

# **A Guide to Implementing Children's System of Care In California**

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About our cover art:

*“A Great Day” – Monoprint by Chris, aged 17, a consumer participating in the Arts in Mental Health Program, Metropolitan State Hospital.*

This multi-disciplinary fine arts program gives persons with mental illnesses the opportunity to develop artistic skills, build self-discipline, and use creativity in construction problem solving. This image was previously published in the 1999 Art of Healing Children Calendar.

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## Preface

The State Department of Mental Health is directed within the Children's Mental Health Services Act to work with counties to create Children's Systems of Care. The language was carefully

crafted to contain both the mission of the Department, and the essential values that would guide the process while working with community members and county administrators.

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5855. The department shall adopt as part of its overall mission the development of community-based, comprehensive, interagency systems of care that target seriously emotionally and behaviorally disturbed children separated from their families or at risk of separation from their families, as defined in Section 5856. These comprehensive, interagency systems of care shall seek to provide the highest benefit to children, their families, and the community at the lowest cost to the public sector. Essential values shall be as follows:

- (a) Family preservation. Children shall be maintained in their homes with their families whenever possible.
- (b) Least restrictive setting. Children shall be placed in the least restrictive and least costly setting appropriate to their needs when out-of-home placement is necessary.
- (c) Natural setting. Children benefit most from mental health services in their natural environments, where they live and learn, such as home, school, foster home, or a juvenile detention center.
- (d) Interagency collaboration and a coordinated service delivery system. The primary child-serving agencies, such as social services, probation, education, health, and mental health agencies, shall collaborate at the policy, management, and service levels to provide a coordinated, goal-directed system of care for seriously emotionally disturbed children and their families.
- (e) Family involvement. Family participation is an integral part of assessment, intervention, and evaluation.
- (f) Cultural competence. Service effectiveness is dependent upon both culturally relevant and competent service delivery.

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In the spring of 1997, California State Department of Mental Health funds were set aside to establish a technical assistance center for counties implementing Children's System of Care. A contract was awarded to the California Institute for Mental Health, a non-profit public interest corporation, to join the Department in operating the project. The center was named in honor of Senator Cathie Wright, in recognition of her efforts to expand mental health services to children with serious emotional disabilities. The mission of

**The Cathie Wright Center for Technical Assistance to Children's System of Care (CWTAC)** is to provide training, workshops, consultation and resource materials to county personnel serving children diagnosed with serious emotional disabilities and their family members.

The Children's System of Care (CSOC) project is conducted out of the Specialized Programs Branch of the State Department of Mental Health Systems of Care Division.

Administrators and staff members working in the Branch are charged with monitoring existing CSOC counties' progress, assisting counties in the planning stages for CSOC development, and of awarding new CSOC funds to county collaboratives through a competitive request for proposal process. Contracts for the CWTAC, the CSOC independent evaluator, and parent as partners efforts are also monitored by Branch staff, providing the Department with ample opportunities and resources to direct necessary technical assistance and support services to county projects. In addition to activities directly related to CSOC development, Branch staff are involved with other statewide initiatives involving children's mental health, health and educational needs.

This manual represents one of the first efforts of the Cathie Wright Technical

Assistance Center to produce materials to assist county mental health, social service, probation, education, family and other child and family service organizations to develop Children's System of Care. The Center was fortunate to have some of California's experts in Children's System of Care provide their assistance in writing this manual, and is grateful to them for their willingness to share their time, energy and expertise, a further demonstration of their commitment to the principles of System of Care and the children of California.

For more information regarding Children's System of Care implementation opportunities and processes please contact the Specialized Programs Branch directly at (916) 654-2147.

## I. Introduction

The purpose of this manual is to serve as a resource to counties and communities interested in implementing the California Children’s System of Care (CSOC) model for children and their families. It is intended to summarize the basic principles of the model, share the experiences of counties that have successfully implemented a system of care, and provide technical assistance in the way of written materials such as samples of documents, forms, evaluation instruments, etc. In many cases samples used were chosen because they were readily available, and were intended as

examples only. There was no rigorous effort to identify those most frequently used or considered to be exemplary models.

The manual is intended as a guide for counties, not as a “recipe.” One of the greatest strengths of the model is its flexibility. Every county is unique, and each system of care needs to reflect the particular needs of children and families within the county, as well as the county’s political, social and economic situation.

***“Every county is unique, and each system of care needs to reflect the particular needs of children and families within the county, as well as the county’s political, social and economic situation.”***

## II. History of System of Care Development in California

The California Children’s System of Care (CSOC) model was developed in Ventura County during the mid-1980s. In 1984, State Assembly Bill 3920 granted state general funds to Ventura County through the State Department of Mental Health to pilot a “new way of doing business” in child and family services. At this time a State Advisory Board was also created to assess the model and its evaluation efforts for possible statewide replication.

The Advisory Board report and the evaluation results of the Ventura demonstration documented the CSOC model’s success. As a result, AB 377 was passed in 1988, granting funds to expand the model. Through a Request for Proposal process by the State Department of Mental Health (DMH), three additional counties—Riverside, San Mateo and Santa Cruz were awarded system of care funding in 1989. AB 377 also required that the model be extensively evaluated. The California Children’s System of Care Evaluation Project is a multi-year collaborative effort between the University of California, San Francisco (UCSF) and DMH. Executive Summaries of the reports entitled “The California AB 377 Evaluation Project Three Year Summary Report,” and “The California AB 377 Evaluation Project Five Year Report” are attached as

Appendix A. Complete copies of the reports are available through the Cathie Wright Technical Assistance Center, 2030 J Street, Sacramento, California 95814.

Subsequent state legislation, AB 3015 in 1992, “The Children’s Mental Health Services Act” (attached as Appendix B), federal block grant funding and federal grants from the Substance Abuse Mental Health Services Administration Center for Mental Health Services (SAMHSA/

CMHS) have added new counties to those already funded to develop and implement systems of care. The chart on the next page provides an overview of expansion of the CSOC.

***“It is the single largest effort in terms of youth served, multiple replications, and scope of services provided in the nation that is dedicated to replicating and implementing a single model.”***

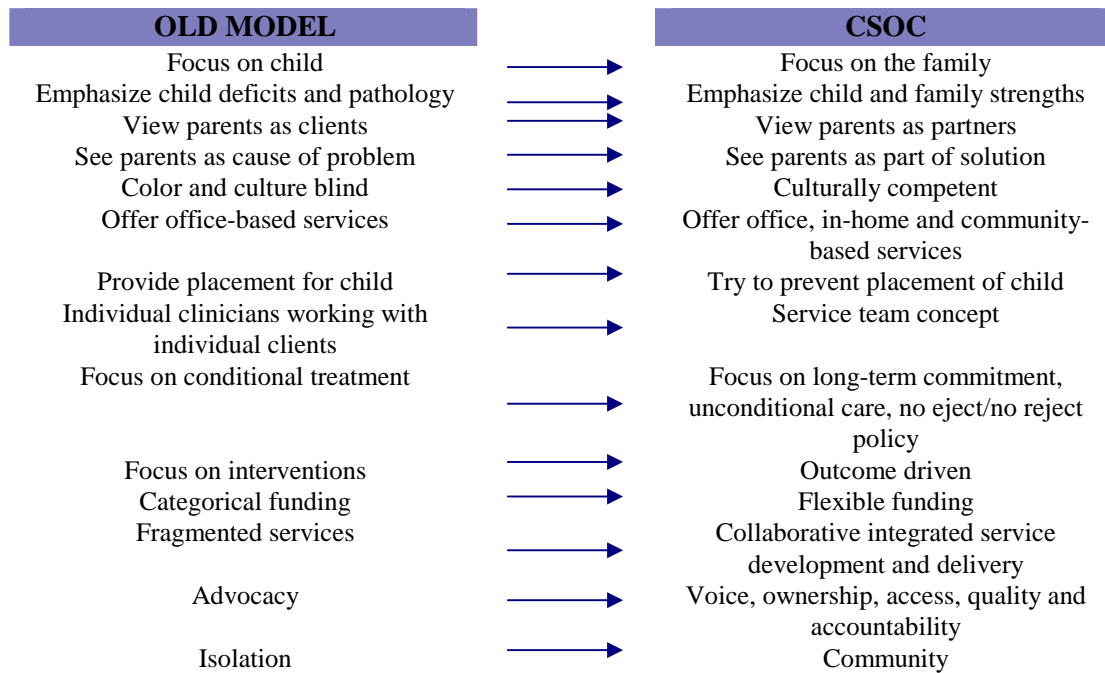
At the present time, 36 counties are funded for implementation and 16 more counties have received barrier elimination grants. Over half of the children and families in the state are served by care systems that are implementing this model. It is the single largest effort in terms of youth served, multiple replications, and scope of services provided in the nation that is dedicated to replicating and implementing a single model. The goal of existing legislation and state policy is to implement the CSOC statewide. This manual is designed to assist counties in achieving this goal.

### III. Value and Relevance of the California Children’s System of Care Model

The California Children’s System of Care model is a planning model constructed to guide the development and implementation of an effective multi-agency system of service delivery for children and their families. It is

intended as a system redesign at all levels, from top managers to service delivery staff, involving families and all relevant public and community-based agencies.

**The CSOC represents a paradigm shift as illustrated below:**



Implementing a system of care involves changing the service delivery culture to one in which clearly identified values and principles provide a foundation for the achievement of specific goals through a flexible network of services and supports provided by a team for a targeted group of children and their families. Services are designed to fit the individual child and family, rather than to focus on programs into which a child must fit or fail. Negative outcomes are viewed as system failures, rather than

child and family failures. Every family embodies strengths. The service delivery system needs to identify these and collaborate with the family to build upon them. The model is both results and cost focused. This emphasis on accountability, on providing the most effective services in the most efficient manner, has been the strategy that has perhaps contributed the most to the successful expansion of Children’s System of Care in California.



## IV. Components of the System of Care Planning Model

The original construct consisted of five steps. As the model evolved, two additional components were added to reflect the importance of cultural competence and partnerships with families. The current components of the CSOC model are as follows:

- 1. A clearly identified target population**
- 2. Clearly defined and measurable goals and objectives**
- 3. Partnerships across agencies**
- 4. Family/professional partnerships**
- 5. Community based, individualized services**
- 6. Cultural competence**
- 7. Evaluation, performance outcomes and accountability**

As previously noted, the model is intended to serve as a planning tool and a guide. It can apply to any target population and can integrate any child and family-serving agency. It would be difficult however, to begin to implement a system of care in any sizable area that encompasses all children and includes all child-serving agencies. Therefore, in keeping with its focus on results and costs, existing statute mandates that implementation begin with creating a system of care for those children with the most serious emotional problems, and their families. More specifically, implementation must begin with those children already in or at risk of out-of-home placement, and those children in special education who are mandated to be served under Chapter 26.5 of the Education Code. This is the population for which the model has been implemented and evaluated. Thus much of the information in this manual will be directed toward this target population, though the model may also be useful for developing service systems for expanded populations under such new initiatives as Medi-Cal managed care, welfare reform, and Healthy Families.

