Arizona's Children's System of Care Practice Review
Fiscal Year 2014 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 195 reviews were conducted across Arizona in FY2013-2014.

Methodology

Interviews were drawn from a sample of children and families identified as having high/complex levels of need. For the FY2013-2014 it should be noted that there was a change to the sampling methodology. *For the purposes of 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

Quantitative Summary

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, over 55% of the sample, with the overall average age at 10.5 years. With regard to ethnicity, nearly half of the sample was White (48%), while 21% was Latino/Hispanic, and almost 12% was multi-racial. The remaining 19% of the sample was Black and Native American. Ninety-five percent of the sample spoke English as their primary language. Spanish was identified as a primary language in 5% of the families. From a total range of 1-6 systems, the average number of child-serving systems involved per child was 2.26. All 195 cases were recorded as showing behavioral health system involvement. A review of the services or treatments utilized showed 93% of the children received Support Services, with Case Management being received by 91% of the families. Treatment Services were utilized by 78% of youth while Medical Services were utilized by 52%. The average number of services used per child or youth was 4.14.

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 195 cases, mean scores ranged from 5.14 to 5.64 for the four SOCPR domains, with an overall case mean score of 5.35. 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

GSA (N=195)	Case Mean (SD)	CCFF Mean (SD)	CB Mean (SD)	CC Mean (SD)	IMP Mean (SD)
Statewide	5.35 (0.97) Min 2.74 Max 6.98	5.34 (1.06) Min 2.83 Max 6.98	5.64 (0.80) Min 2.75 Max 7.00	5.14 (1.14) Min 2.46 Max 7.00	5.29 (1.37) 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 Child-Centered Family-Focused and Impact domains followed next. Providers were most tested in the Culturally Competent domain.

For FY 2013-2014 SOCPR scores ranged from the high 4s to the low 6s. All four SOCPR domain scores fell within the 5 range (representing enhanced implementation of a system of care principle). In the Community-Based domain all subdomains and areas scored in the low 5 to low 6 range with the area of Appropriate Language scoring highest (6.30). Other high scoring subdomains included Access to Services (6.04) and Minimal Restrictiveness (5.82) from the Community-Based domain. High scoring areas included Convenient Locations (5.98) and Convenient Times (5.83) in the Community-Based domain. These scores represent strengths in the Arizona's Children's System of Care as reviewed through these 195 SOCPR cases.

The data also revealed a few 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, the Informal Supports subdomain had a score of 4.99. This score may indicate the need for service providers to make sure that the informal supports identified by the child and family are included in all aspects of service planning and delivery. Another high 4 scoring area, Intensity of Services/Supports, is within the Individualized subdomain of Child-Centered, Family-Focused and scored a 4.84. The amount of services and supports provided to families should be a reflection of not only their needs but also the strengths the family demonstrates.

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 Medical Services, Support Services (especially Peer Support and Respite Support), and Skills Development and Training Services were associated with higher SOCPR scores. Residential Services and Family Support were associated with higher SOCPR case and

domain scores for children and youth.

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, services provided at convenient locations and times, 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=195). 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. For the FY2013-2014 it should be noted that there was a change to the sampling methodology. *For the purposes of 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 Provider Network Organization or service agency in the state. No cases were chosen for the SOCPR from agencies who served fewer than 25 children who met the 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 195 cases being completed in FY2013-2014.

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=195). 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.

Results

Demographics

The 195 SOCPR cases completed during FY2013-2014 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=70). The other GSAs provided between 15 and 35 cases.

Table 1. Demographic Characteristics of SOCPR Cases

Demographic Characteristic	Statewide N=195	GSA 1 n=35	GSA 2 n=20	GSA 3 n=15	GSA 4 n=25	GSA 5 n=30	GSA 6 n=70
Age (years)	10.53	12.54	10.05	11.27	10.8	12.87	8.40
Gender (Male)	54.9%	45.7%	70.0%	80.0%	76.0%	50.0%	44.3%
Race:							
White	48.2%	60.0%	35.0%	33.3%	44.0%	43.3%	52.9%
Black	8.2%	5.7%	0.0%	6.7%	4.0%	6.7%	14.3%
Latino/Hispanic	20.5%	8.6%	45.0%	40.0%	28.0%	20.0%	12.9%
Native American	9.2%	17.1%	15.0%	6.7%	0.0%	10.0%	7.1%
Multi-racial	11.8%	5.7%	5.0%	6.7%	20.0%	16.7%	12.9%
Missing	2.1%	2.9%	0.0%	6.7%	4.0%	3.3%	0.0%
Primary Language:							
English	94.9%	100.0%	70.0%	86.7%	100.0%	100.0%	97.1%
Spanish	5.1%	0.0%	30.0%	13.3%	0.0%	0.0%	2.9%

As shown in Table 1, the overall mean age for the 195 cases was 10.53 years. The means for age across GSA ranged from 8.40 years to 12.87 years. Statewide 55% of the sample was male, ranging from 44% in GSA 6 to 80% in GSA 3. Of the sample, 48% was White, and 21% was Latino/Hispanic. The remaining 31% of the sample was Black, Native American, multi-racial, or data were missing. Statewide, 95% of the children and youth in the sample spoke English as their primary language while Spanish was identified as being a primary language in 5% of families. English was the only language reported in GSA 1, GSA 4, and GSA 5. Spanish was identified as a primary language also in three GSAs. 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

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 195 cases (98%) indicated having behavioral health system involvement, as shown in Table 2. The SOCPR protocols documented that almost 55% of the cases had child welfare involvement, followed by educational services involvement (44%). Juvenile justice, developmental disabilities, and "Other" rounded out service system involvement. The "Other" system category was documented by 2.1% of the GSAs. The three services included Arizona Early Intervention Program, Guardian ad Litem, and Tribal Social Services.

Table 2. Child-Serving Systems Involvement

Service System	Statewide N=195	GSA 1 n=35	GSA 2 n=20	GSA 3 n=15	GSA 4 n=25	GSA 5 n=30	GSA 6 n=70
Behavioral Health	98.0%	97.1%	95.0%	100.0%	100.0%	96.7%	98.6%
Child Welfare	54.9%	45.1%	35.0%	13.3%	20.0%	66.7%	81.4%
Juvenile Justice	14.4%	25.7%	5.0%	6.7%	12.0%	16.7%	12.9%
Educational Services	44.1%	48.6%	50.0%	46.7%	52.0%	46.7%	35.7%
Developmental Disabilities	12.8%	11.4%	15.0%	6.7%	12.0%	10.0%	15.7%
Other	2.1%	0.0%	10.0%	0.0%	0.0%	0.0%	2.9%

The results of the 195 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 195 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 2.26. The shape of the histogram is slightly skewed, but still resembles a normal distribution. 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.

