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Learning Objectives

The Supervision Curriculum for Family and Person Centered Practice – *Supervision 401: The System of Care Track*

❖ Systems of Care: What and Why?

Readers will be able to:

- Define systems of care descriptively and accurately
- State why systems of care are needed and why supervisors have important contributions to make in their local systems
- Describe at least eight possible influential factors that may drive local system of care development
- Analyze what is most likely affecting the development of their own local system of care

❖ Service Design and Implementation: Design Options and Modifications

Readers will be able to:

- Differentiate between components of the following service examples and whether they reflect categorical, modified categorical or individualized practice in their values, design and implementation:
 - Options for Crisis Services
 - Options for Care Coordination (aka Case Management)
 - Options for Mental Health Services
 - Options for Residential Treatment Centers/Group Homes
 - Options for Services to Women, Infants and Children
 - Options for Treatment Foster Care Services
- Think through how to modify a service to make it more individualized
- Think through how to modify a service your organization provides to make it more individualized

❖ Components of Local Systems of Care: Service Descriptions

Readers will be able to:

- Describe key design and implementation features of the following service types:
 - Assessment
 - Care Coordination
 - Therapy
 - Mentoring
 - Respite
 - In-Home Services
 - Wraparound
 - Family Group Conferencing
 - Multisystemic Therapy
 - Foster Care
 - Medical Foster Care
 - Treatment Foster Care
 - Emergency Foster Care
 - Shared Caregiving
 - Services for Sexual Abuse and Trauma Victims
 - Services for Sexual Offenders
 - Supports for Education
 - Services for Children and Families Involved in Protective Services
 - Protective Services for Adults
 - ACT Teams and Related Supports
 - Residential Treatment
 - Psychiatric Hospitalization
 - Crisis Services
 - Services for Basic Needs
 - Drug and Alcohol Treatment
 - Medication Monitoring
 - Services for People who Commit Crimes
- Analyze their local systems of care

❖ Supervisors, Information and Evaluation

Readers will be able to:

- State at least three reasons supervisors need information to operate effectively in local systems of care
- Describe at least seven sources of information supervisors can use to be informed about their local systems of care

❖ What Supervisors Need to Know

Readers will be able to:

- Identify and describe at least six categories of information supervisors need to know about their local systems of care

❖ Developing Evaluation Systems

○ Outcome Evaluation

Readers will be able to:

- List the key parts of outcome evaluation systems plus eight steps to develop these systems
- Identify at least five outcomes the following systems or programs can measure:
 - Education Programs
 - Child Welfare Programs
 - Programs for Young Offenders
 - Mental Health Programs
 - Health Programs
 - Financial Assistance Programs
- Describe how specific outcome statements are defined and how information on outcome achievement is collected and utilized

○ Process Evaluation

Readers will be able to:

- Define process evaluation and how it is tied to outcome evaluation, including at least three possible predictive variables for four possible outcomes
- Describe seven steps that will help supervisors develop process evaluation systems for their programs

○ Evaluation of Consumer and Family Satisfaction

Readers will be able to:

- Describe why and how consumer satisfaction with services is measured

❖ Developing Evaluation Systems: An Exercise

Readers will be able to:

- Complete a planning guide on how to develop evaluation strategies to implement in their local systems of care, including both outcome and process evaluation

❖ Informal Resources in Systems of Care

Readers will be able to:

- Find, include and retain volunteers to assist consumers and families in local systems of care
- Find and utilize community and informal resources to augment and improve on what is available in local systems of care

❖ Supervisors and Money

Readers will be able to:

- Describe how their systems of care function financially: funding practices, sources and specific costs and cost ranges for traditional and for newer services for both children and adults

❖ Collaboration in Systems of Care

Readers will be able to:

- Explain why collaboration is essential in local systems of care
- Describe both actual and possible structures for increasing and building on collaboration in local systems of care, including both formal and informal resources
- List at least 10 decisions communities may make collaboratively
- Analyze the state of collaboration in their communities

❖ Sales, Persuasion and Supervisors

Readers will be able to:

- Describe how to persuade people that systems of care represent best practice across service modalities, including at least five examples
- Analyze how they may best persuade a variety of stakeholders about creating and developing local systems of care

What is a System of Care?

A system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families.¹

The idea of developing local systems of care began to resonate with people in the late '70s and '80s in the United States. The authors of most published, relevant works view it as a reaction to the lack of effective and coordinated mental health services for children and families, particularly when the children were diagnosed with severe emotional disturbance. Jane Knitzer coined the term “unclaimed children²,” referring to the fact that the systems assumed to be responsible for the care of these children were fractured, unresponsive and filled with gaps. Clearly, change was needed and that change was ultimately called systems of care.

Establishing a local system of care is an enormous undertaking. Despite the obstacles involved, the system of care movement grew thanks to the collaborative work of family members, children, professional service providers, members of government and experts of all kinds.

It's still moving forward. Now, system of care values and principles form the basis of how we think about and serve people who have complex, unmet needs. The ideas that once defined systems of care for children now inspire the development of resources for many people working to cope with a wide variety of disabilities and circumstances, both adults and children.

Why a system of care?

Almost every community includes people who have disabilities. Many of these children and adults, along with their families, friends and other helpers are dissatisfied with aspects of their lives and would like to change them. Sometimes they know exactly how they'd like things to be and can clearly describe the changes they seek. Others need help thinking through and articulating what they'd like to achieve.

There are also people, in almost every community, whose actions have compromised their own safety and sometimes the safety of their families and/or their communities. For them, government can and does dictate what must change about their actions. Even though the idea of systems of care began in the context of children with severe emotional disturbance and their families, these mandated service recipients – children

¹ Stroul, B.A. & Friedman, R.M. (1986). A system of care for children and youth with severe emotional disturbances. (Revised edition). Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

² Knitzer, Jane. (1982). Unclaimed Children. Washington, D.C.: Children's Defense Fund.

and adults – also benefit from the services and supports available because local systems of care exist in many communities.

Family and Person Centered Practice shares many of the roots of system of care philosophy. The values are similar, as are many of the operating assumptions. It's likely that Family and Person Centered Practice evolved because of the national effort to promote, educate people about and evaluate systems of care.³

This 401 volume of *The Supervision Curriculum for Family and Person Centered Practice* focuses on systems of care. The rationale for its inclusion is that supervisors are leaders in their organizations and communities. Their work keeps them in constant touch with what is available to the consumers and families they serve, as well as what is missing. Supervisors also tend to know which programs and services deliver what they promise and which don't.

Supervisors are typically advocates for consumers and families as well as for their staff. Many want to change how the systems utilized by their customers work: what they do, what they produce, what is available, etc.

In Family and Person Centered Practice, a system of care is:

- A range of services and supports that meet the needs of local consumers, children and families
- ...with adequate capacity to address needs without lengthy delays
- ...that reflects local customs, cultures, faiths and traditions
- ...that is effective as evidenced by ongoing evaluation, especially related to consumer satisfaction and the achievement of important outcomes

Services and supports in systems of care can be formal or informal. They are delivered in a variety of ways, in a variety of settings. They are delivered to the people who need them, across multiple age ranges, disabilities and circumstances.

Supervisory input in systems of care is predicated on the fact that effective resources don't simply appear when and where they are needed. Typically, a local system offers what it does because key people advocated for the creation, design and delivery of each element it includes.

Systems of care are important in Family and Person Centered Practice and supervisors, especially as they gain experience and insight as leaders, should expect to participate in how they are designed and implemented. Supervisors will find that their work and the work of the employees they manage is more effective when local people can get what they need where they live and where the people they choose to include in their plans are available.

³ CASSP Technical Assistance Center for Child Health and Mental Health, Georgetown University Child Development Center Policy

Why are Systems of Care Important to Supervisors?

The title above could easily be switched: why are supervisors important to systems of care? Both questions are equally important.

In Family and Person Centered Practice, supervisors are the most significant leaders for line staff. Supervisors teach, motivate and inspire staff to do certain things and to do them in certain ways. These are basic functions of leadership. Without supervisors to set the stage for staff and hold them accountable, Family and Person Centered Practice would not be implemented or would not be implemented with fidelity.

Supervisors share in the responsibility to make sure families and consumers get what they need. That requires them to operate, at least partly, outside of one exclusive system or program.

Many if not most consumers these days need services and supports from multiple service providers. This means that no matter what service supervisors oversee, they must acknowledge that consumers' total results often include and depend on others who are also involved with them. Even if your staff, in other words, do everything right and the consumer achieves the intended results from your staffs' involvement, the consumer or family may still see the plan as a failure because none of the other parts worked. This is an unacceptable result for Family and Person Centered Practice.

Failed plans are often caused by incomplete local systems of care or a poor match between what people need and what is available. Clearly, developing a system of care is a community responsibility that should include lots of stakeholder input and supervisors should participate in both dialogue and design activities to the extent that they are able. If supervisors don't jump in and inform these processes, they will instead have to watch their staff and the consumers they serve, at least in part, fail. For supervisors, this is not theoretical. Their responsibility to their consumers and staff means they have to make it all work better, even when it's across programs or systems.

Supervisors aren't researchers but they are often consumers of research who learn by experience as well, with an emphasis on translating the lessons learned in research to reality. People – families and consumers – need to know what works and what doesn't; what people are most successfully served by which intervention or program and which aren't. Supervisors help staff help service recipients know what to expect from services and how everything works. They help everybody involved understand what they're being promised, what their choices are, what they're likely to get, how they should evaluate what they get and generally, how to navigate the maze the systems present to many consumers.

In a simpler world – not this one – supervisors would be able to read about a service, visit its website and learn all about it. What the service is called would be a tool to better understand exactly what it offers. If, for example, group homes are offered at levels 1, 2 and 3 to differentiate lower, medium and higher levels of treatment,

supervisors, staff and consumers would be able to use those numbers to choose from these three service options. The numbers, used as levels, would reflect only what happens in each program and how intensively each service is being implemented. It's not that simple though and it's not that clear. In a system like this, how much the group homes are paid per day is almost always tied to those three numbers – 1, 2 and 3 – which are supposed to represent truly different levels of care.

Providers want to be funded. It's just plain smart to keep in mind that describing a program as level 3 translates into more money than a level 1 program would receive. People choose the words to describe the services they offer that serve their organization's best interest. The only way to control for this normal marketing is well defined service standards and definitions and the capacity to evaluate and enforce them. This is a capacity many communities just can't afford. That leaves supervisors – and others – responsible for finding out what services produce and how they operate. In this volume of *The Supervision Curriculum for Family and Person Centered Practice*, supervisors will find some basic evaluation strategies to help them make accurate recommendations to staff, consumers and families.

Supervisors also help staff learn how to access services. Supervisors know practical things like who is eligible, who to contact, where to find an open door and how to open a closed one. They have this information because they and their staff need it. It comes from paying attention, relationships with colleagues and experience. It also comes from their understanding of the local system of care.

Components of Systems of Care: What Influences Which Services are Included?

