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Abstract The Comprehensive Services for Children and Their Families or System of Care (SOC) is the largest mental health project ever conducted by the US federal government. These programs are based on a value-driven framework that includes: child/youth centered and family driven practice, community-based practice, and culturally competent practice (Stroul and Friedman in A system of care for children and youth with severe emotional disturbances, Georgetown University Child Development Center, CASSP Technical Assistance Center, Washington, DC, 1986). The aim of this study is to determine the extent of the adoption of SOC values by families, system partners, providers and community organizations in a countywide SOC. Using a retrospective design, data was collected through a system-wide survey and focus groups, which asked respondents to rate the presence of SOC core values prior to and four years following its creation. Results suggest that system partners, provider staff, and families are aware of the changes that have occurred within the system as a result of the SOC.

Keywords Children's mental health · Systems of care · Core values · Families

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Introduction

The Comprehensive Services for Children and Their Families or System of Care (SOC) grant program is the largest mental health project ever conducted by the US federal government. Systems of Care programs are guided by a set of core values and associated principles that provide a value-driven framework for children and youth who have emotional and behavioral disorders. The core values include child/youth-centered and family driven practice, community-based practice, and culturally competent practice (Stroul and Friedman 1986; Stroul and Blau 2010). The inherent assumption behind the SOC philosophy is that behavioral health services for children and youth delivered in adherence to these core values will promote positive outcomes for children and youth. However, while SOC has become a foundation for many children's behavioral health service systems across the country, the degree to which communities implement these core values and the impact of these values on children and families (Cook and Kilmer 2004) has not been ascertained.

Youth-Guided and Family-Driven Care

Youth-guided and family-driven care is based on the premise that mental health care for children and youth should be tailored to the individual needs of the child, strength-based, and involve the family in all aspects of service delivery from implementation to evaluation. Methods to operationalize this value at the program level have changed over time. In particular, the emphasis on family-driven care has shifted dramatically within the past two decades. In the original SOC framework proposed by Stroul and Friedman (1986), the language describing family involvement was "family-focused" care. However, several critical scholars

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and activists critiqued this language, arguing that it served to maintain the traditional power structure between "experts" and parents, in which parents merely support the agenda determined and defined by mental health professionals (Bruns et al. 2004, 2005; Bruns and Walker 2010; Burchard et al. 2002; Chenven 2010; Hernandez et al. 2001; Hoagwood 2005). As a result, a more empowering approach developed, shifting the language to "family-driven" or "family-centered", giving parents more of a central role in the decision-making across all levels of service provision (Duchnowski and Kutash 2007; Hogan 2003). After years of resistance, family advocacy models have become a core feature of federally funded programs.

Community-Based Practice

Community-based practice also represented a significant shift in the children's mental health service delivery. Prior to the SOC model, many children were treated in restrictive settings, including psychiatric hospitals and long-term residential treatment facilities. Widespread recognition about the ineffectiveness of these approaches to yield positive outcomes, especially for individuals with complex needs, lead to the development of community-based interventions (Farmer et al. 2004; Burns 2002). Community-based interventions are based on social ecological theory, which views the child as embedded within interconnected systems that include family, school, and other community institutions (Bronfenbrenner 1979; Owens et al. 2006; Bruns et al. 1995). Interventions in the community are ecologically targeted, address barriers to care and build upon the strengths and resources in the child's natural environment (Davis 2007; Pullmann et al. 2010; Winters and Pumariega 2006; Heflinger and Christens 2006).

Culturally Competent Practice

Cultural competence is defined as a "set of congruent behaviors, attitudes, and policies found in a system, agency, or a group of professionals that enables them to work effectively in a context of cultural difference" (Cross et al. 2010; Pumariega et al. 2005). Cross et al. (2010, cited in Pumariega et al. 2005; Mistry et al. 2009) state that cultural competence is best understood as a developmental process in which there is no particular point whereby a SOC community fully achieves cultural competence. Previous evaluations of SOC implementation in grant communities suggest that changes in cultural competence across the system often occur in incremental stages, such that improvements measured at any fixed point in time may be difficult to assess (Brashears et al. 2005).

Several studies have attempted to assess the degree to which SOC core values are adopted in targeted sites (Brannan et al. 2002; Stanhope et al. 2005; Vinson et al. 2001). Overall, sites adopting SOC values and principles have been more consistent with SOC values and principles than non-comparison sites, although several studies also suggest that non-SOC comparison sites have also adopted SOC values and principles over time. For example, in their system-level assessment comparing three federally funded SOC matched comparison sites, Brannan et al. (2002) found that the language of SOC values and principles were present in all of the comparison communities. However, the authors note that without funding to fully operationalize and infuse these core values into practice, the execution of these values lagged behind execution in funded sites.

