themselves. Programs that have been successful in serving this population have certain characteristics in common (Pires & Silber, 1996). They tend to be adolescent centered, community-based, collaborative, flexible, family-focused, and culturally sensitive. Collaboration between public and private agencies is necessary to the success of such programs and collaboration increases in importance as time passes (Pires & Silber, 1996).

Another area where SOC may prove useful is that of child abuse and neglect. The Children's Bureau funded a series of projects to focus on the prevention, intervention, and

treatment needs of children who were victims of neglect (National Clearinghouse on Child Abuse and Neglect Information, 2004). With respect to addressing families' needs, strategies that were identified in the programs included customizing services, offering multiple core components (such as assistance obtaining support from resources in the community), and developing relationships with families (National Clearinghouse on Child Abuse and Neglect Information, 2004). These strategies are very much in line with the systems of care approach. Indeed, two of the factors identified as being vital to program success are using multidisciplinary teams and collaboration with community partners (National Clearinghouse on Child Abuse and Neglect Information, 2004). Both of those factors are central to systems of care. It is clear that the systems of care approach has broad applicability to child welfare in general.

## CONCLUSION

Systems of care is a promising practice to revamp social service delivery systems. It is also a major challenge to existing organizational structures and norms. Theory about the potential of SOC and growing evidence of effectiveness should provide the basis to adopt it; but the challenges of such a paradigm shift may undermine attempts.

Successful adoption and implementation of SOC is more likely if the core values and ten principles are understood, operationalized and integrated fully in the change process. Too often true collaboration with the families is not built into the system and high levels of cultural competency are not achieved. Without these fundamentals, SOC will not be realized.

Evaluation activities must be incorporated into the change process from the beginning. A specific understanding of the goals and outcomes for a particular system are essential to the evaluation plan. Evaluations are on-going throughout the period of time when change is being implemented in order to provide feedback for corrective action.

With collaboration among agencies, adequate resources to train workers in the SOC principles, and personnel dedicated to the promise and practice of SOC, system integration delivered at the community level can be a reality.

## REFERENCES


Barclay, P. (1982). *Social Workers, Their Role and Tasks*. London: Bedford Square Press for National Institute of Social Work.

Barnes, J., Stein, A., & Rosenberg, W. (1999). Evidence based medicine and evaluation of mental health services: Methodological issues and future directions. *Archives of Disease in Childhood, 80,* 280-285.

Bickman, L. & Heflinger, C. (1995). Seeking success be reducing implementation and evaluation failures. In Leonard Bickman and Debra J. Rog (Eds.), *Children's Mental Health Services: Research, Policy, and Evaluation* (pp. 171-205). Thousand Oaks, CA: Sage Publications, Inc.

Bruns, E.J., Burchard, J.D., & Ermold, J.M. (2001). The wraparound fidelity index: Results from an initial pilot test. In Newman C., Liberton C.J., Kutash K. et al. (Eds.) *The 13th Annual Research Conference Proceedings. A System of Care for Children's Mental Health: Expanding the Research Base.* Tampa, FL: Research and Training Center for Children's Mental Health, 339-342.

Burns, B.J. & Goldman, S.K. (Eds.) (1999). Promising practices in wraparound for children with serious emotional disturbances and their families. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume IV.* Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

Cablas, A. (1998). Culturally competent methods based on evaluation and research: How to use research results in a system of care. In Mario Hernandez and Mareasa R.

Isaacs (Eds.), *Promoting Cultural Competence in Children's Mental Health Services* (pp. 1-25). Baltimore: Paul H. Brookes Publishing Co.

Carpenter, B. (1997). Empowering parents: The use of the parent as researcher paradigm in early intervention. *Journal of Child and Family Studies, 6(4),* 391-398.

Chenven, M. & Brandy, B. (2003). Collaboration across disciplines and among agencies within systems of care. In Andres J. Pumariega and Nancy C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry*, (pp. 66-81). San Francisco: Jossey-Bass.

Conner, R.F. (2004). Developing and implementing culturally competent evaluation: A discussion of multicultural validity in two HIV prevention programs for Latinos. *New Directions for Evaluation, 102,* 51-65.

Conner, R.F. & Kirkhart, K.E. (2003, November). Boundaries, borderlands, and border-crossers: Notes from a dialog on theory and practice. Document developed for workshop, Hazel Symonette (organizer and chair), American Evaluation Association Annual Convention in Reno, NV.