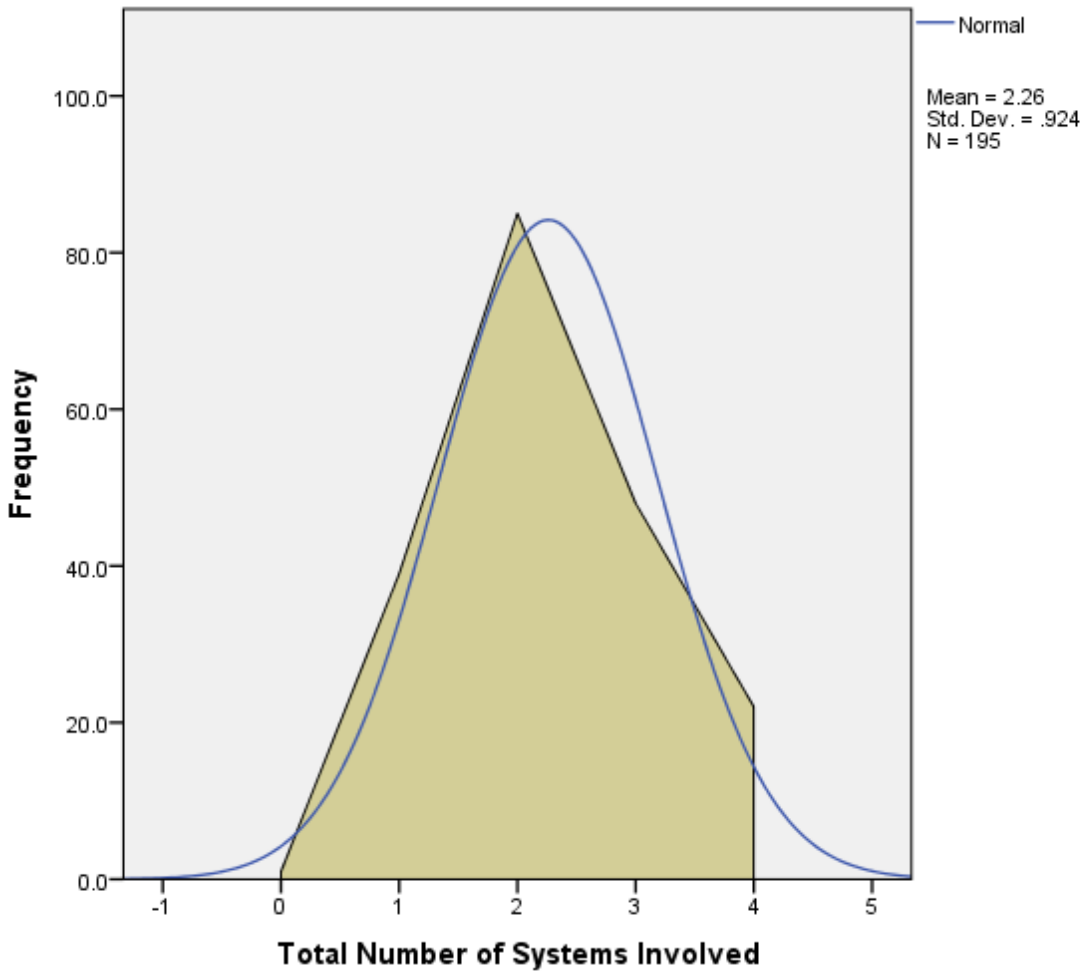

Figure 1. Histogram of child-serving system involvement.

Receipt of Services or Treatments

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

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	152 (78.0)	27 (77.1)	14 (70.0)	9 (60.0)	20 (80.0)	25 (83.3)	57 (81.4)
• Individual Counseling	142 (72.8)	25 (71.4)	14 (70.0)	9 (60.0)	20 (80.0)	24 (80.0)	50 (71.4)
• Family Counseling	76 (39.0)	13 (37.1)	8 (40.0)	1 (6.67)	12 (48.0)	11 (36.7)	31 (44.3)
• Group Counseling	37 (19.0)	9 (25.7)	6 (20.0)	0 (0.0)	4 (16.0)	8 (26.7)	10 (14.3)
• Alcohol/Drug Counseling	11 (5.6)	4 (11.4)	0 (0.0)	0 (0.0)	2 (8.00)	2 (6.67)	3 (4.29)
Medical Services							
• Psychiatric Medication	102 (52.3)	23 (65.7)	13 (65.0)	8 (53.3)	12 (48.0)	20 (66.7)	26 (37.1)
Support Services	181 (92.8)	33 (94.3)	20 (100.0)	13 (86.7)	25 (100.0)	30 (100.0)	60 (85.7)
• Family Support	75 (38.5)	15 (42.9)	9 (45.0)	7 (46.7)	11 (44.0)	15 (50.0)	18 (25.7)
• Peer Support	17 (8.7)	1 (2.86)	6 (30.0)	0 (0.0)	4 (16.0)	2 (6.67)	4 (5.71)
• Respite Support	35 (18.0)	10 (28.6)	3 (15.0)	3 (20.0)	1 (4.00)	10 (33.3)	8 (11.4)
• Home Care Training	11 (5.6)	3 (8.57)	0 (0.0)	0 (0.0)	2 (8.00)	3 (10.0)	3 (4.3)
• Case Management	177 (90.8)	33 (94.3)	20 (100.0)	13 (86.7)	24 (96.0)	29 (96.7)	58 (82.9)
• Skill Develop & Train	45 (23.1)	15 (42.9)	2 (10.0)	5 (33.3)	6 (24.0)	7 (23.3)	10 (14.3)
Inpatient Services	19 (9.7)	4 (11.4)	0 (0.0)	0 (0.0)	1 (4.0)	2 (6.7)	12 (17.1)
• Psychiatric Hospitalization	6 (3.1)	1 (2.9)	0 (0.0)	0 (0.0)	1 (4.00)	0 (0.0)	4 (5.7)
• Level I Residential	16 (8.2)	3 (8.6)	0 (0.0)	0 (0.0)	1 (4.00)	2 (6.7)	10 (14.3)
Residential Services	14 (7.2)	3 (8.6)	0 (0.0)	0 (0.0)	0(0.0)	2 (6.7)	9 (12.9)
• Level II Residential	9 (4.6)	2 (5.7)	0 (0.0)	0 (0.0)	0 (0.0)	2 (6.7)	5 (7.1)
• Level III Residential	5 (2.6)	1 (2.9)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	4 (5.7)
Other	44 (22.6)	8 (22.9)	6 (30.0)	3 (20.0)	7 (28.0)	6 (20.0)	14 (20.0)

Across the state the most utilized service or treatment provision was Support Services (92.8%) followed by Treatment Services (78.0). Residential Services (7.2%) 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 (91%) followed by Individual Counseling (73%) and Psychiatric Medication (52%). Level III Residential and Psychiatric Hospitalizations were the least utilized services or treatments (2.6% and 3.1% respectively) statewide. Across GSAs, Case Management was utilized in six out of six GSAs, and was utilized in at least 82% of the cases in each GSA. Level III Residential was utilized in only

two GSAs (5 cases), and Psychiatric Hospitalizations was used in three GSAs equaling 6 cases.