Exactly what comprises, or belongs in, a local system of care would be, ideally, determined one community at a time. It would require service providers to create support options one consumer, or one family, at a time. In this imagined world, everybody would get their own program, designed specifically for each of them. In the real world, system of care thinkers look at the following and other factors to figure out what should or could be in their local systems:

- **Lessons learned from families and consumers**

Sometimes new treatment options are added to systems of care initially for a particular family or consumer. This gives system stakeholders a chance to test something new on a small scale. It allows everybody involved – the consumer or family, service providers, line staff, funders and others – to learn a new way to meet emerging needs. Lessons like these often have an impact on the system of care. The new service may be a good fit for other local service recipients, even though no one suggested it until it was tried for a particular family or consumer. Participants can also finish serving the person for whom the new service was developed and shut it down until a similar situation arises, with lessons intact and ready to be applied again in a new situation. Other times, the new service has been so useful that planners decide to include it in their system in the future. One county developed a one person, intensive residential setting for a particular person's short term use and kept it in place after that individual's discharge so it could be used as short term care for a number of other families and consumers.

- **Population trends and birth rate data**

In one community, due to immigration and a growing young population, planners expanded prenatal care, early childhood services and added options for infant healthcare and early intervention for children with disabilities. Instead of simply responding to what was currently needed, planners anticipated needs that were likely to come up given the facts they had at hand.

- **Prevalency and utilization statistics**

Both how many people face a particular situation and how people respond to it provide useful information for system designers and stakeholders. What works best here is to look at local, state and federal prevalency and utilization trends but be more guided by the local numbers in actual planning. Information about the prevalency of disabling conditions helps planners understand how frequently people face or experience a challenge of some sort in a larger sense. Utilization data helps service providers remain aware that large numbers of people, for whatever reason, participate in service systems. When it comes to specific capacity development, stakeholders are advised to focus on local needs and count requests, referrals or other specific indications of what people seem to want and to

what degree they want it. In one community, looking at the rate at which consumers used Assertive Community Treatment --ACT--⁴ led the county to double capacity and add a second ACT team.

- **Complaints and grievances from consumers and families**

When people feel strongly enough about something to make a complaint or file a grievance, they may have important information for system planners. The only way to really test a service or the process required to access it is to try it. Service providers and system planners don't typically have this experience but consumers and families do. This further underlines the need for consumers and families to participate in planning how to meet community needs. They know things about what it's like inside the system. When parents say that they wait an average of two hours to see a service provider, system planners should hear them – loud and clear – and fix the problem or change what the provider promises to deliver. When consumers report that the services they need are only delivered during their work hours, system planners have another opportunity to make things work better.

- **Service providers' reports about unmet needs**

Service providers, like care coordinators (aka case managers), social workers and others have a great deal of information about what is available in their local system of care, what is missing, what is in short supply and so on. Some case managers, for example, suggest that families and consumers sign up for services they might need before they need them in order to trump a waiting list.

- **Access issues**

A service may be available on paper but not actually available to people who need it. This may be due to restrictive eligibility or admission criteria, waiting lists, lack of transportation and a number of other factors but the result is the same: families' and consumers' needs are not met. If a crisis service is designed to respond to emergencies in less than one hour but takes four or five hours instead, there is no immediate crisis intervention. There is only a service description and possibly the need for resources, funding, better leadership or whatever else the crisis program needs to provide the immediate intervention it promised.

- **Social and environmental factors**

System designers have to pay attention to levels of poverty and unemployment, whether or not families and consumers live in dangerous communities or in substandard housing, whether or not they have access to medical care and many other factors that may influence what service participants need. High unemployment in one area, for example, appeared tied to increased needs for services that addressed domestic violence, child abuse and alcohol problems. In another place, an institution that served children and adults with developmental disabilities was a major employer in a small town. Its closing became an opportunity to implement large scale treatment foster care for the children who had

⁴ www.actassociation.org

lived in the institution and shared caregiving for the adults who were placed there. These options became intelligent alternatives to unemployment for the now laid off people who had worked at the institution. Many of these former employees served consumers they already knew but they now served them in their homes, and for most, the fact that their per diem payments were tax exempt helped them replace lost income. It was a “win-win” solution for everybody involved.

- **Legal issues**

Some systems of care have been the subject of litigation which, when resolved, has specified what should be available in their system of care. These efforts have produced mixed results but most have significantly expanded both service options and capacity. In some systems, these legal efforts have made available services that were completely or almost completely unavailable prior to the initiation of legal action, like Wraparound, Family Group Conferencing, Multisystemic Therapy and other innovative approaches.

- **Funding**

It works best when data drives the development of systems of care and when the design of the system then drives funding. Often, however, it's reversed: the system of care develops because of what is “fundable” rather than what is needed. In some communities, promising newer services can't be funded because the money earmarked for consumer and family use is tied up in more traditional and sometimes, less effective services. In others, decisions to limit funding to a few services have resulted in systems of care that exclusively provide the funded services. In one state, a new social services commissioner was appointed who decided that flexible spending was confusing and instead, funded five services. Within six months, those five services became the only options that remained available in county systems of care throughout the state.

Another major influence on the development of systems of care are the cooperative agreements between federal, state and local governments. They function as grants once did but with added accountability, an emphasis on evaluation, innovative technical assistance, long range planning and more. Of particular note is the work of SAMHSA which focuses directly on systems of care in addition to other areas. Other influential groups make funding available to improve practice in both adult and juvenile or family courts. Others encourage the development of public health resources with judicious financial support for programs that teach toddlers how to care for their teeth, that help seniors remain active or that help people quit smoking.

Efforts to use funding to improve systems of care are both public and private. Some are broad, like the above referenced system of care initiatives while others are very specific: to make job coaches available to people who need them; to fund electronic equipment that makes in-home detention a possibility; to provide education and advocacy for parents of children who have complex, medical needs, who receive special education and/or behavioral healthcare. While these efforts

are diverse, they are unified in their intent and often in their results: to improve what people are offered because, for a variety of reasons, they need help (in the voluntary systems) or intervention (by the mandated systems).

The common thread among these funding options is the ongoing effort to make things work better and to improve the outcomes for people who participate in systems of care.

- **Research and the growing evidence base**

Most system of care thinkers keep a close eye on promising practices as they are implemented in different ways, in different places. Stakeholders want effective services. They are looking for practices that produce measurable results. They want to know if any information is or will be available to help them decide on the services their systems provide. Additionally, planners want to ensure that people are satisfied with what they're getting, a key factor in deciding which services will be offered.

This underlines the need for all services, new and old, to measure what they do in terms of results (i.e., outcomes) and user satisfaction. Rigorous scientific review is always a plus but system designers will need to consider less formally researched but promising new service options that have not been tested thoroughly or scientifically. This will allow consumers and families to select services they've heard about despite the delay between implementation of new, potentially evidence-based practices and formal study, which some estimate is 10-20 years.⁵

⁵ National Alliance for the Mentally Ill: Beginnings. Fall, 2003, Issue 3. Kimberly Hoagwood, Ph.D. "Evidence-based Practices in Child and Adolescent Mental Health: Its Meaning, Application and Limitations."

How have the factors listed affected your local system of care? How could they become influential?

Factors	Current Effects	Possibilities and Strategies
Lessons learned from families and consumers		
Population trends and birth rate data		
Prevalency and utilization statistics		
Complaints and grievances from consumers and families		
Service providers' reports about unmet needs		
Access issues		
Social and environmental factors		
Legal issues		
Funding		
Research and the growing evidence base		

Service Design and Implementation: Differentiating Categorical, Modified and Individualized Services

An old saying tells us that if it walks like a duck and quacks like a duck, it is a duck. In systems of care, it's not that simple. The names or categories of services do not describe the difference between what happens when one provider implements them as opposed to when another provider does so.

The differences between providers can be obvious or subtle. These differences may be present in all the services offered by a provider organization or they may be specific to particular services offered by a single organization.

In keeping with the growing emphasis on Family and Person Centered Practice, many providers have changed how they deliver services to better reflect the values and principles of this practice. Those changes may be little "tweaks"; or larger efforts to improve services and service delivery.

The terms used in this Curriculum to differentiate the service examples that follow are categorical, modified categorical and individualized. Categorical services are provided for a category of people, funded by a category of money. In this usage, categorical also describes traditional service customs which have not been flexible historically. Modified categorical services are the same but service providers have altered or modified traditional service customs to make the service more flexible, more available and more responsive to consumers. Individualized services are delivered with complete flexibility. They differ from child to child, family to family and consumer to consumer.

As readers interested in Family and Person Centered Practice consider how to transform the services they provide or how to select or recommend the best of them to families and consumers, consider the following examples of shifting service design. They are not intended as complete descriptions that accurately reflect each service modality and each local system of care. Add to them and alter them to best represent your experiences with services you have first hand knowledge about.

Options for Crisis Services

Individualized	Modified Categorical	Categorical
All crisis plans are individualized	Crisis plans follow the same format but they are “tweaked” to fit better	Everybody has the same crisis plan
Informal and formal support people are included in crisis plans	Crisis plans include at least one resource that does not rely on law enforcement	The crisis plan is call the police
Service providers go wherever they are needed	Service providers back up phone support with some in-person contact when events warrant it	Service providers are available on the phone
Crisis supports include communication, problem solving, negotiation, behavioral strategies, access to psychiatric/psychological and medical resources and whatever else is needed	Crisis supports include communication, problem solving, negotiation and behavioral strategies	Crisis supports are largely oriented around communication
Anyone can access crisis services: consumers, families, resource (foster) families, group home staff, law enforcement and others	Groups, i.e., classes of people are pre-approved for services; others are accepted when specific approval is granted	Only certain service providers or funders can authorize utilization of crisis assistance
The duration of crisis services varies and is determined by family and consumer needs	Crisis services are available in time ranges; 2-6 weeks, up to 3 months, etc.	Crisis services are approved in small allotments of hours through repeated utilization review
Crisis services carry over for up to six weeks, with six additional weeks available through utilization review if needed	Crisis services resolve immediate problems and have the potential to carry over through the next 24-72 hours	Crisis services are situation specific, i.e., available on a “one shot” basis
The service provider interacts with and assists the identified service recipient and anyone he/she (i.e., the recipient) chooses to include	One person is identified as the service recipient but the service provider can also interact with others involved in the service recipient’s life	Only one person is identified as the service recipient and the service provider interacts with that person only
Crisis service providers are available who speak the languages the people in the community speak and who can acquire additional translation resources as needed	Crisis service provider organizations must have the capacity to speak 3 or more languages across their work force and have access to translation for at least 3 more	Crisis service provider organizations must have the capacity to speak 2 languages across their work force

Crisis service providers' staff include people from diverse backgrounds and who have a variety of experiences, including qualified consumers, family members and people at all degree levels	Crisis service providers' staff include BA level and some MA/MSW level staff who are QMHPs and have at least 2 years relevant experience	Crisis service providers' staff are BA level staff, many of whom are new to the field
Everybody trains everybody else, in a structured training plan that facilitates top down, bottom up and crosstraining	Supervisors train and pair more experienced workers with less experienced workers	Supervisors take the lead in training staff.

