Arizona's Children's System of Care Practice Review
Fiscal Year 2015 Statewide Report

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EXECUTIVE SUMMARY

Background

Research has identified that outcome evaluation is key to achieving and sustaining transformation initiatives in Systems of Care (Hodges, Hernandez, Nesman, & Lipien, 2002). The System of Care Practice Review (SOCPR) was implemented in FY2009-2010 as the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) practice review method of choice in Arizona. It was developed at the University of South Florida (USF) by Dr. Mario Hernandez, Ph.D. Research has demonstrated high inter-rater reliability in the use of the tool, which is based on face to face interviews with multiple informants as well as file/record reviews (Hernandez et al., 2001). A total of 185 reviews were conducted across Arizona in FY2014-2015. Because the sampling emphasis was placed on children and families involved with the child welfare system, the outcomes of this year's SOCPR report will include two separate analyses and results sections: All Cases and CW Cases.

Methodology

Interviews were drawn from a sample of children and families identified as having high/complex levels of need. For FY2014-2015, the sampling emphasis was placed on children and families involved with the child welfare system. Therefore, the sample pool of cases contained all children and youth age 6 –18 years who had scores of 4 or higher on the Child and Adolescent Service Intensity Instrument (CASII). Children aged 0-5 were included if they met one or more of the following criteria: other agency involvement (Arizona Early Intervention Program [AZ EIP], Department of Child Safety [AZ DCS], Department of Developmental Disabilities [AZ DDD]); out of home placement (within past 6 months); psychotropic medication utilization (2 or more medications); and/or CGAS of ≤50. In addition, selected cases had to be enrolled in services at least 90 days, and be currently active at the time the sample was drawn. Also if multiple siblings were receiving services from the same agency only one child was included in the sample. For each agency under review, a case manager could have no more than 2 of their cases identified for the SOCPR review.

The SOCPR uses a case study methodology informed by caregivers, youth, formal providers, informal supports, and extant documents related to service planning and provision. The SOCPR tool itself is comprised of 4 domains and 13 sub-domains and areas:

- *Child-Centered, Family-Focused (CCFF)*
  - *Individualized, Full Participation, and Case Management*
- *Community Based (CB)*

- *Early Intervention, Access to Services, Minimal Restrictiveness, and Integration and Coordination*

- *Culturally Competent (CC)*
  - *Awareness, Sensitivity and Responsiveness, Agency Culture and Informal Supports*
- *Impact (IMP)*
  - *Improvement and Appropriateness*

SOCPR results include a combination of quantitative and qualitative data. Quantitative data are scored on a scale of 1-7. Scores from 1–3 represent lower implementation of a system of care principle, and scores from 5–7 represent enhanced implementation of a system of care principle. A score of 4 indicates a neutral rating, meaning a lack of support for or against implementation. Qualitative data are analyzed for themes that are identified in at least half of examined cases.

Results

ALL CASES

Quantitative Data Summary

During FY 2014-2015, a total of 185 cases were sampled from six GSAs in Arizona. In addition to results related to the four domains, other areas of analysis included: *demographics, service system involvement*, and *receipt of services or treatments*. The demographic profile for All Cases showed that males were more commonly represented, over 57% of the sample, with the overall average age at 9.5 years. With regard to ethnicity, half of the sample was White (50%), almost 23% was Latino/Hispanic, and over 16% was multi-racial. The remaining sample consisted of Black and Native American (over 9%) and 1.1% missing data. Over 96% of the sample spoke English as their primary language. Almost 4% of the sample did not respond to the question or listed "not applicable" as their response. From a total range of 1-6 systems, the average number of child-serving systems involved per child was 2.15. Almost 96% of the 185 All Cases were recorded as showing behavioral health system involvement. A review of the services or treatments utilized showed over 96% of the children received Support Services, with Case Management being received by almost 94% of the families. Treatment Services were utilized by 78% of youth while Medical Services were utilized by almost half of the families. The average number of services used per child or youth was 4.01.

Scores range from a low of 1 to a high of 7, with scores 5 and higher representing *enhanced implementation* of the item of interest. For the statewide sample of 185 All Cases, mean scores ranged from 4.93 to 5.45 for the four SOCPR domains, with an overall case mean score of 5.12. It should also be stated that because of the sample size variance between Geographic Service Areas (GSAs), comparisons between GSAs is not possible.

SOCPR Overall Domain Mean Scores All Cases

GSA (N=185)	Case Mean (SD)	CCFF Mean (SD)	CB Mean (SD)	CC Mean (SD)	IMP Mean (SD)
Statewide	5.12 (0.93) Min 1.77 Max 6.65	5.03 (1.09) Min 1.77 Max 6.78	5.45 (0.76) Min 2.96 Max 7.00	4.93 (1.17) Min 1.11 Max 7.00	5.09 (1.30) Min 1.25 Max 7.00

In Arizona, provider agencies performed best at including the Community Based system of care value when serving children and families. The domains of Impact and Child-Centered Family-Focused followed next. Providers were most tested in the Culturally Competent domain.

For FY2014-2015 SOCPR All Cases scores by GSA ranged from the mid 4s to 6. Three of the four SOCPR *domain* scores fell within the 5 range (representing enhanced implementation of a system of care principle) with one domain in the 4 range (neutral). In the Community-Based domain all subdomains and areas scored in the high 4 to low 6 range with the area of Appropriate Language scoring highest (6.11). High scoring *subdomains* included Access to Services (5.90) and Minimal Restrictiveness (5.65) from the Community-Based domain. High scoring *areas* included Convenient Times (5.84) and Convenient Locations (5.76) in the Community-Based domain. These scores represent strengths in the Arizona's Children's System of Care as reviewed through these 185 SOCPR cases.

The data also revealed scores in the high 4s. A score of 4 indicates a neutral rating, meaning a lack of support for or against implementation of the value or principle. For example, within the Culturally Competent domain, all subdomain and area scores were in the high 4s (ranging from 4.72 to 4.99) with the exception of the subdomain of Agency Culture which had a score of 5.11. These scores may indicate the need for service providers to be aware of both the families and providers culture and to be responsive and adapt to any differences during all aspects of service planning and delivery. Additionally, service providers need to be sensitive to and include the informal supports identified by the child and family in services. Another high 4 scoring area, Appropriateness, is within the subdomain of Impact and scored a 4.97. The services provided to families should have a positive effect and been appropriate for meeting their needs.

A series of variables of interest were tested to identify if there was a statistically significant relationship to the outcome of the SOCPR results. There were a variety of significant differences in SOCPR case and domain scores across the variables examined. Some of each of the

demographic variables, service systems, systems categories, and services measured showed significant differences.

Receiving Support Services (especially Family Support and Skills Development and Training), Inpatient Services, and Other were strongly associated with GSA. Treatment Services and Total Number of Services were associated with higher SOCPR case and domain scores for children and youth as were Geographic Service Area (GSA) and multiple types of support and counseling services.

Summary of Qualitative Analysis

Qualitative data were derived from brief narratives prepared by SOCPR reviewers to support final ratings to the Summative Questions that conclude the SOCPR. Themes derived from Summative Questions narratives are organized by SOCPR domain and subdomain. The frequency of responses to Summative Questions were examined and analyzed for emerging patterns/trends. Some notable strengths that were identified across case files include completion of thorough assessments for children and/or families, needs were clarified in a timely manner, some awareness of the family's culture, and improvements in child/youth functioning. Opportunities for improvement were also identified, including the need to ensure youth and family strengths are clearly incorporated into service planning goals, the need for increasing identification of informal supports for families, and ensuring that the mix of services and supports provided are appropriate for the youth and family.

The Qualitative Analysis section presents a review of data compiled from responses to Summative Questions that SOCPR reviewers use to summarize and integrate the information gathered throughout the Document Review and the series of interviews completed with a particular child/youth and family to address each of the four SOCPR domains. The Summative Questions call for the reviewer to provide a rating for each statement and to give a brief narrative in support of that rating. Individual ratings serve as indicators of the extent to which the sub-domain elements (e.g., individualized services, full family participation) or SOC principles are being implemented within the System of Care under review. The narrative portion of each Summative Question response provides evidence for a given rating and is used to determine the presence or absence of system of care principles for each sub-domain. Where an overall summative rating relates to a reviewer's determination of completion of a thorough assessment, for instance, qualitative analysis examines the evidence provided to explain the rating.

In the final analysis, ratings for each item are clustered and considered in conjunction with the respective brief narrative provided to determine a general assessment for each sub-

domain. The compiled narratives for all Summative Questions were coded and sorted to assess the degree to which System of Care principles were implemented in each SOCPR domain area (N=185). The frequency of Summative Question responses were examined and analyzed for emerging patterns/trends. In order to be considered a trend, at least of half of the responses associated with a particular rating had to provide similar information related to a given measurement and/or sub-domain area. Trends in each sub-domain are then reviewed together to provide an overall assessment for the larger domain area. This report section also highlights particular successes and challenges with regard to implementation of System of Care principles for each of the SOCPR Domain Areas.

Child Welfare (CW) CASES

Quantitative Data Summary

Of the 185 SOCPR cases sampled during FY2014-2015, the state of Arizona was also interested in only those cases where the children and families had child welfare involvement. The 99 CW Cases completed during FY2014-2015 were sampled from all six GSAs. In addition to results related to the four domains, other areas of analysis included: *demographics, service system involvement*, and *receipt of services or treatments*. The demographic profile showed that males were more commonly represented, almost 56% of the sample, with the overall average age at 8.1 years. With regard to ethnicity/race, almost 42% was White, 22% identified as Multiracial, and 19% was Latino/Hispanic. The remaining sample consisted of Black and Native American (over 13%) and 3% missing data. Almost 94% of the sample spoke English as their primary language. Over 6% of the sample did not respond to the question or listed "not applicable" as their response. From a total range of 1-6 systems, the average number of child-serving systems involved per child was 2.53. Almost 94% of the 99 CW Cases were recorded as showing behavioral health system involvement. A review of the services or treatments utilized showed 97% of the children received Support Services, with Case Management being received by almost 93% of the families. Treatment Services were utilized by almost 82% of youth while Medical Services were utilized by more than a third of the families. The average number of services used per child or youth involved with CW services was 3.66.

Scores range from a low of 1 to a high of 7, with scores 5 and higher representing *enhanced implementation* of the item of interest. For the sample of 99 CW cases, mean scores ranged from 4.66 to 5.42 for the four SOCPR domains, with an overall case mean score of 5.04. It should also be stated that because of the sample size variance between Geographic Service Areas (GSAs), comparisons between GSAs is not possible.

SOCPR Overall Domain Mean Scores CW Cases

GSA (N=99)	Case Mean (SD)	CCFF Mean (SD)	CB Mean (SD)	CC Mean (SD)	IMP Mean (SD)
Statewide	5.04 (0.93) Min 2.49 Max 6.58	5.02 (1.06) Min 2.35 Max 6.73	5.42 (0.74) Min 3.42 Max 7.00	4.66 (1.20) Min 1.69 Max 7.00	5.06 (1.35) Min 1.50 Max 7.00

In Arizona, provider agencies performed best at including the Community Based system of care value when serving children and families. The domains of Impact and Child-Centered Family-Focused followed next. Providers were most tested in the Culturally Competent domain.

For FY2014-2015 SOCPR CW Cases scores by GSA ranged from the mid 3s to 6. Three of the four SOCPR *domain* scores fell within the low to mid-5 range (representing enhanced implementation of a system of care principle) with one domain in the 4 range (neutral). In the Community-Based domain almost all subdomains and areas scored in the low to high 5 range with the exception of area of Appropriate Language scoring highest (6.05) and the subdomain of Integration and coordination scoring lowest (4.94). High scoring *subdomains* included Access to Services (5.84) and Minimal Restrictiveness (5.63) from the Community-Based domain. High scoring *areas* included Appropriate Language (6.05), Convenient Times (5.84) and Convenient Locations (5.64) also in the Community-Based domain. These scores represent strengths in the Arizona's Children's System of Care as reviewed through these 99 SOCPR CW Cases.

The data also revealed scores in the low to high 4 range. A score of 4 indicates a neutral rating, meaning a lack of support for or against implementation of the value or principle. For example, within the Culturally Competent domain, all domain, subdomain, and area scores were in the 4 range. Agency Culture scored the highest with a mean score of 4.86. These scores may indicate that greater attention needs to be paid to providing information to families about service providers' culture and including the informal supports identified by the child and family in services. Other high 4 scoring areas included Types of Services/Supports (4.94), Intensity of Services/Supports (4.87), and Service Planning (4.68) within the domain of Child-Centered Family-Focused.

A series of variables of interest were tested to identify if there was a statistically significant relationship to the outcome of the SOCPR results. There were a variety of significant differences in SOCPR case and domain scores across the variables examined. Some of each of the demographic variables, service systems, systems categories, and services measured showed significant differences.

Receiving Support Services (specifically Family support, Peer Support, and Skills

Development and Training) was strongly associated with GSA. Treatment Services and Inpatient Services were associated with both SOCPR case and domain scores.

Summary of Qualitative Analysis

Qualitative data were derived from brief narratives prepared by SOCPR reviewers to support final ratings to the Summative Questions that conclude the SOCPR. Themes derived from Summative Questions narratives are organized by SOCPR domain and subdomain. The frequency of responses to Summative Questions were examined and analyzed for emerging patterns/trends. Some notable strengths that were identified across case files include provision of individualized services for children and/or families, services provided at convenient locations and times, awareness of and responsiveness to a family's culture, and improvements in child/youth functioning. Opportunities for improvement were also identified, including the need to ensure youth and family strengths are clearly incorporated into service planning goals, the need for increasing identification of informal supports for families, and ensuring that the mix of services and supports provided are appropriate for the youth and family.

The Qualitative Analysis section presents a review of data compiled from responses to Summative Questions that SOCPR reviewers use to summarize and integrate the information gathered throughout the Document Review and the series of interviews completed with a particular child/youth and family to address each of the four SOCPR domains. The Summative Questions call for the reviewer to provide a rating for each statement and to give a brief narrative in support of that rating. Individual ratings serve as indicators of the extent to which the sub-domain elements (e.g., individualized services, full family participation) or SOC principles are being implemented within the System of Care under review. The narrative portion of each Summative Question response provides evidence for a given rating and is used to determine the presence or absence of system of care principles for each sub-domain. Where an overall summative rating relates to a reviewer's determination of completion of a thorough assessment, for instance, qualitative analysis examines the evidence provided to explain the rating.

In the final analysis, ratings for each item are clustered and considered in conjunction with the respective brief narrative provided to determine a general assessment for each sub-domain. The compiled narratives for all Summative Questions were coded and sorted to assess the degree to which System of Care principles were implemented in each SOCPR domain area (N=99). The frequency of Summative Question responses were examined and analyzed for emerging patterns/trends. In order to be considered a trend, at least of half of the responses associated with a particular rating had to provide similar information related to a given measurement and/or sub-domain area. Trends in each sub-domain are then reviewed together

to provide an overall assessment for the larger domain area. This report section also highlights particular successes and challenges with regard to implementation of System of Care principles for each of the SOCPR Domain Areas.

Background

Arizona's Behavioral Health Care System

The Arizona Department of Health Services/Department of Behavioral Health Services (ADHS/DBHS) is responsible for administration of Arizona's publicly funded behavioral health service system for individuals, families, and communities. As such, ADHS/DBHS provides services both to populations eligible for federal entitlement programs such as Title XIX and Title XXI of the Social Security Act, as well as those receiving State funding only. ADHS/DBHS funding is derived from a variety of sources: Title XIX (Medicaid), TXXI (Kids Care), federal block grants, state appropriations, and intergovernmental agreements.

Service Provision

ADHS/DBHS' mission includes providing services to children and adults with substance use and/or general mental health disorders. Sub-populations include children with a serious emotional disturbance and adults with a serious mental illness. Children's Behavioral Health Services in the State of Arizona are delivered in accordance with the 12 principles of the Children's System of Care (see Appendix A), and delivered via the "Arizona Practice Model". This "System of Care" approach to service delivery in Arizona developed in response to the JK class action lawsuit, as part of the settlement agreement between ADHS/DBHS and the plaintiffs in the case.

The Arizona Practice Model is based on the "wrap-around" model (VanDenBerg, 2003), and includes formation of Child and Family Teams as a means of organizing and directing care. The Child and Family Team may be composed of family members, behavioral health service providers, and representatives of other child-serving agencies, as well as other identified helpers and "natural supports". Teams are typically facilitated by a case manager or other behavioral health representative, and are responsible for identifying the strengths and needs of children and families and identifying and monitoring treatment goals and tasks. Teams are also responsible for obtaining any and all covered behavioral health services *not* requiring prior authorization by the Regional Behavioral Health Authority (RBHA). Teams may also request services requiring prior authorization, which will be subject to medical necessity determination by the RBHA. Services requiring prior authorization include out of home care and psychological testing. Other ADHS/DBHS Covered Services include (for a comprehensive list refer to the ADHS/DBHS Covered Behavioral Health Services Guide):

- Treatment Services – behavioral health counseling and therapy
- Medical Services – medication services and laboratory
- Rehabilitation Services – living skills training
- Support Services – case management, home care training, respite, and transportation
- Crisis Intervention – ADHS/DBHS also oversees a statewide crisis system including crisis phones, warm lines, mobile teams, and inpatient psychiatric and detoxification facilities which operate seven (7) days a week.

ADHS/DBHS also oversees provision of prevention programs for children and adults. These services are funded separately, and are not included as Medicaid covered services.

In Arizona, services for children and adults have separate funding streams, and state law prohibits children's services from being funded with adult monies and vice versa. For purposes of this report, the focus will be on children/youth under the age of 18 (and their families) served by ADHS/DBHS. Quality improvement and evaluation activities related to services provided to adult populations are considered to be outside the scope of this report.

Contracting Process

Contracts are bid on a 3-5 year competitive cycle. There are six Geographic Service Areas (GSAs) across the state. Currently, four (4) Regional Behavioral Health Authorities (RBHAs) serve the 6 GSAs. In addition there are five (5) Tribal Regional Behavioral Health Authorities (TRBHAs) and Tribal Contractors. Each T/RBHA contracts with various provider agencies to deliver the full array of covered behavioral health services to children and families within its region. Augmenting the efforts of these service providers are Family Run Organizations, who partner with ADHS/DBHS and the T/RBHAs to promote family involvement as well as family and youth voice and choice across the system. Additionally, they are also providers of services to support youth and families.

Coordination of Care

ADHS/DBHS works in tandem with a variety of potential stakeholders on behalf of youth and families. Child and Family Teams may include one or more of these stakeholders in addition to behavioral health system providers. These include:

- Physical healthcare providers
- Arizona Department of Economic Security (including):

    - Department of Developmental Disabilities
    - Rehabilitation Services Administration
    - Division of Children, Youth and Families (DCYF) (child welfare)
- Department of Juvenile Corrections
- Administrative Office of the Courts
- Arizona Department of Housing
- Arizona Department of Corrections
- Arizona Department of Education

Since Child Welfare, Developmental Disabilities, Education, and Juvenile Justice are funded separately in Arizona, a mixture of cooperative agreements and contractual relationships have been defined. Of the stakeholder organizations, only the Department of Developmental Disabilities has established a contract with ADHS/DBHS to provide behavioral health services for its eligible members. All other stakeholder agencies operate with collaborative agreements developed individually with each T/RBHA. These agreements define how the respective agencies are to work together to provide services such as counseling, crisis intervention, and residential treatment on behalf of individuals and families "shared" by the systems. Each T/RBHA has regular meetings with representatives of these stakeholder agencies to coordinate their collaborative efforts. In addition, ADHS/DBHS maintains communication and collaboration through ongoing meetings involving stakeholders and state-level leadership.

Adoption of the SOCPR

Research has identified that outcome evaluation is key to achieving and sustaining transformation initiatives in Systems of Care (Hodges, Hernandez, Nesman, & Lipien, 2002). This is illustrated by a five-year study of children's mental health sponsored by the University of South Florida. In the study, researchers identified key elements for accomplishing goals and sustaining theory-based efforts at system change. These included the finding that organizations must have methods to ensure that service implementation is consistent with underlying theory, "regardless of the information source". According to the authors, it is important that organizations have a means to confirm that their theory-based strategies are actually serving intended recipients, are providing intended services and supports, and are producing desired results. Finally, the authors conclude that as a consequence of such outcome evaluation, decision makers are better equipped to identify and to anticipate challenges to implementation and sustainability.

For ADHS/DBHS, research findings underscoring the need for outcome measures coincided with requirements of the settlement agreement entered into by ADHS/DBHS with plaintiff's counsel in the Jason K. class action lawsuit. Under the terms of this agreement, ADHS/DBHS committed to undertake development of a process to evaluate the quality of practice throughout the state. The J.K. Settlement Agreement, provision VIII, under "Quality Management and Improvement System", indicates that the measurement process will include as an integral component, "an in-depth case review of a sample of individual children's cases that includes interviews of relevant individuals in the child's life". In response to this agreement, in its 5th Annual JK Action Plan, ADHS/DBHS established twelve objectives. One of these pertained to the implementation of the Practice Improvement Review process, and stipulated that ADHS/DBHS would settle on a practice review instrument for use statewide.

As of June of 2007, the practice review method in use by ADHS/DBHS was the Wraparound Fidelity Assessment Scale (WFAS), developed by Dr. Eric Bruns of the University of Washington. The WFAS, as implemented in Arizona, consisted of two components; the Wraparound Fidelity Index (WFI), and the Document Review Measure (DRM). The WFAS was used to evaluate the degree to which services were being delivered according to the 12 Principles, and in keeping with Child and Family Team Practice. In October 2008, ADHS/DBHS implemented a taskforce to evaluate the efficacy of the WFAS as a performance improvement measure for Arizona's System of Care. This taskforce, chaired by the ADHS/DBHS Medical Director for Children's Services, included representatives from a number of ADHS/DBHS functional areas including Children's System of Care, Children's Networks, Quality Management, and Clinical Practice Improvement.