Support Services were utilized in all six GSAs with three 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 82% by all GSAs. Treatment Services and Medical Services were documented as the next two most frequently utilized services with 68% and 60% of cases respectively. Residential services were not utilized in GSAs 1, 3, and 4. Inpatient Services were not utilized in GSAs 2 and 3. GSA 3 had the smallest number of cases as a part of the overall statewide sample, while GSA 6 (n=70) had the largest number of cases using services in all 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, 30% of cases in GSA 2 had "Other" services, which represents only 6 youth, as only 20 total SOCPR cases were completed for this GSA. Statewide, about 23% (N=44) 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

Treatment	Chi-Square Statistic
Treatment Services • Individual Counseling • Family Counseling • Group Counseling • Alcohol/Drug Counseling	
Medical Services • Psychiatric Medication	X^2 (5, N=195)=12.9379, p=.0240
Support Services • Family Support • Peer Support • Respite Support • Home Care Training (HCTC) • Case Management	X^2 (5, N=195)=12.0707, p=.0338 X^2 (5, N=195)=16.9444, p=.0046 X^2 (5, N=195)=12.9876, p=.0235
Inpatient Services • Psychiatric Hospitalization • Level I Residential	
Residential Services • Level II Residential • Level III Residential	
Other	
Skills Development and Training	X^2 (5, N=195)=13.5906, p=.0184

Statewide, a significant relationship between GSA and services received was shown for Medical Services, Support Services, and Skills Development and Training. Specifically, Psychiatric Medication, Peer Support, and Respite Support were all 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 195 cases in the sample, the range of services used was 1 to 11. 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 4.14 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.

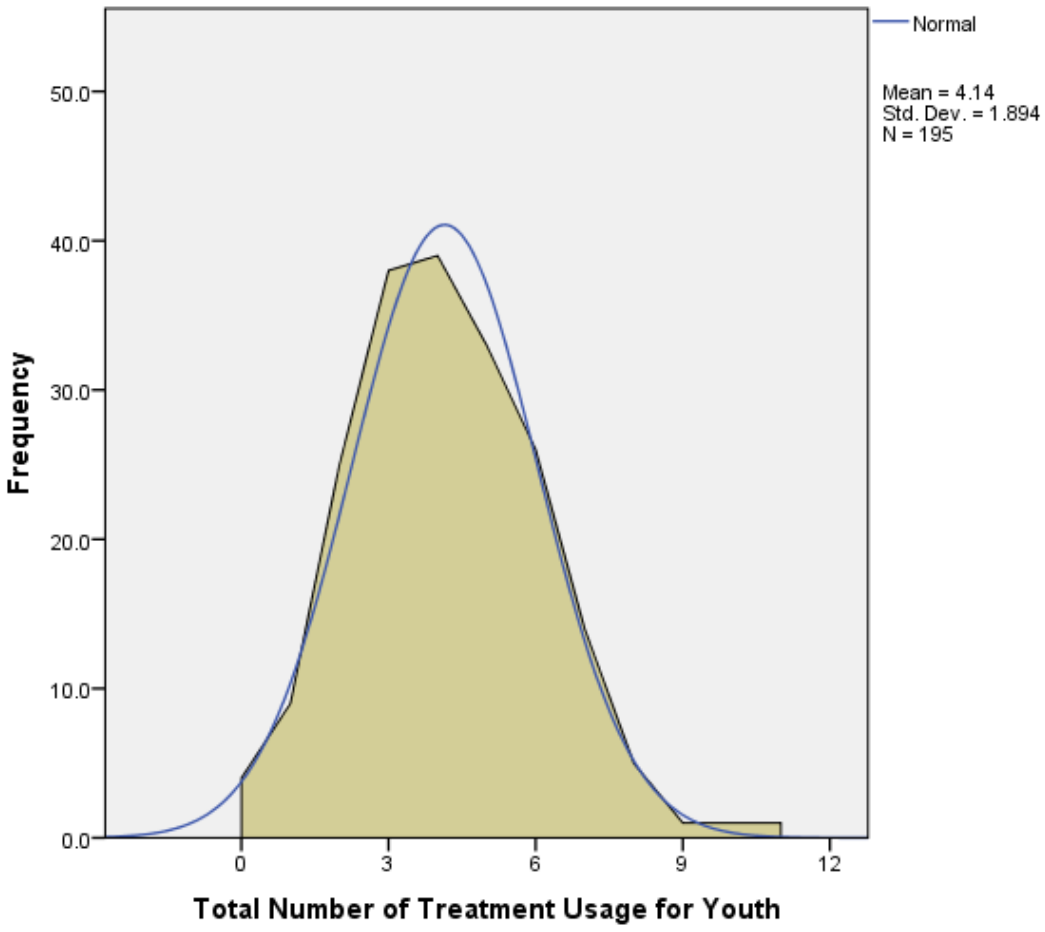

Figure 2. Histogram of service or treatment usage for youth.

Quantitative Analysis

SOCPR Scores – Overall Case and SOCPR Domains

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 195 cases, indicated by individual GSA. As explained in the Methodology section, SOCPR 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. At the statewide level, SOCPR mean scores ranged from 5.14 to 5.64 with an overall case mean score of 5.35. 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 mid to high 5s, 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

GSA (N=195)	Case Mean (SD)	CCFF Mean (SD)	CB Mean (SD)	CC Mean (SD)	IMP Mean (SD)
Statewide	5.35 (0.97) Min 2.74 Max 6.98	5.34 (1.06) Min 2.83 Max 6.98	5.64 (0.80) Min 2.75 Max 7.00	5.14 (1.14) Min 2.46 Max 7.00	5.29 (1.37) Min 1.25 Max 7.00
GSA 1 (n=35)	5.51	5.57	5.81	5.28	5.41
GSA 2 (n=20)	5.70	5.71	5.83	5.46	5.80
GSA 3 (n=15)	5.39	5.16	5.68	5.32	5.40
GSA 4 (n=25)	5.36	5.13	5.67	5.12	5.51
GSA 5 (n=30)	4.96	4.98	5.51	4.78	4.59
GSA 6 (n=70)	5.33	5.40	5.54	5.09	5.29

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 = 5.64). This was followed by Child-Centered Family-Focused (Mean = 5.34), Impact (Mean = 5.29), and Culturally Competent (Mean = 5.14). 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.