Options for Care Coordination (aka Case Management) Services

Individualized	Modified Categorical	Categorical
Open to consumers (identified in columns to the right) and those involved with more than one organization or service. Consumers can also self-refer	Eligibility determined by diagnosis, IQ score, status of protective services or court involvement	Eligibility determined by diagnosis, IQ score or other fixed criteria
Intake involves a brief referral via phone or email followed by a personal interview or home visit, depending on consumers' needs and preferences	Intake includes a personal interview and a chance to ask questions	Intake involves completing forms and submitting documents
Care coordinators are assigned to serve varying numbers of consumers and families and their workloads vary to reflect the specific needs of the people they currently serve	Care coordinators serve families and consumers who have differing levels of need over time so they adjust what they provide accordingly	Care coordinators serve lots of consumers and families and can only offer them limited help
Staff/consumer ratios are revisited every three months and adjusted to account for consumers' current level of need	Staff/consumer ratios are about 15-25 but are adjusted to account for consumers who are in complex situations	Staff/consumer ratios (aka caseload) are normally 15-30 consumers

Care coordinators have typical educational backgrounds (for the field) and are recruited along with consumers, family members, experienced advocates and others who don't have typical credentials	Potential care coordinators are recruited who are college graduates with a variety of academic backgrounds	Care coordinators who are college graduates in social work are recruited and hired
Care coordinators receive basic training which is updated and expanded to reflect the people currently being served in ongoing, individualized professional development plans.	Care coordinators receive the same basic training and some individualized coaching to understand specific people the care coordinator serves	Care coordinators are trained by reading policies and procedures and shadowing other staff
Staff arrange their schedules to accommodate consumers' schedules, report them weekly and update them quickly when they change	Staff work 9-5 three days a week and 11-7 two days a week to accommodate consumers	Staff work 5 days a week during the day
Service duration is based on factors like severity of disability and the potential for consumers to learn how to navigate systems independently	Service duration is standard but exceptions are possible when justified	Services are available for a set period of time
Main function is to help consumers achieve measurable changes that are important to them and their communities	Functions are referral to services and assistance in accessing, getting to, participating in and monitoring services	Main function is to get people referred to services
Care coordinators can help people access both funded services and flexible funds to purchase what they need	Care coordinators can provide access to funded services and also have access to a small amount of flexible funds to purchase supports that are not already funded	Care coordinators qualify people for services and all funding is attached to services
Each consumer has an individualized service or treatment plan that includes defined outcomes, needs statements and strength-based strategies	Some goals repeat in treatment and service plans and others are unique to each consumer	Service and treatment plans are similar across consumers, often containing the same goals

Staff write plans with consumers and others who are involved with them with the consumer determining who participates	Staff include a few standard services on treatment and service plans and meet with consumers to write the rest of each plan	Staff talk to consumers, review assessments, write up service or treatment plans and review them with consumers
Care coordinators are available who speak the languages people in the community speak and who can acquire additional translation resources as needed	Organizations that employ care coordinators must have the capacity to speak 3 or more languages across their work force and have access to translation for at least 3 more	Organizations that employ care coordinators must have the capacity to speak 2 languages across their work force
Care coordinators recommend only services that measure their results and make them known to consumers and stakeholders	Care coordinators have at least some outcome and consumer satisfaction data about service providers they can share with families and consumers	Care coordinators make informed guesses when they recommend service providers to consumers and families
Services are delivered in community settings with individualized supports whenever possible	Services are delivered in both specialized locations and community settings	Services tend to occur in specialized locations like sheltered employment settings, club house type programs, etc.
Due to flexible (based on consumer/family needs) staff/consumer ratios, care coordinators are able to use their phone and in-person time prescriptively (again, based on consumer/family needs)	Due to adjustable staff/consumer ratios, personal contact occurs around twice a month, phone contact more frequently	Due to higher staff/consumer ratios, much time is spent on the phone, much less in-person
Staff can provide direct assistance to consumers and families as well as find resource people who will assist them	Staff find resource people to provide direct assistance to consumers and families and occasionally "fill in" when they are needed	Staff do not provide direct assistance and instead, help people find others to assist them
Care coordinators design reactive and proactive crisis plans with consumers and assist as needed with an eye to replacing themselves as crisis resource people with friends, family members, etc.	Care coordinators work in teams and split after hours/crisis call, each covering a week at a time	There are no after hours services beyond law enforcement, hospitals and community providers

Staff and consumers and families have personal, positive, supportive relationships	Staff and consumers and families have positive, supportive relationships	Staff and consumers and families have positive relationships
Staff interact with consumers and families and others whom they decide to include	Staff interact mainly with identified consumers and occasionally with people close to them	Staff interact with identified consumers only

Options for Mental Health Services

Individualized	Modified Categorical	Categorical
Time spent with each consumer/family is determined prescriptively based on consumer needs	Mental health professionals have the flexibility to serve several consumers/families intensively for periods of time	Mental health professionals provide talk therapy in the traditional 50 minute hour
Mental health professionals can shift services in and out of settings based on consumer needs: homes, workplaces, schools, etc.	Some mental health professionals do neighborhood outreach work in community settings	Therapeutic services occur at a program site
Each consumer/family has an individualized service or treatment plan with defined outcomes, needs statements and strength-based strategies	Some goals repeat in treatment and service plans and others are unique to each consumer/family	Service and treatment plans for consumers/families are similar, often containing many of the same goals
24/7 crisis services are available from consumer's regular mental health professional/s who get back-up and breaks from supervisors and managers	One member of each team of mental health professionals is on call for crises, rotating on a schedule and keeping each other up-to-date on consumer needs	There are no after hours, crisis mental health services or they are provided by unfamiliar workers
Staff/consumer ratio (a.k.a. caseload size) are not preset	Average Staff/consumer ratio (a.k.a. caseload size) is predetermined, exceptions made as needed	Staff/consumer ratio (a.k.a. caseload size) is predetermined
Services include anyone the consumer wants to include	Some consumers' and families' relatives, spouses, friends, etc. are involved when that meets consumer needs	Consumer/family centered therapy

Staff routinely co-train each other across specialties and become generalists	Ongoing education is available to produce cross-trained staff over a 1-2 year period	Each mental health professional practices the therapeutic interventions in which s/he was trained
Cross system collaboration is expected and supported	Collaboration is supported for consumers who have the most complex, unmet needs	Mental health professionals have little or no time for cross system participation
The mental health professional/s help/s the consumer achieve outcomes that the consumer selects and values	Therapeutic goals are negotiated by the consumer and the mental health professional/s	Mental health professionals assess consumers' needs and propose appropriate therapeutic goals
One or more mental health professionals are available for emergency assessments	Several slots per week held for emergency assessments	Waiting list is the norm for assessments
Flexible dollars are available for mental health professionals to fund (in the short term) practical strategies that help consumers achieve outcomes that are important to them and their communities and meet their high priority needs	A small flex fund can be accessed by mental health professionals for consumer emergencies	Mental health professionals do not control any funding to help consumers meet basic needs when they are unmet
Participants and providers in local systems of care decide service priorities together, in collaborative, community structures, including who qualifies, when, for admission, services or assessments	There are identified blocks of time for other system admissions, services and/or assessment priorities (emergencies in residential treatment centers, group homes, jails and community settings)	Who qualifies for admission, services and/or assessments, when, is solely a MH center decision

Options for Residential Treatment Centers and Group Homes

Individualized	Modified Categorical	Categorical
No defined admission criteria	Admission for some consumers delayed pending safety plan	Defined admission criteria
Flexible staffing patterns	Defined hours; flexibility through overtime or comp time	Staff work defined shifts

Brief length of stay; post-discharge planning for each consumer begins at admission	Medium length of stay; discharge criteria and timelines set for each consumer at admission	Longer length of stay; sometimes duration predetermined; standard discharge criteria
Consumers, families and others involved with them create service and treatment plans with full consumer or family input	Staff drafts plan and presents it to consumers and families for their input	Staff writes plan and presents it to consumers
Each resident has an individualized treatment or service plan with defined outcomes, needs statements and strength-based strategies	Residents work on group goals and each also works on several individual goals	Residents work on goals that mainly reflect needs that derive from living in a group
Each resident's plan is unique	Defined service plus modifications for certain residents who need them	Defined service delivered to all residents
Most residents in community settings for work or learning with program support	Some residents in community settings for work or learning at least part time	On grounds educational or work opportunities
Most residents involved in community activities as individuals	Group activities plus at least a few residents in community activities as individuals	Program activities occur mostly in groups, on site
Clinical services shift depending on current resident needs; occur on-site and in community	Basic clinical menu delivered prescriptively, occurs on-site and in community	Defined clinical services delivered to all residents; occurs on site
Some residents have jobs in the community	Some residents have jobs at the program	Only pre-vocational and employment readiness services
Visits may commence immediately if that best meets a resident's needs	Beginning of visits determined from a menu of options as per each resident's needs	Pre-set period in program before visiting can begin
Visitors in and out of program site as per preference of each resident, changing as influenced by changing preferences and needs	Visiting schedule individualized in service plan	Set visiting hours
Consumers and family members on Board; Consumers and family members in advisory role to program administration	Consumers and family members represented on Board	Board composed of community leaders

Flex dollars are part of basic rate	Basic rate plus flex dollars for residents identified as needing extra services or supports	Basic rate
All residents discharged with individualized follow through plan	Some consumers receive follow-up support	No or occasional post discharge contact
Consumers in crisis invited to contact RTC/GH for help if they wish	Consumers most at risk have support people at RTC/GH identified and permission to contact them	Consumers use community services if crises occur

Options for Programs for Women, Infants and Children

Individualized	Modified Categorical	Categorical Services
Maternal and infant health services are available prescriptively and are not terminated until outcomes are achieved	Exceptions to the six week post delivery service norm are considered when the need is established	Maternal and infant health services are available through pregnancy and for six weeks post delivery
Neighborhood people and groups are invited to identify pregnant women in need of prenatal care, new mothers and mothers of young children	Providers work through neighborhood groups to identify pregnant women, new mothers and mothers of young children who may need services	Pregnant women, new mothers and mothers of young children come to places where services are available, after learning about them through word of mouth, referral or advertising
Non-medical maternal support is available for whatever number of visits allow the planned outcomes to be achieved	There is a procedure in place to request an exception in the standard maximum for women most in need of maternal (non-medical) support	There is a maximum of X maternal (non-medical) support visits
The maternal support team has access to a collaborative list of people in different disciplines who respond to requests from the main team for additional expertise	The typical maternal support team (on the right) is able to access additional help and arrange at least some consultation time from other professionals for their use	A nurse, a social worker and a nutritionist are the members of the team that provides maternal support