The taskforce recommendations included: 1. Finalizing the Arizona-developed "Low Needs Tool", (henceforth referred to as the Brief Practice Review), and 2. Combining what had been separate moderate and high needs reviews into one process, to be referred to as the Practice Review for Children with Complex Needs. For purposes of implementing a practice review tool, ADHS/DBHS determined that it was not practicable to employ the same method for reviewing cases with a high level of complexity/acuity as for those with a lower level of complexity. The Child and Adolescent Service Intensity Instrument (CASII) was identified as a mechanism for providers to rate levels of need/acuity on a scale from 0-6, with 6 representing the greatest intensity of need. Thus, the initial sample pool of cases deemed "high complexity" contained all children and youth age 6-18 years who had scores of 4 or higher on the CASII. Children ages 0-5 were also included if they had met the criteria of being involved in two or more child-serving systems; i.e., being involved in Behavioral Health plus an additional service such as Child Welfare, Juvenile Justice, or the Department of Developmental Disabilities. All other children not meeting these criteria were included in the sample for the

Brief Practice Review.

In response to the taskforce's first recommendation, a workgroup was formed, and subsequently developed "The Practice Review for Children with Standard Needs". This tool, consisting of 15 questions, was to be administered telephonically with a child's primary caregiver. To address the second objective, the taskforce consulted with a number of local and national experts in practice review and survey development, including Mario Hernandez, Ph.D., of the University of South Florida. Ultimately, the Committee determined that the System of Care Practice Review (SOCPR) methodology developed by Dr. Hernandez would satisfy its requirements for the Complex Needs review process in Arizona. Subsequently, the SOCPR was adopted by ADHS/DBHS as its practice review methodology with implementation beginning in FY2010.

SOCPR and Quality Management/Practice Improvement

SOCPR results constitute one of the many data sources utilized by the ADHS/DBHS Quality Management (QM) Department. These results are intended to be used as a mechanism to provide feedback to the Behavioral Health System regarding areas of strength and areas where improvement is needed in System of Care implementation. The feedback/improvement process occurs at two levels. The first is the individual provider agency level, where SOCPR feedback is utilized to develop individualized performance improvement plans. Second, as trends and common themes are identified across the state, these are incorporated into the ADHS/DBHS System of Care Planning and Development process as goals and objectives for the T/RBHAs for the coming year.

Methodology

SOCPR Introduction

The System of Care Practice Review (SOCPR) collects and analyzes information regarding the process of service delivery to document the service experiences of children and their families, and then provides feedback and recommendations for improvement to the system. The process yields thorough, in-depth descriptions that reveal and explain the complex service environment experienced by children and their families. Feedback is provided through specific recommendations that can be incorporated into staff training, supervision, and coaching, and may also be aggregated across cases at the regional or system level to identify strengths and areas in need of improvement within the system of care. In this manner, the SOCPR provides a measure of how well the overall system is meeting the needs of children and their families relative to system of care values and principles.

The reliability of the SOCPR has been evaluated, and high inter-rater reliability has been reported in its use (Hernandez et al., 2001). The validity of the protocol is supported through triangulating information obtained from various informants and document reviews. The SOCPR was found to distinguish between a system of care site and a traditional services site. Moreover, Hernandez et al. (2001) found in their study that the SOCPR identified system of care sites as being more child-centered and family-focused, community based, and culturally competent than services in a matched comparison site offering traditional mental health services. System of care sites were more likely than traditional service systems to consider the social strengths of both children and families and to include informal sources of support such as extended family and friends in the planning and delivery of services. In addition, Stephens, Holden, and Hernandez (2004) found that the SOCPR ratings were associated with child-level outcome measures. In their comparison study, Stephens and colleagues discovered that children who received services in systems that functioned in a manner consistent with system of care values and principles compared with traditional services had significant reductions in symptomatology and impairment one year after entry into services, whereas children in organizations that did not use system of care values demonstrated less positive change. The study also found that as system of care-based practice increased, children's impairments decreased.

SOCPR Method

The SOCPR relies on data gathered from interviews with multiple informants, as well as

through case files and record reviews. Document reviews precede interviews and provide an understanding of the family's service history, including the presence and variety of services from sectors outside of behavioral health care systems. These reviews also provide the chronological context of service delivery and help to orient the reviewer to the child and family's strengths, needs, and involvement with services.

The interviews are based on a set of questions intended to obtain the child and family's perceptions of the services they have received. Questions related to accessibility, convenience, relevance, satisfaction, cultural competence, and perceived effectiveness are included. These questions are open-ended and designed to elicit both descriptive and explanatory information that might not be found through the document review. The questions provide the reviewer with the opportunity to obtain information about the everyday service experiences of the child and family and thereby gain a glimpse of the life experience of a child and family in the context of the services they have received.

The SOCPR uses a case study methodology informed by caregivers, youth, formal providers, informal supports, and extant documents related to service planning and provision. The unit of analysis is the *family case*, with each case representing a test of the extent to which the system of care is implementing its services in accordance with system of care values and principles. The family case consists of the child involved in the system of care, the primary caregiver (e.g., biological parent, foster parent, relative), the primary formal service provider (e.g., behavioral health case manager, therapist), and if present, a primary informal helper (e.g., extended family member, neighbor, friend).

Domains

The SOCPR assesses four domains relevant to systems of care: 1) Child-Centered and Family- Focused, 2) Community Based, 3) Culturally Competent, and 4) Impact.

Domain I, Child-Centered and Family-Focused, is defined as having the needs of the child and family dictate the type and combination of services provided by the system of care. It is a commitment to adapt services to children and families, as opposed to expecting children and families to conform to pre-existing service configurations. Domain I has three subdomains: 1) Individualized, 2) Full Participation, and 3) Case Management.

Domain II, Community Based, is defined as having services provided within or close to the child's home community in the least restrictive and most appropriate setting possible, and

coordinated and delivered through linkages between a variety of providers and service sectors. This domain is composed of 4 subdomains: 1) Early Intervention, 2) Access to Services, 3) Minimal Restrictiveness, and 4) Integration and Coordination.

Domain III, Culturally Competent, is defined by the capacity of agencies, programs, services, and individuals within the system of care to be responsive to the cultural, racial, and ethnic differences of the population they serve. Domain III has four subdomains: 1) Awareness, 2) Sensitivity and Responsiveness, 3) Agency Culture, and 4) Informal Supports.

Domain IV, Impact, examines the extent to which families believe that services were appropriate and were meeting their needs and the needs of their children. This domain also examines whether services are seen by the family to produce positive outcomes. This domain has two subdomains: Improvement and Appropriateness.

Taken individually, these measures allow for assessment of the presence, absence, or degree of implementation of each of the domains and subdomains. Taken in combination, they speak to how close a system's services adhere to the values and principles of a system of care. The findings can also highlight which aspects of system of care-based services are in need of improvement. Ultimately, results provide the basis for feedback, thus allowing a system's stakeholders to maintain fidelity to system of care values and principles.

Organization of the SOCPR

The SOCPR is organized into 4 major sections.

Section 1:
Includes demographic information and a snapshot of the child's current array of services.

Section 2:
Organizes the case records review and comprises the Case History Summary and the Current Service/Treatment Plan; the Case History Summary requires the reviewer to provide a brief case history based on a review of the file. It also provides information about all of the service systems with which the child and family are involved (e.g., special education, behavioral health, juvenile justice, child welfare). It summarizes major life events, persons involved in the child's history and current life, outcomes of interventions, and the child's present status. Review of the Individualized Service Plan

provides information about the types and intensity of the services received, integration and coordination, strengths identification, and family participation. The Document Review is completed prior to any interview so that the information gathered through the documents can inform and strengthen the interviews.

Section 3:
Consists of the interview questions organized by the type of informant (primary caregiver, youth, formal service provider, informal helper); the interviews are designed to gather information about each of the four identified domains (Child-Centered and Family-Focused, Community Based, Culturally Competent, and Impact). Questions for each of the four domains are divided into subdomains that define the domain in further detail and represent the intention of the corresponding system of care core value. Questions in each of the subdomains are designed to indicate the extent to which core system of care values guide practice. Data are gathered through a combination of closed-ended questions (i.e., quantitative) that produce ratings and explanatory responses from participants through more open-ended questions and narrative responses (i.e., qualitative). The open-ended questioning provides an opportunity for the reviewer to probe issues related to specific questions so that answers are as complete as possible. In addition, direct quotes from respondents are recorded whenever appropriate and possible.

Section 4:
Consists of the Summative Questions, the section in which reviewers record their ratings and the evidence derived from the file review and interviews to support the reviewer rating for each summative question. These ratings represent the reviewer's belief of the extent to which system of care values and principles are actualized.

Training of the Interview Team

Training for the SOCPR follows strict procedural guidelines which are outlined below. These steps were implemented and followed by the ADHS/DBHS review team. Before data collection begins, the team conducting the SOCPR must be identified and trained. Case reviews may be conducted using single reviewers or paired review teams. The use of single reviewers allows for more cases to be reviewed at a lower cost. Pairing reviewers provides the advantage of being able to validate and discuss what is being learned through the review process. The use of paired reviewers is obviously more costly and may not always be feasible. However, when individual reviewers are conducting the SOCPR, it is recommended that reliability checks be conducted with another reviewer.

The didactic training includes a review of the values and principles of systems of care, an orientation regarding the purpose and objectives of the SOCPR, and practice sessions for interviewing and rating the summative questions within the SOCPR. In addition, because much of the useful information about a family is collected through interviews, it was important to train reviewers in the proper methods for conducting interviews and documenting information from the responses that emerge during the review. Without this part of the training, reviewers may not probe adequately, or they may overlook information that helps with both the summative ratings and with the feedback that is later provided to the system of care. In addition, interview training was important so that the reviews are respectful, effective at ensuring that all questions are answered, and able to create a comfortable experience for informants.

During the training of reviewers, it is recommended that each trainee be shadowed by the trainer or another person with experience using the SOCPR protocol. This hands-on training includes the shadowing of a trainee by an experienced reviewer who participates in all aspects of the case review. The trainee conducts the interviews and leads the case review, and the shadow is available to provide support, clarify procedures, answer questions, and complete a separate set of ratings for comparison. Once a training case is completed, the trainee and shadow debrief about the case. It is essential that the debriefing include a discussion of why the ratings were given and the ways in which the notes resulting from the review will be used to give feedback to system stakeholders. Trainees, shadows, and the primary trainer typically meet together for group debriefing.

The coaching/shadowing of two cases per trainee allows for an examination of the trainee's ability to conduct the SOCPR in an appropriate and reliable manner. The reliability of a trainee can be examined through the calculation of three different measures: 1) the percentage of summative question ratings that were exact matches between the trainee and the shadow; 2) the percentage of summative question ratings that were scored in the same direction (i.e., positive or negative scores) by the trainee and the shadow; and 3) the discrepancy value between the trainee and shadow scores displayed as a percentage.

Selecting Cases and Informants

Implementing the SOCPR involves the selection of cases for review and the selection of the key informants for interviews. The number and type of cases to be examined is determined by the agency or system of care using the SOCPR and should be tailored to meet the specific needs and interests of that agency or system. Cases are selected based on characteristics such as the child's

age, gender, and the service sector with which the child is involved. For example, an agency or system may be interested in assessing its service delivery for young children who are not yet in school or for youth involved within the juvenile justice sector. A system of care should be purposeful in its approach to sampling to ensure the usefulness of the results. If a few cases are drawn from too large a pool of services and programs, it will be difficult to understand the results and to later know to whom and in what manner feedback should be provided. Determining the number of cases to be examined and the system's reason for implementing the SOCPR is critical to the usefulness of the results.

Arizona's sample of SOCPR cases could not be guided by examples from other communities who have used the SOCPR, as Arizona is the first state to implement the SOCPR in a systematic statewide manner. Again for FY2014-2015 the sampling emphasis was placed on children and families involved with the child welfare system Therefore, the sample pool of cases contained all children and youth age 6 –18 years who had scores of 4 or higher on the Child and Adolescent Service Intensity Instrument (CASII). Children aged 0-5 were included if they met one or more of the following criteria: other agency involvement (Arizona Early Intervention Program [AZ EIP], Department of Child Safety [AZ DCS], Department of Developmental Disabilities [AZ DDD]); out of home placement (within past 6 months); psychotropic medication utilization (2 or more medications) and /or CGAS of ≤50. In addition, selected cases had to be enrolled in services at least 90 days, and be currently active at the time the sample was drawn. Also if multiple siblings were receiving services from the same agency only one child was included in the sample. For each agency under review, a case manager could have no more than 2 of their cases identified for the SOCPR review.

The next step involved examining the number of children who met this complexity designation at each RBHA-contracted service agency in the state. These samples were further selected to maximize inclusion of children and families who were involved with the Child Welfare System / Department of Child Safety (DCS).

No cases were chosen for the SOCPR from agencies who served fewer than 25 children who met the high-need eligibility criteria. For agencies who served 25 to 400 eligible children, five cases from the agency were chosen for the SOCPR. For agencies who served more than 400 children who met the criteria, 10 cases were chosen. Agencies were contacted and asked to pull a random oversample based on the criteria described above. This oversampling was intended to provide substitute cases where families were not able to be located, chose not to participate in the process, or who upon review were found not to meet the "high complexity" designation. This process resulted in a total of 185 cases being completed in FY2014-2015.

SOCPR Data Analysis and Reporting

The analysis of the SOCPR follows a sequential process, in which data are coded, sorted, rated, and examined. Data are integrated, and ratings are determined for each question, embedded within a subdomain of one of the four main domains, with higher scores indicating that a family's experiences are more consistent with system of care principles. All of the interview questions in the SOCPR are organized into a predetermined coding scheme. This allows for questions to be sorted by interview (e.g., primary caregiver, child, formal provider) and by domain. Once all of the required data for the protocol have been collected, the information is integrated to rate the summative questions, each relating to a specific domain. The ratings specified for each subdomain are averaged to provide a global rating for that domain. In addition, the summative questions for each domain are clustered, with their average rating representing a measurement of the individual components in each domain. Finally, reviewers support their final ratings with a brief explanation and direct quotes from the interviews.

The SOCPR produces findings such as mean ratings that reveal the extent to which the services and/or system under review adhere to the system of care philosophy (i.e., the extent to which services are child-centered and family-focused, community-based, and culturally competent). A mean rating is also completed that assesses the impact of services on children and their families. The ratings are supported and explained by reviewer's detailed notes and direct quotes from respondents to provide objective, evocative, and in-depth feedback. The findings are used to document the specific components of service delivery that are effective or that need to be further developed and improved to increase fidelity to the system of care approach. One of the strengths of the SOCPR derives from its production of both quantitative and qualitative data. The mean ratings provide a discrete number to indicate the level of system of care values and principles implementation that is present within the family case. The file review data, interview contents, and reviewer reasoning to support summative question ratings provide the "why" to support the mean ratings scores. In addition, overall themes can be gleaned from these writings to provide information about larger systemic issues, community resources or needs, or other unique events that affect system of care values implementation.

SAS® Analytics software (version 9.4) was used to analyze the quantitative data. The results of the SOCPR are organized and presented on the basis of the four domains: Child-Centered and Family-Focused, Community Based, Culturally Competent, and Impact. Each summative question is rated on a scale of –3 (disagree very much) to +3 (agree very much). These scores are then

transformed on a scale from 1 (disagree very much) to 7 (agree very much) to eliminate the – and + signs. Thus, –3 is transformed to 1; –2 to is transformed to 2; –1 is transformed to 3, and so forth.

Thus, a rating ranging from 1–7 is derived for each of the domains and their embedded measurements. Scores from 1–3 represent lower implementation of a system of care principle, and scores from 5–7 represent enhanced implementation of a system of care principle. A score of 4 indicates a neutral rating, meaning a lack of support for or against implementation.

Means were calculated for the overall case, domains, subdomains, and individual items. The range of scores, minimum and maximum values, and standard deviations for each data point were also examined. The total set of cases as well as groups of cases determined by GSA were "slices" of data used to examine the relationship between SOCPR scores and a variety of demographic variables, including age, gender, race/ethnicity, child's primary language, service systems utilized, specific services accessed, and length of services at the agency. SOCPR quantitative score comparisons among GSAs were not made, as each GSA encompasses a unique set of children and families receiving services, and provider agencies providing services. Data are reported to provide state-level information to guide ADHS/DBHS planning and to assist provider agencies within a specific GSA to improve their services to best serve their children and families.

For the qualitative analysis, ratings for each item were clustered and considered in conjunction with the respective brief narrative provided to determine a general assessment for each sub-domain. The compiled narratives for all Summative Questions were coded and sorted to assess the degree to which System of Care principles were implemented in each SOCPR domain area (N=185). The frequency of Summative Question responses were examined and analyzed for emerging patterns/trends. In order to be considered a trend, at least of half of the responses associated with a particular rating had to provide similar information related to a given measurement and/or sub-domain area. Trends in each sub-domain are then reviewed together to provide an overall assessment for the larger domain area.

Data Quality

Initial verification of data from SOCPR reports were conducted by the contractor who reviewed submitted SOCPR instruments, and identified any omissions or other obvious errors in recording. Subsequently, data were forwarded to ADHS/DBHS for entry into the SOCPR database. The quality of the SOCPR data was checked again as data entry was completed for

each provider agency. A summary of each provider's quantitative data was produced and reviewed again for errors. If errors were found, clarification was sought from the data collection team leader and corrected in the database. Quantitative data were also compared by reviewer and provided to the data collection team leader in order to ensure accuracy. As part of preparation for provider feedback sessions, data from each provider agency review were assembled into a report format, which was forwarded to the Children's System of Care Bureau Chief and staff to review prior to sending to the contractor for final report preparation. Annually, various data reports were completed as part of the quality check process to assist with training and ensure continued data integrity needs were addressed.

Qualitative data derived from Summative Questions were monitored as follows. Summaries were reviewed for clarity and edited for consistency in of use of terms, spelling, jargon, and identifying information. Additionally, a sample of responses from each rater was reviewed for consistency between the rating and the narrative summary by the Project Manager with the individual rater. The scope and quality of these brief narrative responses can vary, though initial reviewer training and ongoing training and supervision are implemented to promote consistency.

Because the sampling emphasis for FY2014-2015 was placed on children and families involved with the child welfare system, results of this year's SOCPR report (both quantitative and qualitative) will be divided into 2 sections: Results All Cases and Results CW Cases. This will provide an opportunity for side-by-side comparison of the whole sample (of children and families identified as having high/complex levels of need) and the sample of interest (children and families involved with the child welfare system).

Results All Cases

Demographics All Cases

The 185 SOCPR cases completed during FY2014-2015 were sampled from all six GSAs in Arizona. A summary of the demographic characteristics are presented in Table 1. Due to the sampling scheme employed by ADHS/DBHS (previously described in the Methodology section), different numbers of cases were completed in each GSA. The most populous area, GSA 6, provided the greatest number of case for the sample (n=65). The other GSAs provided between 10 and 50 cases.

Table 1. Demographic Characteristics All Cases

Demographic Characteristic	Statewide N=185	GSA 1 n=35	GSA 2 n=15	GSA 3 n=10	GSA 4 n=10	GSA 5 n=50	GSA 6 n=65
Age (years)	9.54	8.37	11.87	11.30	12.00	8.94	9.43
Gender (Male)	57.3%	68.6%	46.7%	70.0%	80.0%	50.0%	53.9%
Race:							
White	50.3%	74.3%	53.3%	20.0%	30.0%	50.0%	44.6%
Black	7.0%	0.0%	0.0%	0.0%	10.0%	4.0%	15.4%
Latino/Hispanic	22.7%	2.9%	26.7%	80.0%	40.0%	22.0%	21.5%
Native American	2.2%	2.9%	0.0%	0.0%	10.0%	4.0%	0.0%
Multi-racial	16.2%	14.3%	20.0%	0.0%	10.0%	20.0%	16.9%
Missing	1.1%	5.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Primary Language:							
English	96.2%	91.4%	100.0%	90.0%	100.0%	100.0%	95.4%
Missing/NA	3.8%	8.6%	0.0%	10.0%	0.0%	0.0%	4.6%

As shown in Table 1, the overall mean age for the 185 cases was 9.54 years. The means for age across GSA ranged from 8.37 years to 12.00 years. Statewide over 57% of the sample was male, ranging from 47% in GSA 2 to 80% in GSA 4. Of the sample, 50% was White, almost 23% was Latino/Hispanic, and 16% identified as Multi-racial. The remaining 11% of the sample was Black, Native American, or data were missing. Statewide, 96% of the children and youth in the sample spoke English as their primary language. English was the only language reported in GSA 2, GSA 4, and GSA 5. No other language was identified as a primary language. Chi-square analyses were used to look for demographic differences in cases by GSA, with age bands, gender, race, and primary language under consideration.

Service System Involvement All Cases

Five different child-serving systems and an "Other" category were used to capture service system involvement as part of the services profiles of children and youth whose cases were

chosen as part of the sample. Almost all 185 cases (95.7%) indicated having behavioral health system involvement, as shown in Table 2. The SOCPR protocols documented that about 54% of the cases had child welfare involvement, followed by educational services involvement (41%). Juvenile justice, developmental disabilities, and "Other" rounded out service system involvement. The "Other" system category was documented by 1.6% of the GSAs. The three services included Arizona Early Intervention Program (AZEIP), Occupational Therapy (OT), and Criminal Justice.