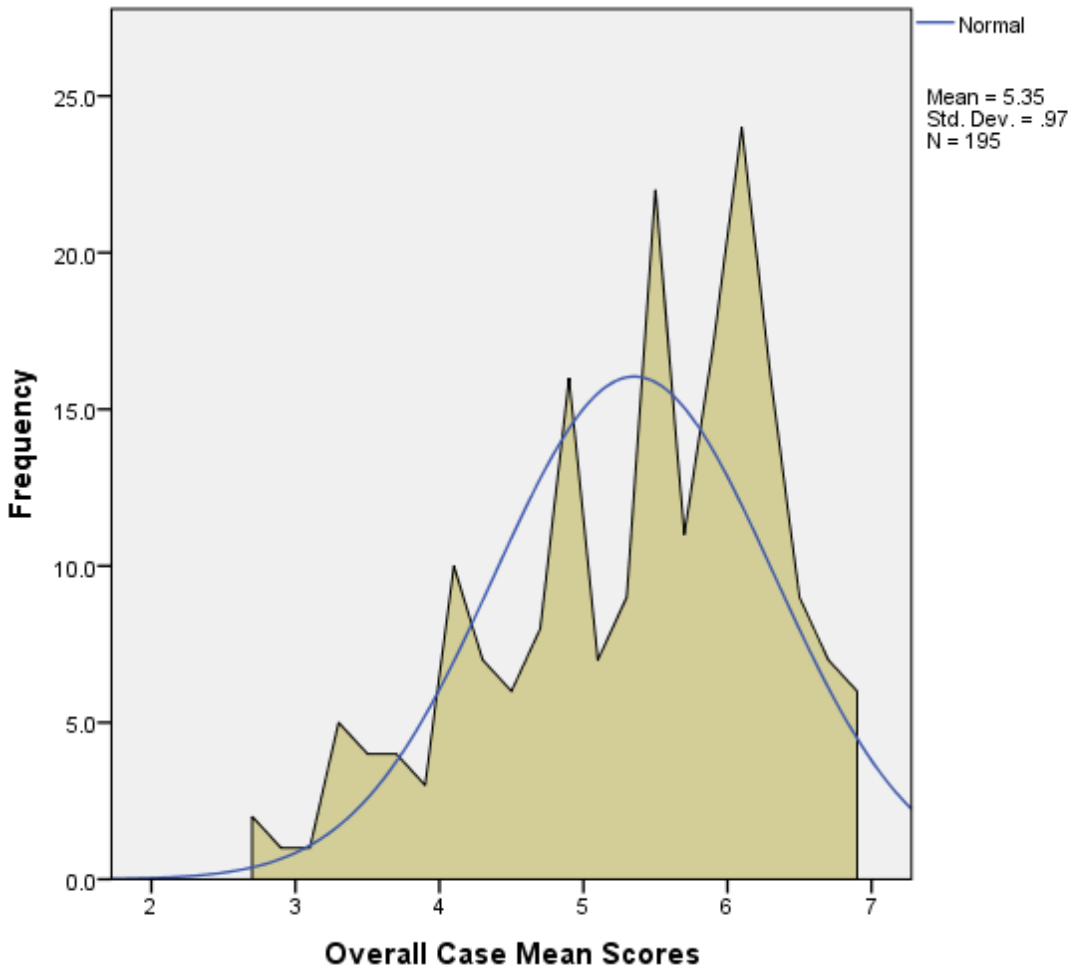

Figure 3. Histogram of SOCPR Overall case mean scores.

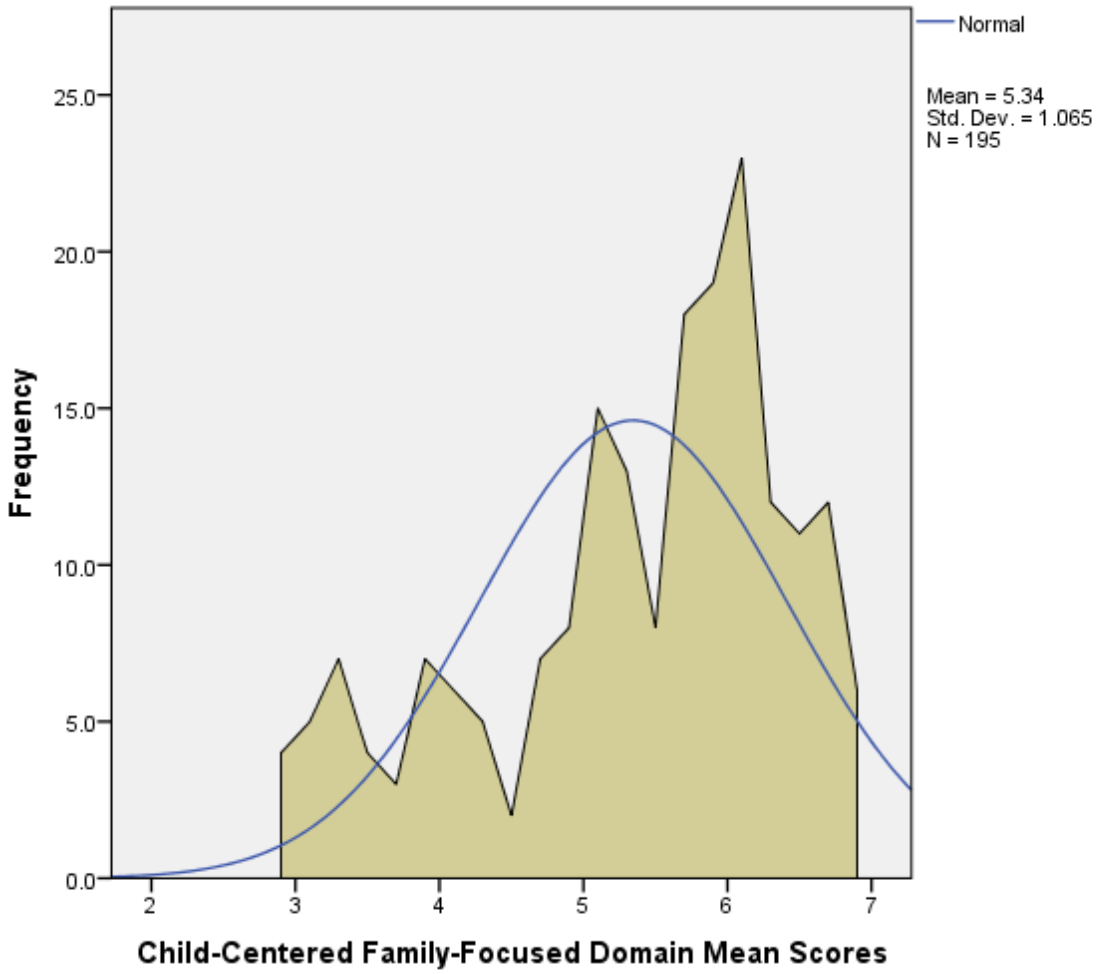

Figure 4. Histogram of SOCPR Child-Centered Family-Focused domain mean scores.