## **A. Target Population**

This component stresses that it is important that the Children’s System of Care be designed around a **specific** target population. It is doubtful that public systems will ever have sufficient resources to serve everyone who might have any need for their services. Defining who is to be served, rather than just serving whoever “comes through the door” allows identification of the outcomes to be achieved, the partners that need to be involved and the service system that needs to be in place. The model suggests three criteria for identifying specific target populations: (1) an identifiable problem or disorder

which leads to, (2) an observable functional impairment which leads to, (3) measurable public costs.

In developing the model, Ventura County chose those children and their families that were in highest need, that were most visible, and upon whom the largest amount of resources were being spent. Selecting this target population first has allowed the model to prove its effectiveness in a short period of time by dramatically avoiding escalating out-of-home placement costs, thereby freeing up resources to be used to expand and refine the system of care.

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**Section 5600.3 (a) (2) of the Welfare and Institutions Code (W&I Code)** defines the target population as follows:

For the purposes of this part, “seriously emotionally disturbed children and adolescents” means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child’s age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

- (A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
  - (i) The child is at risk of removal from home or has already been removed from the home.
  - (ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
- (B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.
- (C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Some counties have used or adapted a screening instrument developed by Ventura County to help effectively identify target population eligibility. A copy of that instrument is included as Appendix C.

Social and fiscal responsibility suggest that public agencies first give priority to children with complex needs and their families who are the most vulnerable, most in need of services and most costly to society. Children meeting the criteria above must be **given priority** by counties receiving funding for systems of care under the existing state and federal legislation. As noted previously, however, the CSOC model can be used with all target populations of children and their families. Targeting those most in need should be viewed as a starting point for the system of care. Ultimately, the goal is to build an effective system that includes prevention and early

***“Social and fiscal responsibility suggest that public agencies first give priority to children with complex needs and their families who are the most vulnerable, most in need of services and most costly to society.”***

intervention services as well. As outcomes are met and cost savings are generated for the priority populations, it is highly recommended that these cost savings be used to expand services to the target population and/or to expand the target population to include new populations under such initiatives as Medi-Cal managed care, welfare reform, and Healthy Families.

***“As outcomes are met and cost savings are generated for the priority populations, it is highly recommended that these cost savings be used to expand services to the target population and/or to expand the target population...”***

## **B. Goals and Objectives**

The concepts of goals and objectives and how they differ from and relate to one another are always the subject of much discussion. For purposes of this manual, the following definitions apply:

**Goals** represent the system of care's "envisioned future." They are broad statements about what the system of care is striving to achieve. **Objectives** put those goals into operation and make them more concrete. They should be both specific and measurable.

The goals selected for the system of care should reflect not only the goals and objectives of one agency, but also those of the other principals in the partnership—families and other public and private child-serving agencies. It is critical that the goals be **relevant** to all players in order to sustain their commitment to the system of care. The following goal statement represents the cornerstone upon which the CSOC is based:

**"To develop and implement a system of care which will bring together the resources and expertise of families and appropriate public and private agencies to provide the highest quality services to the target population in the most efficient and cost effective manner."**

In this age of accountability the ability to: 1) define clearly the objectives and outcomes desired, 2) evaluate the program to determine whether or not these objectives and outcomes are being

achieved, and 3) to change the system if they are not is critical for both the sustainability and the expansion of the model.

The CSOC incorporates three standards for selecting objectives:

**Objectives should be clear and understandable.** Start with the few simple objectives that are in the system of care statutes. These include both individual child and family objectives and system objectives. The individual child and family objectives are to achieve measurable improvement in functioning as well as child/family satisfaction. The system objectives are to keep children "at home, in school and out of trouble."

**Objectives must be translated into outcomes that are observable and measurable.** These measures should be child and family, cost and interagency specific. Again, start with the existing statutes. This defines the measurements used to assess the interagency system objectives. These are as follows:

- "at home" - reductions in group home costs, state hospital programs, nonpublic school residential placement costs
- "in school" - improvement in school attendance and academic performance
- "out of trouble" - a reduction in juvenile justice arrests and incarcerations

Measurement of service effectiveness, or child and family-specific objectives can

be very complex. **Start somewhere and get better!** Statute requires the measurement of “improvement in individual and family functional status for a representative sample of children enrolled in the system of care” (W&I Code Section 5880(a) (6)). More information on outcomes will be presented in the section on evaluation.

**Objectives must be important enough to justify the spending of public monies on them.** This is necessary to

build a constituency for the system of care. Again, in these times when value is so important, taxpayers want to know that they are getting value for their tax dollars. Important, meaningful goals, objectives and outcomes will do this.

Keeping it simple cannot be stressed enough. Creating lists of goals, objectives and outcomes that are complex and difficult to measure will result in getting bogged down in details. Describe goals and objectives in a few clear statements that anyone can understand.

*“Keeping it simple cannot be stressed enough....Describe goals and objectives in a few clear statements that anyone can understand.”*

### C. Partnerships across Agencies

Without interagency partnerships and collaboration, children with multiple needs can only get single agency solutions. The answer to this situation is a basic principle of the system of care. Interagency partnerships allow a holistic approach to the child and family, access to a comprehensive menu of services and offer the opportunity to develop a seamless service delivery system. Collaboration involves individuals, groups and/or agencies working together for the mutual benefit of the child and family in a teamwork approach, where that approach is a united one and is decided upon jointly by the team.

As previously noted, the selection of a specific target population helps define the interagency partnerships that are needed for a comprehensive system of care for that particular group. All agencies, both public and private, that could potentially provide needed services to the population should be included. Some basic requirements that are essential to successful interagency partnerships are as follows:

- Each agency must respect the laws and policies of their partner

agencies. These rules and regulations most often emanate from federal or state mandates, and dictate the underlying workings of the agency.

- Each agency must become familiar with the “culture” of partner agencies, which is sometimes less evident than its governing policies. The culture evolves from history—both legal and managerial. Time and effort must be put into learning and understanding the cultural climate of the agencies.
- The child and family populations served by each agency must be understood and respected.
- Agencies engaging in partnerships must be willing to devote time to working out their collaboration. Time must be

devoted to meetings as well as ongoing efforts to define and refine the coming together of service delivery and resultant paradigms. Cross-agency training is important. More discussion of this can be found in the section on “Training and

Technical Assistance.”

- Building relationships and trust at multi-levels in the CSOC is essential. Beginning at the top

***“Collaboration involves individuals, groups and/or agencies working together for the mutual benefit of the child and family in a teamwork approach, where that approach is a united one and is decided upon jointly by the team.”***

level of administration through the line staff level, relationships must be developed and nurtured.

- The programmatic products of these relationships must be documented in interagency agreements and/or Memoranda of Understanding (MOUs).

The CSOC model and its enabling statutes which has been documented in the W&I Code prescribes methods to encourage interagency collaboration:

- Section 5866 (b) - The local mental health director shall form or facilitate the formation of a **county interagency policy and planning committee**. The members of the council shall include, but not be limited to, the leaders of participating local government agencies, to include a member of the board of supervisors, a juvenile court judge, the district attorney, the public defender, the county counsel, the superintendent of county schools, the public social services director, the chief probation officer, and the mental health director.
- Section 5866 (d) - The local mental health director shall form or facilitate the formation of a **countywide interagency case management council** whose function shall be to coordinate resources to specific target population children who are using the services of more than one agency concurrently. The membership of this council shall include, but not be limited to, representatives from the local

special education, juvenile probation, children's social services, and mental health services agencies, with necessary authority to commit resources from their agency to an interagency service plan for a child and family.

- Section 5866 (e) - The local mental health director shall develop **written interagency agreements or memoranda of understanding** with the agencies listed in this subdivision, as necessary.

### **Interagency Policy and Planning**

**Committee.** This is the group that will ensure collaboration within the system of care "from the top down." It must include the top county executives, and membership and attendance must not be delegated to others. This group needs to develop broad goals for the system that will drive the interagency work within and among the various agencies. The selection of a chair person and/or staff person assigned to this committee is very important. They will help to set the tone and organization of the meetings, will help facilitate the meetings and will make certain that the time of these top level executives is used to best advantage. This committee should meet as frequently as is needed to ensure commitment at the highest levels of government and to conduct the necessary business of the committee.

### **Interagency Case Management**

**Council.** This group provides a forum for program managers to come together across agencies. The function of this group is to coordinate resources for the target population being served. This

group needs to set goals and objectives for the collaborative programs and the children and families served. These goals will be more specific and child, family and program focused, but must relate to the attainment of the overall system of care goals. Many counties use this group as their interagency placement review committee as well. Again it is important that membership include all **relevant** agencies. The term relevant is important here. If the group becomes too inclusive there is danger of losing the focus of the target population. With too large a group it is hard to do business, and it is almost impossible to keep the agenda relevant to all members. Many counties have found it helpful to get the agendas for these meetings to the participants ahead of time, so everyone comes prepared to discuss the issues. It is important to keep these meetings focused and productive. If people believe that this forum helps them to do a better job, they will attend more regularly.

*“The process of developing interagency agreements is, in itself, an important element in building and nurturing the partnership.”*

**Interagency Agreements.** Interagency agreements or MOUs (different counties use different terminology) document the programmatic products of the partnerships. They should include a statement of commitment to the collaborative, including an agreement to develop and participate in a structured process for collaborative planning and

problem solving, a description of shared programs and services, and a delineation of staff roles and responsibilities. A sample generic outline and samples of specific interagency agreements are included in Appendix D.

The process of developing interagency agreements is, in itself, an important element in building and nurturing the partnership. Depending upon the level of trust among the partners, initial agreements will have a tendency to either be overly broad, or may get bogged down in minute details. Remember that the first attempt at an agreement doesn't have to be perfect. Start simple and get better! The annual (or more frequently, if needed) review is a good task-focused process to deal with issues and concerns that have arisen within the partnership over the past year.

As partnerships are developing, it may be helpful to examine the collaborative effort through a kind of self-assessment. Some challenges/questions for individual members include:

- Am I really here to collaborate, or am I too focused on what the other partners can provide for **my** children and families?
- Am I willing to devote the time and resources to make it work (i.e., to develop agreements, to engage in problem solving and team building, etc.)?
- Am I willing to hire and/or train staff and parents who can



- develop and maintain good collaborative relationships and programs?
- Is there sufficient commitment at the top administrative level of my agency to make it responsive to the requirements of a good collaborative partnership?

It is important to get answers to these questions on the table for discussion. It is also important to be aware of and look out for potential risks that threaten successful collaboration such as:

- Goals of the system and the various partnerships are not clearly defined.
- Agency or department heads commit to working together, but do not identify managers or supervisors who are responsible for maintaining the collaborative relationship.
- Leadership changes without managers “passing on” the philosophy and methods of good collaboration.

- Roles and expectations of staff are not clearly defined as they pertain to working partnerships.
- Staff is not educated through in-service training about methods of

***“Build on the strengths of the partnership and encourage those who are new to system of care to continue to participate.”***

service delivery in a collaborative model.