Coulter, W.A. (1996). *Alarming or Disarming? The Status of Ethnic Differences within Exceptionalities.* Paper presented at the annual convention of the Council for Exceptional Children, Orlando, FL.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1998). *Towards a culturally competent system of care: Vol. I. A monograph on effective services for minority children who are severely emotionally disturbed*. Washington, D.C.: Georgetown University, Child Development Center, Child and Adolescent Service System Program, Technical Assistance Center.

Cross, T., Earle, K., Echo-Hawk Solie, H., & Manness, K. (2000). Cultural strengths and challenges in implementing a system of care model in American Indian communities. *Systems of Care: Promising Practices in Children's Mental Health, 2000 Series, Volume I.* Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

"Embracing the Dynamics of Difference: Cultural Competence in Children's Mental Health." (Spring 1997). *Networks: National Technical Assistance Center Newsletter*.

Epstein, M.H., Nordness, P.D., Kutash, K., Duchnowski, A., Schrepf, S., Benner, G.J., & Nelson, J.R. (2003). Assessing the wraparound process during family planning meetings. *The Journal of Behavioral Health Services and Research, 30(3),* 352-362l

Forness, S., Kavale, K., MacMillan, D., Asarnow, J., et al. (1996). Early detection and prevention of emotional or behavioral disorders: Developmental aspects of systems of care. *Behavioral Disorders, 21(3),* 226-240.

Goldman, S. (1999). The conceptual framework for wraparound: Definition, values, essential elements, and requirements for practice." In Burns and Goldman (Eds.), "Promising Practices in Wraparound for Children with Serious Emotional Disturbance and their Families." *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume IV*. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

Grady, D. (July 23, 2003). Major changes in mental health care is urged." *New York Times*, Section A , Page 13 Accessed 07/23/2003. http://www.nytimes.com/2003/07/23/health/23MENT.html

Gutierrez-Mayka, M., & Contreras-Neira, R. (1998). A culturally receptive approach to community participation in system reform." In Hernandez and Isaacs (Eds.) *Promoting Cultural Competence in Children's Mental Health Services*. Baltimore, MD: Brookes Publishing Co.

Hernandez, M., Hodges, S., & Cascardi, M. (1998). The ecology of outcomes: System accountability in children's mental health. *Journal of Behavioral Health Sciences and Research, 25(2),* 136-150.

Hernandez, M., Isaacs, M., Nesman, T., & Burns, D. (1998). Perspectives on culturally competent systems of care. In Mario Hernandez and Mareasa R. Isaacs (Eds.), *Promoting Cultural Competence in Children's Mental Health Services* (pp. 1-25). Baltimore: Paul H. Brookes Publishing Co.

Hodges, S., T. Nesman, & M. Hernandez. 1999. "Promising practices: Building collaboration in systems of care." *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume IV*. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

Holden, E., Santiago, R., Mantueffel, B., Stephens, R.; Brannan A., Soler, R., Liao, Q., Brashears, F., & Zaro, S. (2003). Systems of care demonstration projects: Innovation, evaluation, and sustainability. In Andres J. Pumariega and Nancy C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry*, (pp. 432-458). San Francisco: Jossey-Bass.

Huang, L.N. (2002). Reflecting on cultural competence: A need for renewed urgency. *Focal Point, 16(2),* 4-7.

Huffine, C. & Anderson, D. (2003). Family advocacy development in systems of care. In Andres J. Pumariega and Nancy C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry*, (pp. 35-66). San Francisco: Jossey-Bass.

Knitzer, J. (1996). The role of education is systems of care. In B.A. Stroul and R.M. Friedman (Eds.), *Children's Mental Health: Creating Systems of Care in a Changing Society* (pp. 197-213). Baltimore: Paul H. Brookes Publishing Co.

Malysiak, R. (1997). Exploring the theory and paradigm base for wraparound. *Journal of Child and Family Studies, 6(4),* 399-408.

Osher, T. (1998). Outcomes and accountability from a family perspective. *Journal of Behavioral Health Sciences and Researchy, 25(2),* 230-232.

Osher, T., deFur, E., Nava, C., Spencer, S., & Toth-Dennis, D. (1999). New roles for families in systems of care. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume 1.* Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

Osher, T., van Kammen, W., & Zaro, S. (2001). Family participation in evaluating systems of care: Family, research, and service system perspectives. *Journal of Emotional and Behavioral Disorders, 9(1),* 63-70.