Table 2. Service System Involvement All Cases

Service System	Statewide N=185	GSA 1 n=35	GSA 2 n=15	GSA 3 n=10	GSA 4 n=10	GSA 5 n=50	GSA 6 n=65
Behavioral Health	95.7%	94.3%	100.0%	70.0%	100.0%	94.0%	100.0%
Child Welfare	53.5%	45.7%	20.0%	30.0%	50.0%	58.0%	66.2%
Juvenile Justice	10.8%	11.4%	6.7%	20.0%	20.0%	18.0%	3.1%
Educational Services	40.5%	45.7%	53.3%	40.0%	20.0%	38.0%	40.0%
Developmental Disabilities	12.4%	5.7%	0.0%	20.0%	10.0%	10.0%	20.0%
Other	1.6%	0.0%	0.0%	0.0%	0.0%	2.0%	3.1%

The results of the 185 cases were plotted by histogram to explore the distribution of cases for total number of systems involved. The results are seen in Figure 1. The horizontal axis displays the total number of services, while the vertical axis represents the number of cases with that total number of services. The 185 cases represent children and youth who either were receiving behavioral health system services or had recently completed services from the behavioral health system. In addition, cases were only chosen for SOCPR review if the youth was identified as having complex needs.

Overall, systems involvement ranged from 1 – 6 with the mean being 2.15. The shape of the histogram resembles a normal distribution, but is slightly skewed. One might expect that children and youth in this sample to be involved in a significant number of child-serving systems and thus expect the shape/distribution to skew to the right, towards a greater number of service systems. Explanations for this finding might include inadequate record documentation, differences in reviewer interpretations of how to record service system involvement, or data entry errors.

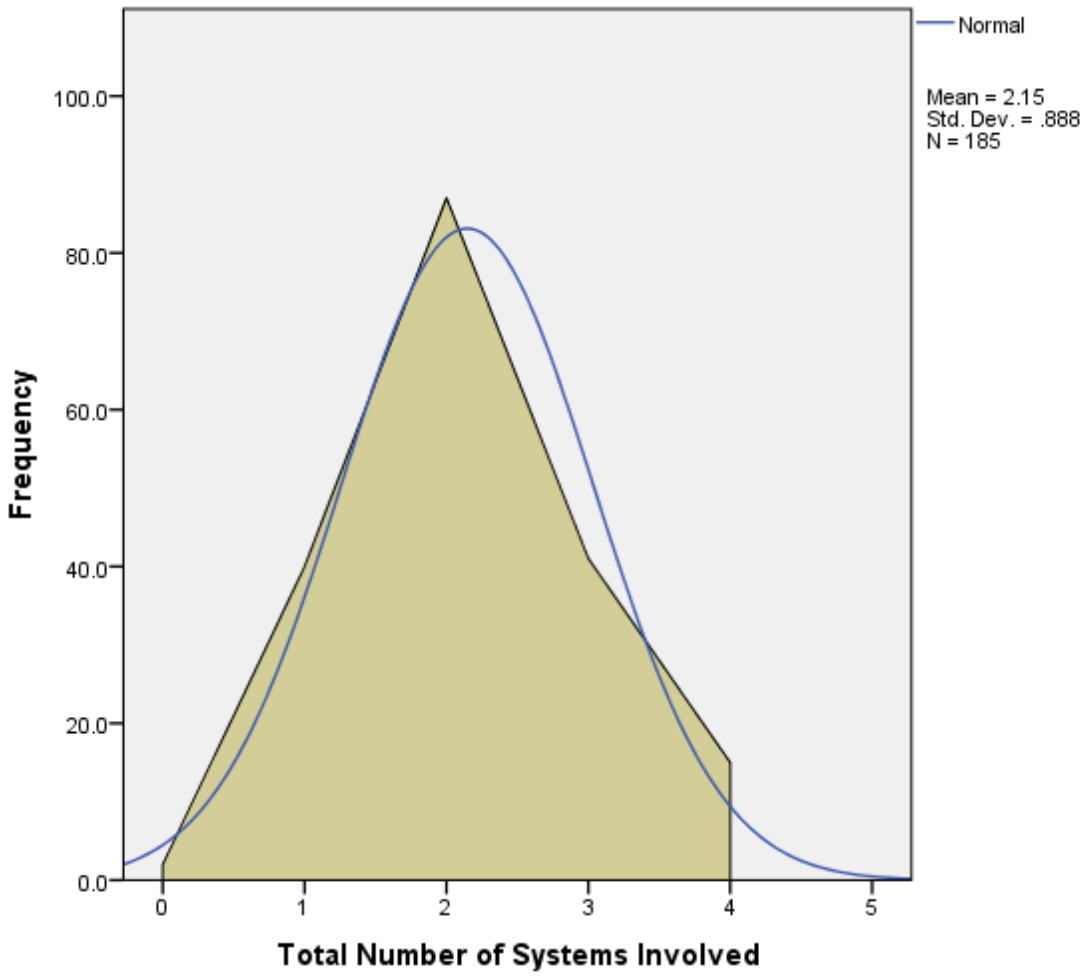

Figure 1. Histogram of child-serving system involvement all cases.

Receipt of Services or Treatments All Cases

Similar to child-serving systems, the kinds of services or treatments children and youth in the sample received were also calculated. Fifteen named types of services as well as an "Other" category (see list in Appendix B) were used to identify categories of service or treatment provision. These service types are shown in Table 3.

Table 3. Services or Treatments Received by Children and Youth All Cases

Services or Treatment	Statewide N (%)	GSA 1 N (%)	GSA 2 N (%)	GSA 3 N (%)	GSA 4 N (%)	GSA 5 N (%)	GSA 6 N (%)
Treatment Services	145 (78.4)	27 (77.1)	14 (93.3)	6 (60.0)	9 (90.0)	37 (74.0)	52 (80.0)
• Individual Counseling	126 (68.1)	22 (62.9)	14 (93.3)	5 (50.0)	8 (80.0)	32 (64.0)	45 (69.2)
• Family Counseling	64 (34.6)	17 (48.6)	6 (40.0)	2 (20.0)	5 (50.0)	18 (36.0)	16 (24.6)
• Group Counseling	31 (16.8)	7 (20.0)	5 (33.3)	2 (20.0)	2 (20.0)	10 (20.0)	5 (7.7)
• Alcohol/Drug Counseling	7 (3.8)	2 (5.7)	0 (0.0)	1 (10.0)	0 (0.0)	3 (6.0)	1 (1.5)
Medical Services • Psychiatric Medication	90 (48.6)	16 (45.7)	8 (53.3)	5 (50.0)	7 (70.0)	19 (38.0)	35 (53.8)
Support Services	178 (96.2)	35 (100.0)	15 (100.0)	9 (90.0)	9 (90.0)	47 (94.0)	63 (96.9)
• Family Support	74 (40.0)	14 (40.0)	12 (80.0)	5 (50.0)	8 (80.0)	18 (36.0)	17 (26.2)
• Peer Support	5 (2.7)	0 (0.0)	1 (6.7)	0 (0.0)	0 (0.0)	3 (6.0)	1 (1.5)
• Respite Support	28 (15.1)	6 (17.1)	4 (26.7)	1 (10.0)	0 (0.0)	10 (20.0)	7 (10.8)
• Home Care Training	7 (3.8)	1 (2.9)	1 (6.7)	0 (0.0)	0 (0.0)	1 (2.0)	4 (6.2)
• Case Management	173 (93.5)	34 (97.1)	15 (100.0)	9 (90.0)	9 (90.0)	44 (88.0)	62 (95.4)
• Skill Develop & Train	76 (41.1)	20 (57.1)	8 (53.3)	5 (50.0)	7 (70.0)	17 (34.0)	19 (29.2)
Inpatient Services	12 (6.5)	0 (0.0)	0 (0.0)	1 (10.0)	0 (0.0)	8 (16.0)	3 (4.6)
• Psychiatric Hospitalization	10 (5.4)	0 (0.0)	0 (0.0)	1 (10.0)	0 (0.0)	6 (12.0)	3 (4.6)
• Level I Residential	3 (1.6)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	3 (6.0)	0 (0.0)
Residential Services	11 (5.9)	3 (8.6)	0 (0.0)	0 (0.0)	0 (0.0)	4 (8.0)	4 (6.2)
• Level II Residential	7 (3.8)	2 (5.7)	0 (0.0)	0 (0.0)	0 (0.0)	2 (4.0)	3 (4.6)
• Level III Residential	5 (2.7)	2 (5.7)	0 (0.0)	0 (0.0)	0 (0.0)	2 (4.0)	1 (1.5)
Other	35 (18.9)	9 (25.7)	6 (40.0)	1 (10.0)	4 (40.0)	6 (12.0)	9 (13.8)

Across the state the most utilized service or treatment provision was Support Services (96.2%) followed by Treatment Services (78.4%). Residential Services (5.9%) was the least used service or treatment provision. More specifically, the most widely utilized service or treatment statewide, based on percentage of cases using the service, was Case Management (94%) followed by Individual Counseling (68%), Psychiatric Medication (49%), and Family Support (40%). Level I Residential, Level III Residential, and Level II residential were the least utilized services or treatments (1.6%, 2.7%, and 3.8% respectively) statewide. Across GSAs, Case Management was utilized in six out of six GSAs and was utilized in at least 88% of the cases in each GSA. Level I Residential was utilized in only one GSA (3 cases), and Level III Residential was used in three GSAs equaling 5 cases.

Support Services were utilized in all six GSAs with two GSAs utilizing them in 100% of the cases. As mentioned earlier in this report one specific support service, Case Management, was received by families over 88% by all GSAs. GSA 2 utilized Case Management in 100% of its families. Treatment Services was documented as the next most frequently utilized service with

over 78% of cases. Inpatient Services were not utilized in GSAs 1, 2 and 4. Residential Services were not utilized in GSAs 2, 3, and 4. GSA 3 had the smallest number of cases as a part of the overall statewide sample, while GSA 6 (n=65) had the largest number of cases using services in all but one service provision categories.

Usage of some services *appears* to be unusually high; therefore, because GSAs vary widely in the number of SOCPR cases completed, both number of cases and percentage need to be examined. For example, 40% of cases in GSA 2 had "Other" services, which represents only 6 youth, as only 15 total SOCPR cases were completed for this GSA. Statewide, about 19% (N=35) of the treatments or services reported were identified as "Other". Several of the services variables differed significantly by GSA and are shown in Table 4. Only statistically significant chi-square statistics are reported.

Table 4. Significant Associations between GSA and Specific Services All Cases

Treatment	Chi-Square Statistic
Treatment Services • Individual Counseling • Family Counseling • Group Counseling • Alcohol/Drug Counseling	
Medical Services • Psychiatric Medication	
Support Services • Family Support • Peer Support • Respite Support • Home Care Training (HCTC) • Case Management • Skills Development and Training	X^2 (5, N=185)= 22.609, p-value < 0.001 X^2 (5, N=185)= 13.251, p-value = 0.021
Inpatient Services • Psychiatric Hospitalization • Level I Residential	X^2 (5, N=185)= 12.201, p-value = 0.032
Residential Services • Level II Residential • Level III Residential	
Other	X^2 (5, N=185)= 11.466, p-value = 0.043

Statewide for All Cases, a statistically significant relationship between GSA and services received was shown for Support Services, Inpatient Services, and Other. Specifically, within Support Services, Family Support and Skills Development and Training were found to show strong significant associations with GSA.

In order to examine the breadth of services used by children and youth in the sample, a simple summation was calculated for the 16 potential service categories. Thus, the possible range for this variable was from 0 to 16 services utilized. For the total 185 cases in the sample, the range of services used was 1 to 9. These data are displayed via histogram to examine the distribution of total number of services used. The results are displayed in Figure 2. The histogram closely resembles a normal distribution, with a mean of 4.01 services per child or youth recorded. The number of services used during the time a case is open could vary greatly, depending on the needs of the child and family, the array of services that are available, and the length of time the case is open.

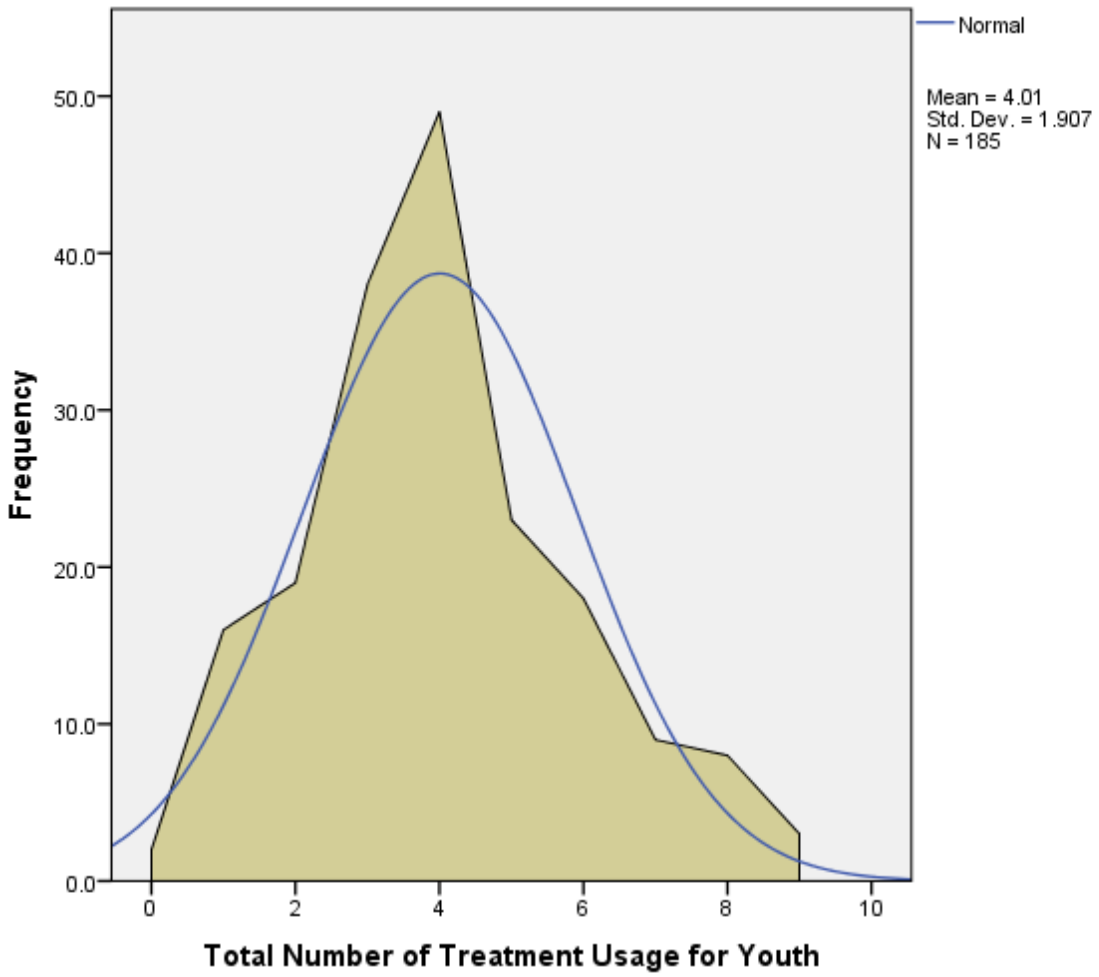

Figure 2. Histogram of service or treatment usage for youth all cases.

Quantitative Analysis All Cases

SOCPR Scores – Overall Case and SOCPR Domains All Cases

Mean scores were computed for the overall case, as well as for each of the four SOCPR domains (Child-Centered Family-Focused, Community Based, Culturally Competent, and Impact). In addition, mean scores were computed for those subdomains contained within the domains. Finally, each summative question was examined individually. In general, the mean score for each item of interest was an important statistic to be examined. In addition, the minimum and maximum scores, as well as the standard deviation for each item of interest, were examined. Using these four statistics, an understanding of the range of scores, the average score, as well as an indication of the variability from case to case, could be examined. This section will

report on the overall findings, and then report on specific items of interest which demonstrate extreme scores.

Table 5 shows the overall case scores as well as those for each SOCPR domain for the entire statewide sample of 185 cases, indicated by individual GSA. As explained in the Methodology section, SOCPR scores range from a low of 1 to a high of 7. Scores from 1–3 represent lower implementation of a system of care principle, and scores from 5–7 represent enhanced implementation of a system of care principle. A score of 4 indicates a neutral rating, meaning a lack of support for or against implementation. At the statewide level, SOCPR mean scores ranged from 4.93 to 5.45 with an overall case mean score of 5.12. While the SOCPR scores for the case and domains are not normally distributed and so the standard deviation is a less useful statistic, in conjunction with minimum and maximum scores, a more complete picture of the data emerges. The statewide overall case score suggests that, like all of the SOCPR domains, great variability exists across cases. The minimum and maximum scores are to their greatest possible extremes, representing exemplary cases of good and poor system of care values implementation. The means range from the high 4s to 6, showing enhanced implementation of system of care values. The scores indicate that across the state, behavioral health provider agencies included in the sample performed best at including the Community Based system of care values in service planning and provision. Behavioral health provider agencies were most challenged by providing culturally competent care.

Table 5. SOCPR Case and Domain Scores All Cases

GSA (N=185)	Case Mean (SD)	CCFF Mean (SD)	CB Mean (SD)	CC Mean (SD)	IMP Mean (SD)
Statewide	5.12 (0.93) Min 1.77 Max 6.65	5.03 (1.09) Min 1.77 Max 6.78	5.45 (0.76) Min 2.96 Max 7.00	4.93 (1.17) Min 1.11 Max 7.00	5.09 (1.30) Min 1.25 Max 7.00
GSA 1 (n=35)	5.31	5.21	5.65	5.17	5.22
GSA 2 (n=15)	5.78	5.74	6.00	5.70	5.68
GSA 3 (n=10)	4.91	4.84	5.14	4.93	4.75
GSA 4 (n=10)	5.29	4.91	5.79	4.84	5.60
GSA 5 (n=50)	4.90	4.92	5.23	4.46	4.99
GSA 6 (n=65)	5.05	4.91	5.38	4.99	4.93

Minimum and maximum values are not presented for individual GSAs, as they are a subset of the statewide scores. At the state level, the highest scoring SOCPR domain was Community Based (Mean = 5.45). This was followed by Impact (Mean = 5.09), Child-Centered Family-Focused (Mean = 5.03), and Culturally Competent (Mean = 4.93). The GSA data show similar patterns when compared with statewide scores; i.e., the domain Community-Based had the highest mean score for all six GSAs. Additionally, standard deviation data are not presented at the GSA level because some of the GSAs had small sample sizes; therefore, presenting standard deviation data would not be statistically meaningful. Because of the sample size variance among the GSAs, comparisons between GSAs are not possible.

Histograms were drawn at the statewide level to better demonstrate the range of SOCPR scores for the overall case and the four SOCPR domains. These results are displayed in Figures 3 – 7. Scrutiny of these graphs shows a similar pattern for the overall average and each SOCPR domain. The data are not normally distributed and are skewed slightly towards the right, toward higher scores.

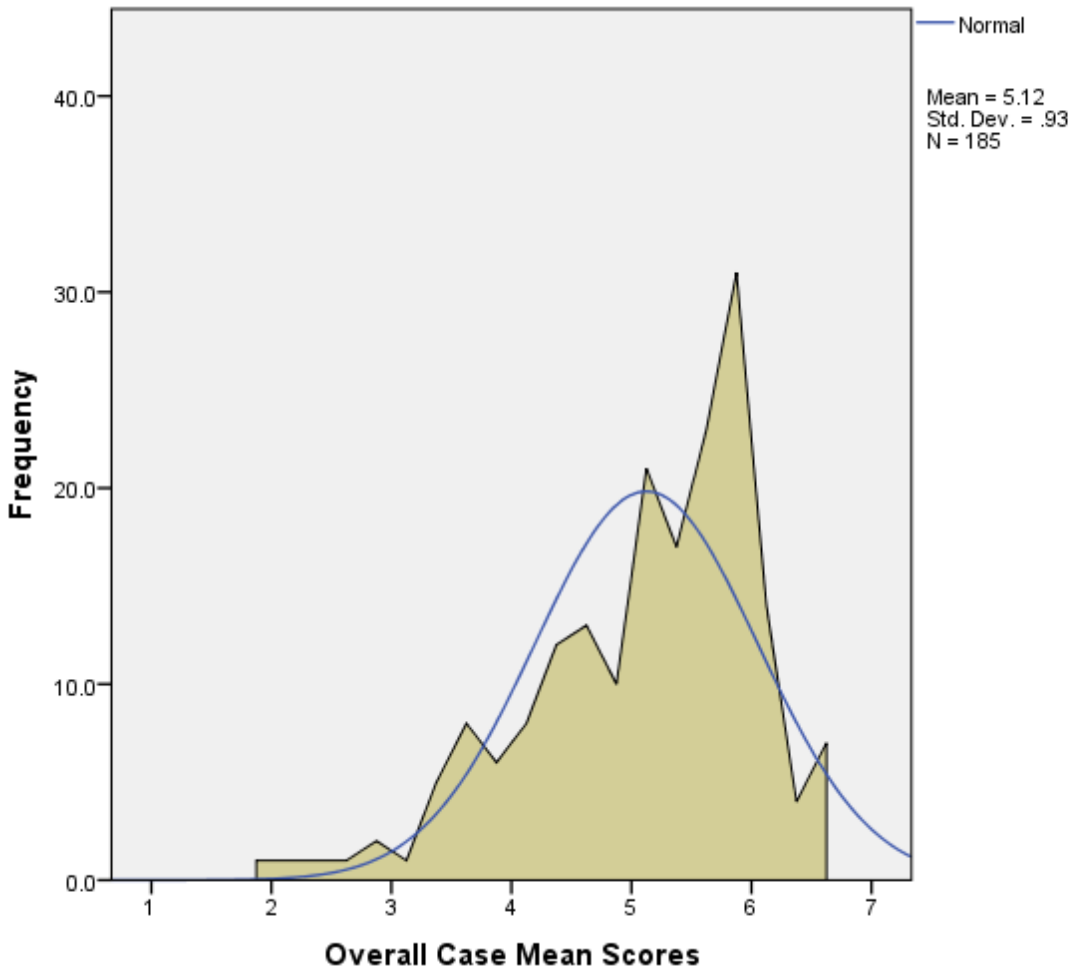

Figure 3. Histogram of SOCPR Overall case mean scores all cases.