Research also suggests that the value of cultural competence has rarely been infused into practice; Vinson et al. (2001) found that SOC communities received the lowest scores for cultural competence in a review of 27 community practices. SOC communities receive the highest scores for adherence to family focused care (Vinson et al. 2001), though this is often limited solely to family involvement in the specific treatment of individual children with little evidence of family involvement in broader infrastructure issues such as service planning and evaluation (Cook and Kilmer 2004). Evaluations of SOC communities have found adherence to community-based practice to be high in grant communities (Vinson et al. 2001).

Beaver County's SOC: Optimizing Resources, Education and Supports (BC-SCORES), a SOC funded by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA) established a countywide collaborative effort to develop a youth guided and family driven comprehensive SOC through a coordinated network of community-based services and supports that were organized to meet the needs of families and youth with a serious mental health and/or co-occurring mental health and substance abuse diagnosis (COD). To determine the extent of the adoption of SOC values by families, system partners, providers and community organizations, data was collected through a system-wide survey and focus groups. BC-SCORES initially targeted adolescent and transition age youth (14–21) with a co-occurring mental health and substance use disorder who were involved in the Juvenile Justice System. However, the rates of referral and enrollment in the SOC were lower than anticipated. Consequently, the population of focus was expanded to include youth 10–21 with a mental health or COD who were involved in the legal system or were experiencing problems in school. Youth were provided multiple opportunities to complete the survey, they chose not to participate. It may be due to the broad age range or youth's limited interest in providing input as it relates to

core values. This paper describes the level of adoption of SOC core values over a four year period.

Methods

Survey

A workgroup comprising case management supervisors and staff, providers, community organizations and family members provided input in the development of a survey to measure changes in attitudes and knowledge related to the core values from 2006 (prior to the implementation of BC-SCORES, to 2010, year 4 of BC-SCORES implementation). Representatives from the workgroup piloted the survey, and a final survey was developed. Survey questions were organized into categories reflecting the three core values. From these final versions, two types of on-line surveys were constructed and posted: an administrator/staff survey, and a family/youth survey.[1] An initial e-mail solicitation was sent to SOC participants with a link to the survey for which they were targeted. Contact information was provided for questions. Follow-up was sent to all targets to remind recipients of the deadline; thank those who had already completed a survey; and request that supervisors/directors forward the survey link to their staff.

Focus Groups

After collecting and analyzing survey data, focus groups[2] were conducted to gain a better understanding of how providers and families perceive and are affected by the changes in the SOC and the adoption of core values. Four focus groups were conducted; two with administrators and staff and two with families involved in BC-SCORES. Families and youth were identified through family support groups and the family and youth coordinators.[3]

Results

Sixty-four individuals completed the administrator and provider survey; respondents represented the three system partners (behavioral health, children and youth services, and juvenile services) and community based supports.

A paired-samples t test was conducted to compare provider knowledge and attitudes pre BC-SCORES and four years following the development of the SOC in each of the core value domains. The results indicate there was a statistically significant increase in scores for each area. The significant difference in the scores by domain are: youth guided-family driven ($M = -0.41$, $SD = 0.50$), $t(59) = 6.33$, $p = 0.000$, culturally competent ($M = -0.47$, $SD = 0.68$), $t(59) = 5.35$, $p = 0.000$, community based ($M = -0.49$, $SD = 0.54$), $t(59) = 7.10$, $p = 0.000$ and provider specific ($M = -0.47$, $SD = 0.58$), $t(59) = 6.23$, $p = 0.000$. These results suggest that the providers are aware of and adopting SOC core values (Table 1).

A paired-samples t test was conducted to compare family knowledge and attitudes pre BC-SCORES and five years into the SOC process in each of the core value domains. The results in bold indicate there was a statistically significant increase in scores for the Community Based Domain ($M = -0.33$, $SD = 0.79$), $t(32) = 0.2.74$, $p = 0.02$. These results suggest that families[4] are aware of and adopting the SOC community based services core value (Table 2).

Discussion

Results from the core values survey and SOC stakeholder focus groups suggest that when considering the three core values, system partners, provider staff, and family and youth are aware of the changes that have occurred within the SOC as a result of the implementation of BC-SCORES. Furthermore, with the exception of the cultural competence core value, families and youth tended to report greater amounts of change in the core values compared to treatment providers and community supports.

Youth Guided and Family Driven Core Value

Commitment to youth guided and family driven care represents a paradigm shift in the mental health service delivery system for children and youth (Osher and Osher 2002). While it can be challenging for providers to fully commit to this value, our findings suggest that promising changes as a result of BC-SCORES efforts to strengthen youth guided and family driven care are occurring. Both providers and families reported increased youth guided and family driven care, including increased family voice, choice in treatment planning, family involvement in the development of materials, and the inclusion of a variety of

[1] Initially the family and youth survey was posted online. As not all family members have access to e-mail, the BC-SCORES interviewers collected surveys when meeting with families and at BC-SCORES events, such as support groups and a picnic. At the meetings, youth were asked to complete the survey and were told that participation was voluntary.