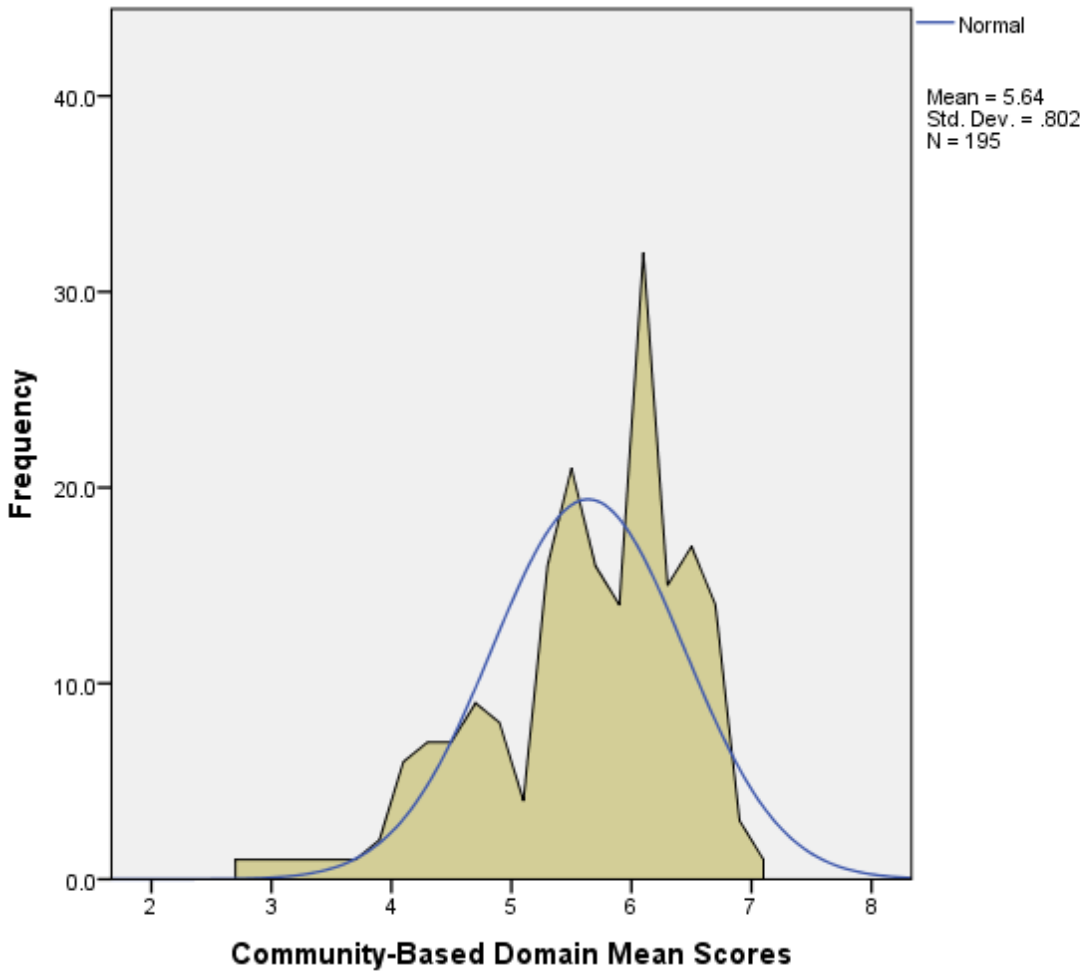

Figure 5. Histogram of SOCPR Community-Based domain mean scores.

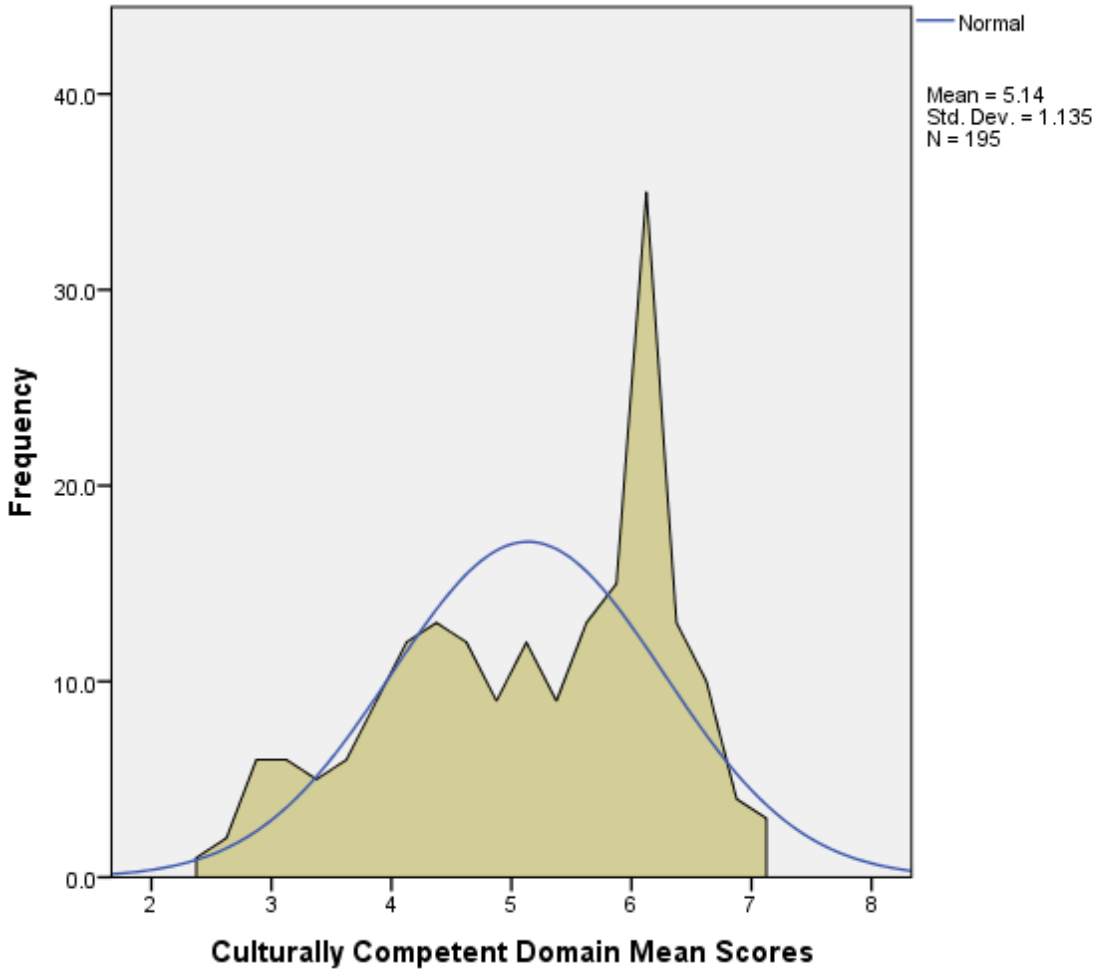

Figure 6. Histogram of SOCPR Culturally Competent domain mean scores.