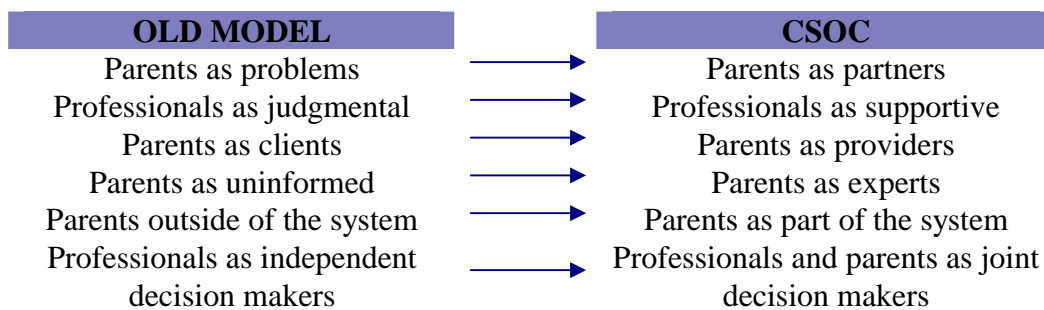
Almost always, there are different levels of “buy-in” from the collaborative partners. Build on the strengths of the partnership and encourage those who are new to system of care to continue to participate. If it can be demonstrated to managers, supervisors and line staff that partnerships will make their jobs easier and will benefit children and families, the level of commitment will increase over time.

## D. Family/Professional Partnerships

A basic tenet of the Children’s System of Care is the involvement of parents and families of children and youth with serious emotional disturbances as full partners in **every** aspect of the system.

This means that families are full partners with all child-serving agencies. It represents a paradigm shift—a new way of seeing the roles of both professionals and parents.

### The CSOC represents a paradigm shift in family/professional partnerships:



**Types of Family/Professional Partnerships.** Again, as with other parts of the model, there is no “recipe” and no right or wrong way. Appendix E represents a sample family/professional partnership development plan for mental health departments created by family members involved in the federally-funded System of Care efforts of the Centers for Mental Health Services (CMHS) in Washington, D.C. Three major types of partnerships, which may exist separately or in combination, have evolved from the experiences of various counties:

1. “innies” - parents are hired by the children’s service as staff
2. “outies” - parent group is independently run outside of the children’s service with no financial support
3. “middies” - independent parent group provides services under contract to the children’s system

of care, or children’s system of care contracts with another agency to hire parents to work within the CSOC

In many cases the types of partnerships used depend on county hiring and/or contracting policies. There are advantages and disadvantages to each of these partnerships in areas such as financial benefits, ease of bringing parents into the system, fully integrating parents in administrative and clinical functions, advocacy functions, etc. Sample profiles of family/professional partnerships in three different counties are attached as Appendix F.

The Family/Professional Partnership Matrix on the next page describes the relationships and services provided by parent partnerships in eight existing CSOC counties.

## PARENT PARTNERSHIP MATRIX

COUNTY	ORGANIZATIONAL STATUS	SERVICES PROVIDED
<b>CONTRA COSTA</b>	Employees of Mental Health	Support groups, advocacy/education, committees & boards, direct work with families, attend staff meetings, membership on Children's Mental Health Senior Management Team
<b>NAPA</b>	Contract with non-profit agency: Matrix	Joint meeting with parents on intake (orientation) and ongoing support, support groups, advocacy/education, boards & committee representation, hiring panel, attend staff meetings, resource library, sibling support group, local access television training
<b>RIVERSIDE</b>	Mental Health employees. Also contract with nonprofit, Family Service Association & UACC, some centralized services through county	Support groups, respite, youth mentor, committee representation, resource library, advocacy/education, clinic and in-home mentoring and advocacy for parents, inclusion as clinic staff in meetings and other activities.
<b>SAN MATEO</b>	Employees of Mental Health-contract	Family partnership teams-direct work with referred families home & clinic, advisory and other committee representation, education/advocacy, respite, hiring panel, staff meetings, family and youth mentors, family volunteers, Shadow Program
<b>SANTA CRUZ</b>	Two part-time Mental Health employees plus stipends to other parents	Advisory committee, support groups, participation on department committees, staff meetings, advocacy/education, respite, peer mentoring, newsletter
<b>SOLANO</b>	Contract with non-profit	Support groups, advocacy/education, respite/Camp Aldea, committee representation, newsletter, support group for siblings, activity group for exceptional needs children
<b>SONOMA</b>	Employees of Mental Health, full-time with benefits, 5 FTEs, other part-time parents (extra help status)	Support groups, newsletter, advocacy/education, committee representation, hiring panel, staff meetings, direct work with referred families-clinic and home, parent resource library, parent representation at administration level, parent advisory board
<b>VENTURA</b>	Independent nonprofit	Support group, respite, advisory committees, in-home alternative to hospitalization, newsletter, education, hiring panel, training of new employees, library

**Parent/Family Roles in the System of Care.** Parents have many roles and provide a range of services which are determined and defined in each county by both partners in the partnership. These roles may include, but are not limited to those of policy makers, resources to both the families and the professionals, service providers, advocates and support for other parents.

**Key Components for Meaningful Partnerships.** A true family/professional partnership is based upon shared beliefs and commitment to the CSOC philosophy.

- **Parents and professionals must trust and respect one another.** Both parents and professionals must be open to new ideas and willing to change. The role of parents must be real, not just tokenism. Some counties have used co-location of parents and professionals, and joint projects where parents and professionals work together to increase trust and respect and combat tokenism.
- **Equal accountability for all team partners.** The standards should be the same for all members of the partnership, and they must be held equally accountable for their performances.
- **Open communication is critical and needs to be at a level that everyone can understand.** One county uses a “communications checklist” and another has an annual round table meeting with agency and family partners to share ideas, voice concerns and problem solve together.
- **All partners need to be willing to accept constructive criticism, and**

**to be able to disagree and move forward.** One Special Education Local Planning Area (SELPA) is using Alternative Dispute Resolution teams of parents and professionals to solve disagreements in Individual Education Plans (IEPs) as a step before going to mediation and fair hearing.

- **Parents need to be able to consult with top management for information and support.** Many counties provide this channel for family members. Top management can also offer referrals to other contacts family members may need.
- **Expectations from both partners need to be realistic.** The partnership will not be able to start where it intends to end up. Building the partnership takes time and understanding.

*“A true family/professional partnership is based upon shared beliefs and commitment to the CSOC philosophy.”*

**Making these Components Real and Integrating them into the CSOC.** It takes leadership and support from all interagency partners, starting with top management and moving up and down all levels of staff, to build a successful family/professional partnership. Many counties have started with a series of

informal meetings with parents and system administrators. Some counties have used needs assessments to see what families and professionals want—where there is congruence and where there is dissonance. If there is already a parent group in the county, its support should be enlisted.

As the partnership begins to develop, a formal meeting should be held to develop mutual goals and objectives. Another good activity is to have parents and children’s service staff share in training, where both parent roles and staff roles are emphasized. Some of the training areas parents have found to be most beneficial are:

- California Children’s System of Care components
- Facilitation skills - running support groups and business meetings
- Understanding laws and rights
- Cultural competency
- Sensitivity training
- Communication skills
- Computer skills
- Leadership skills
- How to recruit parent partners

Contact the Cathie Wright Technical Assistance Center for schedules of on-going training activities that involve and include parents.

Expand the partnership, programs and parent involvement in direct proportion

to the number of parents involved. Avoid parent burnout! One or two parents cannot do it all. Don’t hesitate to take small steps. The best parent programs have been built with a lot of patience and understanding on behalf of both partners!

### **Barriers to Successful Partnerships.**

Some of the barriers that counties and parents have encountered that get in the way of successful partnerships are listed here, together with suggestions for overcoming them:

- **Preconceived opinions** of either or both partners.
- **Professionals’ fear of empowering families.** Some of the methods used by counties to overcome these barriers include joint trainings, informal forums to discuss issues, shared projects and tasks, and co-location of parents and professionals.
- **Unrealistic expectations** by either or both partners. These can be overcome by such things as clear job descriptions, networking with peers who are at a similar or more advanced stage in CSOC development, and jointly developing realistic work plans with clear time frames.
- **The use of confidentiality issues as a reason to exclude parents.** The Technical Assistance Center is working on a confidentiality manual to address this issue.

## ***E. Community Based, Individualized Services***

The fifth component of the Children’s System of Care refers to the service delivery system and the services that must be available and accessible to children and their families. There are several service principles that are a basic part of the model:

- **Services should be individualized and flexible.** They should focus on the child and family’s goals and objectives, rather than on the needs of a particular program or agency. They should be provided in whatever combination or manner is needed by the child and family.
- **Services should be based on the child and family’s strengths.** In many cases, traditional systems have had a problem-oriented focus. They need to move from this to a strength-based approach. Every individual and every family has strengths that can be enlisted and expanded to help solve their issues and concerns.
- **Services offered should represent a broad range of options.** There should be a full continuum of services, from the most to the least restrictive, in order to meet as many of the child’s and family’s needs as possible. Individualized, “wrap-around” services should be available to extend the range of services when needed for a particular child and family.

- **Services should be community-based.** Locate the target population of children and families, and deliver services in those locations—schools, homes, shelters, foster homes, juvenile halls, community agencies, public and private community organizations, recreational centers, etc. Delivering services where people live and congregate makes services more accessible and available as well as less restrictive, less institutional, and less “unnatural.” Think about the concept of a “clinic without walls.” This speaks to a full range of locations where services can be delivered.

The following questions may be helpful in planning for and developing the service delivery system. All partners in the process, including families, public and community-based agencies should be involved in looking at these issues:

- Does service planning begin with an assessment of the strengths of the child and family?
- Does service planning begin by ascertaining what families need and want?
- What services currently exist and are available within reasonable distance in all parts of the county?
- What collaborative services are available **across** agencies that meet the needs of the target population?

- Does the system allow services to be tailored to meet individual family needs?
  - Are services developed with a focus on having a range of options available at less restrictive levels, including non-traditional options such as respite, shadowing, mentoring, pre-vocational services, transitional services, after-school services, etc.?
  - Which existing community agencies, groups and individuals can be enlisted to provide services or supports to families and children?
  - Have volunteer resources been put to good use in the community?
- In keeping with the flexibility of the model, a specific set of services is not required.