Pregnant women and mothers are offered a comprehensive list of people from different disciplines who can respond to their individual needs and become part of their teams	Pregnant women and mothers are asked what they most need in terms of help to deliver, nourish and raise their children and who they think can or may help them do it so that a team can be convened	Each woman receives services from the same team of professional service providers
Infant mental health and child development support services available to all mothers and children	Infant mental health and child development support people are in place to train mothers to recognize potential mental health issues	The team (above) is available for infant support, augmented by infant mental health support
Support teams have the flexibility to augment visit schedules prescriptively, regardless of the etiology of the concerns	After the standard number of support visits, X more may be requested	Up to X support visits can be scheduled for support of drug exposed infants
Well child clinics are staffed similarly across all communities	Well child clinics are located in underserved neighborhoods	Well child clinics are staffed effectively in some communities but not in others, causing service norms to vary
Family planning provided as a basic health service for those unable to pay	A small fund is available to pay for family planning for those who can't pay the sliding fee but do not qualify for government funded services	Family planning is available on a sliding fee basis for women who have Medicaid, public assistance or WIC
Staff assist consumers and families in finding and funding transportation	Transportation vouchers are available for consumers who need them	Consumers and families are expected to get to clinics and other settings on their own
All service providers who work with families are educated about the dangers of lead poisoning and that lead poisoning can cause behavior problems later on in a child's development	Physicians, nurse practitioners and social workers give mothers the brochures on lead poisoning and spend a moment discussing them	Information about lead poisoning prevention, treatment and abatement services is available in brochures
Families choose and develop their own service plans that focus on defining important outcomes, unmet needs and strength-based strategies to meet the needs	Families are offered an array of potential services from a menu plus there is some flexibility to meet needs that don't match the menu	Families are offered an array of potential services from a menu

Options for Treatment Foster Care

Individualized	Modified Categorical	Categorical Services
Treatment parents (TPs) recruited for each child as needed; a pool of different types of often requested TPs also available (Bilingual people who have no small children, etc.)	Pool of TPs recruited with occasional child-specific efforts	Standard recruitment campaign approach
Recruitment messages change for each child, approach changes to target each new audience needed	Message features family advocacy, need for lots of different people	"Fix the child" or "Save the child" message
Longer pre-service training, emphasis on advanced behavior intervention, assessment, mental illness and used as final screening tool	Longer pre-service training, more skill oriented and further used as final screening tool	Pre-service training on basics of foster care and policy
TP training is plan specific and reflective of the needs of the children and families they serve	TPs get some general training, some plan specific training and some input into what they get in ongoing inservice training	Standardized TP Pre-service training and inservices planned by agency staff and dictated by regulation and custom
TPs' performance is evaluated at 6 months, 12 months and annually thereafter and tied to merit raises	TPs are recertified for regular foster care with additional review of how they performed overall	TPs are recertified annually to assess compliance with relevant regulations: smoke alarm, TB tests, etc.
Individualized TP support, supervision and Professional Development Plans in place for each TP.	Some TP supports are standard, the TFC Program can individualize supports and technical assistance as needed	All TPs get basically the same support/monitoring
TP role and expectations are determined as children's plans are written or revised by their treatment teams	TP role is defined by agency, with occasional exceptions when specific expectations are agreed upon or negotiated	TP role is defined by agency for all placements
TPs interact with parents as indicated by treatment or service plan, in keeping with TFC values for compassion, respect and impeccable manners	Some TPs work with parents but are not typically required to do so	TPs can opt to have no contact with parents

Staff are recruited who have diverse backgrounds, experiences and skills, partnered with others and cross-trained	Staff are recruited who represent several types of backgrounds and experiences with a deliberate plan to “cross fertilize”	Staff are recruited with a defined set of education, skills and experiences and taught the basics of foster care
Staff have no pre-set time schedules, supervisors help each to manage her/his schedule	Flexible scheduling is supported, accommodations are made for staff to take time off	Staff work on a fixed schedule and earn compensatory time they can't actually take
There are no pre-set staff/children served ratios; they are established after review of the time likely involved and averaged over groups of staff	Average ratio for staff/children served; exceptions made as needed.	Staff/child ratio is predetermined
Staff are as accountable to parents as they are to TPs and remain in close contact, make home visits and assist personally	Staff keep parents informed, make sure they have access to needed supports and services and sometimes help out personally	Foster care staff keep parents informed while they or other staff monitor their needs and progress
A treatment team is convened around each child placed and that team makes therapeutic decisions and develops plans	Staff and supervisors make therapeutic decisions with families and with input from other service providers who are involved with the child; parents' and TPs' input is as important as input of participating professionals	Key staff, with supervisory assistance and input from the child's parents and TPs, make treatment decisions
The treatment team includes the parent/family and the TP and at least one of their informal resource people or is actively working toward that goal while respecting family choices	TPs team with professionals across disciplines in multi-disciplinary teams, meetings are scheduled with an eye to parent, family and TP availability	TPs team with social workers and other professionals as required, parents are invited, often by formulaic methods that don't allow them to influence the time and date of meetings
Each treatment plan is unique to each child, each family and each TP	Treatment plans are the result of tailoring services from a defined menu of options with some capacity for more individualized responses as needed	Service plans, while described as individualized, are pretty similar to each other

Treatment plans are individualized, cover 4 or more life domain areas and focus on activity related to defined outcomes for a portion of each day as planned by treatment team members, with ongoing adjustment as indicated	Treatment plans focus on several life domain areas and tie daily activity to outcomes at least once per day	Service plans focus largely on parent training for the family, therapy for the family and the child, homemaker and related supports, education and medical help
Interventions designed to manage/change child behavior are based on each child's strengths, culture, values, etc, completely individualized, outcome driven, behaviorally specific and based on professional, family and TP expertise and knowledge of the child in question	In addition to the resources provided to manage and change children's behavior, TPs and family members get specific help from each other, professionals and specialists on some child issues	TPs are trained in groups, at pre-service and inservice sessions, theory and some practice as relates to child behavior, they call staff with questions if they have any
Children spend lots of time (defined by the TFC Program) in activities determined to be therapeutic by their treatment teams, including nontraditional supports, resources, lessons, teams, etc.	Children are involved in therapy and other frequently selected services plus community activities that reflect their strengths, resources and family/personal preferences	Children attend counseling, therapy or other traditional supports up to 3 hours a week
There is a specific, written plan designed and implemented by a treatment team, to link children with community activities, mentors and friends who know their languages, faiths and cultures	Children are involved in activities through school and the TP's family and religion (rather than their family of origin's religion) and some community activities, TPs sometimes get help to access activities related to the child's and their family of origin's faith and culture	In-program service-related activities are common (like recreation groups for placed children), children have little access to diverse community activities, TPs are largely responsible for accessing them
Safety and crisis plans designed by treatment teams in place for each child for each element of the plan indicated	Some flexibility in crisis help for crises and unsafe or potentially unsafe situations, time-bound, specific safety/crisis plans or other special arrangements	Standard crisis response typically by community resources (police, hospitals, etc.)

Children visit with family as decided by the treatment team, in compliance with court, custody orders & other mandates, usually in community or home settings that reflect their preferences	Children visit with family where, how and as determined by a multi-disciplinary team with TP and parent input	Children visit with family where, how and as determined by the placing authority
Child is often the only foster child in the home (exceptions are made for a child's siblings if they are also served in TFC). Other potential exceptions are reviewed by treatment team members and policy level staff	Limit of 2 children, if 1 is doing well and nearing graduation	2 or more children in the home if referrals indicate and beds are available
No intake policy, referrers send children in greatest need and the TFC program finds the needed resources	Some children are seen as exceeding TFC program capacity with a plan in place to increase capacity over time	Written intake policy specifies who is eligible for admission and who is ineligible
No punitive discharge, TFC program serves children who have complex needs and tries to secure the resources they need to succeed in TFC	A few children are discharged punitively because their needs are beyond program capacity, with plan in place to increase capacity	"Emergency discharge" by policy or pre-set conditions if children or families step over an identified line

How to Modify Services: An Exercise

Pick the service you would like to analyze for purposes of this exercise: crisis services, job programs, day treatment, etc. Complete the following chart, keeping in mind that there aren't three degrees of everything, even though there are three columns in the chart. Enter N/A when there are only two degrees in whatever block of the chart seems to fit best.

Similarly, not all the prompts in the left hand column will be relevant or as relevant for each type of service. For example, consider the following factors (an incomplete list):

- Not every service has clinical elements
- Family involvement is a very different issue in services for adults than it is in children's services
- Visiting is only relevant when people are away from their usual locations
- Some services will and should continue longer than others, based on the complexity and duration of the consumers' unmet needs.

With all that in mind, the format follows.

Service:

	Individualized	Modified Categorical	Categorical
Admission criteria/ eligibility			
Intake procedures and requirements			
Duration of service eligibility/length of stay			
Staffing			
Access to family or friends			
Access to community			

Treatment/Service Plans			
Clinical approach/es			
Funding			
Management and leadership			
Crisis/after hours support			
Discharge/transition planning/post discharge support			

How to Modify a Service You Provide: An Exercise

Keeping in mind the instructions you read in the last exercise, analyze a service you are part of providing. Consider, for each relevant element identified in the left hand column, where it currently is (Categorical, Modified Categorical or Individualized) and what it would take to move it from Categorical to Modified or from Modified to Individualized. If your service is already completely individualized, please skip this exercise.

Service:

	Individualized	Modified Categorical	Categorical
Admission criteria/eligibility			
Intake procedures and requirements			
Duration of service eligibility/length of stay			
Staffing			

Access to family or friends			
Access to community			
Treatment/service plans			
Clinical approach/es			
Funding			

Management and leadership			
Crisis/after hours support			
Discharge/transition planning/post discharge support			

Components of Systems of Care: Brief Descriptions

Systems of care include different services and supports in different areas. Some of the forces that influence what is available were discussed previously in this document. There is also variety in how services are designed, implemented, accessed, etc. Despite all of these differences, the following brief descriptions of common elements in systems of care are presented for interested supervisors.

Instructions:

As you think about your local system of care and complete the information at the end of each service description that follows, try to pull out the following information or note it on the System of Care Worksheet for Supervisors on pages 85 and 86.

- What are the strengths of your local system of care?
- What are the gaps in your local system of care, including gaps caused by insufficient capacity or degree of competence in service delivery?
- Who are your most competent providers and what about them inspires your confidence?
- How could people in your community fix or improve your local system of care?

When supervisors flex their intellectual muscles in this type of analysis, they are able to process all the information they receive from multiple sources and personal experience. Supervisors have an important responsibility to participate in developing local systems because of the information they can contribute. The continued development of a system of care improves life for consumers and families. It also improves the “work lives” of staff whose jobs are often difficult even when the right resources are available. Being part of the solution is an incredible morale builder for everyone involved.

Assessment*

** Strengths and needs assessment, an important tool in systems of care, is not included here because it is not usually a “free standing” assessment but is rather part of the delivery of Wraparound and similar service models.*

Every system of care needs resource people who can help families and consumers identify challenges, disabilities and issues that compromise their opportunities for success and well being. Assessment often gives consumers and the people around them insight into what their difficulties are and influences how they decide to approach them.

The following types of assessment are among those most frequently requested in local systems of care:

- Medical of all types, from general well being to specialized
- Mental and behavioral health status
- Educational including both general achievement and diagnostic measures
- Occupational
- Vocational
- Risks and protective factors
- Drug and alcohol use, abuse and addiction
- Parenting
- Safety
- Developmental

Not only should multiple types of assessment be available, they must be available in the languages people in the community speak. They must be culturally competent and delivered respectfully regardless of the situation that triggers the assessment process.