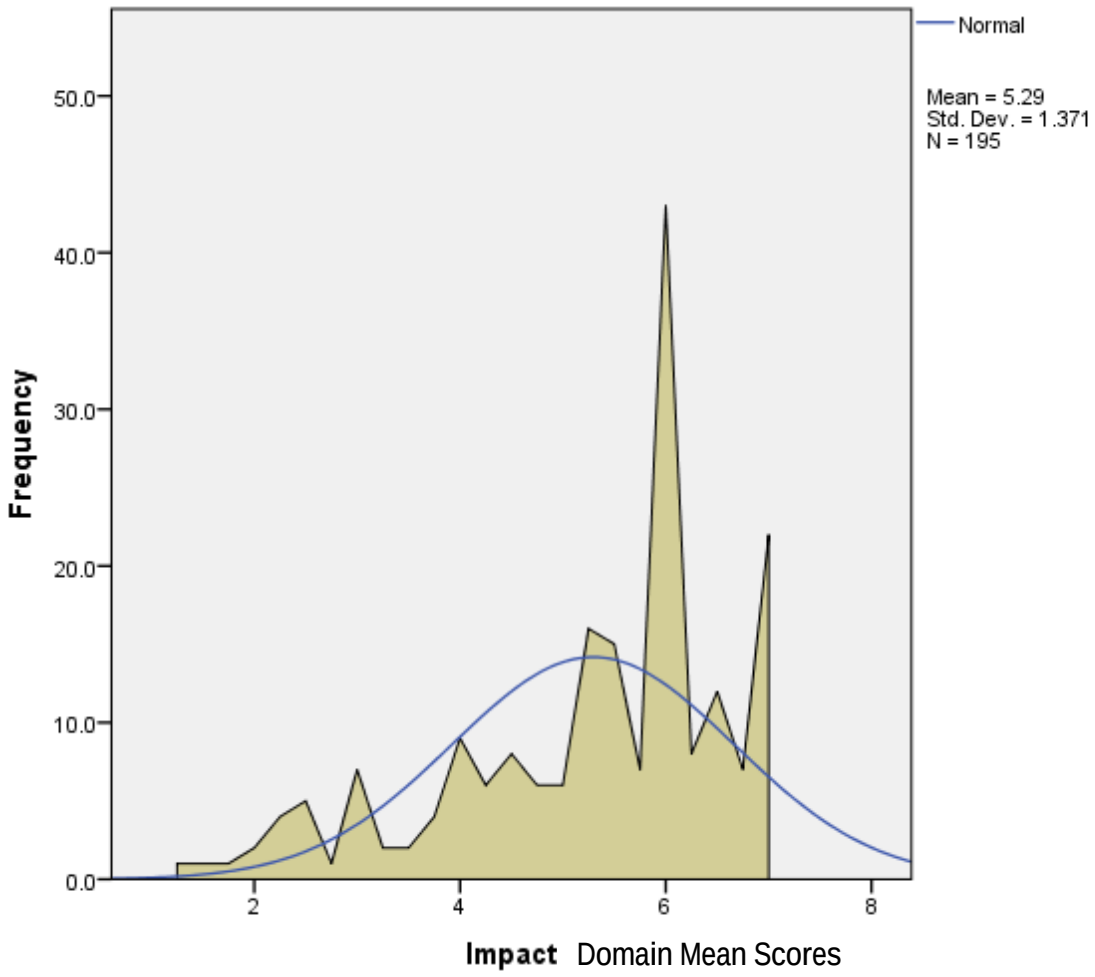

Figure 7. Histogram of SOCPR Impact domain mean scores.

SOCPR Scores – SOCPR Subdomains and Areas

Table 6 presents statewide SOCPR data for most levels of the instrument, including the total case mean score, SOCPR domain scores, and SOCPR subdomain 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

Overall Score – all cases: 5.35 (0.97)		
	Area Mean (SD)	**Subdomain Mean (SD)**
Domain I: Child-Centered, Family-Focused: 5.34 (1.06)		
Individualized		5.12 (1.17)
Assessment/Inventory	5.65 (0.86)	
Service Planning	5.65 (0.86)	
Types of Services/Supports	5.16 (1.20)	
Intensity of Services/Supports	4.84 (1.68)	
Full Participation		5.66 (0.91)
Case Management		5.25 (1.47)
Domain II: Community-Based Domain Score: 5.64 (0.80)		
Early Intervention		5.47 (1.26)
Access to Services		6.04 (0.78)
Convenient Times	5.83 (1.33)	
Convenient Locations	5.98 (1.10)	
Appropriate Language	6.30 (0.69)	
Minimal Restrictiveness		5.82 (0.89)
Integration and Coordination		5.23 (1.38)
Domain III: Culturally Competent Domain Score: 5.14 (1.14)		
Awareness		5.26 (1.15)
Awareness of Child/Family's Culture	5.16 (1.32)	
Awareness of Providers' Culture	5.32 (1.35)	
Awareness of Cultural Dynamics	5.31 (1.23)	
Sensitivity and Responsiveness		5.03 (1.55)
Agency Culture		5.26 (1.26)
Informal Supports		4.99 (1.65)
Domain IV: Impact Domain Score: 5.29 (1.37)		
Improvement		5.40 (1.36)
Appropriateness		5.19 (1.49)

As reported previously, the highest scoring SOCPR domain was Community Based. This was followed by Child-Centered Family-Focused, Impact, and finally Culturally Competent. All of the SOCPR domain scores and most subdomain scores fell in the 5 range (representing enhanced implementation of a system of care principle). One subdomain score was in the 6 range (Access to Services) while one was on the cusp of the 5 range (Informal Supports, Mean = 4.99). All but two Area scores were in the 5 range. Appropriate Language, in the subdomain of Access to Services was in the low 6 range while Intensity of Services/Supports in the Individualized subdomain was in the high 4 range.

In the Community Based domain all subdomains and areas scored in the low 5 to low 6 range with the subdomains of Access to Services and Minimal Restrictiveness scoring highest (6.04 and 5.82 respectively). All three areas in the subdomain of Access to Services had mean scores in the high 5 to low 6 range: Appropriate Language (6.30), Convenient Locations (5.98) and Convenient Times (5.83). These subdomain and area scores indicate that a wide array of services were accessible and available to families, and they were provided in the most flexible and least intrusive manner possible. These represent strengths in Arizona's Children's System of Care, as reviewed through these 195 SOCPR cases.

The data also revealed a few 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 the Culturally Competent domain, the subdomain of Informal Supports had a score of 4.99. This score may indicate the need for service providers to make sure that the informal supports identified by the child and family are included in all aspects of service planning and delivery. Another high 4 scoring area, Intensity of Services/Supports, is within the Individualized subdomain of Child-Centered, Family-Focused and scored a 4.84. The amount of services and supports provided to families should be a reflection of not only their needs but also the strengths the family demonstrates. 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

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

Variable	Case	CCFF	CB	CC	IMP
Demographics					
Age Bands					
Gender					
Race					
Primary Language			0.050	0.050	
GSA					0.041
Case Longevity					
Service Systems					
Behavioral Health					
Child Welfare					
Juvenile Justice					
Educational					
Developmental Disabilities					
Total Systems					
Services Categories					
Treatment Services			0.034		
Medical Services					
Support Services					
Inpatient Services					0.023
Residential Services	0.005	0.008	0.024	0.002	
Services					
Individual Counseling			0.030		
Family Counseling					
Family Support	0.015	0.045	0.006		0.037
Respite Support					
Case Management				0.006	
Psychiatric Hospitalization					0.039
Total Number of Services			0.045	0.023	

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, and services measured showed significant differences.