**The following service standards are required for mental health agencies under W&I Code Section 5868:**

- (b) The standards shall include, but not be limited to:
- (1) Providing a comprehensive assessment and treatment plan for each target population client to be served, and developing programs and services that will meet their needs and facilitate client outcome goals.
  - (2) Providing for full participation of the family in all aspects of assessment, case planning, and treatment.
  - (3) Providing methods of assessment and services to meet the cultural, linguistic and special needs of minorities in the target population.
  - (4) Providing for staff with the cultural background and linguistic skills necessary to remove barriers to mental health services resulting from a limited ability to speak English or from cultural differences.
  - (5) Providing mental health case management for all target population clients in, or being considered for, out-of-home placement.
  - (6) Providing mental health services in the natural environment of the child to the extent feasible and appropriate.
- (c) The responsibility of the case managers shall be to ensure that each child receives the following services:
- (1) A comprehensive assessment of child and family needs
  - (2) Case planning with all appropriate interagency participation
  - (3) Linkage with all appropriate children's services
  - (4) Service plan monitoring
  - (5) Client advocacy to ensure the provision of needed services

The service delivery system should be planned with the families it is targeted to serve and will differ based upon the particular characteristics of each county. As system of care is implemented, look at existing services and determine what needs to be retained, what needs to be changed, and what needs to be added to

be able to achieve the goals, objectives and outcomes defined. Developing the service delivery system is a dynamic and ongoing process. The service delivery system and progress in meeting agreed-upon performance objectives need to be continually assessed, based on the principles delineated above.

## F. Cultural Competence

The sixth component in the Children’s System of Care stresses the importance of creating a system that meets the needs of the diverse ethnic populations served. As part of Phase II Consolidation implementation, each county mental health plan is required to develop and submit a cultural competency plan to the State Department of Mental Health. It is critical that Children’s System of Care efforts and strategies for cultural competence are included in the county’s cultural competency plan submission.

In developing and implementing a culturally competent system of care for children and youth, counties should be guided by DMH Information Notice #97-14, available from the State Department of Mental Health. In addition, material contained in the two-volume, Towards a Culturally Competent System of Care, (Cross, Bazron, Dennis, and Isaacs, 1989; Isaacs and Benjamin, 1991) provides a cultural competency model developed by the authors which is widely used in all levels of mental health and other public and private service systems.

In the monograph, cultural competency is defined as a system that

“acknowledges and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs” (Cross, Bazron, Dennis, and Isaacs, 1989). Cultural is defined as the “integrated pattern of human behavior that includes thoughts,

communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group” (Cross, Bazron, Dennis, and Isaacs, 1989).

The cultural competency model involves several levels of understanding and commitment to engage. Its basic goal is that systems, agencies, and practitioners have

the “capacity to respond to the unique needs of populations whose cultures are different than that which might be called ‘dominant’ or ‘mainstream’ American” (Cross, Bazron, Dennis, and Isaacs, 1989). First and foremost, one must understand and support internally and externally that cultural competency is a developmental process that agencies and individuals continually strive to attain. It requires a plan that must be put into

***“...cultural competency is defined as a system that ‘acknowledges and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs.’”***



place to move a system toward cultural competency. Strategies are planned so that they are tailored to the individual community and are responsive to its many changes. No two counties' cultural competency plans will be exactly the same.

Creating a culturally and linguistically competent system of care requires developing and strengthening competence at all levels of the system - institutions, agencies, administration, management and personnel, and throughout the service delivery system. Five elements have been identified by Cross, et al. as essential to becoming culturally competent:

- **Diversity is valued.** In the system of care, acceptance of the fact that different cultures view behaviors, interactions and values differently and may define concepts such as “health” and “family” differently are critical to effective service delivery.
- **The system has the capacity for on-going self-assessment.** Policy-making, program goals and objectives, minority-group access to both services and decision-making, and the degree to which services can be and are adapted to meet the unique cultural needs of a diverse target population all need to be addressed. Identify barriers and strengths in such things as the current composition of administration and staff, hiring practices, training policies, culturally specific service components, etc.
- **The system is aware of the “dynamics of difference.”** When cultures interact, people from both cultures bring to the interaction their unique differences, histories, and patterns of communication and problem-solving skills. Without an understanding of cross-cultural dynamics, misinterpretation and misjudgments may occur.
- **Cultural knowledge is institutionalized.** The ability to access cultural information must be available at all levels of the organization. This must be provided through training as well as through community contacts and/or consultants available to help staff with cultural awareness and cultural competency-related issues.
- **The system demonstrates the ability to adapt to diversity.** Policy changes may need to be made that impact attitudes and practices. Service delivery adaptations need to be tailored to the needs of the population being served.

There needs to be local efforts to hire staff that are culturally and linguistically competent, knowledgeable and have expertise in working with diverse ethnic/cultural groups. Attention should be given to the diversity of the community being served and the cultural competence of the staff to serve them.

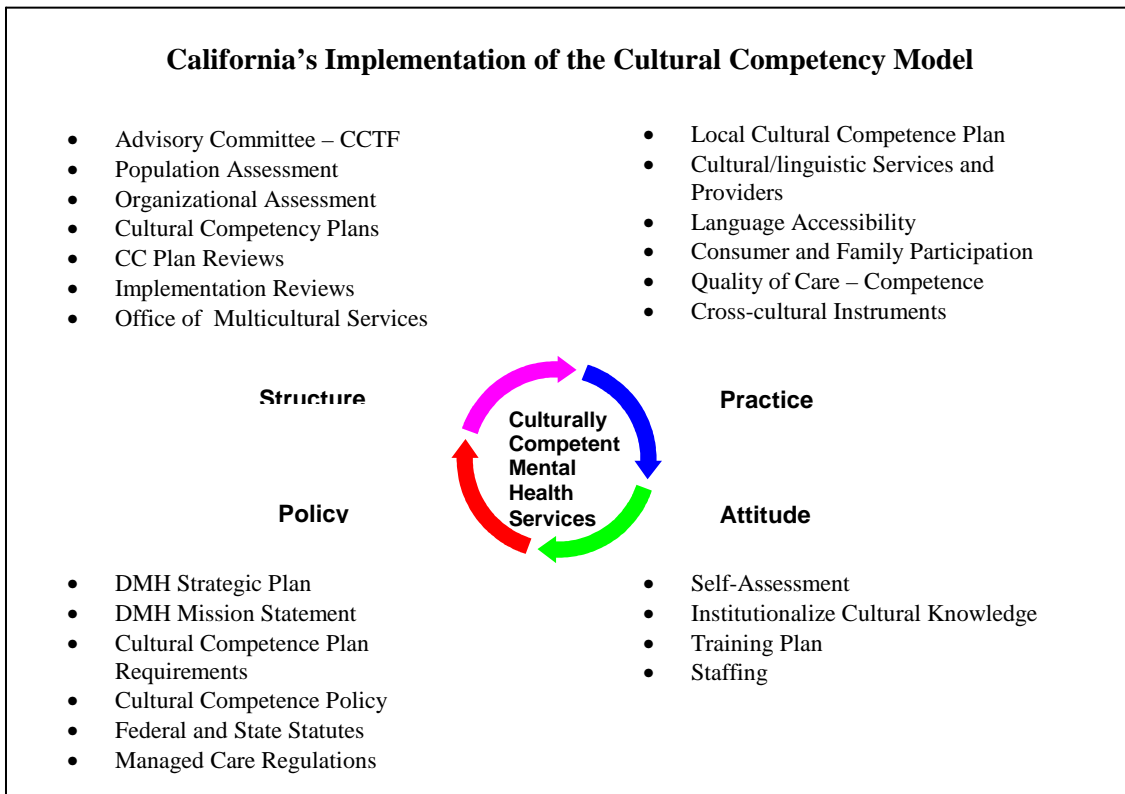
This attention should also include an awareness of avoiding “tokenism” in

hiring and also address retention of staff. Retention of staff is as important as hiring culturally competent staff. Programs should be mindful of the need for not only cultural competency in hiring but also the need for developing “critical” mass within a program as an issue of retention. This is an awareness of the need for a number of ethnic staff in the organization to create “critical” mass, i.e. diverse staff representation within an organization. Ideally diverse staff would be reflected in all levels of the organization.

Other areas of focus may include the importance of extended family and the use of non-traditional healing techniques. More acceptable service delivery settings should be developed. Natural community support systems and

helpers should be utilized. These are just a few examples of ways in which systems can create a better fit between the needs of the population and the services available.

The diagram below is adapted from a cultural competency model developed by the National Indian Child Welfare Association (© NWICWA, 1993). In this model, four essential areas are identified - **structure, practice, policy** and **attitudes** - that local children’s service agencies should address in moving their system of care toward becoming culturally competent systems. Counties should have specific strategies for each of these areas. They can serve as a framework for developing system of care plans.



The challenge for developing a truly culturally competent system of care is how to move the **entire** children's system toward cultural competency. The optimal answer would be that the system of care would have agreed-upon cultural competency values as described above, and that each agency would develop its own cultural competency plan, with specific strategies and goals unique to that agency and its level of cultural competency efforts and needs.

Those developing Children's Systems of Care should remember that cultural competency is a developmental process. The challenge for system of care leadership is to view cultural competency as an intrinsic part of system of care planning and implementation, and not as something to be pulled out or kept separate. Counties can share resources, cultural competency plans and trainings, and can help identify goals, timelines and activities across systems to address the needs of all children in their communities from a cultural competency perspective.

*“The challenge for system of care leadership is to view cultural competency as an intrinsic part of system of care planning and implementation, and not as something to be pulled out or kept separate.”*

## G. Evaluation, Performance Outcomes and Accountability

This component of the Children’s System of Care ensures accountability and a means of tracking progress of stated goals and expected outcomes. The focus is not just on child and system outcomes and costs, but also on process and structure. The key role of evaluation is to help determine whether progress is being made over time on the stated goals of **interagency, family-centered, culturally competent, community-based, individualized and outcome driven service delivery** to the **identified target population**. Although the second (**goals and objectives**) and seventh (**outcomes**) steps in the planning model most explicitly articulate the role for evaluation and research, in implementing the model all of the planning steps are interwoven with ongoing evaluation and feedback. Each planning step is evaluated, and feedback regarding the success of each step is provided through a continuous process into the service delivery system.

Each planning step leads to choices in developing and implementing outcome measures and reminds evaluators of important practical aspects of creating an evaluation protocol. Just as not following each step of the planning process can lead to problems in the implementation of a system of care, failing to understand the implications of each step for evaluation may lead to problems in evaluating a system of care.

*“Each planning step is evaluated, and feedback regarding the success of each step is provided through a continuous process into the service delivery system.”*

### Target Population

- The success of the system in providing equitable access to the intended target population should be evaluated early on in the implementation of the program and should continue throughout the life of the system.
- The demographic characteristics of the youth receiving care must be profiled to determine if certain ethnic, gender, or age groups are either over- or under-represented in the care system. For example, many counties find that girls tend to be under-represented in the service population. This may be due to several factors. Girls are more likely to internalize symptoms, more likely to be depressed, and less likely to come to the attention of public systems. Public agencies,

including schools, are more likely to respond to the aggressive, loud behavior more characteristic of boys, and less likely to recognize girls in serious trouble. If the demographics of those receiving care indicate that

girls are under-represented, corrective action can be taken which may include efforts such as targeted outreach, education

designed to identify at-risk girls, etc.

- The characteristics of the youth enrolled in the system of care constitute an indicator of the success of the first planning step. Low levels of functional impairment, lack of diagnosis, or lack of indicators for risk of placement in a large number of youth enrolled in the system would point to problems in implementation.
- The characteristics of the target population can point to areas of need that can be considered for future development as resources allow.