Assessment has a number of purposes:

- It is typically required to qualify for services and the funding that supports them
- It helps people find out about potentially useful remedies and interventions that are suggested by assessment results
- It helps people, related to the remedies above, track the progress achieved by the consumer or family and evaluate the efficacy of each intervention
- It increases everybody's insight into the barriers people face and how to minimize their impact
- It allows people to learn about triggers and stressors that affect people in negative ways and how to avoid them

Assessment Myths

- One or more diagnoses will clearly be indicated as the result of an assessment.
- The result will be accurate and other assessors will agree with the result and confirm it
- The answers and diagnoses resulting from assessment will provide a clear and obvious path to intervention planning
- The diagnosis will not change over a person's life
- All assessors perform equally
- There are no "diagnoses du jour" that result in over diagnosis of one or more particular diagnoses for certain groups of children and adults

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Care Coordination (a.k.a. Case Management)

Care coordination is one of the most popular services provided in local systems of care, especially when it is designed to help consumers meet their needs, whatever they are. It's also available, although less well received, as a service designed to assist in a limited or specific way.

People who use systems of care, voluntarily or because they are legally compelled to do so, enter a complicated path. First, they must establish that they are eligible for assistance or that the assistance they're pursuing meets the requirements of the courts. This involves assessments, sometimes multiple studies of multiple aspects of the person's situation. Lest that sound simple, the consumer has to schedule required appointments, often with long waits, then needs to find transportation, get time off from work and possibly find care for a child or another family member.

Funding of some sort will have to be available to access these assessments which means wading through insurance or government procedures. Sometimes, consumers and families find themselves giving the same information over and over again. Other times, assessors, service providers and public sector staff have to be asked to exchange the information they have about a consumer, which generally requires both phone calls and signed documents. All of this, remember, is the prequel to qualifying for the assessment to qualify for assistance.

Along the way, there will be waiting lists and service providers who don't fit well with consumers or possibly don't speak their language. Appointments will be cancelled (on both sides) and people will have to figure out how to get themselves where they need to go.

All of this requires time, lots of it. There is broad agreement across recipients and service providers and from system to system that the process is complex. Accessing it can feel like a full time job. People have lost jobs trying to get all of this done. Most people work or attend school during the day but that's also when the assessors, screeners and qualifiers work. For many, this creates a conflict between getting what they need or doing what they must do and remaining employed or in school.

In most systems of care, care coordination is the remedy for this confusion. Care coordinators help consumers navigate the maze and get what they need. They are good listeners and frequently, effective advocates for the consumers they serve. The good ones are tenacious people who have excellent communication skills and impeccable manners. The good ones always do what they say they will do and so become a predictable, positive part of a consumer's life.

The following draft job description for Care Coordination is provided as a starting point.

Draft Job Description⁶: Care Coordinators

Core Responsibilities and Activities

- Consumer and family identification and outreach – trying to enroll consumers who are not using services
- Inventory – determining a consumer's strengths, weaknesses and needs
- Planning and coordination – developing a comprehensive Life Plan for consumers through Permanency Planning, Wraparound, Family Group Conferencing, etc., and facilitating the coordination of categorical planning requirements like Individualized Education Plans, Individualized Service Plans, etc.
- Linking – referring consumers to services, treatment and supports
- Quality Assurance – helping consumers evaluate how well or poorly service providers are helping them meet their needs and make progress
- Information – providing and/or helping consumers access up-to-date, accurate information about diagnosis, treatment options, resources, etc.
- Family and consumer advocacy – intervening at the request of consumers to assure appropriate services
- Direct service – providing direct services to consumers
- Funding – assisting consumers to access whatever funding is available and utilize it to meet specific needs
- Crisis intervention – assisting consumers through direct intervention, stabilizing them and marshalling necessary supports and services
- System advocacy – intervening with systems of care to ensure consumers' access to services (mediation and negotiation)

⁶ Dr. Ken Klein, Pathways Home: Diversion, Strategies for Children with Complex Medical Needs, Family/Consumer Experiences and Care Management. Susan Davis, M.Ed. and John Pierce, JD, Ph.D., The Diversion Grant: A Compilation of Research, Best Practices and Points of View, February 28, 2007.

- Reporting – documenting and reporting critical incidents to those entitled to be informed in keeping with HIPPA standards
- Resource development – creating new services to meet consumers’ needs
- Transition planning – facilitating consumers’ transition from one setting or service to another

Care Coordinator assistance is delivered

- In holistic and collaborative ways
- In the context of positive and personal relationships and in partnership with consumers and families
- In an emotionally supportive way
- In whatever setting the consumer selects, including the family’s home and other preferred community settings
- Without redundancies
- On an ongoing basis

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Therapy

Therapy helps people meet a wide variety of needs and achieve a wide variety of goals. These include the following:

- To improve relationships: spouses, partners, parents, family members, friends and others
- To better understand the past, respond to the present and to better prepare for the future
- To understand why we react to things in ways that don’t serve our best interests
- To stop making the same mistakes over and over again

- To process experiences and feelings that are difficult to understand without help from someone outside the situations that trigger the feelings
- To find, learn and practice new skills
- To heal from trauma
- To build functional, positive reactions to historically problematic stimuli
- To learn how to make and act on good decisions
- To sort through and determine life priorities
- To face the truth about unsafe, unhealthy and nonproductive personal behavior and to acquire the tools to change it

Many people have met needs and achieved results like these in the context of relationships developed in therapy.

A lot of people have a specific mental picture of what constitutes therapy; what it looks like. Therapy takes many different forms and system designers and stakeholders have to make sure that lots of options are available.

The traditional therapist/client relationship is a place to start in any consideration of what should be available in a local system of care, but group therapy may be a better fit for some consumers. People also benefit from family and couple's therapy and sometimes, peer to peer therapeutic contacts as well.

Therapists specialize in specific types of therapy: play, recreational, occupational and more. They practice specific therapeutic models (or combine them) like narrative or solution focused approaches. Therapists focus on people who confront a variety of challenges: abuse, victimization, disability, grief, illness, addiction and so on. Therapy occurs in offices and clinics but it also happens in homes and work places; at scout meetings and worship services. Supervisors are advised to monitor what types of therapy their staff provide if that is the purpose of their organization. Other supervisors will monitor what types of therapy their staff refer consumers to so they can ensure that it reflects the true breadth of the consumers' needs.

Supervisors have to make sure, if they supervise therapists, that their staff are competent, responsive and flexible. When they supervise staff who have other roles in the system of care, like Care Coordinators, supervisors should ensure that staff know exactly what each consumer wants to get out of therapy and what it is supposed to accomplish. They should monitor how well or poorly those results are achieved without compromising the confidential nature of the relationship between therapists and the consumers they serve. Supervisors should also remind staff to ask consumers if they are pleased with their therapy services.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Mentoring and Coaching

Mentors used to be people who coached other people on how to succeed at work, especially and in life, occasionally. More recently, mentors serve on a much larger stage. They provide inspiration and practical guidance to both children and adults. Their service has expanded broadly, outside the workplace, to include parenting, recovery, behavior change, academic success, safety and many other areas of personal growth.

Mentorship is a positive, personal relationship in which the mentor provides practical guidance, instruction and good advice to the person being mentored. Mentors often teach by example, as good models of lots of positive behaviors. Theirs is a unique contribution of inspiration, hope for the future and motivation to achieve personal goals.

Much mentoring occurs informally, with extended family members, friends and neighbors stepping in to help a vulnerable child or a fragile adult. Some is informal but organized by the faith community, cultural groups, professional groups, sororities and fraternities and others. Some informal mentoring programs are intended to focus on certain aspects of helping mentees develop. Others focus, one child or adult at a time, on whatever that person wants to learn, process or achieve. Although there are many programs that work like this, Big Brothers Big Sisters, founded in 1904, is likely the most well-known volunteer mentoring program, because of the contributions they have made in the communities they serve.

Formal, meaning funded in at least some if not all aspects of service delivery, mentoring programs are part of many systems of care. These programs provide leadership by helping mentees lead productive lives and stay out of trouble. Others provide parent coaches who teach and model safe, effective ways to care for children. Youth mentors,

also part of many systems of care, provide everything from a sympathetic sounding board to social skills coaching.

Both formal and informal mentoring programs are key parts of systems of care. In one local system, a private agency’s recruitment of volunteers has ensured that each child in their program has a mentor.⁷ Another agency recruits mentors who join the younger children they serve for lunch, a good talk and maybe a ride on the swings.⁸ Other groups focus on children and young adults who are at risk of failure in schools and getting in trouble in their neighborhoods and communities.⁹

Mentors and coaches are not therapists but they can be very therapeutic. When available in local systems of care, they are often popular to the point that more are needed, sometimes urgently. The most likely solutions to this shortage are partnerships between formal and informal mentorship organizations, at least some funding for recruitment, background checks and training of mentors and sometimes, community investment in making sure those funds are available.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Respite

Respite, a service that gives family members a chance to take a break from each other, is (ironically) a service that keeps families together.

Historically, extended family members helped parents care for children. Children were part of and were absorbed by their kinship networks. Most people didn’t move far away from their families and everybody pitched in, particularly when children – and some adult family members – needed extra help.

⁷ Eastfield Ming Quong, Campbell, Los Gatos, San Jose and elsewhere in California

⁸ Alexander Youth Network, Charlotte, Lenoir and elsewhere in North Carolina

⁹ Department of Social Services, Orange County, New York

These family structures and kinship networks are no longer the norm for most people. Families are stretched by multiple, often competing responsibilities and family members are scattered all over the world. This has increased the pressure on consumers and parents, especially when they and their children have disabilities or special needs.

For these reasons, respite has become an important service offered by local systems of care. It is available in different forms in different communities. The definition of respite is the same across the various ways it is implemented: it's a break for parents and caregivers that is intended to leave them refreshed and in better shape to care for the loved ones who depend on them. Sometimes it's also a break for the person, generally but not always a child, who receives respite care.

For systems of care planners, the main lesson to be learned about respite is that a variety of types of it are needed by people who participate in services:

- Families want respite providers to come into their homes (once they are screened, selected and trained) to care for their vulnerable family members at home so they can go out and do errands, spend time with other family members, etc.
- Families want respite providers to care for vulnerable family members outside of their homes so that they can capture a few pressure-free moments in their own homes to get things organized, relax or whatever.
- Families and caregivers sometimes need breaks of several days duration to recover from an illness or accident, to bury a loved one or even to take a vacation.
- Families also need respite as a form of back up when they and their loved ones are in crisis. This form of respite, implemented well, often prevents out-of-home placement which is more likely to be needed when no crisis respite response (or assistance) is available.

When a complete array of respite services is offered by local systems of care, unnecessary placements are often avoided and families, consumers and caregivers report greater satisfaction with what they receive from the system. Respite is an important resource that delivers benefits well beyond its cost. It's an important tool in keeping families together and functioning at their best, despite the presence of disability, illness or other intervening factors.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

In-Home Services

In-home services first became available several decades ago.¹⁰ The idea of serving people in therapeutic ways outside of traditional facility-based structures was both an enormous philosophical change and ironically, one of the most logical movements in human service history. People who served adults and children in out-of-home care had long reported their frustration with how poorly the results they helped people achieve transferred successfully to their home and community environments. Consumers and families reported equal degrees of frustration. Many times consumers received support, as did their families and the people who helped them, only when the consumers were not in their homes. Eventually, everybody involved decided that better results would likely be achieved if consumers could learn and practice new skills in the environments in which they lived, learned, etc.