[2] Focus groups questions were developed by the evaluator for BC-SCORES.

[3] Although youth were invited to participate in the focus groups, none attended.

[4] Families consisted of parents or other family members.

Table 1 Comparison of core value domains (provider perspective)

	Mean	SD	SE	95 % CI		t	df	*p* value
				Lower	Upper			
Youth guided family driven	−0.41	0.50	0.06	−0.54	−0.28	−6.33	59	0.000
Culturally competent	−0.47	0.68	0.09	−0.64	−0.29	−5.35	59	0.000
Community based	−0.49	0.54	0.07	−0.63	−0.35	−7.10	59	0.000

Table 2 Comparison of core values domains (family perspective)

	Mean	SD	SE	95 % CI		t	df	*p* value
				Lower	Upper			
Youth guided	−0.13	0.56	0.10	−0.32	0.07	−1.33	33	0.19
Culturally competent	−0.12	0.63	0.11	−0.34	0.10	−1.11	32	0.27
Community based	−0.33	0.70	0.12	**−0.58**	**−0.09**	**−2.74**	32	**0.01**
Provider	−0.47	0.58	0.08	**−0.62**	**−0.32**	**−6.23**	59	**0.000**

Bold values indicate that changes in knowledge and awareness of core values between the two time periods were significant

stakeholders in meetings. However, the youth guided core value continues to be an ideal that has not yet been realized. While these findings are promising, increased effort is necessary to fully engage families and recognize and respect parents and youth as experts in their own treatment needs.

Community Based Core Value

The greatest changes in BC-SCORES core values were reported in the community based value. The greatest increase was in the development and use of natural supports in the community, e.g. faith-based organizations and youth programs. One factor contributing to this change was the extensive efforts expended to expand the inclusion of natural supports in the SOC, as well as to emphasize the important role they play in supporting families. Service availability has increased in the community and education efforts have increased family awareness and utilization of these services.

Culturally Competent Core Value

Family and youth reported little change in cultural competence,[5] indicating that the SOC's impact on cultural competency was negligible. Conversely, service providers reported greater change in cultural competence. These findings mirror the findings from previous evaluations of SOC core values implementation in other grant communities. For example, Vinson et al. (2001) in their national evaluation of SOC implementation in 27 communities found that the least amount of change occurred in cultural competence. Indeed, research suggests that system changes in cultural competence often occur in small increments (Brashears et al. 2005).

While providers indicated high rates of change for the core values, survey results suggest that provider administrators have a greater awareness of the changes that have occurred when compared to provider staff. Administrators have been involved at multiple levels of the BC-SCORES SOC through activities such as the preparation of the initial application, participation on an administrative committee that provides oversight to the program, and participation in various trainings. While the aim of this article was to explore changes in awareness of SOC core values, actual adoption of core values will be explored as the entire mental health system undergoes a transformation. Lessons learned from BC-SCORES are being incorporated in current SOC efforts, which will be discussed in future research.

Recommendations

While there were significant increases in SOC core values, the overall scores were still low. System change is an ongoing process that can take more than five years of effort to be effectively realized (Hogan 2003), consequently, these values continue to be addressed as part of the Mental Health Transformation and countywide SOC efforts. The findings also suggest a few areas where more change is needed.

- *Youth guided and family driven care* The survey and focus group findings suggest that efforts to strengthen youth guided and family driven care can be improved particularly in the areas of family friendly service materials and information, and recognition and respect for parents and youth as experts. To improve youth

[5] Slightly less than half, 48.1 % of family and youth respondents were African American.

guided and family driven care, the following strategies for mental health service providers are recommended:

- Develop a mechanism by which to solicit feedback from families when developing service materials and information.
- Conduct outreach to engage families into the system, including building family support groups and encouraging involvement in the countywide SOC.

- *Cultural competence* Family and youth survey and focus group respondents reported little change in cultural competence and indicated that more improvement related to cultural competence in the SOC is needed. To strengthen and enhance cultural competence in the BC-SCORES service delivery system, the following strategies for mental health service providers are recommended:
  - Administrator and staff participation in ongoing professional development training in culture and diversity that is part of a countywide CLC implementation plan.
  - Continue to partner with and utilize natural support networks in the community so as to facilitate the transfer of culturally relevant knowledge and information to mental health service providers.
  - Continue to sustain the increase in participation of the African American population in the SOC.
- *Staff support for core values* As highlighted in the discussion, survey results suggest that provider administrators have a greater awareness of the changes that have occurred within the SOC when compared to provider staff. To increase staff awareness of the SOC changes, the following strategies for mental health service providers are recommended:
  - Engage staff in the ongoing SOC process through information ssharing, training opportunities and membership in on-going SOC activity.
  - Establish formal mechanisms through which staff can learn of the changes happening in the service delivery system on an ongoing basis.

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