Pires, S. & Silber, J. (1996). Services for runaway and homeless youth. In B.A. Stroul and R.M. Friedman (Eds.), *Children's Mental Health: Creating Systems of Care in a Changing Society* (pp. 513-531). Baltimore: Paul H. Brookes Publishing Co.

Pires, S. & Ignelzi, S. (1996). The role of the state in system development. In B.A. Stroul and R.M. Friedman (Eds.), *Children's Mental Health: Creating Systems of Care in a Changing Society* (pp. 115-130). Baltimore: Paul H. Brookes Publishing Co.

Pumariega, A. & Vance, H. (1999). School-based mental health services: The foundation for systems of care for children's mental health. *Psychology in the Schools, 36(5),* 371-378.

Ring-Kurtz, S., Sonnichsen, S., & Hoover-Dempsey, K. (1995). School-based mental health services for children. In Leonard Bickman and Debra J. Rog (Eds.), *Children's Mental Health Services: Research, Policy, and Evaluation* (pp. 117-144). Thousand Oaks, CA: Sage Publications, Inc.

Rosenblatt, A. & Woodbridge, M.W. (2003). Deconstructing research on systems of care for youth with EBD: Frameworks for policy research. *Journal of Emotional and Behavioral Disorders, 11(1),* 27-37.

SenGupta, S., Hopson, R., & Thompson-Robinson, M. (2004). Cultural competence in evaluation: An overview. *New Directions for Evaluation, 102,* 5-19.

Simpson, J.S., Koroloff, N., Friesen, B.F., & Gac, J. (1999). Promising practices in family-provider collaboration. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume II*. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

Singh, N.N., Curtis, W.J., & Wechsler, H.A. et al. (1997). Family friendliness of community-based services for children and adolescents with emotional and behavioral disorders and their families: An observational study. *Journal of Emotional and Behavioral Disorders, 5,* 82-92.

Stephens, R., Holden, W., & Hernandez, M. (2004). Systems-of-care practice review scores as predictors of behavioral symptomatology and functional impairment. *Journal of Child and Family Studies, 13(2),* 179-191.

Stroul, B. (1996). Profiles of local systems of care. In B.A. Stroul and R.M. Friedman (Eds.), *Children's Mental Health: Creating Systems of Care in a Changing Society* (pp. 149-176). Baltimore: Paul H. Brookes Publishing Co.

Stroul, B, & Friedman, R. (1986). *A System of Care for Emotionally Disturbed Children and Youth*. Washington, DC: CASSP Technical Assistance Center.

Stroul, B. & Friedman, R. (1996). The system of care concept and philosophy. In B.A. Stroul and R.M. Friedman (Eds.), *Children's Mental Health: Creating Systems of Care in a Changing Society* (pp. 3-16). Baltimore: Paul H. Brookes Publishing Co.

Symonette, H. (2004). Walking pathways toward becoming a culturally competent evaluator: Boundaries, borderlands, and border crossings. *New Directions for Evaluation, 102,* 95-109.

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.* Rockvill, MD: U.S. Department of Health and Human Services, Public Health Services, Office of the Surgeon General.

Winters, N. & Terrell, E. (2003). Case management: The linchpin of community-based systems of care. In Andres J. Pumariega and Nancy C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry*, (pp. 171-200). San Francisco: Jossey-Bass.

"What is the Wraparound Process?" Training and Presentation Materials by John VanDenBerg. Accessed 10/04/2004. http://air.org/cecp/wraparound/intro.html

Woodbridge, M. & Huang, L. (2000). Using evaluation data to manage, improve, market, and sustain children's services. *Systems of Care: Promising Practices in Children's Mental Health, 2000 Series, Volume II.* Washington, D.D.: Center for Effective Collaboration and Practice, American Institutes for Research.

"Wraparound." By Tricia Luker. Accessed 10/04/2004. http://www.bridges4kids.org/Wraparound.html

Zachik, A., Heffron, W., Junek, W., Pumariega, A., & Russell, T. (2003). Relationships between systems of care and federal, state, and local governments. In Andres J. Pumariega and Nancy C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry*, (pp. 353-379). San Francisco: Jossey-Bass.