There are several important things for supervisors to understand about in-home services.

- A major feature of in-home models, as stated above, is that they address the fact that new skills and insights don't automatically transfer from one environment to another. Because a person can do a thing in one environment doesn't mean that the person will be able to do the same thing in a completely different environment. (In this instance, the term "environment" is used as broadly as possible and includes who is present, what is required of the person, etc.).
- Assessment is improved when assessors are able to observe a person in his/her environment, interacting with those with whom the person typically interacts. Simply put, much more information is available when assessments are conducted in the consumer's environment. The assessor adds

¹⁰ Home Builders, David Haapala and Jill Kinney, 1991

observation to the tools used in the assessment and is not limited strictly to the consumer's verbal self report and office-based observation. Even the most basic element of in-home services – the home visit – is powerfully informative.

- The term “in-home” has grown to encompass a wide variety of environments including schools, workplaces and community settings. This has allowed service providers to better understand what service recipients need in a practical, day-to-day context.
- The relationships between service providers and recipients are more likely to develop in positive ways in home and community environments, especially when the service provider is seen as a much needed resource person which is frequently how in-home providers are perceived.
- Supervisors can get lots of information that is useful in building local systems of care from in-home service providers and recipients because their experiences expose them to direct information about what resources are needed and at what level of capacity. They know all about waiting lists and needs that can't be met.
- Similarly, service recipients and providers can educate supervisors about access issues, including funding and restrictive intake policies, from a completely different point of view and one that is central to how service systems are designed.

Diverse groups of people have used in-home services to meet a variety of needs:

- Home and community care workers who assist people with disabilities and complex health care needs
- Expert, specialized in-home caregivers who help families raise children who are medically fragile at home
- In-home parent coaches who work directly with parents who are under the supervision of protective services or courts
- Probation officers who monitor and counsel youth who have engaged in illegal behavior
- Job coaches who help people learn what they need to know in order to earn a living and be more independent
- Service providers who help students succeed in whatever learning environment suits them best
- Therapists who work clinically with people to help them resolve personal and family relationships, find new ways to communicate with each other or solve problems without hostility
- Crisis responders who intervene in possibly explosive circumstances, help people stay out of trouble and remain in their homes
- Nurses who address public health needs with consumers and assist people who need medical care
- Community workers who teach and assist people in daily life activities

Challenges for In-Home Service Providers

- Relationships can get complicated so staff may need guidance on boundaries
- Some staff may be reluctant to work in certain communities and may benefit from safety training and planning
- There is a greater burden on supervisors who work for in-home programs because they rarely see staff interact with consumers. Supervisors need to make sure that specific, effective, accountability procedures are in place (see Supervision 101, Remote Supervision)
- Staff may become out of touch with the main things they are supposed to help consumers achieve as they respond to consumers' immediate, emerging concerns. Supervision, augmented with well documented treatment and service plans, is the best vehicle to help staff stay connected to the purposes of their activity as well as respond to crises
- Staff may have difficulty maintaining safe, usable transportation which is essential to in-home service providers in most areas, except for a few large cities that have adequate public transportation. This is typically resolved by adding this requirement to in-home workers' job descriptions, checking potential employees' driving records, requiring employees to provide up-to-date evidence that they are both licensed and adequately insured and that their vehicles pass the appropriate inspections and more.
- While in-home services seem like a logical service delivery model, it is a difficult one to implement because it's "live," very human and often unpredictable. Staff training that includes shadowing experienced practitioners can ameliorate this difficulty and provide effective ways to help staff develop good judgment.
- It's not easy to select the right people to staff in-home provider organizations. Interview and selection processes that allow potential employees to be observed interacting with consumers in community settings are often helpful tools for supervisors who are involved in employee selection processes.

In-home services, from a variety of perspectives and in a number of defined models, are often very well received by a lot of very different people. This is particularly true when the above issues and others are investigated, discussed and resolved. This is a particular concern for supervisors who play, arguably, the most influential role in making in-home services effective, ethically delivered and cost efficient.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Wraparound

The main feature of Wraparound is the development of individualized plans that reflect an important fact: one size really doesn't fit all. It never has and never will.

Wraparound started out primarily as an intervention designed to benefit children and families served by mental health agencies and providers. As such, it was initially a voluntary program. Probably the earliest example of Wraparound, however, that had more flexible intake policies and worked with young people who were involved with court and protective services was Kaleidoscope, in Chicago, directed by Karl Dennis.

The utilization of Wraparound has expanded a great deal over the last decade. Although it remains a voluntary process in many communities, it is now also used in coercive situations to build consent and cooperation even when participation is mandated.¹¹ The process has been used successfully with a wide variety of at risk children and adults. It has also been successfully implemented in support of families that have adopted children who have complex needs, typically as a post adoption support strategy. Wraparound has not yet been broadly implemented for people who have developmental or medical disabilities. There is, however, no reason to exclude these children and their families or adult consumers from such a potentially helpful intervention.

Wraparound works best when:

- The intended outcomes for each service and support are spelled out, in detail and in measurable terms.

¹¹ Andrew Turnell and Steve Edwards, *Signs of Safety: A Solution and Safety Oriented Approach to Child Protection Casework*, 1999.

- Needs are defined as needs rather than as service statements, i.e. she needs friends rather than she needs therapy and peer group interaction classes.
- The needs people have, are clearly tied to the outcomes, i.e. the results they wish or are required to achieve.
- The outcomes and needs that are important to consumers, families and communities are the guiding principles for everything that follows: what is funded, how treatment plans are designed, how interventions are delivered, how they are evaluated and how service and support priorities are determined.
- Strength assessment reveals useful information that is both significant and specific enough to inform interventions and strategies to meet consumer and family needs.

Wraparound is a team based service and this is one of its most helpful and most difficult elements to implement. Teams in Wraparound are composed of both formal service providers and informal helpers like relatives and friends. The teams design and implement Wraparound plans with the families or consumers.

Some providers have decided that whether or not a family or consumer is willing to work with a team is one of the things that determine whether or not they are eligible for Wraparound. This is difficult for families that are burned out or worried that their loved one's issues will lead to rejection by relatives, neighbors and friends. It may also seem invasive to people who value privacy or prefer to keep a low profile. This can be addressed by including in Wraparound the families and consumers who are working on achieving outcomes rather than those that are able to fully embrace the concept of a Wraparound team.

The following are examples of elements of strength based, Wraparound strategies. They are designed to meet needs and help the consumers and families at the center of the process achieve results that are important to them and sometimes, their communities.

Marion

Strengths: Marion enjoys bingo and watching old movies on AMC and TCM¹². Marion also likes Wheel of Fortune and Jeopardy and is pretty good at both. She reports that she calls her daughter Emily her "trusty mule."

Situation:

Marion, age 81, has just been diagnosed with breast cancer, luckily still in an early stage. Her physician recommends a lumpectomy followed by a course of radiation and chemotherapy. Her husband passed away 17 years ago. Marion depends on her daughter, Emily, for everything from rides to cleaning her house and doing her laundry. Emily's daughter, Megan, helps whenever she can.

¹² American Movie Classics and Turner Classic Movies

Life Domain: Health

Outcome: Marion will be as free as possible from cancer and will live as long and as well as possible.

Measurement: Physician reports, MRI results, Marion’s and Emily’s ratings on a health and wellness questionnaire

Needs	Strength-Based Strategies
<ul style="list-style-type: none">Rides and support to pursue/continue chemotherapy and radiation therapy	<ul style="list-style-type: none">Emily and her daughter will contact Marion’s bingo friends and set up a schedule for rides and “be-withs” to remain with her throughout each therapy sessionEmily will tape her mother’s favorite game shows so that the “be-withs” and Marion can play Jeopardy and Wheel of Fortune right along with the contestants during Marion’s treatment.Emily will help Marion rent DVDs and video tapes of favorite old movies from Netflix or other sites that offer classic movies. (The hospital has a VCR set up and Megan will loan her portable DVD player to her grandmother.)

Kelly

Strengths: Kelly loves animals, hip hop music and the kind of dancing in *You Got Served*¹³. She’s a great dancer and can make up her own video-style performances for her favorite tunes. Kelly also likes to read, especially fiction, and has kept a journal from time to time since she was about 7. Her granddad is the only person she lets read her journal.

Situation: *Kelly, age 16, has been described by her mom and dad as “out of control” since she was little. She was kicked out of day care when she was four because of her challenging and ongoing problem behavior. As a high school student, she was suspended four times for tardiness to homeroom and talking back to her teachers. Kelly was also arrested for shoplifting at the local Camelot Music Store.*

Life Domain: Behavior

Outcomes: Kelly will behave in ways that help her remain in school without being sent home, suspended, or expelled. Kelly will eliminate all criminal activity, related arrests and judicial contacts.

¹³ *You Got Served*, Film, dir. Christopher B. Stokes, 2004 Columbia/TriStar (95 min.)
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Measurement: School attendance and discipline records, police report, court orders

Needs	Strength-Based Strategies
<ul style="list-style-type: none">• Methods to respond to strong emotions in school • Legal things to do that occupy her down time in positive ways	<ul style="list-style-type: none">• Kelly will carry a favorite book of quotes and a journal with her at school. When she feels her emotions escalate, she will read the most calming quotes (identified with help from her granddad) and write her feelings out. • Kelly will be an apprentice dance teacher for young children at the community center 2 afternoons each week. • Kelly will volunteer at the animal shelter on Saturdays.

Isobel, Martin and their Family

Strengths: Isobel and Martin have been married and madly in love with each other for 12 years. They are devout Catholics. They and their children love active sports like tennis and soccer. Both are fans of the Williams sisters, Mia Hamm and Landon Donovan. Martin and Isobel are both great cooks, even better when they're able to cook together.

Situation: *Isobel and Martin, both in their early 30s, have three children, one of whom has a developmental disability. His care, requiring assistance from a number of professional service providers and specialists, eats into their family and couple time. They also have full time jobs, and Martin works an extra, part time job to make ends meet. Their busy calendars sometimes make them feel out of touch with each other and their children.*

Life Domain: **Family**

Outcomes:

1. Isobel and Martin will report that they enjoy each other and their children.
2. They will spend couple time at least once a week.
3. They will spend individual time with each of the children at least once a week.
4. They will spend family time together, engaging in activities they all enjoy at least once a week.

Measurement: Verbal report at planned intervals, family satisfaction survey results

Needs	Strength-Based Strategies
<ul style="list-style-type: none"> • A schedule that reminds them to be with each other, each of their children and their entire family as often as they intend • Someone to take care of the children¹⁴ • Activities they and their children enjoy 	<ul style="list-style-type: none"> • Isobel and Martin will get together with their calendars at least 6 weeks in advance of the actual week and save, in advance, a 3 hour block for couple time, 1 activity with each child and at least one family activity. • Isobel will advertise for possible child care resources in the church bulletin and the local Catholic paper until they find someone who meets their standards • Martin will look online and find family oriented soccer and tennis events in their area • Martin and Isobel will cook (hopefully together, but sometimes solo) at least one family meal a week and the children will take turns choosing the dinner, helping to cook it and making the selected dessert.