Findings indicate that children and youth who received Residential Services and Family Support are associated with Child-Centered, Family-Focused domain. Children and youth who received Treatment Services, Residential Services, Individual Counseling, and Family Support are associated with higher Community Based scores. Primary Language of the children also contributed to the higher scores. Those with Primary Language, Residential Services, and Case Management are more associated with higher Culturally Competent scores. Children and youth with Inpatient Services, Family Support, and Psychiatric Hospitalizations were associated with

higher Impact scores with GSA contributing to the higher score. Residential Services and Family Support were associated with higher SOCPR case and domain scores for children and youth.

SOCPR Scores – FY2012-2013 and FY2013-2014 Comparison

Table 8 shows a comparison of domain and subdomain scores across two administrations of the SOCPR. Overall, scoring differences in the four main domain categories between FY2012-2013 and FY2013-2014 were not statistically significant. This may be due in part to the different sample of children and families that was utilized for the FY2013-2014 as compared to the sample utilized for the FY2012-2013. However, some subdomains and areas did show positive improvements.

Table 8. SOCPR Score Comparisons between FY2012-2013 and FY2013-2014

	2012-2013		2013-2014		Change	p-value[1]
	Mean	(SD)	Mean	(SD)		
Overall Score	5.51	(0.90)	5.35	(0.97)	-0.16	0.11
Domain I: Child-Centered, Family-Focused	5.52	(1.01)	5.34	(1.06)	-0.18	0.10
Individualized	5.34	(0.95)	5.12	(1.17)	-0.22	0.05*
Assessment/Inventory	5.78	(0.78)	5.65	(0.86)	-0.13	0.11
Service Planning	5.42	(0.98)	5.16	(1.20)	-0.26	0.02*
Types of Services/Supports	5.11	(1.41)	4.84	(1.68)	-0.27	0.09
Intensity of Services/Supports	5.03	(1.43)	4.84	(1.67)	-0.19	0.23
Full Participation	5.70	(0.99)	5.66	(0.91)	-0.04	0.71
Case Management	5.53	(1.31)	5.25	(1.47)	-0.28	0.05*
Domain II: Community-Based	5.74	(0.70)	5.64	(0.80)	-0.10	0.18
Early Intervention	5.61	(1.06)	5.47	(1.26)	-0.14	0.27
Access to Services	5.98	(0.67)	6.04	(0.78)	0.06	0.46
Convenient Times	5.91	(0.88)	5.83	(1.33)	-0.08	0.45
Convenient Locations	5.96	(0.89)	5.98	(1.10)	0.02	0.83
Appropriate Language	6.07	(0.83)	6.30	(0.69)	0.23	<0.01**
Minimal Restrictiveness	5.93	(0.80)	5.82	(0.89)	-0.11	0.22
Integration and Coordination	5.46	(1.16)	5.23	(1.38)	-0.23	0.08
Domain III: Culturally Competent	5.30	(1.06)	5.14	(1.14)	-0.16	0.15
Awareness	5.22	(1.15)	5.26	(1.15)	0.04	0.76
Awareness of Child/Family's Culture	5.22	(1.30)	5.16	(1.32)	-0.06	0.63
Awareness of Providers' Culture	5.21	(1.34)	5.32	(1.35)	0.11	0.45
Awareness of Cultural Dynamics	5.24	(1.25)	5.31	(1.23)	0.05	0.60
Sensitivity and Responsiveness	5.16	(1.47)	5.03	(1.55)	-0.13	0.42
Agency Culture	5.53	(1.07)	5.26	(1.26)	-0.27	0.03*
Informal Supports	5.29	(1.52)	4.99	(1.65)	-0.30	0.07
Domain IV: Impact Domain Score:	5.47	(1.24)	5.29	(1.37)	-0.18	0.18
Improvement	5.57	(1.19)	5.40	(1.36)	-0.17	0.19
Appropriateness	5.38	(1.38)	5.19	(1.49)	-0.19	0.21

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

There is consistency in Arizona's Children's System of Care as evident in the ranking of domain scores across both FY2012-2013 and FY2013-2014. The highest scoring SOCPR domain was Community Based across both administrations. This was followed by Child-Centered Family-Focused, Impact, and lastly Culturally Competent. 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 Locations.

One of Arizona's Children's System of Care strengths is the positive changes in the domain of Community Based. The subdomain of Access to Services showed a small but positive change from FY2012-2013 to FY2013-2014. This increase shows that families are provided services in the most convenient, least restrictive, and highly flexible way possible.

Within the subdomain of Access to Services, one area showed substantial and statistically significantly increases. The positive change was in the area of Appropriate Language. This positive increase indicates that service providers are verbally communicating and providing written documentation about services are in the primary language of the child and family. Another evident strength within Access to Services was the positive increase in Convenient Locations. This indicates that services are being provided to families close to their homes and that supports are given families to increase their access to services.

A final strength is in the domain of Culturally Competent. The positive improvements in this domain are evident in the increases in the Awareness subdomain, as well as the two areas of Awareness of Providers' Culture and Awareness of Cultural Dynamics. These increase indicate not only a general understanding of how culture and cultural context affects service delivery to families, but they also indicate that providers have an understanding of their own culture and how it affects interactions with families.

Qualitative Analysis

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 each SOCPR domain area (N=195). 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 cases reviewed had to provide similar information for a given sub-domain area. These 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 identified. Additionally, reviewers noted that caregivers and providers reported that providers informally acknowledge child/family needs and strengths, even when these are not adequately documented in case files. A key challenge related to this sub-domain area was identified in various reviewer comments related to a lack of clear reflection or articulation of child/youth and family strengths in documented service plan goal statements. Such comments were evident in summative responses associated with a rating of "5" and lower. This finding provides an opportunity for growth and training of providers, to more clearly identify and articulate child/youth and family strengths, and to develop strengths-based goals that can encourage child/youth and family participation in service planning.

A review of responses related to the existence of primary service plan that documents service integration across providers found that reviewers reported some inconsistent documentation among providers serving children/youth and families in the sample. Although only 28 percent of cases received scores of "3" ("Disagree Slightly") or less regarding the existence of a primary service plan that integrates all services received, comments about inconsistent documentation were also found in those items rated "5" ("Agree Slightly") or more. A review of responses related to whether the types and intensity of services provided to children/youth and their families reflect needs and strengths also suggested that reviewers felt there was inconsistent documentation in this regard in about 30 percent of cases. Although these findings do not constitute a trend, as defined for the purposes of analysis, they provide another opportunity for growth and training of providers to improve service plan documentation and integration.