### Goals and Objectives

- Goals should be designed with an eye toward both how they will be evaluated and their importance to the stakeholders who are invested in the system.
- System goals should be designed to be consistent with the principles and values underlying systems of care. Child and family level goals directly relate to positive changes such as improved social functioning, improved academic functioning, improved behaviors in the community, and consumer satisfaction.
- Not all goals are easily put into operation. The system evaluator can provide direction regarding which goals can be measured and

which cannot. An understanding of how specific goals can be measured will help service administrators understand which goals may appeal to which stakeholders in the system, thereby aiding in prioritizing goals.

- In the initial stages of service development, it may be more important to demonstrate that the system is efficient for purposes of gaining resources and political support for system development. Consequently, initial priority may be given to goals that appeal to policy-makers, such as reducing costly placements.

### Interagency Partnerships

- Remember that the goals of all partner agencies should be considered on an equal footing. Outcomes based on the missions of all partner agencies strengthen collaborative partnerships.
- Part of the process of forming interagency partnerships involves the negotiation of how specific data elements related to outcome measurement will be retrieved from partner agencies. Baseline information on the cost and functioning of the target population can serve as the basis for interagency meetings and partnership developments. A range of outcome information may reside in partner agency records or management information systems.

- Gaining access to partners' data raises all of the same collaborative problems as providing interagency services. Technical difficulties in obtaining and understanding data systems are often far less problematic than collaborative difficulties such as a sense of protectionism regarding data, lack of a shared mission that justifies data access, and concerns regarding how information will be used. The evaluator can play an important role in assuring a continued focus on the goals of the service system as the basis for all collaborative efforts.
- Finally, partnerships between the evaluator and the service systems need to be developed early in the process so that the evaluator can fully understand what data are currently available and useful to evaluating specific goals.

### **Family/Professional Partnerships**

- Families must be involved in all aspects of the evaluation process. Input from family members is helpful in the design of local evaluation strategies and in the interpretation of results. Involving family members in data collection results in better response rates.
- It is important to assess the involvement of families in the delivery of services. Some of the ways to do this include tracking whether caregivers attend

treatment sessions, whether family programs exist and are effective, and whether services are in place that are designed specifically to meet the needs of family members.

- Whenever feasible, include outcomes that are of special interest to family members. Mandated areas of measurement include consumer satisfaction, family involvement and participation in service delivery, family functioning, and caregiver perspectives on child outcomes.

### **Services**

- In designing services, the evaluator can play a role by bringing existing knowledge of empirically effective programs to the service planners. The evaluator can help maintain congruence between service system goals, the actual services implemented and the desired child, family and system outcomes.
- Be aware that certain types of services are more or less likely to have impact on certain types of outcomes, and the evaluator can provide guidance regarding such relationships. A placement screening committee, for example, may reduce out-of-home placements but may have limited impact on psycho-social functioning of the child.
- On-going evaluation of services will enable modification of

services that are not achieving desired outcomes. The development of a residential program in one California county designed to provide services for juvenile offenders who were wards of the court illustrates the interplay between service development and evaluation data. In 1989, this residential program was developed specifically to increase family re-unification, control group home placements, and reduce re-arrest rates. After five years of implementation, the results appeared promising, leading to an expansion of the program from 12 to 18 beds. However, as this expansion was occurring, the longer-term data on re-arrests indicated that the program was not as effective as early results had indicated. Consequently, an intensive interagency study was conducted and the new, expanded 18-bed program was significantly modified. Currently, re-arrest rates for the program are once again back to lower, more desirable levels.

### **Cultural Competence**

- Evaluation strategies need to be sensitive to the ethnic and cultural diversity of the community. This includes an understanding of the cultural sensitivity and bias of instruments that are used in the evaluation process.
- Results from evaluation activities also need to be interpreted in the

context of the ethnic and cultural characteristics of the community. Results need to be examined to ascertain that findings include sufficient numbers of youth from different ethnic and cultural groups to ensure the findings are representative of the cultural diversity of the community.

- Evaluation data can help assess whether the system of care is culturally competent. Access to care can be monitored to ensure that specific ethnic and cultural groups are appropriately represented and not excluded from services. Functional status at intake can be examined to assess whether youth from different ethnic groups are similar with regard to their level of impairment. Similarly, outcomes should be examined by ethnicity to ensure that different ethnic and cultural groups are benefiting from the services provided by the care system.

### **Outcomes**

The development of processes for collecting and reporting information on outcomes is the final step in the planning process. Just as developing services is often the first step for providers in designing programs, selecting outcome measures is often the first step for evaluators in the process of designing an evaluation. In this model, the step of establishing how the system will be measured is final only after the groundwork for determining target populations, goals, partnerships, and services is established.

- Outcome monitoring and feedback need to occur at a range of levels within the system of care, including at the system, program, and service levels. Monitoring at the systems level can provide information back to groups that set policy and establish the direction and goals of the system. Programmatic feedback can be used by managers at the program level to fine-tune services. Finally, feedback at the consumer and service level can assist line staff in producing consumer level outcomes.
- To maximize the chances for success, local feedback should occur at the level at which results are expected. It is at the level of the individual child and family that the success or failure of an intervention is most acutely felt. The family, child, and clinician/caseworker all require incremental feedback to sustain their efforts on a daily basis. Evaluation also provides important information serving to reinforce clinician/caseworker efforts at the individual level. Systematic feedback on a regular basis at the service delivery level acknowledges that aggregated system outcomes are created one child at a time.
- The CSOC model affords a set of outcome measurement principles and state and local measures designed to be implemented in care systems that are at a range of developmental stages. The

principles of local outcome measurement tool selection are meant to operate in conjunction with the planning model as a guide to establishing outcome measures within a given community. These principles are:

1. Tool selection is based on the CSOC model and philosophy
2. Measures should have maximum value for all stakeholders
3. Measures should promote efficiency and effectiveness in implementation
4. Measures should have known psychometric properties
5. Measures should yield clear and understandable results
6. Measures should be meaningful to the local CSOC

The core implication of the CSOC approach for assessing outcomes is the need to clearly delineate consistency between choices made at all seven steps of the model. **Table 1** (next page) draws from evaluation experiences to illustrate how each of the individual components of the target populations, goals, partnerships, services, outcomes, and audiences or stakeholders can interrelate. Selections made in any of these individual components will impact other components. Although not illustrated in the table for purposes of simplicity,



many measures may be suitable across a range of target populations and may have multiple impacts beyond those specified in the table. In reality, the ultimate choice of which outcome measures to select will rest on some combination of the planning model process with the

availability of measures, and available resources. However, the success of outcome studies relies on the congruence between goals, desired impacts, and the availability of quality measures or indicators.

**Table 1: Example of Matching Goals, Populations, Measures and Impacts**

STEP 1: Define Target Population	STEP 2: Set Goals	STEP 3: Create Partnerships	STEP 4: Establish Services	STEP 5: Establish Outcomes	Stakeholders
Youth at risk of out-of-home placement	In Home	Social Services, Juvenile Justice, Mental Health	Placement Screening	Placements and Expenditures in Restrictive Levels of Care	Consumers Managers Policy Makers
Youth enrolled in special education programs	In School	Education, Mental Health	Special Day Schools	School Attendance School Achievement	Consumers Policy Makers Teachers
Wards of the court	Out of Trouble	Juvenile Justice, Mental Health	Juvenile Hall Support	Re-arrest rates	Consumers Judges Policy Makers
Younger youth with multiple risk factors	Healthy	Primary Health Care, Mental Health	Assessment and Brief Therapy	Child Behavior Checklist	Clinicians Consumers Managers

**Table 2** (next page) delineates a full range of possible outcome measurement strategies in use in counties implementing the CSOC model. As noted on the chart, not all counties follow all the criteria. Also included in the chart is a list of primary audiences for each measurement tool. Although many of the measures have multiple uses, each is specifically chosen to

provide primary feedback to different levels of the care system. It is important to note that these indicators constitute a “least common denominator” outcome data set. Many counties collect a range of additional outcome and other indicators that are tailored for the needs of managing their specific county care systems.

**Table 2: Full Ongoing Outcome Data Set for California Children’s System of Care Model Counties**

**Systems Level Measures and Outcomes**

WHAT	SOURCE	WHEN	PRIMARY AUDIENCE
1. PLACEMENTS: a. State hospital: number, length of stay, cost b. Group home: number, cost c. Foster homes: number, cost d. Acute psychiatric hospital: bed days, cost e. Restrictiveness of living environment (Restrictiveness of Living Environment Scale – ROLES)	State data systems  County data  Clinician/ Case manager	Collected monthly  Collected monthly Entry, exit, annual	State and local policy makers, interagency partners, program managers, clinicians, consumers
2. EDUCATIONAL PERFORMANCE: For youth in select special education/mental health programs a. School attendance b. School performance	School records Achievement tests	Ongoing Annually	Program managers, interagency partners, local policy makers, clinicians, consumers
3. JUVENILE JUSTICE: For youth in selected mental health, juvenile justice programs a. Recidivism: arrests and citations by type of offense	Court records	Ongoing, one-year pre- and post-program	Program managers, interagency partners, local policy makers, clinicians, consumers

**Consumer Level Measures and Outcomes**

WHAT	SOURCE	WHEN	PRIMARY AUDIENCE
1. Functioning, competence, and impairment from caregiver, consumer, and clinician perspectives a. Child Behavior Checklist b. Youth Self-Report c. Child and Adolescent Functional Assessment Scale	Caregiver Child Clinician	Entry, six-months, <sup>1</sup> annually and discharge	Clinicians and consumers, program managers, local policy makers
2. Satisfaction, CSQ - 8	Caregiver, child <sup>1</sup>	Sampled periodically	Consumers, program managers, clinicians
3. Family Empowerment Scale <sup>1</sup>	Caregiver	Sampled periodically	Consumers, program managers, clinicians

<sup>1</sup>Required only for counties receiving a Children’s Mental Health Initiative grant from the Center for Mental Health Services

The system level indicators have been used routinely for system management, program development, and policy purposes. They do not lend themselves to frequent use by clinicians/caseworkers, who may not even be aware of some of the indicators. The utilization data regarding group home, foster home, state hospital, and hospital utilization represent indicators of the system level goal of keeping youth in the least restrictive environment possible. The educational and juvenile justice data speak specifically to the performance of programs designed to impact specific sub-populations of youth within the overall care system. They are valuable as system indicators, but are especially suitable to the performance of key programs.

The addition of consumer-level measures was prompted by the expansion of the CSOC model through the Children's Mental Health Services Act. This act calls for the measurement of child and family level outcomes within a care system. This need derived, in part, from concerns by a range of stakeholders regarding the fates of individual youth within the care system. The measures selected for use are among the most popular in the research and clinical communities. Parents or caregivers complete the Child Behavior Checklist (CBCL) and children age 12 and over complete the Youth Self-Report (YSR) (Achenbach and Edelbrock, 1983). These measures provide data on social competencies (functional status) across a range of social contexts (school, home, community) and syndrome scales

(clinical status). Clinicians complete the Child and Adolescent Functional Assessment Scale - a clinician rating scale that yields scores regarding the child's functioning in the domains of: role performance (including school/work, home, and community sub-scales); thinking; behavior towards others; moods/self-harm (including moods/emotions and self-harmful behavior sub-scales); and substance use (Hodges, 1989, 1994). Together, these measures provide three perspectives on the functioning of the child: the caregiver's, the child's, and the clinician's.