Jason

Strengths: Jason is a big fan of Will Smith's movies: *Independence Day*¹⁵, *Ali*¹⁶, *Men In Black* and *Men In Black II*¹⁷, *I, Robot*¹⁸ and *Wild Wild West*¹⁹. He likes to be physically fit and feels better overall when he works out several times each week. Jason's favorite holiday is Thanksgiving because it's about gratitude.

Situation: Jason, age 17, grew up in the foster care system after being removed from his parent's custody when he was four. His original family scattered to the winds over the years he was in the system. As he ages out of the system, he has no durable resource people or permanent relationships. He's a spiritual young man who seeks a faith that gives him hope and reflects his interest in Islam.

Life Domain: Spiritual/Permanent Relationships

¹⁴ Kathy Carter, Protection and Safety Administrator, HHSS, Gering, Nebraska

¹⁵ *Independence Day*, Film, dir. Roland Emmerich, 1996 20th Century Fox (153 min.)

¹⁶ *Ali*, Film, dir. Michael Mann, 2004 Columbia/TriStar (165 min.)

¹⁷ *Men In Black* and *Men In Black II*, Films, dir. Barry Sonnenfeld, 1997 (98 min.), 2002 (88 min.)
Columbia/TriStar

¹⁸ *I, Robot*, Film, dir. Alex Proyas, 2004 (115 min.) 20th Century Fox, suggested by Bill Reyes, PSW, Guam

¹⁹ *Wild Wild West*, Film, dir. Barry Sonnenfeld, 1995 Warner Bros. (105 min.)

Outcomes:

1. Jason will have at least three relationships with adults that are likely to last at least five years.
2. Jason will decide whether or not to become a Muslim and take action that reflects his informed decision.

Measurement: Quality assurance phone interviews, transportation services receipts

Needs	Strength-Based Strategies
<ul style="list-style-type: none">• Spiritual instruction and mentoring; a mosque in which he feels comfortable and an Iman with whom he feels comfortable• Relationships that have the potential to last	<ul style="list-style-type: none">• Jason’s Care Coordinator will make sure he has transportation to and is scheduled to visit several mosques and talk with several Imans so he can decide where to worship and learn.• Jason will learn what the Koran and the faith in which he’s interested teaches about friendship and loyalty.• Jason will review his favorite movies with his guardian and list qualities he’ll seek in people and in long term relationships.• Jason will join a gym and pick people there who match what’s identified in the previous strategy. He’ll do the same at the Mosque and ask his spiritual instructor what his faith dictates about friendship

Sam

Strengths: Sam is very knowledgeable about classical music. Before the onset of his illness, he studied the works of Bach, Beethoven and Debussy. Sam prefers operas by Mozart and considers Wagner a little too heavy handed. He enjoys card games and has just learned how to use email (which he considers magical in a good way) to connect with his brother and sister, his only living relatives. In his youth, Sam enjoyed hiking and a chance to experience new places.

Situation: *Sam, age 60, is diagnosed with schizophrenia, paranoid type. He lives in a group setting with several other guys, all younger than he is. Sam is considered an elopement risk because he has gone AWOL (absent without leave) several times, most recently to a large casino property near the group home in which he resides. He returned two days later with \$230.00, a big smile and reports of “happy, friendly women.”*

Life Domain: **Safety/Place to Live/Social**

Outcome: Sam will remain where he is supposed to be, i.e., he will not elope from his placement.

Measurement: Incident reports, daily census, billing records (can't bill when he's AWOL)

Needs	Strength-Based Strategies
<ul style="list-style-type: none"> • Something to do during the day that he likes/looks forward to • Access to music he likes 	<ul style="list-style-type: none"> • Sam will join AARP and attend meetings and outings • Sam will email family • Sam will play card games online or against the programs (solitaire, gin, etc.) on the library computer • Sam will go to the public library to listen to music and borrow it for later appreciation and access

Service Providers	Your Rating Excellent Good Fair Poor	Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?

Family Group Conferencing²⁰

Family group conferencing came primarily from juvenile justice systems and protective services as a way to bring families together and enable them to work with each other to keep children safe and legal. There are currently other applications (i.e., not related to child welfare or court) emerging for families and consumers experiencing other types of difficulties.

²⁰ <http://justice.govt.nz/youth/fgc.html> The first efforts in this service delivery model occurred in New Zealand, around 1989

There are important definitional characteristics central to family group conferencing in its earliest and most faithful applications. These elements of the process follow:

- A facilitator assists the family in determining which family members will be included in convening the planning session.
- The facilitator also invites professional service providers (after talking to the parents and sometimes, representatives from child protective services and the court)
- The role of the professional service providers is to present and describe the resources they offer and what the family or consumer is required to achieve (if mandates are present)
- The role of the consumer and family members is to select, from the options presented, those that seem most likely to meet their needs (initially, the need to keep children safe and to keep communities safe from criminal behavior)
- The service providers leave the planning session so that the family may deliberate privately
- The family's situation is not discussed unless they are present for the discussion. In family group conferencing, participating professionals share their options and insights at the family meeting and not privately among themselves

The above characteristics are present in varying degrees as more people try to deliver family group conferencing. In some places, service providers remain at the meeting, limiting the family's ability to deliberate privately. The idea in the last bullet, above, (in New Zealand terms "not about us, without us") is a defining characteristic of this practice but it is a major shift which some providers have trouble appreciating and/or implementing.

An important feature of family group conferencing is the idea that service plans resulting from the process are more "owned" by families than plans that are imposed on them by external forces. This increases the chances that the selected interventions will succeed.

Another key feature of family group conferencing is the shift of responsibility for keeping children safe and legal to the family and away from formal service providers. This shift, while central to this model, does not in any way change the legal responsibility to make sure that children and communities are safe for the agencies mandated to ensure it.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Multisystemic Therapy²¹

Multisystemic Therapy, often called MST, is described by its creators as a “unique and exciting treatment methodology proven to have positive effects on serious, violent and chronic juvenile offenders” that also serves “the families of youths with serious behavior problems.” It has been around since the late 1970s and is now a part of many local systems of care, largely because there are few effective options to serve this population. It is not currently available to adult offenders.

A big part of MST is its focus on the identification of peers who influence the child served to engage in antisocial, illegal or dangerous behavior. The therapist delivering the intervention works with the child’s family and helps adults establish or regain disciplinary control of the child. This emphasis is based on another tenant of MST, which is that a child’s caregivers have or should have a major role in ensuring that the child abides by the law and succeeds at school and in the community. Ideally, in MST terms, this person is the child’s parent/s. If that hasn’t, or for whatever reason can’t occur, the MST therapist tries to find another family member who fills this role. Additionally, strategies used involve helping children get busy with work and positive activities like sports, increasing their academic and behavioral performance at school, and increasing their exposure to children who are not in trouble.

MST is delivered in the family home and in other community settings. The therapist who works with the child and family sees them multiple times each week and the service generally lasts for about four months.

Another key aspect of MST is an intensive care coordination, aka, case management function that is aimed at removing barriers that prevent children and families from

²¹ www.mstservices.com MST was developed in the late 1970s, Medical University of South Carolina. Supervision 401 © 2008. ALL RIGHTS RESERVED. May not be copied, duplicated and/or transmitted electronically without written permission from E. Mary Grealish

getting needed services. Therapists also provide direct services to children and families, as needed and as identified when service priorities are defined.

MST is an alternative to out-of-home options like incarceration, residential treatment and psychiatric hospitalization. Its impact has been studied with positive results, particularly when it is compared to the results achieved by the out-of-home options listed above.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Foster Care

The role of foster care has changed a great deal over the last couple of decades. It was once a resource aimed exclusively at nurturing and protecting children who were not safe in their homes. That need continues and many of the children who have that need continue to be served in foster care. Now, given the realization that children who are taken into protective custody grieve for their families, even when they haven't been safe in those families, the function of foster care has expanded to address that grief. Today, foster parents expect the children they help to feel a sense of loss because they are separated from the families they know.

The situations that trigger entry into foster care have become more diverse. While some of the children served come from neglectful and abusive homes, a group traditionally served in foster care, some have parents or other caregivers who have mental illness. Some themselves are mentally ill or have emotional disturbances and behavior problems. Some may have disorders like autism or attachment problems. Some of the children (and some of their parents) are struggling with substance abuse or addiction.

These trends in foster care have resulted in increasing difficulty in providing services to this complex group of children. Many of these children were once served in group

homes and residential treatment settings. All in all, that's good news for children and families since it often means they can live in the same community and hopefully remain in the same school. It only works, though, if foster parents get everything they need to provide competent, nurturing, family based care. Foster parents can't drift along on their own, without supervision and support, and do their best with children whose needs are this complex. They have to be part of a coordinated effort to make life work as well as possible for the children who need them, at home, at school, in the community, etc.

Another important change in foster care is the increased likelihood that foster parents will interact with and sometimes assist the children's parents. This occurs only when the contact will be safe for everyone involved and potentially productive.

Important supports for foster parents

- Respect for the critical work they do and the contribution they make to the world
- Adequate payment
- Access to supports and funding for clothing, activities, school supplies and more
- Access to medical, dental and other types of care children need
- Up-to-date pre-service training that provides the tools and insights they need to work with children and when indicated, with members of their families
- Personalized supervision and technical assistance that help them work with the children in their homes
- Liaison and advocacy assistance in schools and other settings in which children learn, interact, socialize, etc.
- Opportunities to receive specialized training
- Opportunities to network with other foster parents
- Assistance with and funding for transportation to family visits, appointments, court, etc.
- Respite

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Medical Foster Care

This is a specialized form of foster care, dedicated to children who are born with or who acquire disabilities and/or complex health care needs. Some of these children enter care from hospitals and other facilities after they are born or after they are stabilized. Other children enter medical foster care because their families are not able to meet their needs at home.

Foster parents who provide this level of service have to be trained and supported by people who understand the children’s circumstances and whatever technology or medication they need to remain as well as possible. Many care for these children 24 hours a day and can not work outside their homes. Per diem schedules have to be adjusted to take that into account. Many will also need help from home and community caregivers and providers of skilled health care services.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Treatment Foster Care

Treatment foster care works best when treatment parents are considered “front line staff” and when the source of program design and implementation reflects mental health and treatment perspectives rather than a traditional child welfare model. Also fundamental to the success of treatment foster care is the relationship between the treatment parents and the agency they represent. From a treatment perspective, treatment parents participate in a professional parenting model rather than serving as caregivers who are largely responsible for nurturant care. When treatment foster care works well, treatment parents fully understand that the purpose of their service is usually to help children and families achieve changes so they can be reunified.

Another important element in treatment foster care success is how treatment parents are supported, supervised and acknowledged in their work. They need supervision that

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acknowledges that they are professionals. It should help them develop the skills they need to work with children who act out, act in and have special needs. Support can include respite, a sympathetic listener and a useful problem solver, or help in resolving crises. Acknowledgement of treatment parents takes many forms in successful treatment foster care programs but payment commensurate with the difficulty of their work is an important part of it.