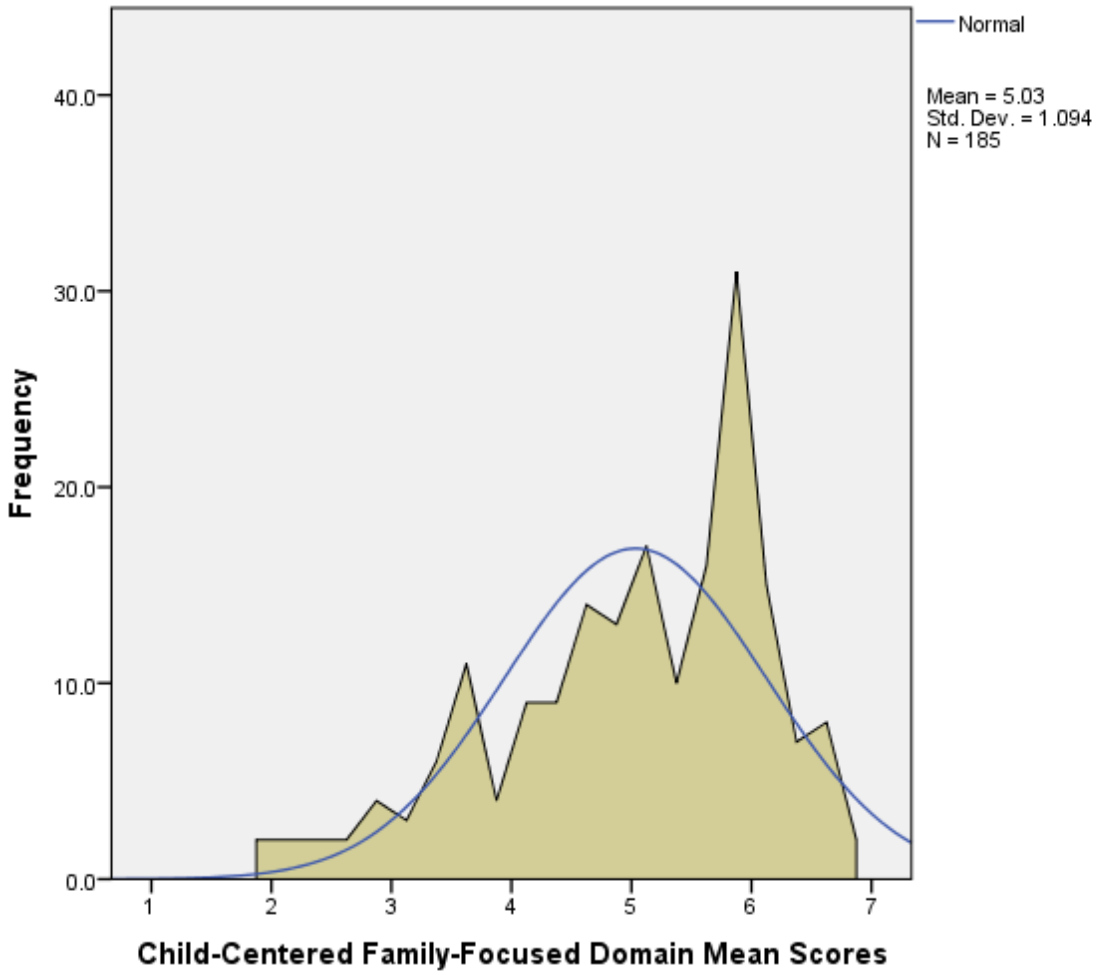

Figure 4. Histogram of SOCPR Child-Centered Family-Focused domain mean scores all cases.

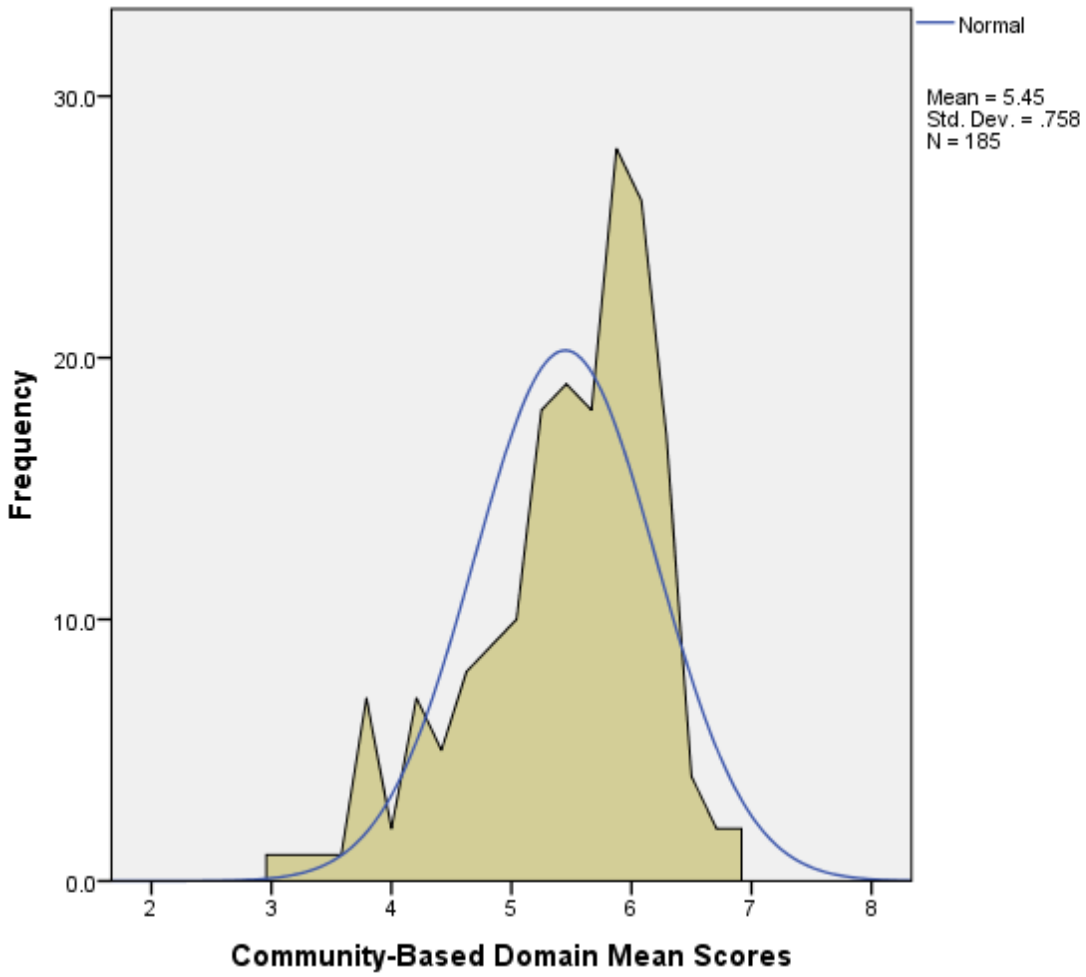

Figure 5. Histogram of SOCPR Community-Based domain mean scores all cases.

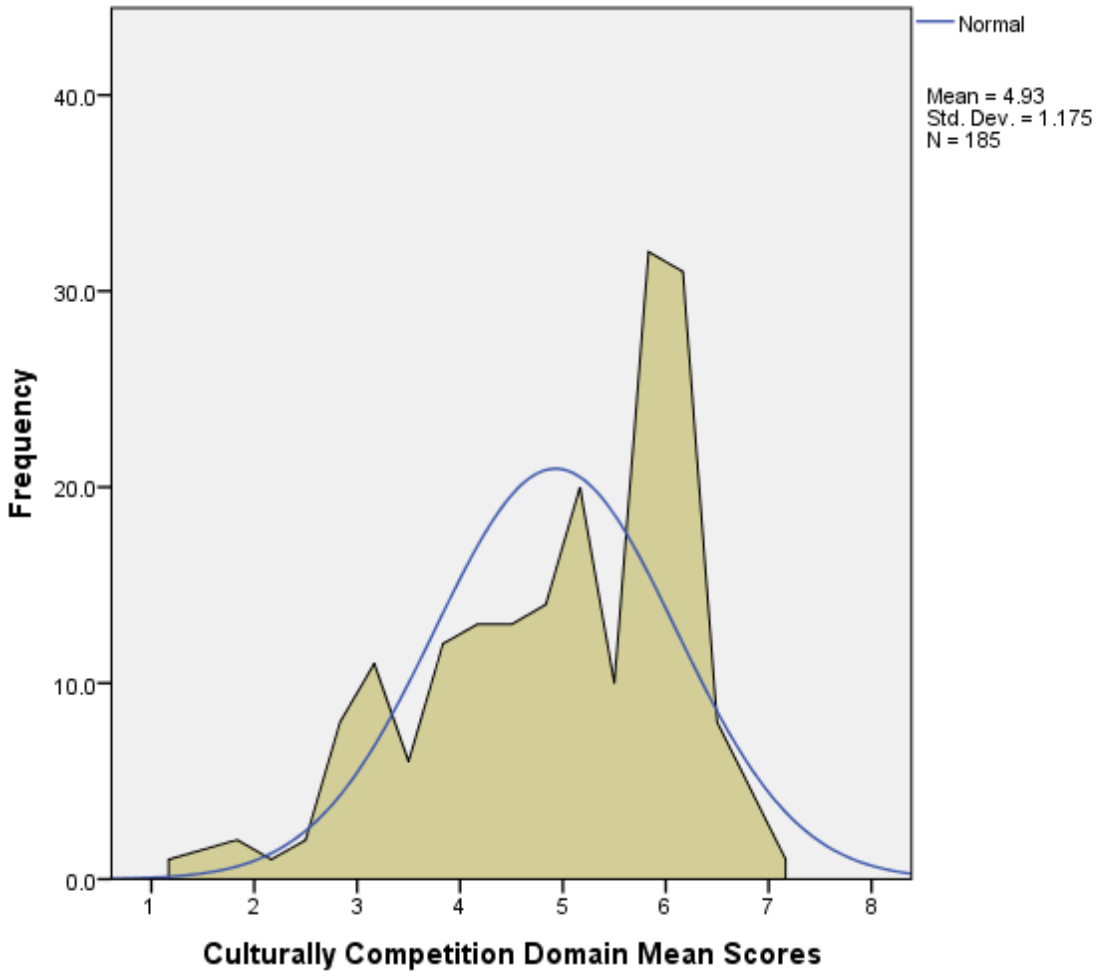

Figure 6. Histogram of SOCPR Culturally Competent domain mean scores all cases.

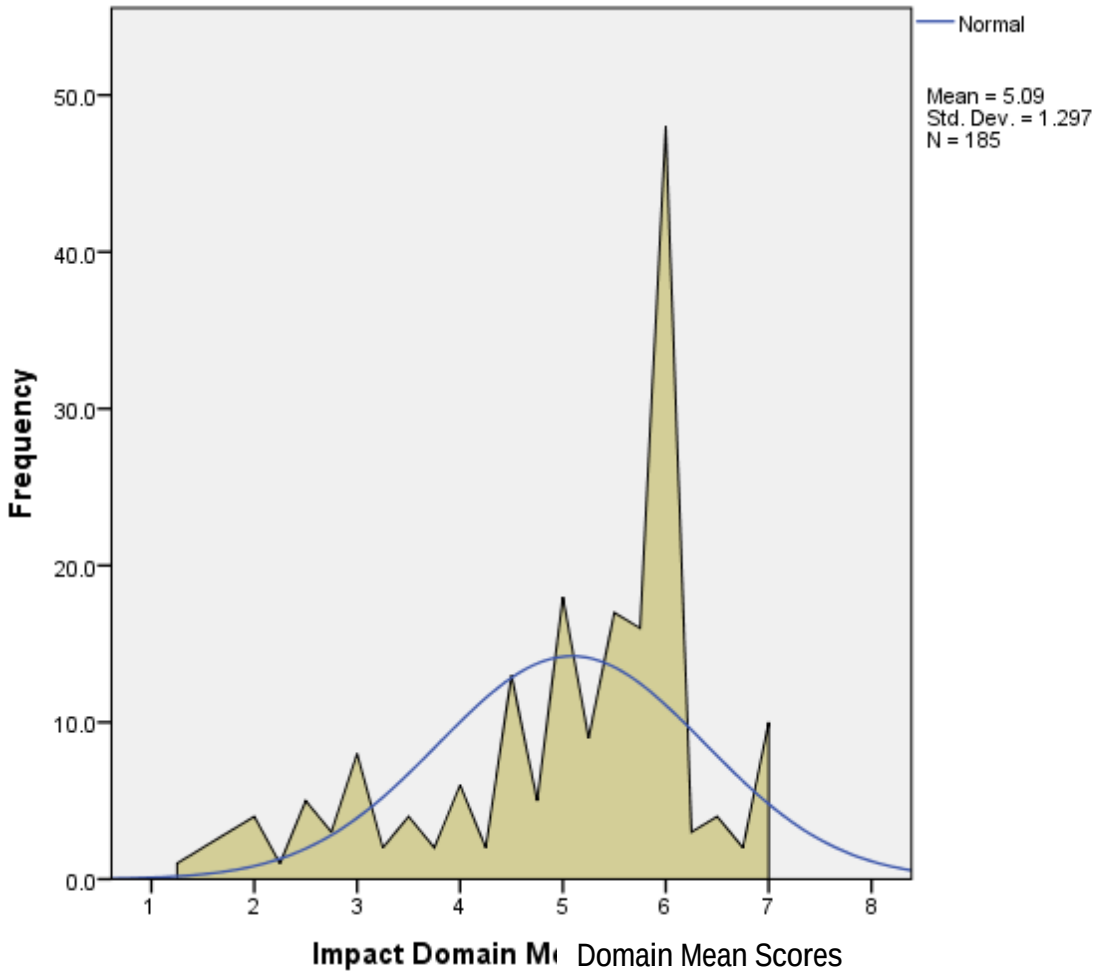

Figure 7. Histogram of SOCPR Impact domain mean scores all cases.

SOCPR Scores – SOCPR Domains, Subdomains, and Areas All Cases

Table 6 presents statewide SOCPR data for most levels of the instrument, including the total case mean score, SOCPR domain scores, SOCPR subdomain scores, and SOCPR Area scores. Because some of the GSAs had very small sample sizes, the standard deviation data are not statistically meaningful; consequently, SOCPR subdomains and their areas of interest are not reported at the GSA level.

Table 6. Arizona Statewide SOCPR Scores by Domain, Subdomain, and Area All Cases

Overall Score – all cases: 5.12 (0.93)		
	Area Mean (SD)	**Subdomain Mean (SD)**
Domain I: Child-Centered, Family-Focused: 5.03 (1.09)		
Individualized		4.88 (1.11)
Assessment/Inventory	5.20 (1.07)	
Service Planning	4.78 (1.22)	
Types of Services/Supports	4.78 (1.48)	
Intensity of Services/Supports	4.77 (1.60)	
Full Participation		5.35 (1.00)
Case Management		4.86 (1.51)
Domain II: Community-Based Domain Score: 5.45 (0.76)		
Early Intervention		5.29 (1.16)
Access to Services		5.90 (0.75)
Convenient Times	5.84 (1.14)	
Convenient Locations	5.76 (1.21)	
Appropriate Language	6.11 (0.81)	
Minimal Restrictiveness		5.65 (0.87)
Integration and Coordination		4.95 (1.32)
Domain III: Culturally Competent Domain Score: 4.93 (1.17)		
Awareness		4.97 (1.25)
Awareness of Child/Family's Culture	4.94 (1.27)	
Awareness of Providers' Culture	4.99 (1.52)	
Awareness of Cultural Dynamics	4.97 (1.44)	
Sensitivity and Responsiveness		4.91 (1.48)
Agency Culture		5.11 (1.25)
Informal Supports		4.72 (1.71)
Domain IV: Impact Domain Score: 5.09 (1.30)		
Improvement		5.21 (1.26)
Appropriateness		4.97 (1.44)

As reported previously, the highest scoring SOCPR domain was Community Based. This was followed by Impact, Child-Centered Family-Focused, and finally Culturally Competent. All but one of the SOCPR domain, subdomain, and area scores fell in the high 4 (neutral) to high 5 (enhanced implementation of a system of care principle) range. Appropriate Language, in the subdomain of Access to Services was in the low 6 range.

In the Community Based domain all subdomains and areas except for the subdomain of Integration and Coordination (4.95), scored in the low 5 to low 6 range. Further, the subdomains of Access to Services and Minimal Restrictiveness had the highest mean scores (5.90 and 5.65 respectively). All three areas in the subdomain of Access to Services had mean scores in the high 5 to low 6 range: Appropriate Language (6.11), Convenient Times (5.84), and Convenient Locations (5.76). These subdomain and area scores indicate that the primary language of the family was considered when coordinated services were provided. These services were accessible and available to families, and they were delivered in the most flexible and least intrusive manner possible. These represent strengths in Arizona's Children's System of Care, as reviewed through these 185 SOCPR cases.

The data also revealed scores in the high 4s. Although these scores indicate neither support for nor against implementation of system of care principles, they may stress the need for additional attention or support. For example, within Culturally Competent all domain, subdomain, and area mean scores were in the high 4s except for the subdomain of Agency Culture (5.11). These scores may indicate that providers are giving families information and expectations about the role of the agency, but providers may not be fully aware of or accepting the cultural differences of the children and families they are serving and thus not adapting services to the cultural context of the family. For instance, service providers need to make sure that the informal supports identified by the child and family are included in all aspects of service planning and delivery. Other high 4 scoring areas are within the subdomain of Individualized in the domain of Child-Centered Family-Focused. These areas include Intensity of Services/Supports (4.77), Types of Services/Supports (4.78), and Service Planning (4.78), Service providers, when creating a service plan and its related goals, need to make sure that it is integrated across agencies and providers. Within this service plan they need to consider that the amount of services and supports should be a reflection of not only the families' needs but also their strengths. It should be noted that some of the lower scoring areas had higher standard deviation scores which suggest that variability exists across cases and that while some cases scored poorly, others were more exemplary.

SOCPR Scores and Tests of Significant Differences All Cases

Because the SOCPR case and domain scores do not fit the pattern of a normal

distribution, nonparametric statistical tests were performed to examine the data for differences between groups within a specific variable in relation to SOCPR scores. SOCPR scores are continuous data, while most of the other variables were categorical data. Thus, for statistical tests in which the variable to be examined in relation to SOCPR scores consisted of more than 3 groups, such as race, the Kruskal- Wallace test was performed. For variables with only 2 groups, such as gender, the Mann-Whitney U test was performed. Age was transformed into an Age Band variable with 3 groups: 0 through 5, 6 to 12, and 13 to 18. Table 7 shows the results of these statistical tests for a variety of variables. A value of .05 or lower indicates a significant difference between groups for the variables involved in the statistical test, with lower scores indicating a higher likelihood of true significant differences.

Table 7. SOCPR Scores and Significant Differences with Variables of Interest All Cases

Variable	Case	CCFF	CB	CC	IMP
Demographics					
Age Bands				.039	
Gender					
Race	.050			.022	.031
Primary Language					
GSA	.008	.032	.001	.011	
Case Longevity					
Service Systems					
Behavioral Health				.034	
Child Welfare				.001	
Juvenile Justice					
Educational					
Developmental Disabilities					
Total Systems					
Services Categories					
Treatment Services	.001	.002	<.001	.005	.008
Medical Services					
Support Services	.011	.014	.020		.018
Inpatient Services					
Residential Services					
Services					
Individual Counseling	.020	.027	.004	.042	
Family Counseling	.003	.003	.015	.008	
Family Support	.008	.016	.008	.005	
Respite Support					
Case Management					
Psychiatric Hospitalization					
Total Number of Services	.001	.006	.002	.005	.012

There were a variety of significant differences in SOCPR case and domain scores across the variables examined. Some of each of the demographic variables, service systems, services categories, and services measured showed significant differences.

Findings indicate that children and youth who received Treatment Services and Total Number of Services were associated with higher SOCPR case and domain scores. Children and youth who received Treatment Services, Individual Counseling, Family Counseling, and Family Support are associated with Child-Centered, Family-Focused, Community Based, and Culturally Competent domains. The Geographic Service Area (GSA) of the children also contributed to higher scores. Those youth with Behavioral Health and Child Welfare systems involved are associated with higher Culturally Competent scores. Children and youth with Treatment Services and Support Services were associated with higher Impact scores with Race contributing to the higher score. Higher SOCPR case and domain scores were also associated with multiple types of support and counseling services as well as race and GSA.

SOCPR Scores – FY2013-2014 and FY2014-2015 Comparison All Cases

Table 8 shows a comparison of domain, subdomain, and area scores across two administrations of the SOCPR. Overall, scoring differences across all domain, subdomain, and area scores indicate a down trend from FY2013-2014 to FY2014-2015. Some of these downturns were statistically significant. One area score Convenient times showed a slight improvement. This may be due in part to the different sample of children and families that was utilized for the FY2014-2015 as compared to the sample utilized for the FY2013-2014.