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. In addition, reviewers 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 in service planning, reviewers noted that not all formal providers involved in service delivery participated in service planning, even though they may be continuing to provide services to children/youth and their families. Reviewers also made note of inconsistent documentation regarding the inclusion of informal helpers in service planning meetings.

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. Where challenges are reported, reviewers noted a lack of agreement between parents/caregivers and lead care coordinators (case managers or in some cases, therapists) regarding the amount of coordination and responsiveness on the part of care coordinators. However, there were no clear trends related to the reasons identified for these disparities. Cases where such lack of agreement was found included those where a parent/caregiver was not satisfied with the level of case management services despite clear documentation of coordination of and changes in service delivery. Lack of agreement was also found in cases where reviewers reported a lack of documentation related to service coordination and limited responsiveness on the part of providers. A few reviewers found that case managers had difficulty coordinating services because services were not available to the child/youth or family within their home communities or were only available in certain parts of the state.

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

- 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
- Case managers successfully coordinate services
- Service plans are responsive to changing family needs and are generally updated in a timely fashion
- Service planning is responsive to changing needs and plan is updated accordingly

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

- Service plans don't sufficiently document or reflect assessment of child/youth or family strengths

- Uneven documentation of diverse provider participation in planning process and ongoing service delivery to families
- Service plans don't consistently reflect participation of informal helpers
- Inconsistent documentation regarding whether types and intensity of services provided adequately reflect child/youth and/or family strengths and needs

Potential Systems Issues in Domain 1

The number of review comments related to difficulties coordinating services due to lack of service availability in child/youth and family's home community did not constitute a trend, as defined in the introduction to this section. However, systems leaders might want to examine how distribution of the service array across state geographic areas might present barriers to service retention among children/youth and families served.

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 overwhelmingly reported that child/youth and family needs were identified at intake and that services were provided in a timely manner. However, some reviewers noted (in about 19 percent of cases including those that were rated as "Agree Slightly" or "5") a lack of sufficient documentation available for reviewers to adequately assess that the system was able to identify needs early and to begin addressing them. This appeared to be an issue, particularly with cases that were reported as having been transferred from one provider to another for care coordination (and where the second provider relayed this information during the SOCPR provider interview). Again, although this finding did not constitute a trend, this finding provides an opportunity for growth and training of providers to improve service plan documentation, as well as communication with transferring providers.

Overall, reviewers indicated that the System was ensuring *Access to Services* for children/youth and families. In general, 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. Where issues were

identified (in 10 percent of cases, on average) reviewers noted some disagreement between parent/caregivers and case managers regarding convenience of services related to time and location. In general however, where accessibility barriers related to time and location were noted, reviewers found evidence that supports were being provided to increase access to service locations.

When assessing for *Minimal Restrictiveness* in service delivery, raters reported that overall, 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. Some reviewers did note (in less than 10 percent of cases), however, that documentation did not reflect evidence that services were provided in a location that feels comfortable to 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 at least 29 percent of cases, reviewers noted that it was not always easy to link families to additional services due to lack of service availability in the child/youth and family's home community and/or long waiting lists which lead to lag times following identification of additional needs. Although such responses were not found in at least half of the reviewed cases, this raises a potential systems issue that might be examined to increase overall access to services for families.

Analysis of reviewer comments also suggests that providers should be encouraged to provide additional detail in service plan documentation to allow for better assessment of whether services are being provided within or close to the child's home community, in the least restrictive setting possible, and are coordinated and delivered through linkages between public and private providers.

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

- Child and family needs were identified at intake
- 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

- Case files don't sufficiently document to reviewers to adequately assess that the system was able to identify child/youth and/or family needs early and to begin addressing them
- Increasing communication (and documentation of communication) between providers and families regarding convenience of services would help increase sense of responsiveness and accessibility on the part of the system

Potential Systems Issues in Domain 2

Although such comments were found in less than 50 percent of cases, reviewers noted that it was not always easy to link families to additional services due to lack of service availability in the child/youth and family's home community and/or long waiting lists which lead to lag times following identification of additional needs.

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 of provider awareness of the child/youth and family's cultural beliefs, including how these beliefs shape concepts/beliefs about health and family and child/youth and family 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 SOCPR interviews where they said that they felt that providers understood

their culture. In addition, raters noted that providers generally offered families information to help them better understand their agency's rules and expectations. Providers also appeared to generally provide families with some assistance in understanding/navigating the larger service system and parents/caregivers corroborated that this was the case through interviews with reviewers.

With regard to *Informal Supports*, reviewers generally found that there was some evidence of inclusion of informal supports. While 28 percent of cases were rated as having little to no documentation of informal support participation, providers and family members did generally report that children/youth and family were relying on support from school personnel, extended family members, and even former foster or adoptive parents. The findings related to this particular sub-domain suggest that providers generally worked with families to identify informal supports.

<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
- Providers have some awareness of 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. Providers may need more training on use of Strengths, Needs, and Cultural Discovery documentation and inclusion of these documents in case files.
- Limited documentation found to indicate that providers translate awareness of family culture into action. Providers may need additional coaching to assist them in improving in this area.
- Providers need to demonstrate increased understanding of 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 services provided to children/youth and families had produced a positive impact. When reflecting on the evidence provided for this sub-domain, raters noted that family members did not always agree with providers about the degree of progress and improvement that they and their children had made as a result of services. However, reviewers found that in most cases, providers and parents/caregivers indicated "a little" or 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 less than a quarter of reviewed cases, reviewers noted that services had not had a positive impact on children/youth and families and had not adequately met the identified needs of children/youth. Family circumstances in this subset of cases were diverse and appeared to play a role in this finding. Further, in nearly 30 percent 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.

<u>System Successes</u>

- 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 2013-2014. 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.

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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

Almost 23% 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 treatments or services identified as "Other".

"Other" Category Treatments and Services	N
Art Awakenings	1
Behavior Coach	1
Comprehension Developmental Evaluation	1
CRC	1
Detention Center	1
Family Support Partner Behavior Coaching	1
Flex Funds	2
Foster Care	1
Health Promotion	1
IOPSA	1
Living/Social Skills, Health Promotion Group	1
Medication Monitoring and Behavior Coaching	2
Parenting- Love and Logic	1
Play Therapy	1
Psychiatric Assessment	1
Recreation Therapy	1
Skill Building Group	1
Skill Training, Mood Management Group	1
Skill Training/Mentor	1
Skills Group, Art Therapy	1
Skills Training, Health/Med Education	1
Skills Training, Transportation	1
Smoking Cessation Group	1
Speech, Occupational, Physical Therapy	1
Tip Facilitator	1
Transitional Housing	1
Transportation	13
Transportation To Respite	1
YAP Case Manager with CPS and Living Skills	1
TOTAL	**43**

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