Finally, service satisfaction is being assessed using the Client Satisfaction Questionnaire 8 (Attkisson and Greenfield, 1994). Child and family satisfaction with services is becoming an increasingly important aspect of assessing the success of service delivery efforts. It speaks to the direct experiences of children and families in receiving services. In addition, in counties receiving CMHS federal funding, a newly developed measure of family empowerment, the Family Empowerment Scale developed by the Research and Training Center on Family Support and Children's Mental Health at Portland State University is being completed by the parents or caretakers (Koren, De Chillo and Friesen, 1992). This instrument assesses their perceptions about their roles and responsibilities within the service system and their ability to advocate on behalf of their child.

## V. Governance and Infrastructure

### Governance

Implementing a system of care does not require major organizational restructuring. Systems of care have been successfully implemented in counties with many different kinds of organizational structures. No one model of governance or organizational structure has been identified as necessary, or even as being the most desirable, for a successful system of care. Some counties have “super-agencies” or “umbrella structures” which contain many (but almost never all) of the relevant child-serving agencies within one department. Other counties are organized with all the public partner agencies being independent departments or agencies. Some counties rely heavily on county-run, county-staffed programs; others contract out most of their services. Most counties are probably somewhere in the middle of these continuums—some agencies such as health and mental health, or health and welfare may be within a single department, and services are a combination of contracted services

***“No one model of governance or organizational structure has been identified as necessary, or even as being the most desirable, for a successful system of care.”***

and staff operations. Also, counties have given varying degrees of authority and

***“Implementing a system of care does not require major organizational restructuring.”***

responsibility for coordination to their interagency committee structure.

Several key questions may be helpful in deciding whether or not changes in structure and governance are necessary:

- What do we need to change in order to achieve our agreed-upon outcomes? Form should follow function, not the other way around!
- What structural or governance barriers currently prevent us from achieving these outcomes? Watch out here for “red herrings.” Some perceived barriers will disappear under good leadership and a strong commitment from all partners.
- Do we need to “start over,” or can we build on what we have? Major reorganizations may help to bring about extensive changes that are sought, but can also cost significant amounts of time and money in the short run. Creating collaborative linkages may not provide as much “permanency” as structural changes within the system.
- If we decide on making changes, will they incorporate the flexibility that may be needed

when new initiatives arise or methods of funding change dramatically?

- As we make changes, are we being careful to add value, and not bureaucracy?

Once again, the flexibility of the model is important. Local conditions play a major role in deciding what structure a local county should have when implementing their system of care. Creating collaborative linkages between departments or agencies rather than creating a rigid organizational structure permits continued flexibility. As new target populations are added, appropriate new partners can be added to the collaborative. On the other hand, reorganization under a single structure may do more to “institutionalize” the system. If the commitment to develop and sustain a seamless system of care is there, the structure is less important.

***“If the commitment to develop and sustain a seamless system of care is there, the structure is less important.”***

## **Infrastructure**

In planning for and developing the system of care, it is important to focus sufficient resources on an infrastructure that allows and encourages continued emphasis on CSOC principles. Too often, the tendency is to favor resources being focused exclusively on direct services. When infrastructure and

***“When infrastructure and support is inadequate, services may get provided, but ongoing monitoring, planning, refinement and feedback, particularly across agencies, will suffer.”***

support is inadequate, services may get provided, but ongoing monitoring, planning, refinement and feedback, particularly across agencies, will suffer. Following are some tips for avoiding this situation:

- Supervisory and management staffing must be sufficient to allow time for on-going interagency planning and coordination. The issues to be dealt with increase, as management must focus not just on internal department matters, but also on cross-agency issues.
- Remember that interagency meetings at all levels require time, but are essential to the on-going development of the system. Creating the ability to spend more time on the “front-end” will save time in the service delivery process.
- The need for on-going evaluation requires sufficient resources committed to process evaluation and child, family and system outcome studies. Collecting data, providing feedback across the system and meeting the varied needs of partner agencies for information also take a significant amount of time and energy.

The size of the county also plays an important role in making decisions about governance and infrastructure. What works in a small rural county will probably not work in a large urban one. The common elements of service linkages, coordinated services, collaborative programs, inter- or intra-agency agreements, multiple entry points with a single point of responsibility for each child, and joint planning must be present and adequately supported within

whatever structure and infrastructure exists in the county.

For an illustration of how an interagency governance and service delivery system might be structured, please refer to the two models, the Collaborative Children's Services Model, and the Structurally Integrated Children's Services Model, attached as Appendix G.

## VI. Financing

Without a system of care, the most expensive “high-end” services (hospitalization, group home placement, etc.) absorb an increasing percentage of the available resources. In addition, eighty percent of the resources go to serve twenty percent of the children and families. An environment in which individual agencies only feel responsibility for their own budgets and costs tends to create protective attitudes toward resources and services.

Better management of resources through the CSOC model has been shown to be effective in reducing human service costs. A collaborative fiscal strategy changes “cost shifting” to “cost avoiding.” It allows the system to

*“A collaborative fiscal strategy changes ‘cost shifting’ to ‘cost avoiding.’”*

maximize all existing revenue sources in ways that are not possible for individual agencies acting

alone. When departments agree to a collaborative fiscal strategy, an appropriate mix of cost-effective services to meet the needs of multi-agency involved children and families can be developed more easily.

Fiscal collaboration also increases opportunities to access additional state and federal funds, which can increase the total resources available to finance services within and across participating departments/agencies. Below are five

major steps that have proven to be helpful when developing collaborative fiscal strategies:

- **Map current funding streams.** Make an inventory of all the various funding streams that are used to provide services to the designated target population. It is important that all partners in the system have at least a basic understanding of the types of resources available and the requirements for obtaining these funds.
- **Establish an atmosphere of shared responsibility for resources and outcomes.** Department directors are responsible for achieving certain outcomes with a limited set of resources. A collaborative fiscal strategy must be designed that allows each director to do a better job within his/her own areas of responsibility as well as in the larger system of care. A collaborative feeling of responsibility is strengthened through the concept of shared risks and rewards. When the system is successful, all partners should benefit. Correspondingly, if objectives are not being met, partners will have an investment in making the necessary changes to ensure that things “turn around.”
- **Get the most “bang for the buck!”** Funding for children’s

mental health services, child welfare, education and probation may increase in value and may even leverage additional funds, depending upon where and how they are applied. It is very important to plan carefully how services are financed to make the most efficient use of all available resources. By restructuring system finances, the partners may be able to finance some gaps in existing services without requiring the commitment of additional county resources.

- **Reinvest cost savings.** System sustainability and expansion are contingent upon a strategy to reinvest at least a portion of actual cost savings back into the system of care. Consequently, a fiscal strategy must define a method of measuring cost savings and joint planning for reinvesting those savings.
- **Get “up-front buy-in” from key decision-makers.** Fiscal collaboration and a reinvestment strategy require cooperation from the Board of Supervisors and top county officials. Educating these individuals about the goals and objectives of the CSOC model and informing them of its programmatic and fiscal results is critical to obtaining and maintaining the cooperation of these key participants.

Because both the amounts and types of services and funding vary greatly from county to county, there is no single strategy that applies in all circumstances. There are generally three basic types of

funding for mental health services: Medi-Cal funds including EPSDT, realignment funds, and “other sources” such as local, state and federal dollars. Some pointers for maximizing these sources are listed below. For a more extensive discussion of funding strategies, see Developing Blended Funding Programs for Children’s Mental Health Care Systems: A Manual of Financial Strategies, (Edelman, 1998) available through the Cathie Wright Technical Assistance Center.

- State system of care funding should not be perceived as an augmentation to expand the existing service continuum, but as a catalyst to begin system implementation. This funding is really “seed money.” The on-going funding for the system of care comes from efficient management of services and funding sources.
- Realignment funds are most valuable when they are used for Medi-Cal eligible services.
- Federal dollars are most prudently used for non-Medi-Cal eligible services and functions, since they cannot be used to draw down Medi-Cal.
- Other source dollars, such as state funds for implementing systems of care, are most valuable when they are used for Medi-Cal eligible direct services, which are not eligible for EPSDT reimbursement (since EPSDT State General Funds will not be provided when these other source dollars are used as match).
- Other agencies have access to other funding sources, which may be used to draw down



additional Medi-Cal Federal Financial Participation (FFP).

- Other agencies may be able to access special waiver programs or existing legislation that free-up categorical federal and state funds and enable them to be used more flexibly within the system of care.

It is important to note that the information referenced here is based upon current fiscal policies. The advent

of new initiatives such as the SB 163 Wraparound Services Pilot, Welfare Reform, Healthy Families and the consolidation of Medi-Cal specialty mental health services offer new opportunities to maximize funding for systems of care. Successful counties need to “stay on top” of these changes, and partners need to jointly analyze them to determine the best fiscal strategies.

## VII. Special Issues

Although each county may identify a number of unique issues they need to consider as they develop and implement the Children’s System of Care model, there are several special issues that experience has shown are common to all communities.

### A. Training and Technical Assistance

Training and technical assistance is a process of skill building through the teaching of specific skills, ideas or strategies. Generally, training involves three levels: introducing a concept, developing new skills, then facilitating mastery and independence with those skills. Training and technical assistance serve a number of functions in the development and support of systems of care. Providing technical assistance in a system reform effort, especially one as complicated as a multi-agency effort to coordinate and integrate services to a target population of children with serious emotional disturbances and their families requires attention to multiple areas simultaneously.

***“Representatives of all stakeholders should develop a training plan, and should chart the direction of change across systems, programs and practice levels, based on common values and goals.”***

### Getting Started

- Representatives of all stakeholders should develop a training plan, and should chart the direction of change across systems, programs and practice levels, based on common values and goals. This plan will help the values and priorities of partners to coalesce.
- It is helpful to have a large group introductory cross-agency training in the initial phase of system building to make sure that the same message is delivered and that everyone understands the commitment to change and the reasons for it. Training at the system (leadership), program (supervisory) and practice (line staff) levels simultaneously is helpful in creating a common language for change.
- In terms of providing technical assistance, there are a number of issues to consider during initial implementation of the CSOC. Some of these issues include: managing in a time of change; staff supervision strategies across agencies when staff are co-located; personnel procedures and confidentiality; requirements for integrating family members as staff; implications at all levels of shifting from a clinical mental health model to a system of care model which focuses on a wider service array; a different

decision-making structure; and more individualization of service plans with non-traditional services. Also needing attention are issues of working as a team member rather than an individual mental health worker, social service worker, teacher or probation officer, and the implications for staff of productivity requirements when the collaborative takes on risk.