Table 8. SOCPR Score Comparisons between FY2013-2014 and FY2014-2015 All Cases

	2013-2014		2014-2015		Change	p-value[1]
	Mean	(SD)	Mean	(SD)		
Overall Score	5.35	(0.97)	5.12	(0.93)	-0.23	0.02*
Domain I: Child-Centered, Family-Focused	5.34	(1.06)	5.03	(1.09)	-0.31	0.01*
Individualized	5.12	(1.17)	4.88	(1.11)	-0.24	0.04*
Assessment/Inventory	5.65	(0.86)	5.20	(1.07)	-0.45	<0.01*
Service Planning	5.16	(1.20)	4.78	(1.22)	-0.38	<0.01*
Types of Services/Supports	4.84	(1.68)	4.78	(1.48)	-0.06	0.72
Intensity of Services/Supports	4.84	(1.67)	4.77	(1.60)	-0.07	0.69
Full Participation	5.66	(0.91)	5.35	(1.00)	-0.31	<0.01*
Case Management	5.25	(1.47)	4.86	(1.51)	-0.39	0.01*
Domain II: Community-Based	5.64	(0.80)	5.45	(0.76)	-0.19	0.02*
Early Intervention	5.47	(1.26)	5.29	(1.16)	-0.19	0.13
Access to Services	6.04	(0.78)	5.90	(0.75)	-0.13	0.09
Convenient Times	5.83	(1.33)	5.84	(1.14)	0.01	0.92
Convenient Locations	5.98	(1.10)	5.76	(1.21)	-0.21	0.07
Appropriate Language	6.30	(0.69)	6.11	(0.81)	-0.20	0.01*
Minimal Restrictiveness	5.82	(0.89)	5.65	(0.87)	-0.17	0.07
Integration and Coordination	5.23	(1.38)	4.95	(1.32)	-0.28	0.05
Domain III: Culturally Competent	5.14	(1.14)	4.93	(1.17)	-0.21	0.08
Awareness	5.26	(1.15)	4.97	(1.25)	-0.29	0.02*
Awareness of Child/Family's Culture	5.16	(1.32)	4.94	(1.27)	-0.21	0.11
Awareness of Providers' Culture	5.32	(1.35)	4.99	(1.52)	-0.32	0.03*
Awareness of Cultural Dynamics	5.31	(1.23)	4.97	(1.44)	-0.33	0.02*
Sensitivity and Responsiveness	5.03	(1.55)	4.91	(1.48)	-0.12	0.45
Agency Culture	5.26	(1.26)	5.11	(1.25)	-0.16	0.22
Informal Supports	4.99	(1.65)	4.72	(1.71)	-0.27	0.13
Domain IV: Impact Domain Score:	5.29	(1.37)	5.09	(1.30)	-0.21	0.13
Improvement	5.40	(1.36)	5.21	(1.26)	-0.19	0.15
Appropriateness	5.19	(1.49)	4.97	(1.44)	-0.22	0.14

[1] p-values were obtained through a two-sided two independent samples t-test

Although the change in mean scores from FY2013-2014 and FY2014-2015 reflect an overall decrease, the ranking of domain scores remains consistent. The highest scoring SOCPR domain was Community Based across both administrations. As in previous years, the subdomain of Access to Services was the highest scoring subdomain and Appropriate Language was the highest scoring area. The subdomain of Minimal Restrictiveness scored high as well across both administrations of the SOCPR, as did the area of Convenient Times.

One of Arizona's Children's System of Care strengths can be seen in the domain of Community Based. The area of Convenient Times within the subdomain of Access to Services rose slightly from FY2013-2014 to FY2014-2015. This increase shows that accessible and flexible services are provided at convenient times for families.

Again, within the subdomain of Access to Services, another area, Appropriate Language, scored in the low 6 range although the score dropped from last year. This high score indicates that service providers are communicating orally and in writing appropriately with youth and families in their primary language.

It should be noted that FY2015 encompassed some marked changes in the Arizona Behavioral Health system. These included a change in the RBHA contract award for Arizona's most populous county; Maricopa County. This contract which had been managed by Magellan Inc. was awarded to Mercy Maricopa Integrated Care in October of 2013, with implementation beginning on April 1, 2014.

This type of large scale administrative change has significant implications for program staff at all levels, even though no structural changes were implemented until near the end of FY2015. A common artifact of these changes is often increased staff turnover, which in turn leads to disruption of established staff/client relationships. This type of system change and associated instability may be a factors contributing to overall decreases in SOCPR scores for FY2015. The effects of these marked changes are still unfolding, and the full impact may not be registered until the end of FY2016 or later.

Qualitative Analysis All Cases

This section reports a summary of qualitative data compiled from responses to Summative Questions that SOCPR reviewers use to summarize and integrate information gathered throughout the Document Review process and a series of interviews completed with a

particular child/youth and family to address each of the four SOCPR domains. The Summative Questions call for a reviewer to provide a rating for each statement and to give a brief narrative in support of that rating. Individual ratings serve as indicators of the extent to which system of care sub-domain elements (e.g., individualized, full participation) are being implemented. In the final analysis, ratings for each measurement are clustered and considered in conjunction with reviewers' narratives to determine an overall rating for each domain, indicating the extent to which each sub-domain was achieved. The narrative portion of each Summative Question response is used to assess the degree to which SOCPR items tied to each domain were met and an explanation for the evidence provided. Where an overall summative rating relates to a reviewer's determination of completion of a *thorough assessment*, for instance, qualitative analysis examines the evidence provided to explain the rating.

The compiled narratives for all Summative Questions were coded and sorted to assess the degree to which System of Care principles were implemented in cases examined, in each SOCPR domain area (N=185). The frequency of Summative Question responses was examined and analyzed for emerging patterns/trends in 13 sub-domain areas that correspond to the four large SOCPR domains. In order to be considered a trend, at least half of the cases reviewed had to provide similar information for a given sub-domain area. Identified trends are then reported for the entire domain. The qualitative findings section also highlights successes and opportunities for growth related to each of the SOCPR Domain Areas as reported in responses to Summative Questions.

Qualitative Findings

Domain 1: Child-Centered and Family Focused Services

The first domain of the SOCPR is designed to measure whether the needs of the child/youth and family determine the types and mix of services provided within the System of Care. This domain reflects a commitment to adapt services to the child and family rather than expecting them to conform to preexisting service configurations. The review reflects the effectiveness of the site in: providing services that are individualized; that families are included as full participants in the treatment process; and that the type and intensity of services provided is monitored through effective case management.

Overall, scores and descriptive comments provided by SOCPR raters suggest that providers within the System of Care are generally providing child-centered and family-focused services. The review of cases using the measures associated with *Child-Centered and Family-Focused Services* suggests that children and families are generally receiving services that are individualized, that families are included as full participants in the service delivery process(es), and that the type and intensity of services is monitored through effective case management.

When considering whether children/youth and family received *Individualized Services* within the System of Care, reviewers noted that service plans generally reflect the needs of the child/youth and family and the goals established to address the needs were explicitly identified within service plan documents and/or case files. Reviewers noted that child/family needs *and* strengths were generally identified within files, including service plans. Some reviewers noted that strengths identified in documents were not always meaningfully integrated in child and family goals. In general, reviewers also found that caregivers and providers reported informal acknowledgment of needs and strengths on the part of providers.

A review of responses related to the existence of a primary service plan that documents service integration across providers found that reviewers reported some inconsistencies in documentation in this regard. A key challenge identified within this sub-domain area was identified in various reviewer comments related to inconsistent integration of service planning across all systems or organizations serving a particular family. Such comments were evident in summative responses associated with a rating of "5" (about 28%) and lower (ratings of "1" through "4", 28% of responses), of the responses regarding the existence of a primary service plan that integrates all services received. This finding provides an opportunity for growth and training of providers/system representatives serving the families in the current sample to improve service plan documentation and integration. It may also provide an opportunity to assess cross-system training activities designed to ensure that providers and other stakeholders in different systems recognize the importance of coordinated and collaborative service planning and delivery.

Overall, reviews indicate that there was *Full Participation* on the part of children/youth and families in the development, implementation, and evaluation of service plans. In general, reviewers reported that child/youth and caregivers regularly attended service-planning meetings and felt that parent/caregivers influenced the service planning process. Reviewers also noted that most parent/caregivers and some children/youth appeared to understand the service plans developed for them, based on documentation found in record reviews. Despite overall ratings of "5" ("Agree Slightly") or more related to the participation of formal providers and/or informal helpers, reviewers noted some inconsistency in documentation of participation in service planning even though interview responses suggest that they did, in fact, participate. Reviewers also noted that informal helpers participated in service planning meetings less often than did formal providers.

With regard to the *Case Management* sub-domain, reviewers reported that one individual appeared to be responsible for coordinating child/youth and family services and was doing so successfully. Overall, service planning appears to be responsive to the changing needs of the family and that service plans are updated in a timely fashion. In cases that were rated as

"3" (Disagree Slightly) or lower (32% of cases), various reviewers made note of case plans that had not been updated in the months prior to the review. In some cases, service plans had not been updated for months at a time and reviewers were therefore unable to verify that service plans were responsive to family needs.

System Successes in the Provision of Child-Centered and Family-Focused Services

- Assessments of children/youth conducted across multiple domains
- Service plans reflect needs and goals of children/youth and family
- Strengths of youth and family are informally acknowledged by providers
- Child/youth and family attend planning meetings and appear to understand service plans, generally
- Intensity of services provided appears to be appropriate, according to family needs identified
- Services for children and families are coordinated by a case manager
- Service planning is responsive to changing needs and plan is updated accordingly

Opportunities for Growth and/or Training in Domain 1

- Service plan goals don't always incorporate child/youth or family strengths
- Inconsistent documentation regarding service plan integration of all systems or organizations serving a particular family
- Service plans don't consistently reflect participation of informal helpers

Domain 2: Community-Based Services

The second SOCPR domain is designed to measure whether services are provided within or close to the child/youth's home community, in the least restrictive setting possible, and moreover, that services are coordinated and delivered through linkages between public and private providers. The sub-domains in this area are used to evaluate how effective the system is at identifying needs and providing supports early, facilitating access to services, providing less restrictive services, and integrating and coordinating services for families.

When assessing whether child/youth and families received *Early Intervention* related to their identified needs, reviewers reported in about 83% of cases that child/youth and family needs were identified at intake and that services were provided in a timely manner. Reviews noted challenges in system clarification of and response to child/family needs in about 16% of cases. In these cases, reviewers commented on being unable to determine the amount of time it took for the system to clarify child or family needs due to a lack of documentation. Some also shared interview responses indicating that initial services offered to families were not seen as appropriate or timely by the family.

Overall, reviewers indicated that the System was ensuring *Access to Services* for children/youth and families. In the majority of cases reviewed, reviewers noted that services were scheduled at convenient times for the child/youth and family and that these services were most often provided within or close to the home community of the child/youth. Overall, reviewers noted that for most of the families in this sample English was the primary family language and that verbal and written communication was conducted in English. In most cases, reviewers noted that providers did not need to provide supports to increase access to service locations (e.g. bus passes, flex funds). However, in 29% of cases reviewers noted that service plans and other case documents showed evidence that the child and family received supports to increase access to services.

When assessing for *Minimal Restrictiveness* in service delivery, raters reported that services appeared to be provided in environments that feel comfortable to the child/youth and family, in the least restrictive and most appropriate environment. SOCPR raters also noted that case files reflected ongoing communication between formal service providers and family members and that links to additional services were made with few challenges. In about 9% of cases, reviewers noted that documentation did not adequately reflect evidence that services were provided in the least restrictive and most appropriate environment for the child/youth and family.

With regard to *Integration and Coordination* of services, reviewers generally found that there is ongoing two-way communication among and between all team members, including family members. In addition, they also generally noted that there are smooth and seamless processes for linking the child/youth and family to additional services. In just over 29% of cases, reviewers noted that the process to link the child and family with additional services was not always a smooth and seamless one. Although there was not a clear pattern as to why this was the case, a few reviewers noted that families with children needing more intensive services often had to wait for these services much longer than the caregiver/family felt they should.

<u>System Successes in the Provision of Community-Based Services</u>

- Child and family needs were clarified by the system in a timely manner
- Services are generally provided at convenient times and locations
- Service providers verbally communicate in the primary language of the child/youth and family
- Written documentation regarding services/service planning is in the primary language of the child and family
- Services are provided in environment(s) that feel comfortable to the child/youth and family
- Services are provided in the least restrictive, most appropriate environment

- There is ongoing communication between formal service providers and family members

Opportunities for Growth and/or Training in Domain 2

- In a small percentage of cases, documentation doesn't adequately reflect whether the system was able to identify child/youth and/or family needs early and to begin addressing them
- The process for linking children and families to additional services is not always a smooth and seamless one

Domain 3: Culturally Competent Services

The third domain of the SOCPR is intended to measure whether services are attuned to the cultural, racial, and ethnic background and identity of the child/youth and family. Ratings provided in each sub-domain are meant to evaluate the level of cultural awareness of the service provider, whether evidence shows that efforts are made to orient the family to an agency's culture, whether sensitivity and responsiveness is shown for the cultural background of families, and whether informal supports are included in services.

Reviewers assessing for *Cultural Awareness* noted that case files generally showed limited documentation related to the culture of the child and/or the family, including information about the family's beliefs related to health and family. In a number of cases that received a rating of "5" (Agree Slightly), reviewers noted that the case file did not include a copy of the "Strengths, Needs and Cultural Discovery" document (although it is not clear from the comments whether this document is required and/or generally used by providers in the system. Reviewers noted some evidence of provider awareness related to the child/youth and family's cultural beliefs and how they shape their decision-making. In addition, reviewers reported finding limited documentation regarding providers' awareness of their own culture and how differences between provider and family culture may affect dynamics of working together effectively.

When evaluating the *Sensitivity and Responsiveness* of the System, raters noted that there was limited documentation indicating that providers translated awareness of family culture into action. However, a number of reviewers noted that case files did document some awareness of family culture on the part of providers with caregivers corroborating this awareness through interview responses with caregivers, in particular. In addition, raters noted that providers generally offered families information to help them better understand their agency's rules and expectations. Raters also noted that documentation provided evidence that providers supported families with assistance in understanding of and navigating the larger service system. Caregiver interviews generally corroborated that this was the case.

With regard to *Informal Supports*, reviewers generally found documentation that families were asked whether they would like to include informal or natural supports in services. that there was some evidence of inclusion of informal supports. In a number of cases, families declined to include natural supports (e.g. supportive friends or community members) in services. However, about 35% of cases were rated as having little to no documentation that informal supports were incorporated into service planning and delivery process.

<u>System Successes in the Provision of Culturally Competent Services</u>

- Providers exhibit limited awareness of youth and family's concepts of health and family
- Providers have some awareness of their own culture and the cultural dynamics involved when working with families whose culture may be different from their own.
- Some families report that providers are responsive to child and family culture
- Providers give families information to help them understand system/agency rules and expectations
- Providers give family some assistance in understanding /navigating service system
- Providers are working with families to identify informal supports and are incorporating these supports where they are available

<u>Opportunities for Growth and/or Training in Domain 3</u>

- Reviewers noted that providers did not always clearly document how cultural, neighborhood, and community context informed a child/youth and family's identity
- Reviewers identified a lack of documentation related to the Strengths, Needs, and Cultural Discovery and inclusion of this document in case files
- Providers may need additional support to demonstrate understanding that family culture and how it affects dynamic between provider and family, child/youth and family decision-making, and their concepts of health and family

Domain 4: Impact

The final SOCPR domain evaluates whether services have produced positive outcomes for the child and family. This domain includes two sub-domains: *Improvement* and *Appropriateness of Services*, which are meant to determine whether services have had a positive impact on the child/youth and family and if so, whether these services met their identified needs.

In general, raters found that documentation indicated that providers and caregivers generally agreed that services provided to children/youth and families had produced a positive impact. Reviewers found that in most cases, providers and parents/caregivers indicated some

improvement on the part of the child/youth and family. Similarly, raters generally indicated that the services provided to children/youth and families had been appropriate because they were found to have adequately met identified needs.

In about 21% of cases, reviewers reported that they did not find sufficient evidence to definitively say that the services provided adequately met family needs. Although this finding did not constitute a trend, it does identify an opportunity for growth and training on the part of providers with regard to documentation.

System Successes

- Reviewers generally agree that the accumulated evidence shows that services provided to children/youth have improved their situation to some degree
- Reviewers generally agree that the accumulated evidence shows that services provided to families have improved their situation to some degree
- Reviewers generally agree that the services and supports provided to children/youth have adequately met their needs
- Reviewers generally agree that services and supports provided to families have adequately met their needs

Overall, qualitative analysis of responses to Summative Questions suggest that the Statewide System of Care has achieved some success in its effort to implement System of Care values and principles in its service delivery to children/youth and families in 2014-2015. These findings indicate that these successes are most evident in the SOCPR Domain associated with Community-Based Service Delivery, especially with regard to the Access sub-domain. A number of recommendations have been made to help build on these successes by encouraging the work of providers and reviewers through ongoing training and coaching.

Results CW Cases

Demographics CW Cases

The state of Arizona was also interested only in those cases where the children and families had child welfare involvement. During FY2014-2015, 99 CW cases were sampled from all six GSAs from the 185 SOCPR All Cases. A summary of the demographic characteristics are presented in Table 9. Due to the sampling scheme employed by ADHS/DBHS (previously described in the Methodology section), different numbers of cases were completed in each GSA. The most populous area, GSA 6, provided the greatest number of case for the sample (n=43). The other GSAs provided between 3 and 29 cases.

Table 9. Demographic Characteristics CW Cases

Demographic Characteristic	Statewide N=99	GSA 1 n=16	GSA 2 n=3	GSA 3 n=3	GSA 4 n=5	GSA 5 n=29	GSA 6 n=43
Age (years)	8.05	5.00	13.33	12.00	10.00	6.97	9.05
Gender (Male)	55.6%	68.8%	0.0%	66.7%	60.0%	58.6%	51.2%
Race:							
White	42.4%	81.3%	0.0%	33.3%	20.0%	41.4%	34.9%
Black	10.1%	0.0%	0.0%	0.0%	0.0%	6.9%	18.6%
Latino/Hispanic	19.2%	0.0%	33.3%	66.7%	40.0%	20.7%	18.6%
Native American	3.0%	0.0%	0.0%	0.0%	20.0%	6.9%	0.0%
Multi-racial	22.2%	6.3%	66.7%	0.0%	20.0%	24.1%	25.6%
Missing	3.0%	12.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Primary Language:							
English	93.9%	81.3%	100.0%	100.0%	100.0%	100.0%	93.0%
Missing/NA	6.1%	18.8%	0.0%	0.0%	0.0%	0.0%	7.0%

As shown in Table 9, the overall mean age for the 99 cases was 8.05 years. The means for age across GSA ranged from 5.00 years to 13.33 years. Statewide almost 56% of the sample was male, ranging from 0% in GSA 2 to 69% in GSA 1. Of the sample, almost 42% was White, 19% was Latino/Hispanic, and 22% identified as Multi-racial. The remaining 16% of the sample was Black, Native American, or data were missing. Statewide, almost 94% of the children and youth in the sample spoke English as their primary language. English was the only language reported in GSA 2, GSA 3, GSA 4, and GSA 5. No other language was identified as a primary language. Chi-square analyses were used to look for demographic differences in cases by GSA, with age bands, gender, race, and primary language under consideration.

Service System Involvement CW Cases

Five different child-serving systems and an "Other" category were used to capture service system involvement as part of the services profiles of children and youth whose cases were chosen as part of the sample. Almost all 99 cases (94%) indicated having behavioral health system involvement, as shown in Table 10. The SOCPR protocols documented that almost 37% had educational services involvement, followed by developmental disabilities (12.1%), and juvenile justice (10.1%). The "Other" system category was documented by 2.0% of the GSAs. The two services included Arizona Early Intervention Program (AZEIP) and Criminal Justice.

Table 10. Service System Involvement CW Cases

Service System	Statewide N=99	GSA 1 n=16	GSA 2 n=3	GSA 3 n=3	GSA 4 n=5	GSA 5 n=29	GSA 6 n=43
Behavioral Health	93.9%	87.5%	100.0%	66.7%	100.0%	89.7%	100.0%
Child Welfare	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Juvenile Justice	10.1%	6.3%	33.3%	66.7%	0.0%	40.0%	4.7%
Educational Services	36.4%	37.5%	66.7%	66.7%	20.0%	31.0%	37.2%
Developmental Disabilities	12.1%	0.0%	0.0%	0.0%	0.0%	10.3%	20.9%
Other	2.0%	0.0%	0.0%	0.0%	0.0%	3.4%	2.3%

The results of the 99 cases were plotted by histogram to explore the distribution of cases for total number of systems involved. The results are seen in Figure 8. The horizontal axis displays the total number of services, while the vertical axis represents the number of cases with that total number of services. The 99 cases represent children and youth who were involved with the child welfare system and who either were receiving behavioral health system services or had recently completed services from the behavioral health system. In addition, cases were only chosen for SOCPR review if the youth was identified as having complex needs.

Overall, the possible number of systems involvement ranged from 0 – 6 with the mean for the sample being 2.53. The shape of the histogram resembles a normal distribution, but is slightly skewed. One might expect that children and youth in this sample to be involved in a significant number of child-serving systems and thus expect the shape/distribution to skew to the right, towards a greater number of service systems. Explanations for this finding might include inadequate record documentation, differences in reviewer interpretations of how to record service system involvement, or data entry errors.

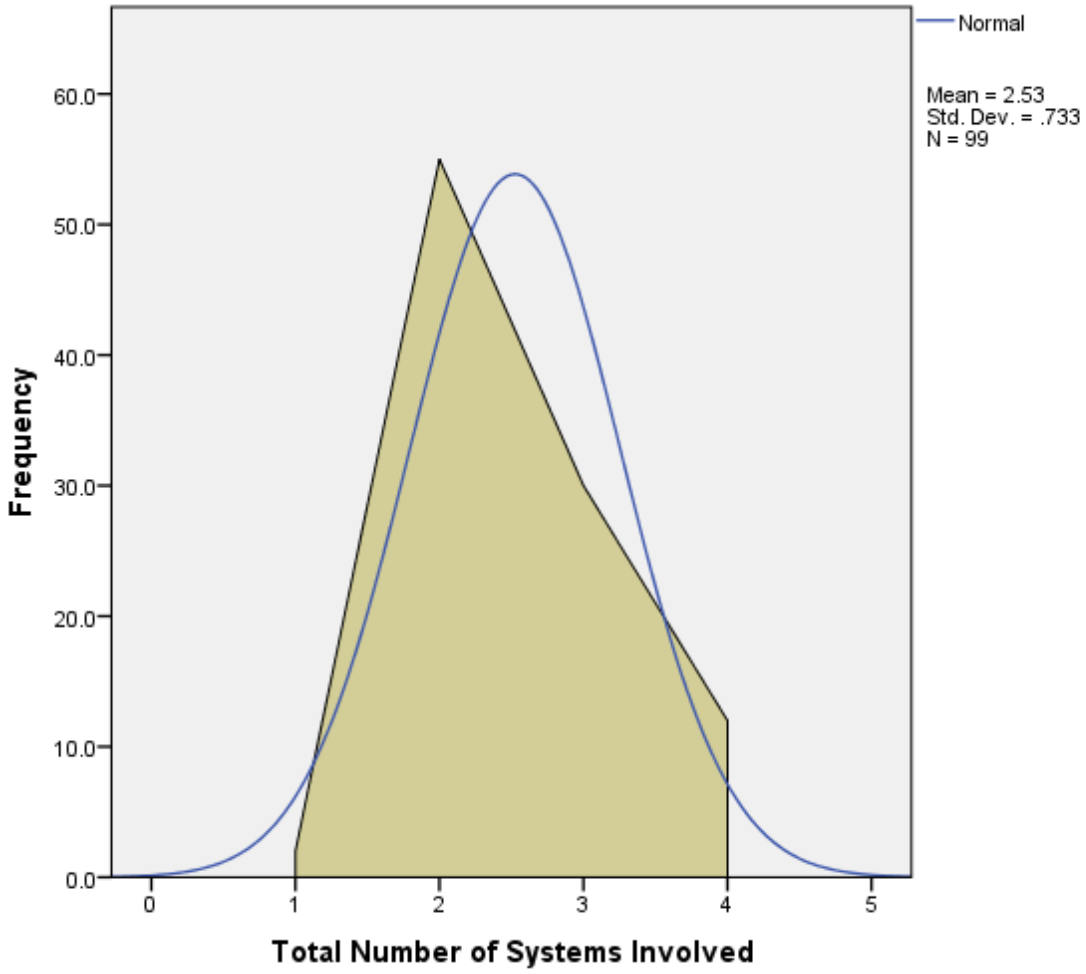

Figure 8. Histogram of child-serving system involvement CW cases.

Receipt of Services or Treatments CW Cases

Similar to child-serving systems, the kinds of services or treatments children and youth in the sample received were also calculated. Fifteen named types of services as well as an "Other" category (see list in Appendix C) were used to identify categories of service or treatment provision. These service types are shown in Table 11.

Table 11. Services or Treatments Received by Children and Youth CW Cases

Services or Treatment	Statewide N (%)	GSA 1 N (%)	GSA 2 N (%)	GSA 3 N (%)	GSA 4 N (%)	GSA 5 N (%)	GSA 6 N (%)
Treatment Services	81 (81.8)	12 (75.0)	3 (100.0)	3 (100.0)	5 (100.0)	20 (69.0)	38 (88.4)
• Individual Counseling	70 (70.7)	9 (56.3)	3 (100)	3 (100)	5 (100)	17 (58.6)	33 (76.7)
• Family Counseling	30 (30.3)	7 (43.8)	0 (0.0)	0 (0.0)	3 (60.0)	10 (34.5)	10 (23.63)
• Group Counseling	14 (14.1)	2 (12.5)	2 (66.7)	0 (0.0)	1 (20.0)	4 (13.8)	5 (11.6)
• Alcohol/Drug Counseling	3 (3.0)	1 (6.3)	0 (0.0)	1 (33.3)	0 (0.0)	1 (3.4)	0 (0.0)
Medical Services • Psychiatric Medication	36 (36.4)	3 (18.8)	2 (66.7)	2 (66.7)	3 (60.0)	8 (27.6)	18 (41.9)
Support Services	96 (97.0)	16 (100.0)	3 (100.0)	3 (100.0)	5 (100.0)	28 (96.6)	41 (95.3)
• Family Support	34 (34.3)	8 (50.0)	2 (66.7)	2 (66.7)	4 (80.0)	8 (27.6)	10 (23.3)
• Peer Support	1 (1.0)	0 (0.0)	1 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
• Respite Support	11 (11.1)	4 (25.0)	0 (0.0)	1 (33.3)	0 (0.0)	5 (17.2)	1 (2.3)
• Home Care Training	5 (5.1)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (3.4)	4 (9.3)
• Case Management	92 (92.9)	15 (93.8)	3 (100.0)	3 (100.0)	5 (100.0)	26 (89.7)	40 (93.0)
• Skill Develop & Train	33 (33.3)	7 (43.8)	3 (100.0)	1 (33.3)	4 (80.0)	7 (24.1)	11 (25.6)
Inpatient Services	5 (5.1)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	3 (10.3)	1 (2.3)
• Psychiatric Hospitalization	4 (4.0)	0 (0.0)	0 (0.0)	1 (33.3)	0 (0.0)	2 (6.9)	1 (2.3)
• Level I Residential	1 (1.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (3.4)	0 (0.0)
Residential Services	7 (7.1)	2 (12.5)	0 (0.0)	0 (0.0)	0 (0.0)	1 (3.4)	4 (9.3)
• Level II Residential	5 (5.1)	1 (6.3)	0 (0.0)	0 (0.0)	0 (0.0)	1 (3.4)	3 (7.0)
• Level III Residential	3 (3.0)	2 (12.5)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (2.3)
Other	20 (20.2)	6 (37.5)	1 (33.3)	0 (0.0)	4 (80.0)	2 (6.9)	7 (16.3)

Across the state the most utilized service or treatment provision was Support Services (97%) followed by Treatment Services (81.8%). Inpatient Services (5.1%) was the least used service or treatment provision. More specifically, the most widely utilized service or treatment statewide, based on percentage of cases using the service, was Case Management (93%) followed by Individual Counseling (71%), Psychiatric Medication (36%), and Family Support (34%). Level I Residential (1%), Peer Support (1%), Level III Residential (3%) and Alcohol/Drug Counseling (3%) were the least utilized services or treatments statewide. Across GSAs, Case Management, Individual Counseling, Psychiatric Medication, Family Support, and Skill Development and Training were utilized in six out of six GSAs. Case Management was utilized in a minimum of 90% of the cases in each GSA. Level I Residential and Peer Support were utilized in only one GSA (1 case each), and Level III Residential and Alcohol/Drug Counseling was used across 2 and 3 GSAs respectively, equaling 6 cases.

Support Services were utilized in all six GSAs with 4 of the six GSAs utilizing them in 100% of the cases. As mentioned earlier in this report one specific support service, Case Management, was received by families almost 90% by all GSAs. GSA 2 utilized Case Management, and Skill Development and Training in 100% of its families (3 cases). Treatment Services were also used in all six GSAs with three GSAs utilizing them in 100% of the cases. Treatment Services was documented as the next most frequently utilized service with almost 82% of cases. GSAs 2, 3, and 4 utilized Individual Counseling in 100% of its families (3, 3, and 5 cases respectively). Inpatient Services were not utilized in GSAs 1, 2 and 4. Residential Services were not utilized in GSAs 2, 3, and 4. GSAs 2 and 3 had the smallest number of cases as a part of the overall statewide sample (3 cases each), while GSA 6 (n=43) had the largest number of cases using services in all but one service provision category (Inpatient Services).

Usage of some services *appears* to be unusually high; therefore, because GSAs vary widely in the number of SOCPR cases completed, both number of cases and percentage need to be examined. For example, 40% of cases in GSA 2 had "Other" services, which represents only 6 youth, as only 15 total SOCPR cases were completed for this GSA. Statewide, about 19% (N=35) of the treatments or services reported were identified as "Other". Several of the services variables differed significantly by GSA and are shown in Table 12. Only statistically significant chi-square statistics are reported.

Table 12. Significant Associations between GSA and Specific Services CW Cases

Treatment	Chi-Square Statistic
Treatment Services • Individual Counseling • Family Counseling • Group Counseling • Alcohol/Drug Counseling	X2 (5, N=99)= 11.550, p-value = 0.041
Medical Services • Psychiatric Medication	
Support Services • Family Support • Peer Support • Respite Support • Home Care Training (HCTC) • Case Management • Skills Development and Training	X2 (5, N=99)= 12.073, p-value = 0.034 X2 (5, N=99)= 32.327, p-value = 0.000 X2 (5, N=99)= 13.947, p-value = 0.016
Inpatient Services • Psychiatric Hospitalization • Level I Residential	
Residential Services • Level II Residential • Level III Residential	
Other	X2 (5, N=99)= 18.736, p-value = 0.002

Statewide for CW Cases, a statistically significant relationship between GSA and services received was shown for Treatment Services, Support Services, and Other. Specifically within Support Services, Family Support, Peer Support, and Skills Development and Training were found to show strong significant associations with GSA.

In order to examine the breadth of services used by children and youth in the sample, a simple summation was calculated for the 16 potential service categories. Thus, the possible range for this variable was from 0 to 16 services utilized. For the total 99 cases in the sample, the range of services used was 1 to 9. These data are displayed via histogram to examine the distribution of total number of services used. The results are displayed in Figure 9. The histogram closely resembles a normal distribution, with a mean of 3.66 services per child or youth recorded. The number of services used during the time a case is open could vary greatly, depending on the needs of the child and family, the array of services that are available, and

the length of time the case is open.

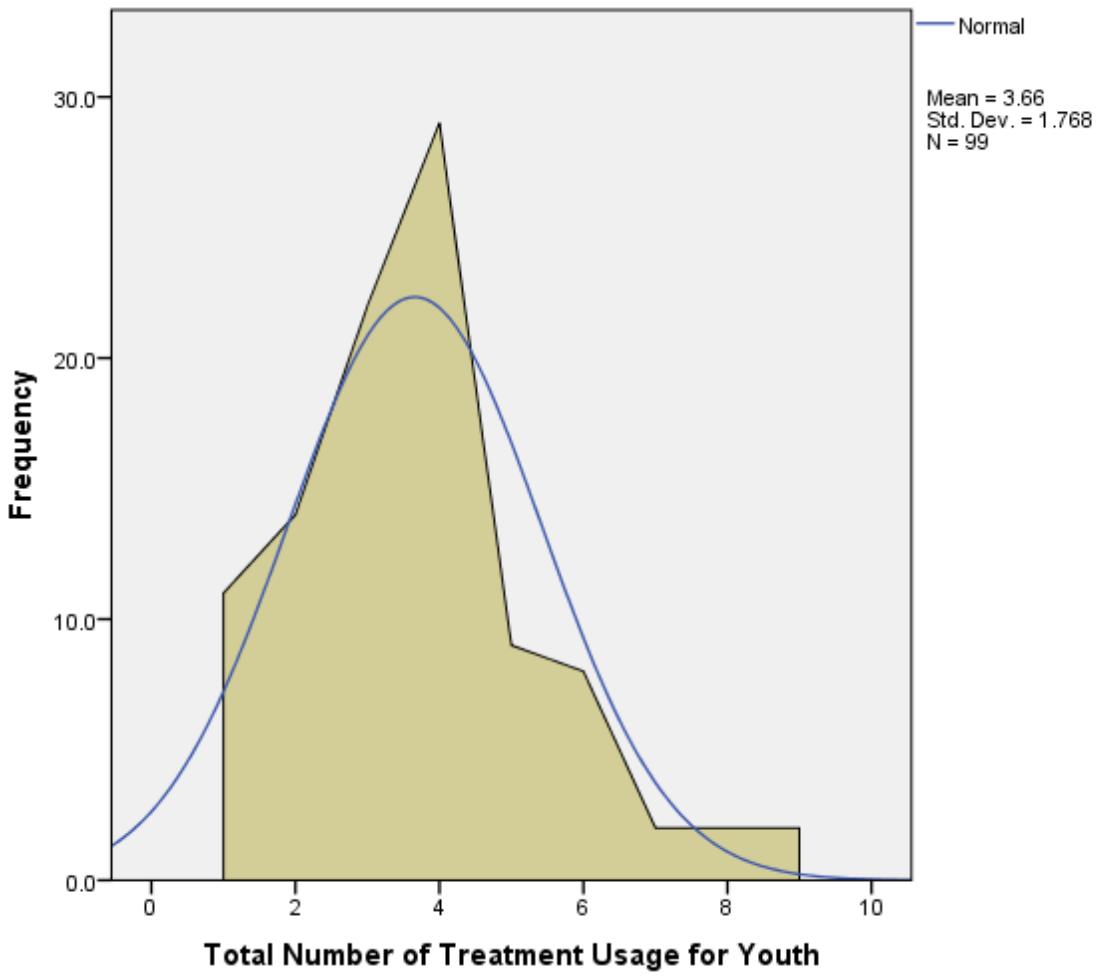

Figure 9. Histogram of service or treatment usage for youth CW cases.

Quantitative Analysis CW Cases

SOCPR Scores – Overall Case and SOCPR Domains CW Cases

Mean scores were computed for the overall case, as well as for each of the four SOCPR domains (Child-Centered Family-Focused, Community Based, Culturally Competent, and Impact). In addition, mean scores were computed for those subdomains contained within the domains. Finally, each summative question was examined individually. In general, the mean score for each item of interest was an important statistic to be examined. In addition, the minimum and maximum scores, as well as the standard deviation for each item of interest, were examined. Using these four statistics, an understanding of the range of scores, the average score, as well as an indication of the variability from case to case, could be examined. This section will report on the overall findings, and then report on specific items of interest which demonstrate extreme scores.

Table 13 shows the overall case scores as well as those for each SOCPR domain for the child welfare sample of 99 cases, indicated by individual GSA. As explained in the Methodology section, SOCPR scores range from a low of 1 to a high of 7. Scores from 1–3 represent lower implementation of a system of care principle, and scores from 5–7 represent enhanced implementation of a system of care principle. A score of 4 indicates a neutral rating, meaning a lack of support for or against implementation. At the statewide level, SOCPR CW mean scores ranged from 4.66 to 5.42with an overall case mean score of 5.04. While the SOCPR scores for the case and domains are not normally distributed and so the standard deviation is a less useful statistic, in conjunction with minimum and maximum scores, a more complete picture of the data emerges. The CW overall case score suggests that, like all of the SOCPR domains, great variability exists across cases. The minimum and maximum scores are to their greatest possible extremes, representing exemplary cases of good and poor system of care values implementation. The means range from the mid 3s to 6. This range indicates that scores fall between a lower implementation of system of care values to an emerging enhanced implementation of system of care principles. The scores indicate that across the state, behavioral health provider agencies included in the sample performed best at including the Community Based values of service planning and provision. Behavioral health provider agencies were most challenged by providing Culturally Competent care.

Table 13. SOCPR Case and Domain Scores CW Cases

GSA (N=99)	Case Mean (SD)	CCFF Mean (SD)	CB Mean (SD)	CC Mean (SD)	IMP Mean (SD)
Statewide	5.04 (0.93) Min 2.49 Max 6.58	5.02 (1.06) Min 2.35 Max 6.73	5.42 (0.74) Min 3.42 Max 7.00	4.66 (1.20) Min 1.69 Max 7.00	5.06 (1.35) Min 1.50 Max 7.00
GSA 1 (n=16)	5.69	5.76	5.93	5.28	5.77
GSA 2 (n=3)	5.51	5.65	6.00	4.81	5.58
GSA 3 (n=3)	4.20	4.16	4.81	3.34	4.50
GSA 4 (n=5)	5.37	5.31	5.89	4.91	5.35
GSA 5 (n=29)	4.67	4.76	5.10	4.05	4.79
GSA 6 (n=43)	5.04	4.91	5.39	4.90	4.95

Minimum and maximum values are not presented for individual GSAs, as they are a subset of the statewide scores. At the state level, the highest scoring SOCPR domain was Community Based (Mean = 5.42). This was followed by Impact (Mean = 5.06), Child-Centered Family-Focused (Mean = 5.02), and finally, Culturally Competent (Mean = 4.66). The GSA data show similar patterns when compared with statewide scores; i.e., the domain Community-Based had the highest mean score for all six GSAs. Additionally, standard deviation data are not presented at the GSA level because some of the GSAs had small sample sizes; therefore, presenting standard deviation data would not be statistically meaningful. Because of the sample size variance among the GSAs, comparisons between GSAs are not possible.

Histograms were drawn at the statewide level to better demonstrate the range of SOCPR scores for the overall case and the four SOCPR domains. These results are displayed in Figures 10 – 14. Scrutiny of these graphs shows a similar pattern for the overall average and each SOCPR domain. The data are not normally distributed and are skewed slightly towards the right, toward higher scores.

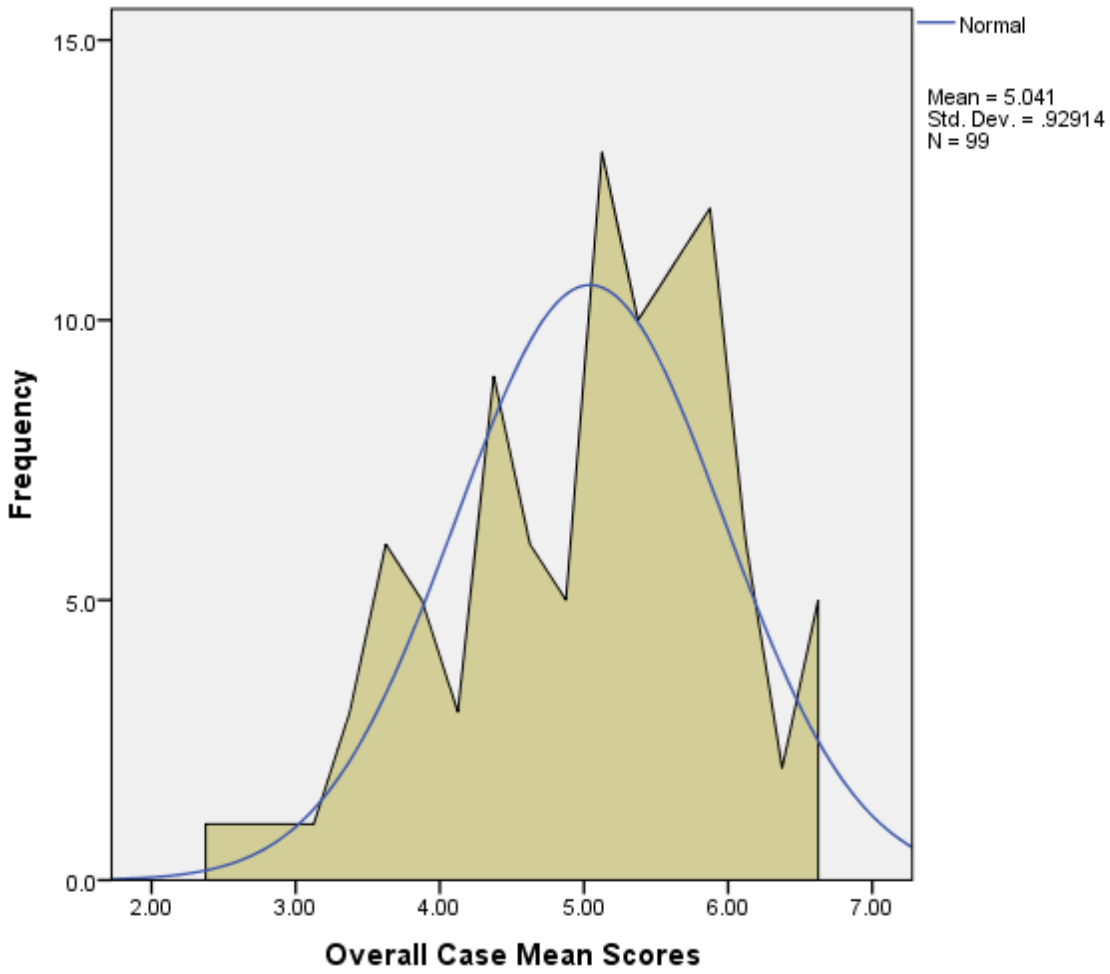

Figure 10. Histogram of SOCPR Overall case mean scores CW cases.

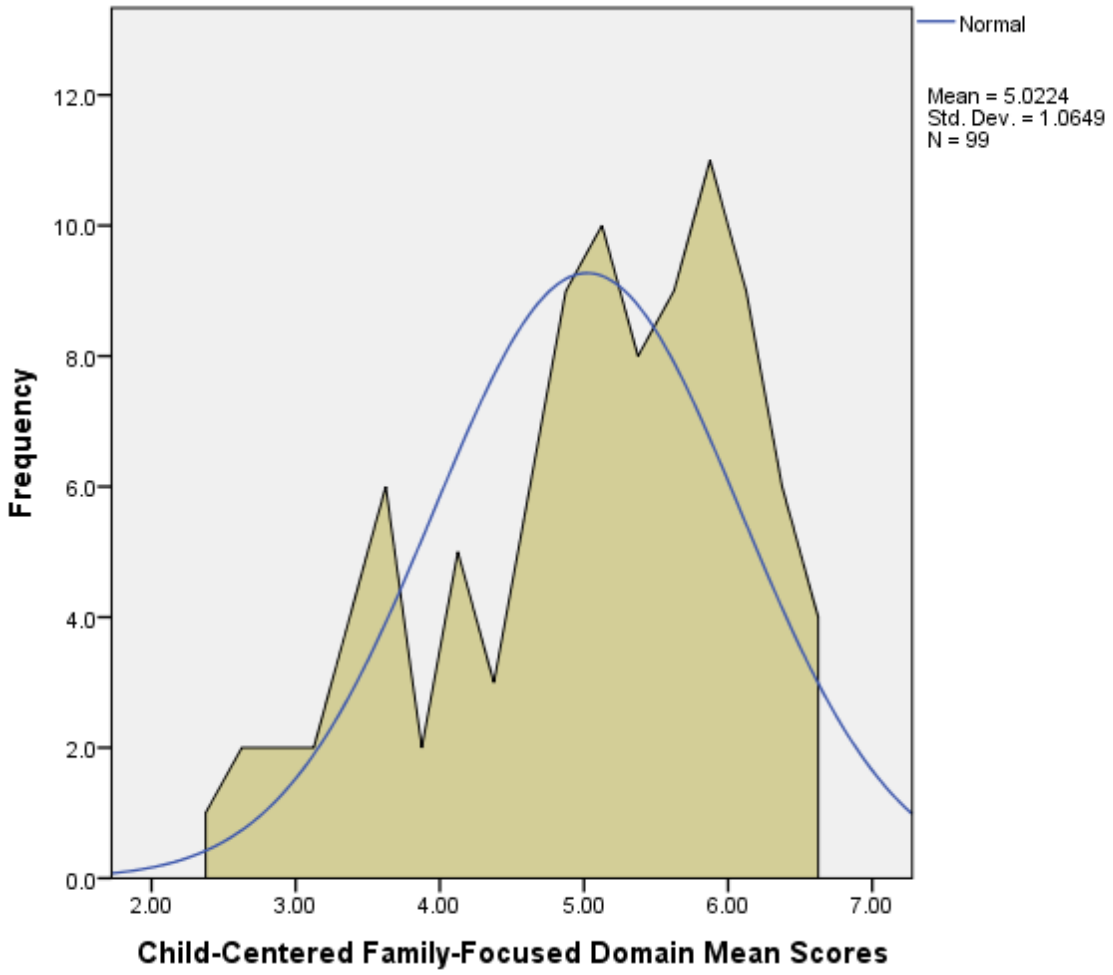

Figure 11. Histogram of SOCPR Child-Centered Family-Focused domain mean scores CW cases.