*“New practice takes time to develop, and recurrent training provides a strategy for proactive supportive system change.”*

## Ongoing Training

Training and technical assistance should best be utilized in two major ways:

- **Training to implement specific projects and train staff.** This type of training addresses special, time-limited activities. For example, for children’s services staff, there is a huge shift in the paradigm of working as an individual therapist with a child and/or family, to using one’s clinical skills primarily in facilitating a team of professionals, family members and community support people. Using one’s clinical skills to help the team decide what services and supports to provide at what

time is a new skill for many in children’s services clinics.

- **Training that involves working regularly, over time, with groups.** Here the focus is on system development and fidelity to values, principles and goals. Recurrent training in regular intervals over the first several years is helpful as a quality check, feedback opportunity and to integrate new-hires. Likewise, at least yearly refreshers, reflecting updated implementation procedures, will keep all staff current. New practice takes time to develop, and recurrent training provides a strategy for proactive supportive system change. What is really being developed is a culture and it must be supported over time or system inertia may take over.

Consistency of message is also critical, as inconsistencies will be picked up by resistant employees and used to create dissension in the ranks and to demonstrate perceived inadequacy or inappropriateness of the reform effort. Likewise, if multiple consultants and trainers are being used within the system of care, it is wise to have a meeting of the minds and ensure that there is continuity of ideas and strategies presented so that staff do not have to sort out the inconsistencies themselves. Counties should view themselves as the “purchasers,” should be clear with consultants and trainers about what they want, and should expect positive outcomes.

## Modeling Team Building

Training seems to be best received when the team represents a diverse cross-section of family, practice, program and system levels. This brings the training into line with system reform principles and values and demonstrates congruence with those values. Some communities have used the development of systems of care as an opportunity to train staff

*“Training seems to be best received when the team represents a diverse cross-section of family, practice, program and system levels.”*

across child-serving agencies or subsystems. Staff come together from different agencies whose missions vary, whose experience with family members vary and whose approach to service delivery and case management may differ. The understanding and empathy which can be created is very useful in developing teamwork across the system which is essential to quality care provision, achievement of outcomes and cost effectiveness. Developing a common language with common expectations of staff at all levels of the system is critical to good implementation.

## Training at all Levels

- **County Leadership and Management.** Involving agency leadership and community policy

makers as well as mid-management, supervisors and line staff in initial and follow-up training is important as it gives everyone the same information and gives concepts and practices a human face. Training and technical assistance can be extremely helpful, initially, in meetings of agency leadership as they begin discussions of internal agency reforms and/or cross agency partnerships.

Assumptions are often made about leadership commitment to the principles and values of a system reform effort. Getting consensus and providing opportunity to question and clarify in a safely challenging environment will save considerable effort over time. The training setting can provide a valuable role in helping leadership to develop a consistent values and principles base for the system of care and the strategies supporting its implementation.

- **Service Delivery Staff.** Those at the practice level who interact with consumer families are often targeted for training first, since they must directly implement the new model. Using technical assistance to create support for system reform at the supervisory level is the next important step. Some communities have simultaneously trained line and supervisory level staff. Several programs have discovered that avoiding training of supervisors can grind the system change effort to a halt. It is this

“program level” staff who manage the implementation of the procedures and policies which support the system reform. If supervisory staff do not “buy in,” great frustration will occur between line staff and supervisors, and between supervisors and leadership. Generally, lack of “buy in” at this level becomes most apparent about one year into implementation. At that point, when supervisors are not committed, line staff are burning out and families are starting to report difficulties obtaining services and supports.

- **Families.** Sometimes overlooked at the initial phase of training is participation by family representatives who can be very helpful in focusing the group on values and principles and providing context as to why these reforms are being enacted. For example, training in alternative service provision practices like wrap-around services are received most favorably and tend to have the most impact when the actual family members needing these services participate in the team process which is being introduced. Services can then be designed specifically for these family members. It is important to note, however, that this requires careful preparation of the family members as well as skillful facilitation of the teams in the training session.
- **Administration and Support Staff.** In addition to families,

leadership, program and practice staff, it is important not to overlook financial office personnel and critical support staff. It is their daily performance that determines whether or not the system will work efficiently. Systems that have incorporated both financial and support staff in training have found that system change is greatly facilitated.

While there may be initial additional fiscal costs to training at all levels, it will be a good investment over time and will ultimately speed and facilitate successful implementation.

### **Building Internal Capacity To Train and Sustain**

It has been estimated that the system change process can take as much as a decade to develop. Therefore it is important to consider how to build up a cadre of trainers, across agencies, who can train new staff and help develop and maintain their skill level and support the emerging organizational culture. Besides new procedures, there are ways of thinking and behaving which are being incorporated into the training, such as working across systems, working in the community instead of an office, and working with families as team members and partners. Using staff as trainers who can facilitate and support the developing culture will be both cost and energy efficient.

***“...the right to privacy and informed consent to release information...”***

## **B. Confidentiality**

Issues regarding confidentiality and client privilege are complex and are sometimes cited as obstacles to the collaborative process. The protection of the right to privacy and informed consent to release information is one of the core trust issues for families seeking services and treatment in any care system. The ability to balance these rights with the need to share information in a collaborative system is critical and should be approached from a comprehensive perspective.

***“The ability to balance these rights with the need to share information in a collaborative system is critical.”***

Participants in the process of policy and procedure review in this area should include representatives from management and direct service staff from each agency, a legal consultant, a consumer and/or consumer’s family member, and a patients’ rights representative, when applicable. The agencies should focus on options for the development of a process to both ensure consumer privacy as well as to ensure that treatment is efficiently delivered in

an interagency context. The options to be explored include:

- Implement a children’s multidisciplinary services team pursuant to W&I Code Sections 18986.40 through 18986.46 (see Appendix H).
- Include in the interagency agreement(s) a section on “confidentiality” specifying information exchange consistent with the above W&I Code Sections. Sample language is included below:

“Staff of the agencies who are parties to this MOU who are qualified and have responsibility to provide services identified in W&I Code Section 18986.46 may disclose to one another information and view records on a child or the child’s family. Information disclosed or records viewed by members of the team shall be limited to relevant information or records necessary to formulate an integrated services plan or to deliver services to children and their family. The release of copies of mental health records, physical health records and substance abuse records may take place only after the agency or party holding the records has received a written authorization to release records, in a format approved by the agencies’ counsel, signed by the child, to the extent that the child has power to consent under state law, or by the child’s parent, guardian, or legal representative including the court which has

jurisdiction over those children who are wards or dependents of the court.

Persons designated by the parties to this MOU as members of a multi-disciplinary team for a particular case may receive and disclose relevant information provided that:

1. Every member of the children's multidisciplinary services team who receives information or records on children and families served through the CSOC shall be under the same privacy and confidentiality obligations and subject to the same confidentiality penalties as the person disclosing or providing the information and records, and
2. The information or records obtained shall be maintained in a manner that ensures the maximum protection of privacy and confidentiality rights

A common data base shall be developed and maintained from information collected and held by parties to this MOU. Information contained in the database will be both child-specific and aggregate. This data base is for the purpose of planning and delivering services, as well as to facilitate tracking of outcome measures and other research data to determine the efficacy of services provided through the System of Care."

- Implement an Interagency Release of Information Form and/or a Court Order to Allow for Exchange of Information (samples of these are included in Appendix I).

The above options represent suggested approaches to the complicated issues of maintaining client confidentiality in an interagency system of care. The sample materials are not meant to be copied directly, but can form the basis for discussion and development of county-specific materials.

### **C. Systems of Care and Managed Care**

In 1993, the California State Department of Health Services released its plan for "carving out" all Medi-Cal funds for mental health services. This was accomplished in two phases. **Phase I** began in 1995. Counties assumed the

***"...an effectively implemented system of care results in a managed care plan that is much more than just a financial tool. With an emphasis on individualized services, family involvement and cultural competence along with consumer and cost outcomes, the managed care plan can achieve cost containment, increased quality of services and a greater 'humanness' in the service delivery system."***

responsibility and risk for all medically necessary mental health inpatient services provided to eligible Medi-Cal beneficiaries. **Phase II** requires the consolidation of all outpatient specialty mental health services and was phased in between 1997 and 1998. With full consolidation, county mental health programs have the risk and responsibility for all medically necessary mental health services to the Medi-Cal population. For services to children and youth, this means the expansion of the originally defined CSOC target population to a broader population of children with less serious emotional problems, and their families. As noted at the beginning of this manual, the CSOC model was designed to be applicable to expanded target populations.

**There are four major concepts in managed care: access, quality, cost and satisfaction.** The goals of a managed care plan are to increase access, maintain or enhance quality of service, produce satisfied consumers and providers and be cost-effective. This section highlights how, in the area of services to children and families, the CSOC model can help successfully address each of these goals.

Too often, the concept of managed care is thought of as simply a financial mechanism designed to control costs. Cost containment is a goal shared by managed care and CSOC. As the following pages point out however, an effectively implemented system of care results in a managed care plan that is much more than just a financial tool. With an emphasis on individualized services, family involvement and cultural competence along with

consumer and cost outcomes, the managed care plan can achieve cost containment, increased quality of services and a greater “humanness” in the service delivery system.

### Access

- Using the first component of the CSOC model, the **clearly defined target population** for managed care becomes all Medi-Cal eligible children and their families. Once defined, it is possible to begin developing a system that will improve access for this population.
- Using the concepts of **agency and family/professional partnerships**, identify a broader “stakeholder” community that can more effectively design and implement the managed care plan.
- **Agency and family/professional partnerships** can assist in developing a broader array of services for this expanded target population.
- **Agency partnerships** can blend and leverage funds to maximize resources needed to expand services to children and families.
- The ability to enter the system through **multiple entry points**, including through partner agencies establishes improved access for this population.
- The concept of **reinvestment of savings** implemented cooperatively across agencies allows creation of prevention and



earlier intervention programs that increase access and help reduce risk.

## Quality

- With a priority on the component of **accountability to outcomes**, the CSOC will help manage care appropriately. One of the measures of quality care is whether or not it produces the desired outcomes and consumer satisfaction.
- The CSOC model offers an “unlimited” benefit package. The broad array of services, along with an emphasis on the component of **individualized services** tailored to the child and family’s needs will result in an increase in the system’s ability to provide quality care.
- The CSOC offers multiple opportunities for families, partner agencies and the community to define and assess “quality.” The incorporation of multiple perspectives across multiple domains will lead to more emphasis on providing what families need and want.

## Satisfaction

- The core concepts of **family/professional partnerships and cultural competence** offer opportunities to influence the values of the service delivery system and its providers, resulting in greater consumer satisfaction. The CSOC provides for broader and

more open feedback about how the system is functioning.

- The CSOC uses standardized instruments for measuring consumer satisfaction.
- The CSOC **agency and family/professional partnerships** allow for broader input into the planning and development of the managed care system. Stakeholders have meaningful involvement, which results in greater satisfaction.

## Cost

- Cost-effective services are continually addressed through the CSOC components of **measurable goals and accountability to outcomes**.
- The CSOC model not only addresses mental health costs, but contains costs across the system, offering opportunities for cost savings which can then be reinvested in additional services and/or expansion of the target population.
- Blending and leveraging funds through **agency partnerships** achieves greater cost efficiencies.
- When agencies work as partners, they can better manage their collective financial risks.

The implementation of managed care also presents some challenges that need to be addressed within the Children’s System of Care:

- The streamlining and centralizing of some functions under managed care may not always be

fully compatible with the CSOC. For example, a centralized access may add a “hurdle” for interagency partners, and may not apply to jointly operated interagency programs. In these instances the system of care should “drive” managed care decisions, rather than the other way around.

- Increased visibility and the expansion of the target population increase demand for services. Be ready to respond to this demand in a timely manner and manage this demand within available resources. The opportunities for service expansion provided through EPSDT are important here.
- Develop ways to define and monitor the quality of services to the expanded target population that may be different from the measures used to assess services for children with more serious emotional disorders. Children and families requiring shorter-term interventions and/or where risk of out-of-home placement is not an issue may require different types of evaluation instruments.
- More formal grievance procedures are required under managed care. Think about the role of families in this procedure.

***“The CSOC offers the best model for organizing and delivering services to children and their families, and is compatible with managed care principles.”***

The formal nature of this process requires creativity in trying to approach this from a partnership point of view.

- Containment of acute care costs is one of the major efforts under managed care. As the system of care successfully returns more children from out-of-home placement, it may have an impact on hospitalizations. Hospitalizations used to avoid longer-term out-of-home placements need to be compared with hospitalizations following returns from placement. An increase in acute care may be appropriate in these instances, but this may raise issues for the larger behavioral healthcare system.

- Explore ways to get better cost data on individual children and their families served in the system of care. To be competitive with the private managed care sector children’s service systems as a whole need to get more sophisticated in their data collection and retrieval capabilities. The

CSOC must be part of this. In the CSOC model this means data across the system, not just within mental health services.

Managed care, in and of itself, is neither bad, nor good; it is merely a tool for organizing and delivering services. The CSOC offers the best model for organizing and delivering services to

children and their families, and is compatible with managed care principles.

#### ***D. Specific Demographic Issues***

Finally, there are some Children's System of Care issues that pertain to the particular demographics of certain counties. These issues are important to small and/or rural counties, and then identify some particular challenges for large urban areas.

#### ***Small/Rural County Issues***

With regard to Children's System of Care development and implementation in rural/small counties, several issues have been raised that, if not addressed, will impede success. Some of them represent issues for all counties, but the impacts are likely to be intensified in small counties. **These issues can be clustered under three broad areas: leadership, interagency program infrastructure and funding strategies.**

**Leadership.** The importance of a tightly functioning policy council is critical to the survival of the system of care in small counties. Every member of the core structure needs to be at the table, and it is recommended that meetings occur weekly during development and early stages of implementation.

**Interagency Program Infrastructure.** While each county has idiosyncratic needs, service gaps and priorities, the following services have generally surfaced as core needs in small counties:

- **The need to develop alternatives to out-of-county**

**placements.** Typically in small counties, the lack of coordination between departments and an overly utilized group home placement strategy need to be addressed. Some suggested ways to alleviate this significant care gap include: 1) development of wraparound service teams and in-home service capacity, 2) development of enhanced inter/intra-agency case management, 3) development of enhanced foster care and therapeutic foster care, 4) development of enhanced "hot spot" serving capacity (shelter care, crisis care), and 5) development of enriched probation services targeted to 602 (non status-offender) wards.

- **The lack of geographically accessible service sites.** One of the key strategies to address this issue is the development of school-based services. Not only are schools often the only facility in rural locations, but they provide services in the least restrictive environment, they allow for coordinated service delivery and they reduce operational costs. A second approach is the development of co-located county departmental satellite or community hubs. These satellites can spread support service costs and maximize other source funding.
- **The lack of evaluation/support service infrastructure.** Exploration of a consolidated evaluation and/or support

services approach across departments in areas where scope of work overlaps may be helpful in addressing this.

- **The lack of sufficient children’s services staffing to adequately impact target population and fiscal outcomes.** Targeting of multi-agency staffing, tapping multi-agency funding augmentations and development of contract providers are just some of the strategies that may be useful here.

**Funding Strategies.** Small and/or rural counties are characterized by an absence of adequate administrative, support and direct service infrastructure, limitations in federal financial participation matching, increased access mandates and a broadened target population. These characteristics coupled with a lack of available realignment and other “front-load” funds are very real variables that can impede successful system of care implementation. Among the things to be addressed are the need to set the stage for protecting existing human service realignment funds for the short-term, and at least a portion of the funds derived from successful cost-avoidance outcomes over the long-term. In addition, although necessary for all counties, it is even more critical for small counties to develop blended funding approaches that maximize FFP for functions not accessible in mental health systems and other source funds.

## ***Large/Urban County Issues***

As with small/rural counties, there are also some specific issues to be highlighted for large/urban counties that are developing and implementing the Children’s System of Care model. Following are issues that need special consideration in the areas of **leadership, program** and **financing**:

**Leadership.** In large/urban counties, there may be “layers” of bureaucracy due to the size of the departments involved. In cases where these layers of bureaucracy exist, it is particularly important that the department heads of participating agencies and the executive management from involved school districts be in agreement with the principles and goals of the CSOC model. Understanding and support is critical, particularly in the implementation process. In addition, when creating local interagency committees that are developing program policies and procedures, it is crucial that managers who have the authority and the ability to make decisions for their departments are appointed.

**Interagency Program Infrastructure.** There are several program issues that need to be considered by large/urban counties:

- Partners in the system of care need to develop a good understanding of how each other’s bureaucracies function. Structures, relationships and politics may be more complex than in other counties, making this task more difficult. The planning and implementation of a

cross-training program should occur early in the implementation process.

- Geographic accessibility is an issue in poor urban communities due to poor transportation systems and gang-related issues. Services need to be provided within the natural boundaries of the community being served rather than within boundaries developed by school districts or other public agencies.
- In some urban settings where the overall infrastructure is adequate, the biggest challenge may be in the coordination and integration of existing community resources. Creating strong linkages among programs with similar philosophies and principles needs to be addressed at the beginning stages of program development.
- In most urban communities there is not sufficient professional staff that reflect the ethnic make-up of the communities being served. This presents particular challenges in developing culturally competent services. Use of natural community leaders, consumers and indigenous helpers may make services more accessible and acceptable.
- Some of the recommended outcome measures may not be as useful, relevant and/or valid due to the diversity in the cultures and socioeconomic backgrounds of the families being served.

Again, the flexibility of the planning model is important here. Outcome measures need to be developed that are meaningful and relevant to all partners, particularly to the families.

**Funding Strategies.** The financial challenges experienced by large/urban counties are similar to those experienced by all counties, but occur on a “grand scale.” The rigidity of the categorical funding streams makes it difficult to implement a seamless system. Wrap-around services need to be organized in ways that allow maximum flexibility. In addition, large/urban counties need to be particularly creative in developing ways to capture federal funds (FFP) for personal services provided to families.

## VIII. Conclusion

The CSOC model is a proven model that works. Based on the number of youth served by counties using this model, it is the single largest system of care effort in the country. It is designed to be adapted to the unique individual needs and situations of California's diverse counties. Some key factors to remember about the components of a successfully implemented model are highlighted below:

- Although originally designed for the specific population of children with serious emotional disorders and their families, **the CSOC is equally applicable to the broader population under Medi-Cal and EPSDT and in the development of earlier intervention programs.** As new initiatives come along, they can be integrated into the existing system of care. Although counties may have several special subsystems for differing target populations, the array of comprehensive coordinated services that serve children and their families should ultimately be linked together into a single system.
- **The foundation of the model is its accountability,** based on clearly defined and measurable goals and objectives. This aspect provides credibility, which is crucial for sustaining the CSOC. Through this model, counties are able to demonstrate that they are achieving better outcomes for children and their families for reasonable costs.
- Interagency partnerships allow agencies to provide **services that appear seamless to the consumer.** Families can enter the system at any point and be assured of getting a comprehensive array of human services. Cost shifting is reduced, since the entire system is accountable for total costs.
- **The CSOC is not only designed to serve children and their families, it is designed with the full participation of families and should reflect what families need and want.** It is based upon mutual trust and respect. Parents and professionals educate one another and combine their skills to provide the “best practices” necessary to help children succeed and thrive.
- Services in the CSOC are designed to meet the individual and unique needs of each child and his/her family. **Family strengths are identified and built upon.** When a child and/or family is not responding positively, the system needs to change its response to the family.
- The CSOC is designed to be effective with the diverse ethnic populations throughout the state. **Emphasis is placed on cultural competence as a developmental process** that will ensure that all children and their families receive culturally appropriate services in culturally sensitive settings that respect cultural differences.

- Evaluation efforts provide checks and balances at the individual child and family level as well as the broader system level. Self-assessment is possible on an on-going basis. If results do not meet expectations, indicators point to areas that need to be changed in order to be more successful. Perhaps even more important, **evaluation enables the system to demonstrate that it can achieve predefined results.**

The contributors who have collaborated to develop this manual are county administrators and staff, family members and employees of the State Department of Mental Health. All have played key roles in establishing successful Children’s Systems of Care in California. This document shares the processes and steps that were followed, identifies some pitfalls to avoid, and

provides suggestions and ideas that will be helpful in implementing CSOC. It is written to be a guide for counties that are early in their CSOC development, a training tool for new staff members and parents in counties with established CSOCs and a resource for members of the community who are interested in CSOC.

The manual will, no doubt, raise questions and issues that will require more detailed information in a variety of areas related to CSOC development. The Cathie Wright Center for Technical Assistance to Children’s System of Care is available to provide the additional information and support to counties prepared to take steps beyond those outlined in the manual. Contact with the Center will serve the dual purpose of guiding the Center in development of future informational materials and resources, and bringing technical assistance activities geared specifically to each county’s CSOC development plan.

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**To contact the Cathie Wright Technical Assistance Center or State Department of Mental Health Specialized Programs Branch:**

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## APPENDICES



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The California Institute for Mental Health is a non-profit public interest corporation established for the purpose of promoting excellence in mental health. CIMH is dedicated to a vision of “a community and mental health services system which provides recovery and full social integration for persons with psychiatric disabilities; sustains and supports families and children; and promotes mental health wellness.”

Based in Sacramento, CIMH has launched numerous public policy projects to inform and provide policy research and options to both policy makers and providers. CIMH also provides technical assistance, training services, and the Cathie Wright Technical Assistance Center under contract to the California State Department of Mental Health.

The Cathie Wright Center for Technical Assistance to Children’s System of Care provides training, consultation and technical assistance to county interagency efforts for System of Care development of community-based, family-centered, culturally-competent, comprehensive services for children with serious emotional disabilities and their families. The intent is to assess needs and identify and respond to requests from local mental health programs, interagency partners, and families to implement the goals and operationalize systems of care at the local level.