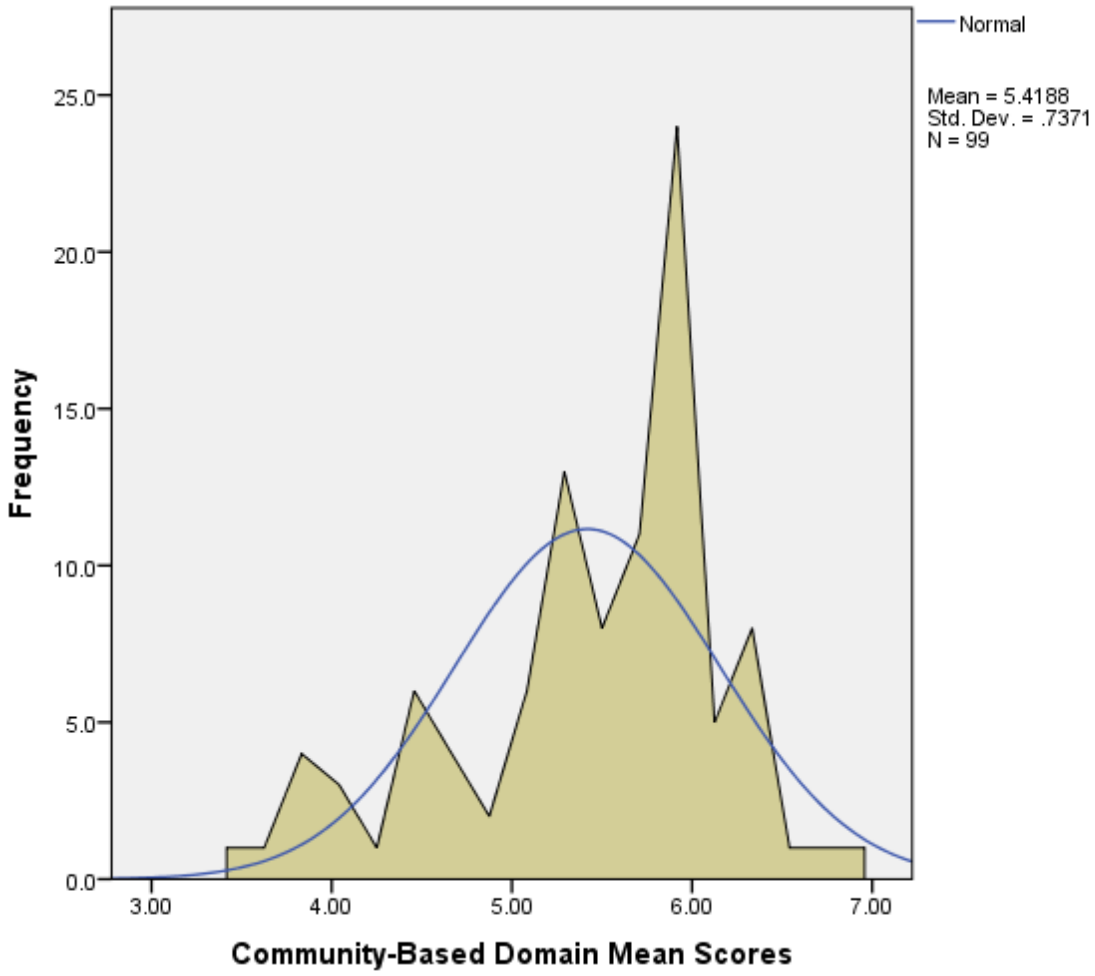

Figure 12. Histogram of SOCPR Community-Based domain mean scores CW cases.

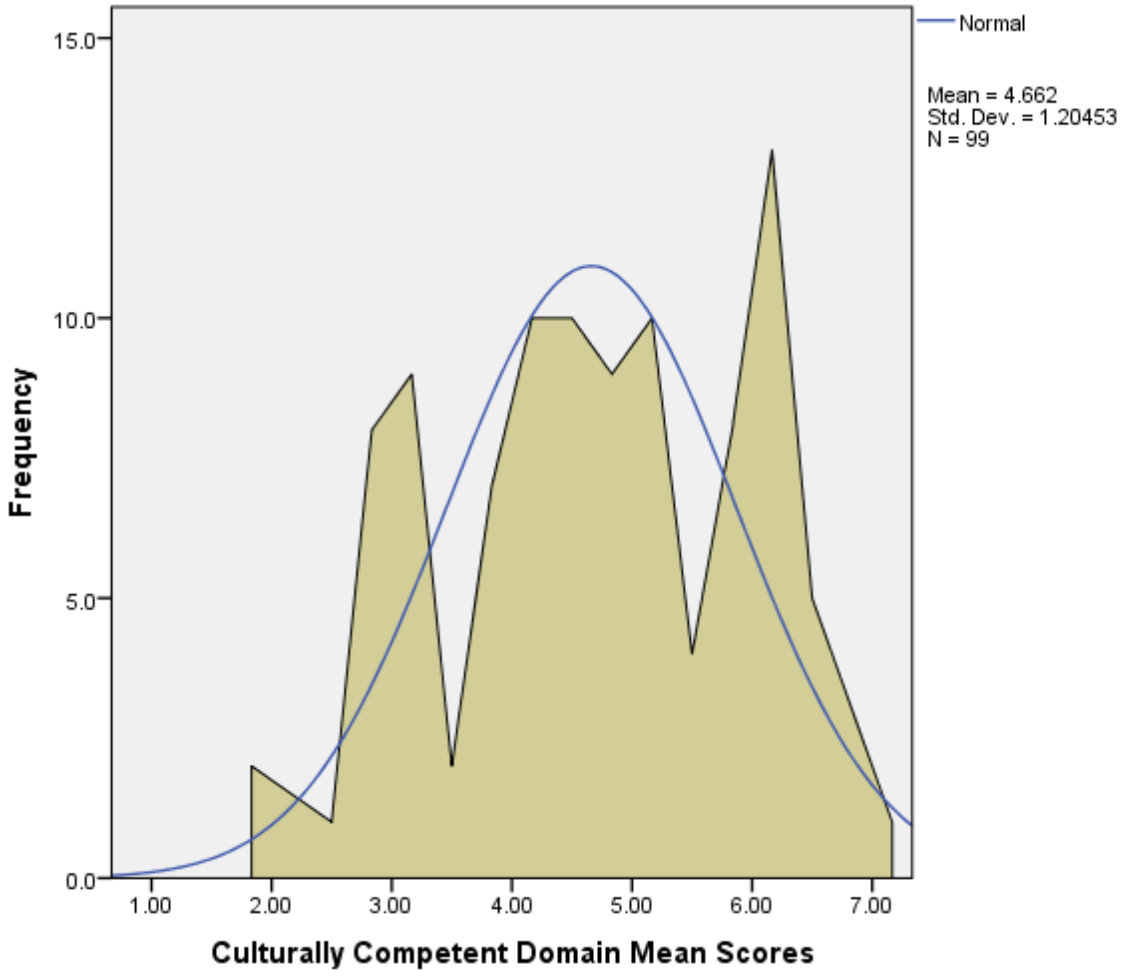

Figure 13. Histogram of SOCPR Culturally Competent domain mean scores CW cases.

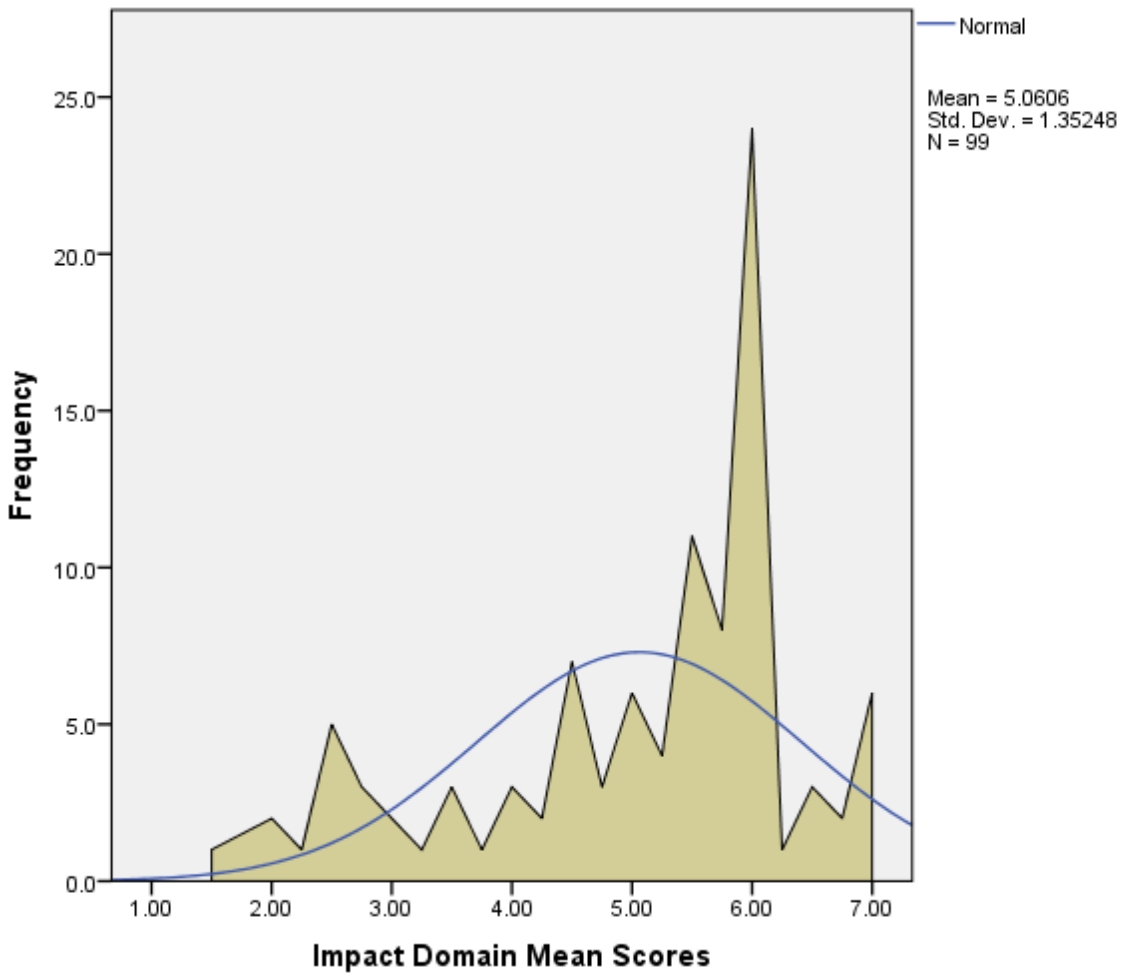

Figure 14. Histogram of SOCPR Impact domain mean scores CW cases.

SOCPR Scores – SOCPR Domains, Subdomains, and Areas CW Cases

Table 14 presents statewide CW SOCPR data for most levels of the instrument, including the total case mean score, SOCPR domain scores, SOCPR subdomain scores, and SOCPR Area scores. Because some of the GSAs had very small sample sizes, the standard deviation data are not statistically meaningful; consequently, SOCPR subdomains and their areas of interest are not reported at the GSA level.

Table 14. Arizona Statewide SOCPR Scores by Domain, Subdomain, and Area CW Cases

Overall Score – CW cases: 5.04 (0.93)		
	Area Mean (SD)	**Subdomain Mean (SD)**
Domain I: Child-Centered, Family-Focused: 5.02 (1.06)		
Individualized		4.91 (1.12)
Assessment/Inventory	5.14 (1.08)	
Service Planning	4.68 (1.23)	
Types of Services/Supports	4.94 (1.48)	
Intensity of Services/Supports	4.87 (1.60)	
Full Participation		5.26 (0.99)
Case Management		4.90 (1.45)
Domain II: Community-Based Domain Score: 5.42 (0.74)		
Early Intervention		5.26 (1.11)
Access to Services		5.84 (0.81)
Convenient Times	5.84 (1.16)	
Convenient Locations	5.64 (1.35)	
Appropriate Language	6.05 (0.95)	
Minimal Restrictiveness		5.63 (0.88)
Integration and Coordination		4.94 (1.28)
Domain III: Culturally Competent Domain Score: 4.66 (1.20)		
Awareness		4.75 (1.35)
Awareness of Child/Family's Culture	4.76 (1.41)	
Awareness of Providers' Culture	4.71 (1.64)	
Awareness of Cultural Dynamics	4.79 (1.46)	
Sensitivity and Responsiveness		4.64 (1.59)
Agency Culture		4.86 (1.34)
Informal Supports		4.39 (1.83)
Domain IV: Impact Domain Score: 5.06 (1.35)		
Improvement		5.15 (1.34)
Appropriateness		4.97 (1.47)

As reported previously, the highest scoring SOCPR domain was Community Based. This was followed by Impact, Child-Centered Family-Focused, and finally Culturally Competent. All but one of the SOCPR domain, subdomain, and area scores fell in the mid 4 (neutral) to high 5 (enhanced implementation of a system of care principle) range. Appropriate Language, in the subdomain of Access to Services, was in the low 6 range.

In the Community Based domain all subdomains and areas except for the subdomain of Integration and Coordination (4.94) and the Area of Appropriate Language (6.05), scored in the low 5 to high 5 range. Further, the subdomains of Access to Services and Minimal Restrictiveness had the highest mean scores (5.84 and 5.63 respectively). All three areas in the subdomain of Access to Services had mean scores in the high 5 to low 6 range: Appropriate Language (6.05), Convenient Times (5.84), and Convenient Locations (5.64). These subdomain and area scores indicate that service providers are cognizant of a family's primary language and utilize it when providing services. They also take into account time and transportation issues families may have and schedule appointments accordingly.

The data also revealed scores in the low to high 4 range. Although these scores indicate neither support for nor against implementation of system of care principles, they may emphasize the need for added awareness, responsiveness, or assistance. For example, within Culturally Competent all domain, subdomain, and area mean scores were in the 4 range. Agency Culture had the highest subdomain mean score (4.86) while the subdomain of Informal Supports had the lowest (4.39).These subdomain scores show that although families are provided with information about their service providers' culture they may not understand their roles and responsibilities. Also, service providers may not be fully utilizing the informal supports as identified by the families when service planning and delivery occurs. Other high 4 scoring areas are within the subdomain of Individualized in the domain of Child-Centered Family-Focused. These areas include Types of Services/Supports (4.94), Intensity of Services/Supports (4.87), and Service Planning (4.68). In creating an integrated service plan the types and intensity of services and supports must reflect the needs and strengths of the family.

SOCPR Scores and Tests of Significant Differences CW Cases

Because the SOCPR case and domain scores do not fit the pattern of a normal distribution, nonparametric statistical tests were performed to examine the data for differences between groups within a specific variable in relation to SOCPR scores. SOCPR scores are continuous data, while most of the other variables were categorical data. Thus, for statistical tests in which the variable to be examined in relation to SOCPR scores consisted of more than 3 groups, such as race, the Kruskal- Wallace test was performed. For variables with only 2 groups, such as gender, the Mann-Whitney U test was performed. Age was transformed into an Age

Band variable with 3 groups: 0 through 5, 6 to 12, and 13 to 18. Table 15 shows the results of these statistical tests for a variety of variables. A value of .05 or lower indicates a significant difference between groups for the variables involved in the statistical test, with lower scores indicating a higher likelihood of true significant differences.

Table 15. SOCPR Scores and Significant Differences with Variables of Interest CW Cases

Variable	Case	CCFF	CB	CC	IMP
Demographics					
Age Bands					
Gender					
Race	.040				.028
Primary Language					
GSA	.005	.018	.001	.004	
Case Longevity					
Service Systems					
Behavioral Health				.032	
Juvenile Justice					
Educational					
Developmental Disabilities					
Total Systems					
Services Categories					
Treatment Services	.005	.013	.006	.002	.034
Medical Services					
Support Services					
Inpatient Services	.006	.048	.003	.024	.021
Residential Services					
Services					
Individual Counseling			.029	.015	
Family Counseling	.040				.030
Family Support	.003	.002	.007	.022	
Respite Support					
Case Management					
Psychiatric Hospitalization	.019		.013		
Total Number of Services	.011	.044	.019		.044

There were a variety of significant differences in SOCPR case and domain scores across the variables examined. Some of each of the demographic variables, service systems, services categories, and services measured showed significant differences.

Findings indicate that children and youth who received Treatment Services and Inpatient Services were associated with both SOCPR case and domain scores. Children and youth who

received Treatment Services, Inpatient Services, and Family Support were associated with Child-Centered, Family-Focused, Community Based, and Culturally Competent domains. The Geographic Service Area (GSA) of the children also contributed to significant associations. Those youth involved with Behavioral Health systems were associated with higher Culturally Competent scores. Children and youth with Treatment Services, Inpatient Services, and Family Counseling were associated with higher Impact scores with Race contributing to the higher score.

SOCPR Scores –FY2014-2015 Comparison: All Cases and CW Cases

Table 16 shows a comparison of domain, subdomain, and area scores across two samples of the SOCPR because a sampling emphasis was placed on children and families involved with the child welfare system for FY2014-2015. These two samples are All Cases and CW (Child Welfare) Cases. All Cases include children and families identified as having high/complex levels of need) while the sample of interest CW cases included children and families involved with the child welfare system. Overall, scoring across the samples indicate a decrease in means scores for the CW sample when compared to the All Cases sample.

Table 16. SOCPR Score Comparisons between All Cases and CW Cases FY2014-2015

	All Cases N=185	CW Cases N=99
	Mean (SD)	Mean (SD)
Overall Score	5.12 (0.93)	5.04 (0.93)
Domain I: Child-Centered, Family-Focused	5.03 (1.09)	5.02 (1.07)
Individualized	4.88 (1.11)	4.91 (1.12)
Assessment/Inventory	5.20 (1.07)	5.14 (1.08)
Service Planning	4.78 (1.22)	4.68 (1.23)
Types of Services/Supports	4.78 (1.48)	4.94 (1.48)
Intensity of Services/Supports	4.77 (1.60)	4.87 (1.60)
Full Participation	5.35 (1.00)	5.26 (0.99)
Case Management	4.86 (1.51)	4.90 (1.45)
Domain II: Community-Based	5.45 (0.76)	5.42 (0.74)
Early Intervention	5.29 (1.16)	5.26 (1.11)
Access to Services	5.90 (0.75)	5.84 (0.81)
Convenient Times	5.84 (1.14)	5.84 (1.16)
Convenient Locations	5.76 (1.21)	5.64 (1.35)
Appropriate Language	6.11 (0.81)	6.05 (0.95)
Minimal Restrictiveness	5.65 (0.87)	5.63 (0.88)
Integration and Coordination	4.95 (1.32)	4.94 (1.28)
Domain III: Culturally Competent	4.93 (1.17)	4.66 (1.20)
Awareness	4.97 (1.25)	4.75 (1.35)
Awareness of Child/Family's Culture	4.94 (1.27)	4.76 (1.41)
Awareness of Providers' Culture	4.99 (1.52)	4.71 (1.64)
Awareness of Cultural Dynamics	4.97 (1.44)	4.79 (1.46)
Sensitivity and Responsiveness	4.91 (1.48)	4.64 (1.59)
Agency Culture	5.11 (1.25)	4.86 (1.34)
Informal Supports	4.72 (1.71)	4.39 (1.83)
Domain IV: Impact Domain Score:	5.09 (1.30)	5.06 (1.35)
Improvement	5.21 (1.26)	5.15 (1.34)
Appropriateness	4.97 (1.44)	4.97 (1.47)

Comparing the demographics of the All Cases (N=185) with the CW Cases (N=99) reveals similarities yet differences. The number of youth per GSA were as low as 3 in the CW Cases to as high as 65 in the All Cases. The average age for All Cases youth was older than for CW Cases youth (9.54 years compared to 8.05). The majority of participants were males (57% vs. 56%) across both types of cases. Although both cases had a majority of White youth the percentage for All Cases was higher (50% vs. 42%). There were more Latino participants in the All Cases yet more identified Multi-racial participants in the CW Cases. English was the primary language for both cases.

When it comes to service system involvement both cases indicated behavioral health system involvement in more than 93% of the cases. CW Cases had child welfare involvement in 100% of the cases while All Cases only 54%. Overall system involvement was higher for CW Cases compared to All Cases (2.53 vs. 2.15).

Utilization of Services or Treatments Received by children and youth appeared to be consistent across both All Cases and CW Cases. Both utilized Support Services the most (96% and 97% respectively) followed but Treatment Services (78% and 82%). The services utilized least did differ however. All Cases utilized Residential Services least while CW Cases utilized Inpatient Services least. Utilization of a specific service or treatment showed similarity between the two types of cases. Both utilized Case Management, Individual Counseling, Psychiatric Medicine and Family Support the most. Level I Residential was the least utilized. Case Management was utilized in all six of the GSAs across both types of cases; however, CW Cases also utilized Individual Counseling, Psychiatric Medication, Family Support, and Skill Development and Training in all six GSAs.

Significant associations between GSA and services received were also similar across both All Cases and CW Cases. Both showed significant relationships for Support Services and Other, specifically Family Support and Skills Development and Training. All Cases showed significant relationships for Inpatient while CW Cases found strong associations between GSA and Alcohol/Drug Counseling and also Peer Support. The mean of services per child or youth for All Cases was 4.01 while for CW Cases the mean was 3.66. In examining the data for differences between groups within a specific variable in relation to SOCPR scores, Treatment Services showed significant differences for both case and domain scores across both All Cases and CW Cases. The main difference between CW Cases and All Cases was that receiving impatient Services was significantly associated with lower SOCPR scores. These results should not be overly interpreted due to the small sample size (e.g., only five received impatient services).

When compared side-by-side, the mean score results for CW Cases for the most part reflect an overall decrease when compared to All Cases mean scores across all domain mean scores. For example, the Overall Case Mean score for All Cases was 5.12 compared with 5.04 for

CW Cases. For the domain of Child-Centered, Family-Focused All Cases mean score and CW Cases mean score were about the same (5.03 vs. 5.02). All Cases mean score for Community Based was 5.45 compared to 5.42 for CW Cases. Culturally Competent mean score was 4.93 for All Cases and 4.66 for CW Cases. The domain of Impact showed a mean score of 5.09 for All Cases and 5.06 for CW Cases.

It should be noted that they seem to be very similar in that they follow a consistent ranking of domain, subdomain, and area scores. For example, the highest scoring SOCPR domain, subdomain, and area are the same across both samples. For example, the highest scoring Domain was Community Based (5.45 All Cases and 5.42 CW Cases), and the highest scoring Subdomain was Access to Services (5.90 All Cases and 5.84 CW Cases). Even the highest scoring Area score was the same - Appropriate Language (6.11 All Cases and 6.05 CW Cases).

There were several mean scores that increased for CW Cases when compared to All Cases. Within the Domain of Child-Centered, Family-Focused, the subdomain of Case Management increased slightly (4.86 for All Cases and 4.90 for CW Cases). Two Area mean scores within this same domain also increased - Types of Services/Supports (4.78 All Cases and 4.94 CW Cases) and Intensity of Services/Supports (4.77 for All Cases and 4.87 for CW Cases). These increases may indicate that service providers working with children and families involved with the child welfare system more consistently created integrated service plans that reflected the strengths and the emerging and changing needs of the family. The data may also indicate that service providers working with children involved with CW often had one person who was responsible for coordinating the planning and delivery of services.

Some scores show consistency across samples. For example, Access to Services for children and families seems to be a recurring positive theme regardless of the population of youth analyzed, although there was a slight decrease in mean scores for All Cases and CW cases. As the scores for All Cases and CW Cases show attention to the families primary language (Appropriate Language 6.11 All Cases and 6.05 CW Cases), and scheduling services at places (5.76 and 5.64) and times (5.84 for both samples) convenient to the family are of utmost importance for service providers.

SOCPR Scores –FY2014-2015 Comparison: CW Cases and non-CW Cases

Table 17 shows a comparison of domain, subdomain, and area scores across two sub-samples of the FY2014-2015 SOCPR administration: CW Cases (n=99) and non-CW Cases (n=86). CW cases included children and families involved with the child welfare system while non-CW Cases included children and families identified as having high/complex levels of need). Overall, scoring differences across the sub-samples indicate significant differences under culture competency with CW cases being generally lower.

Table 17. SOCPR Score Comparisons between CW Cases and non-CW Cases FY2014-2015

	CW Cases		Non-CW Cases		Difference	p-value[1]
	Mean	(SD)	Mean	(SD)		
Overall Score	5.04	(0.93)	5.22	(0.93)	-0.18	0.19
Domain I: Child-Centered, Family-Focused	5.02	(1.06)	5.04	(1.13)	-0.02	0.90
Individualized	4.91	(1.12)	4.86	(1.10)	0.05	0.77
Assessment/Inventory	5.14	(1.08)	5.27	(1.06)	-0.13	0.41
Service Planning	4.68	(1.23)	4.90	(1.20)	-0.22	0.22
Types of Services/Supports	4.94	(1.48)	4.60	(1.47)	0.33	0.13
Intensity of Services/Supports	4.87	(1.59)	4.66	(1.61)	0.21	0.39
Full Participation	5.26	(0.99)	5.45	(1.02)	-0.19	0.20
Case Management	4.90	(1.45)	4.82	(1.57)	0.08	0.72
Domain II: Community-Based	5.42	(0.74)	5.48	(0.78)	-0.06	0.58
Early Intervention	5.26	(1.11)	5.31	(1.23)	-0.05	0.77
Access to Services	5.84	(0.81)	5.97	(0.67)	-0.13	0.23
Convenient Times	5.84	(1.16)	5.84	(1.12)	0.00	0.99
Convenient Locations	5.64	(1.35)	5.91	(1.00)	-0.27	0.13
Appropriate Language	6.05	(0.95)	6.17	(0.62)	-0.13	0.27
Minimal Restrictiveness	5.63	(0.88)	5.69	(0.86)	-0.06	0.64
Integration and Coordination	4.94	(1.28)	4.95	(1.37)	-0.01	0.96
Domain III: Culturally Competent	4.66	(1.20)	5.24	(1.07)	-0.57	0.00**
Awareness	4.75	(1.35)	5.22	(1.09)	-0.47	0.01**
Awareness of Child/Family's Culture	4.76	(1.41)	5.16	(1.05)	-0.40	0.03*
Awareness of Providers' Culture	4.72	(1.64)	5.31	(1.30)	-0.60	0.01**
Awareness of Cultural Dynamics	4.79	(1.46)	5.19	(1.40)	-0.40	0.06
Sensitivity and Responsiveness	4.64	(1.59)	5.23	(1.28)	-0.59	0.01**
Agency Culture	4.86	(1.34)	5.39	(1.08)	-0.53	0.00**
Informal Supports	4.39	(1.83)	5.10	(1.49)	-0.71	0.00**
Domain IV: Impact Domain Score:	5.06	(1.35)	5.12	(1.24)	-0.06	0.77
Improvement	5.15	(1.34)	5.27	(1.17)	-0.12	0.53
Appropriateness	4.97	(1.47)	4.97	(1.41)	0.00	0.98

[1] p-values were obtained through a two-sided two independent samples t-test.

Overall, non-CW Cases SOCPR scores are higher than CW Cases scores when compared across all four domains. Consistent with other sample comparisons, the domain of Community Based scored highest across both sub-samples. In contrast to other sample comparisons this was followed by Culturally Competent, Impact, and finally Child-Centered Family-Focused.

In the majority of domain, subdomain, and area mean scores non-CW Cases scored higher when compared to CW Cases, although there were a few exceptions. Within the domain of Child-Centered, Family-Focused the subdomains of Case Management and Individualized, CW Cases had higher although not significantly different mean scores. Additionally, in the subdomain of Individualized, the areas of Types of Services/Supports and Intensity of Services/Supports had higher mean scores for CW Cases than non-CW Cases.

The subdomain of Appropriateness within the domain of Impact as well as the area of Convenient Times in the domain of Community Based showed no difference between the CW Cases and non-CW Cases. There mean scores were equal.

Although the domain of Culturally Competent was second highest in overall scores, this domain showed significant decreases in scores between the CW Cases and the non-CW Cases. Overall all domain, subdomain, and area scores except Awareness of Cultural Dynamics showed significant lower scores. These differences indicate that CW Cases scored significantly lower than the score for non-CW children and families.

Qualitative Analysis CW Cases

This section reports a summary of qualitative data compiled from responses to Summative Questions taken from a sub-group of 99 cases with children and families that had child welfare involvement to compare findings with the overall sample of cases. As with the analysis of all SOCPR cases included in this report, this section presents a summary of information gathered through the Document Review process and a series of interviews completed with a particular child/youth and family to address each of the four SOCPR domains.

The compiled narratives for all Summative Questions for these 99 cases were coded and sorted to assess the degree to which System of Care principles were implemented with children and families involved in the child welfare system, by SOCPR domain area. The frequency of Summative Question responses was examined and analyzed for emerging patterns/trends in 13 sub-domain areas that correspond to the four large SOCPR domains. In order to be considered a trend, at least half of the cases reviewed had to provide similar information for a given sub-domain area. Identified trends are then reported for the entire domain. The qualitative findings section also highlights successes and opportunities for growth related to each of the SOCPR

Domain Areas as reported in responses to Summative Questions.

Qualitative Findings

Domain 1: Child-Centered and Family Focused Services

The first domain of the SOCPR is designed to measure whether the needs of the child/youth and family determine the types and mix of services provided within the System of Care. This domain reflects a commitment to adapt services to the child and family rather than expecting them to conform to preexisting service configurations. The review reflects the effectiveness of the site in: providing services that are individualized; that families are included as full participants in the treatment process; and that the type and intensity of services provided is monitored through effective case management.

Overall, scores and descriptive comments provided by SOCPR raters suggest that providers within the System of Care are generally providing child-centered and family-focused services to children and families involved within the child welfare system. The review of cases using the measures associated with Child-Centered and Family-Focused Services suggests that children and families are generally receiving services that are individualized, that families are included as full participants in the service delivery process(es), and that the type and intensity of services is monitored through effective case management.

When considering whether children/youth and family received Individualized Services within the System of Care, reviewers noted that service plans generally reflect the needs of the child/youth and family and the goals established to address the needs were explicitly identified within service plan documents and/or case files. Reviewers noted that child/family needs and strengths were generally identified within files. However, about half of all reviewers indicated that service plans did not adequately reflect the strengths of the child and family. The majority of reviewers (approximately 78%) noted that they felt that service planning and delivery informally acknowledges or considers the strengths of the child and family.

A review of responses related to the existence of a primary service plan that documents service integration across providers found that reviewers reported some inconsistencies in documentation in this regard. Reviewer comments identified a key challenge within this sub-domain area related to inconsistent documentation showing integration of service plans across providers serving children and families within the child welfare system. Such comments were evident in cases rated “1” through “5”, by 56% of reviewers. This finding, in particular, provides an opportunity for growth and training of providers serving the families in the current sample to improve service plan documentation and increase integration service planning across providers or systems. It may also provide an opportunity to assess cross-system training

activities designed to ensure that providers are working to coordinate service planning and delivery across systems.

Overall, reviewers indicated that there was Full Participation on the part of children/youth and families in this sample, in the development, implementation, and evaluation of service plans. In general, reviewers reported that child/youth and caregivers regularly attended service-planning meetings and felt that parent/caregivers influenced the service planning process. Despite generally high ratings ("5" through "7"), reviewers identified noted some inconsistencies in documentation regarding participation in service planning on the part of children/youth, formal providers, and informal helpers in about 20% of cases. However, reviewer comments noted that children and families in this sample understood their service plans and actively participated in services.

With regard to the Case Management sub-domain, reviewers reported that one individual appeared to be responsible for coordinating child/youth and family services and was doing so successfully. Overall, service planning appears to be responsive to the changing needs of the family and that service plans are updated in a timely fashion. In cases that were rated as "3" (Disagree Slightly) or lower (between 25% and 30% of cases), various reviewers made note of case plans that had not been updated regularly. In some cases, documentation did not indicate that service plans had been updated regularly, making it difficult for reviewers to verify that service plans were responsive to family needs.

<u>System Successes in the Provision of Child-Centered and Family-Focused Services</u>

- Children and families are receiving individualized services
- Service plans reflect needs and goals of children/youth and family
- Strengths of youth and family are informally acknowledged by providers
- Child/youth and family appear to understand service plans and participate in services
- Services for children and families are coordinated by a case manager
- Service planning is responsive to changing needs and plan is updated accordingly

<u>Opportunities for Growth and/or Training in Domain 1</u>

- Service plan goals don't always incorporate child/youth or family strengths
- Inconsistent documentation regarding service plan integration of across providers (or systems) serving children and families
- Service plans don't consistently reflect participation of informal helpers, nor of all formal providers serving and families in the sample
- Documentation of service plan updates was not consistent

Domain 2: Community-Based Services

The second SOCPR domain is designed to measure whether services are provided within or close to the child/youth's home community, in the least restrictive setting possible, and moreover, that services are coordinated and delivered through linkages between public and private providers. The sub-domains in this area are used to evaluate how effective the system is at identifying needs and providing supports early, facilitating access to services, providing less restrictive services, and integrating and coordinating services for families.

When assessing whether child/youth and families within the child welfare system received *Early Intervention*, reviewers reported that in the majority of cases (80%) child/youth and family needs were identified at intake and that services were provided in a timely manner. In 20% of cases, reviews identified challenges in system clarification of and response to child/family needs. In these cases, reviewers noted that identification of needs was not completed in a timely manner, inconsistent documentation related to assessments used to identify needs, and that families felt that initial services delivered were not seen as appropriate or timely by the family.

The majority of reviewers indicated that the System was ensuring *Access to Services* for children/youth and families involved in the welfare system. About 84% of reviewers noted that services were scheduled at convenient times for the child/youth and family and that these services were most often provided within or close to the home community of the child/youth. Overall, reviewers noted that most of the children and families in this sub-sample spoke English as their primary language and that verbal and written communication was conducted in English. In 7% of cases, reviewers did note that forms were not adequately translated for families for whom English is a second language. Although most reviewers indicated that providers did not need to provide supports to increase access to service locations (e.g. bus passes, flex funds), in 20% noted that service plans and other case documents showed evidence that the child and family received supports to increase access to services.

When assessing for *Minimal Restrictiveness* in service delivery, the majority of raters reported that services seemed to be provided in environments that feel comfortable to the child/youth and family, in the least restrictive and most appropriate environment. SOCPR raters also noted that case documentation showed ongoing communication between formal service providers and family members and that links to additional services were made with few challenges. In 13% of cases, reviewers noted that case files and interviews did not adequately show that children and/or families felt comfortable in the locations where services were provided to them. Eighteen percent of reviewers indicated that there was insufficient evidence to show that services were provided in the least restrictive and most appropriate environment

for the child/youth and family.

With regard to *Integration and Coordination* of services, reviewers generally found that there is ongoing two-way communication among and between all team members, including family members. In addition, the majority of reviewers (72%) also generally noted that there are smooth and seamless processes for linking children/youth and family to additional services. In just over 28% of cases, reviewers noted that the process to link the child and family with additional services was not always a smooth and seamless one. Although there was not a clear pattern as to why this was the case, a few reviewers noted that families with children needing more intensive services often had to wait for these services much longer than the caregiver/family felt they should. In some instances, reviewers also noted that the documentation did not adequately reflect the need for additional services and the process for linking children and families to these.

<u>System Successes in the Provision of Community-Based Services</u>

- Child and family needs were clarified by the system in a timely manner
- Services are generally provided at convenient times and locations
- Service providers verbally communicate in the primary language of the child/youth and family
- Written documentation regarding services/service planning is in the primary language of the child and family
- Services are provided in environment(s) that feel comfortable to the child/youth and family
- Services are provided in the least restrictive, most appropriate environment
- There is ongoing communication between formal service providers and family members

<u>Opportunities for Growth and/or Training in Domain 2</u>

- Documentation doesn't always adequately reflect whether the system was able to identify child/youth and family needs early
- Services provided to children and families were not always provided in a timely manner
- The process for linking children and families to additional services is not always a smooth and seamless one

Domain 3: Culturally Competent Services

The third domain of the SOCPR is intended to measure whether services are attuned to the cultural, racial, and ethnic background and identity of the child/youth and family receiving services. Ratings provided in each sub-domain are meant to evaluate the level of cultural awareness of the service provider, whether evidence shows that efforts are made to orient the

family to an agency's culture, whether sensitivity and responsiveness is shown for the cultural background of families, and whether informal supports are included in services.

Reviewers assessing for Cultural Awareness noted that case files provided limited documentation related to the culture of the child and/or the family, including information about the family's beliefs related to health and family. In 27% of cases receiving a rating of "3" or less (Disagree Slightly) and a number of additional cases that received a rating of "5" (Agree Slightly), reviewers noted that the case file did not include a copy of the "Strengths, Needs and Cultural Discovery" document. Reviewers did note some evidence of provider awareness related to the child/youth and family's cultural beliefs and how they shape their decision-making. However, 23% of reviewers said that the evidence did not clearly show that providers were aware of how their own culture and how differences between provider and family culture affects their working relationship.

When evaluating the Sensitivity and Responsiveness of the System, 26% of raters noted that there was limited documentation indicating that providers translated awareness of family culture into action. However, over 80% of reviewers noted that interviews with caregivers indicated that providers exhibited some awareness of child and family culture. In addition, over 80% of reviewers noted that providers generally offered families information to help them better understand their agency's rules and expectations. They also noted that documentation provided evidence that providers supported families with assistance in understanding of and navigating the larger service system. Caregiver interviews generally corroborated that this was the case.

With regard to Informal Supports, reviewers generally found documentation that families were asked whether they would like to include informal or natural supports in services. However, about 28% of cases were rated as having little to no documentation that informal supports were incorporated into service planning and delivery process.
In a number of cases, families declined to include natural supports (e.g. supportive friends or community members) in services. In one particular case, comments noted that a family felt they could include informal supports due to background check requirements which excluded the supports they had identified.

<u>System Successes in the Provision of Culturally Competent Services</u>

- Providers exhibit some awareness of and responsiveness to child and family culture
- Providers give families information to help them understand system/agency rules and expectations
- Providers give family some assistance in understanding /navigating service system

- Providers are working with families to identify informal supports and are incorporating these supports where they are available

Opportunities for Growth and/or Training in Domain 3

- Reviewers identified a lack of documentation related to the Strengths, Needs, and Cultural Discovery and inclusion of this document in case files.
- Providers may need additional support to demonstrate understanding that family culture and how it affects dynamic between provider and family, child/youth and family decision-making, and their concepts of health and family.

Domain 4: Impact

The final SOCPR domain evaluates whether services have produced positive outcomes for the child and family. This domain includes two sub-domains: Improvement and Appropriateness of Services, which are meant to determine whether services have had a positive impact on the children/youth and families in this particular sample and if so, whether these services met their identified needs.

The majority of raters found that providers and caregivers generally agreed that services provided had improved the situation of both children and families had produced a positive impact. Reviewers found that in most cases, providers and parents/caregivers indicated some improvement on the part of the child/youth and family. Similarly, raters generally indicated that the services provided to children/youth (80%) and families (78%) had been appropriate because they were found to have adequately met identified needs.

In about 22% of cases, reviewers reported that they did not find sufficient evidence to definitively say that the services provided adequately met family needs. Although this finding did not constitute a trend, it does identify an opportunity for growth and training on the part of providers with regard to documentation.

System Successes

- Reviewers generally agree that the accumulated evidence shows that services provided to children/youth have improved their situation to some degree
- Reviewers generally agree that the accumulated evidence shows that services provided to families have improved their situation to some degree
- Reviewers generally agree that the services and supports provided to children/youth have adequately met their needs
- Reviewers generally agree that services and supports provided to families have adequately met their needs

References

Hernandez, M., Gomez, A., Lipien, L., Greenbaum, P. E., Armstrong, K., & Gonzalez, P. (2001). Use of the system of care practice review in the national evaluation: Evaluating the fidelity of practice to system of care principles. *Journal of Emotional and Behavioral Disorders, 9,* 43-52.

Hodges, S., Hernandez, M., Nesman, T., & Lipien, L. (2002). *Creating change and keeping it real: How excellent child-serving organizations carry out their goals*. Tampa, FL: Louis de la Parte Florida Mental Health Institute, University of South Florida.

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

VanDenBerg, J. (2003). *The history of wraparound*. Retrieved from http://www.vroonvdb.com/about_wraparound.html

Technical Appendices

Appendix A

12 Principles of the Children's System of Care

Arizona Vision and 12 Principles of the Children's System of Care

In collaboration with the child, family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child and family's cultural heritage.

1. Collaboration with the child and family
2. Functional outcomes
3. Collaboration with others
4. Accessible services
5. Best practices
6. Most appropriate setting
7. Timeliness
8. Services tailored to the child and family
9. Stability
10. Respect for the child and family's unique cultural heritage
11. Independence
12. Connection to natural supports

Appendix B

"Other" Category of Treatments and Services All Cases

Almost 19% of the service provision treatments reported were identified as "Other", although one participant did not explain the "Other" treatment. Below is a list and frequency of the 15 treatments or services identified as "Other".

"Other" Category Treatments and Services All Cases	**N**
B-5	1
Behavior Coach	1
Bus Passes	1
Counseling (unsure of type)	1
Developmental Assessment	1
Direct Support, Transportation	1
Direct Supports	1
Flex Funds	1
Flex Funds-Bowling Summer Program	1
Flex Funds, Transportation	2
Physical Therapy to Improve Motor Skills	1
Preschool	1
Theraputic Visits	1
Transportation	19
Transportation; Wellness & Education Services	1
TOTAL	**34**

Appendix C

"Other" Category of Treatments and Services CW Cases

Over20% of the service provision treatments reported were identified as "Other", although one participant did not explain the "Other" treatment. Below is a list and frequency of the 13 treatments or services identified as "Other".

"Other" Category Treatments and Services CW Cases	**N**
B-5	1
Behavior Coach	1
Bus Passes	1
Counseling (unsure of type)	1
Developmental Assessment	1
Direct Support, Transportation	1
Direct Supports	1
Flex Funds	1
Flex Funds-Bowling Summer Program	1
Physical Therapy to Improve Motor Skills	1
Preschool	1
Therapeutic Visits	1
Transportation	7
TOTAL	**19**

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