Effective treatment foster care programs emphasize both treatment planning and evaluation processes. Treatment plans specify the outcomes that are the purpose of the placement. Progress on those outcomes is measured on an ongoing basis. The therapeutic relationship between the treatment parents and each child's family is also specified in treatment plans. Plans also typically include what kinds of things the families will do together and how skills will be taught to and modeled for the child, family members and the treatment parents.

In keeping with a core value for unconditional care, the families of children served in treatment foster care are supposed to get what they need from the treatment foster care program. If the program is not able to meet the needs of the family, treatment foster care program staff reach outside of their own programs and include others in treatment and in treatment planning who can meet the family's needs.

Likely the most important core value in treatment foster care is the belief that children do best in their families of origin. Staff and treatment parents are important advocates in ensuring that children are able to grow up in their families. They team with children's families, rather than compete with them. They often seem more allied to families than they are to child welfare staff and other professionals involved with each child.

This requires a lot of coaching from staff, including how to provide advocacy in court, at school, at important meetings and in pre-hearing conferences. Treatment parents learn early on that the families of the children they serve must be respected and treated with dignity. They are well aware that children's relationships with their parents have enormous meaning to the children they serve.

There is disagreement in the field on whether or not treatment parents can or should be potential adoptive parents for children served in treatment foster care. Overall, most people believe that the main purpose of treatment foster care is treatment, with efforts for permanency focused on the families of the children being served. In many programs, when applicants see participation in treatment foster care as a path to adoption, they are screened out and referred to regular foster care or adoption resources.

There are, of course, exceptions to this practice. For the approximately 10% - 15% of the children served in treatment foster care who seem likely to age out in systems of care, other resources must be available so that they too have a path to permanent connections with family members and others.

In the event that treatment parents become potential adoptive resources for the children they serve, it is not unusual for program staff to work toward cementing and building on the relationship between the family of origin and the treatment family. In some situations, contact between parents and adoptive parents continues as they work together on behalf of the child. Staff must be well trained and “programmed” to help all parties maintain a positive relationship, particularly in legal systems that are more adversarial than collaborative.

The impact of organizational culture in some local systems is profound, sometimes leading workers to think in terms of the treatment parents as the “good parents” and the parents/family of origin as the “bad parents.” This sometimes causes decisions about permanency to be made too rapidly, especially when staff who buy into this culture see this type of decision as central to their role as protectors of children.

Achieving a therapeutic balance between treatment parents and parents is an important part of effective treatment foster care. Equally challenging is the balance of nurturance and treatment achieved in the treatment foster home.

Different treatment foster care programs define treatment in different ways. Some emphasize relationships and insights while others deliver a treatment model largely influenced by the principles of applied behavior analysis. Others use both. The key elements in terms of developing good treatment models are:

- Strong, explicitly stated values
- A well articulated and specific model
- Clinical decisions that are driven by data collected in keeping with good clinical practice
- Data that are translated into useable information
- Plans that build on that information and on the strengths of everybody involved
- Real collaboration and partnership
- Commitment to the right of every child to grow up in his/her family, if at all possible

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Emergency Foster Care

Foster care of all of the types described here is sometimes needed on an immediate basis. Children sometimes enter these homes in the middle of the night and even if not then, they enter quickly. Foster parents who serve as emergency resources typically have little information about the children who enter their homes. This difficulty is more pronounced when children enter emergency foster care because of neglect, especially if they are unknown to the system.

This is a much needed and very difficult type of foster care to deliver. Some emergency foster parents serve as resources for children who need care because they can no longer safely remain wherever they were. These children may be angry or depressed. They may require lots of supervision and support. Providers of this type of emergency foster care must be well trained in crisis management, communication and a wide variety of other skills.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Shared Caregiving²²

Note: This service is sometimes called “shared parenting.” The name is changed by the author to acknowledge that the parenting function belongs to parents whose feelings and roles are worthy of acknowledgement and respect. They may feel much more willing to share care than they are to share parenting.

In this model, responsibility for caring for children is shared by their families of origin and other families in, ideally, highly individualized arrangements that can be adjusted to reflect current needs and changing circumstances. This service has been utilized by families of children with developmental and medical disabilities who have traditionally relied on congregate care. This level of care has been needed typically because of the severity and complexity of the children’s needs and the lack of reliable, community resources to help families care for their children at home.

In shared caregiving, the hope is that the children’s families of origin will be as or more comfortable with having another family provide care as they have been with having their children cared for in institutional settings.

This shift in who provides care and the settings in which it occurs represents an enormous and dynamic change. To access this type of help, families need both patience and gentle approval of their choice. It’s important that they see the sharing caregivers as an extension of their own support systems. It’s important that they never view their use of shared caring as a failure on their parts; a failure of love, courage or whatever. Shared caregiving works best when parents can see the other family as resource people who choose to care for a child who has complex needs.

²² The Diversion Grant: A Compilation of Research, Best Practices and Points of View edited by Mary Grealish, John Pierce and Susan Davis. Congregate Care for Children with Disabilities, Literature Review by Nancy Rosenau, Ph.D.

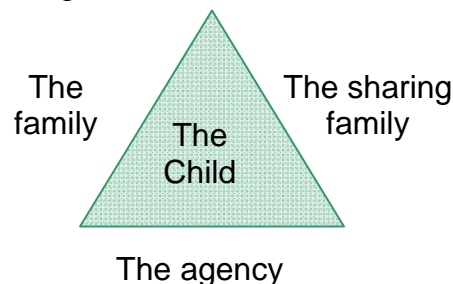
In this model, it is hoped that the two families will see each other as and will interact like extended family in terms of the relationship that develops between them. This is balanced by the professional aspects of the arrangement, namely the pay and the fact that the sharing family receives oversight that is governed by licensing requirements and governmental regulations. For this to work, the family of origin has to feel that the sharing caregivers do not replace them as parents. They remain the top priority in the life of the child in this relationship-based care arrangement.

One way of looking at shared caregivers is to regard them as “step families” without the fact of divorce. Logistics – like holidays, visits, etc. – have to be worked out jointly. Communication here is key. It has to be ongoing and reliable for this to work.

In the most effective shared caregiving arrangements, every effort is made to avoid thinking of the family of origin as the “bad” parents and the sharing caregivers as the “good” parents. Instead, they are viewed, respectively, as the legal parents and the delegated parents.

All of this is overseen by an agency that is selected to facilitate the arrangement. This is at least a three part collaboration: families, sharing families and agency staff. The agencies that are most useful as providers of shared caregiving have a strong and consistent value about the role of the family of origin: they are always that child’s family.

The following illustration defines the roles:



When all entities work together, the benefit to the child is the main priority that links them.

The following elements are important in shared caregiving:

- Recruitment of a variety of support families that produces highly qualified potential resource people
- Assessment and evaluation of the applicant families
- Training and skill development for applicant families
- A responsive system that matches family to family and that takes into account factors like culture, faith, family style, etc.
- A responsive system that provides individualized support to sustain both families

- Proactive, positive ways to resolve conflicts and manage disputes fairly and evenly, without forgetting that the family of origin remains the child's primary family relationship

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Services for Sexual Abuse and Trauma Victims

Sexual Abuse

The general public is aware on a new level of the prevalence and persistence of sexual predators. This is partly because of media attention to (some of) the children who are abducted or worse. It's also the result of much publicized predator reality shows. Because of this, millions of people know that the internet is a powerful tool in many offenders' compulsive quest to find potential victims.

Still, children continue to be victimized by these predators and many, many more by the people around them. Sexual crime is not restricted to child victims. Many adults are sexually assaulted as well, both men and women. Some experts believe that sexual assault against children is more prevalent than many suspect: 27% of females and 16% of males reported having been sexually assaulted or abused in the United States population alone, with low estimates from 20-24% to an estimated high of 54-62%²³ Male victims are thought to under report their victimization due to the fear that they will somehow be shamed.

Systems of care should offer an array of services to these victims including medical care, group and individual therapy, monitoring for STDs and pregnancy and whatever other services meet their needs.

²³ The National Resource Center on Child Sexual Abuse, "Fact Sheet on Child Sexual Abuse," Huntsville: NRCCSA, 1994

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Trauma

Trauma victims are vulnerable to traumatic shock which is caused by many different types of traumatic events and is expressed by a broad array of symptoms. Traumatic shock sometimes follows immediately or soon after the events that trigger it and other times weeks or longer after the event.

Trauma can be personal, like the unexpected loss of a loved one or the undesired end of an important relationship. It's still personal but also somewhat public when it's caused by events like floods, tornadoes or terrorism.

Many mental health and social service workers are qualified by virtue of their education, experience or both to assist people who have experienced trauma. Organizations like the Red Cross recruit these helpers to assist people so they can process their experiences and find the resources they need to facilitate healing.

As many observers saw during Hurricanes Katrina and Rita in 2005 and countless weather-related and other disasters, people suddenly and without much lead time to prepare for serious crises lost the ability to meet their most basic needs. Concrete services are key parts of responses to large scale crises so people can be safe, housed, fed, clothed, etc. These needs persist until the people who have them are able to do what they need to do to get in touch with insurers, representatives of governmental organizations tasked to assist them and others who can help them reclaim their lives as much as they can be reclaimed.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Services for Sexual Offenders

Note: For purposes of this Curriculum, no specific criteria for degrees of criminal sexual behavior or legal definitions will be presented as these are determined by federal and state law, courts and by statute.

Most people these days are aware that sexual offenders live in lots of communities. Some are adults, some are children. They are both male and female (although most are male). What they have done that is defined as a sexual crime varies from one area to another. It may also vary by the age of the victim, the position or role of the offender (when the offender has authority over the victim, for example) or by the amount of force used against the victim. Some of these offenders are required to register with the authorities in the communities in which they live and while some comply, others do not.

Most people would prefer to pretend that there are no sexual offenders in their neighborhoods. People who follow current events even a little bit, however, have heard one horrible story after another about sexual crimes that are perpetrated on both children and adults. These stories appall most people and they want the guilty locked up fast and for a long time, maybe even for good.

The legal system can't and doesn't respond like that nor should it. Proof of guilt is still the standard and these crimes are no exception. They can be difficult to prove, especially when the victims are very young or vulnerable due to disability.

For these and other reasons, people sometimes have a hard time thinking about services for sexual offenders but stakeholders in systems of care must. The reality is that most people (not all) can stop their illegal behavior with the right help. Even when offenders serve prison sentences, many ultimately return to the communities they left or relocate in new areas when their sentences are completed. This group may need

services to help them refrain from criminal behavior and if services are not available, the risk that they will re-offend increases.

A variety of responses are available for the treatment of criminal sexual behavior. Most include, and often require, incarceration although younger offenders are sometimes confined in environments like group homes. If the offense is less serious, electronic monitoring with lots of supervision is an option selected in some communities. The degree of lockdown is typically related to the severity of the offender's behavior and the likelihood that he will re-offend.

Both group and individual approaches are used with sexual offenders, sometimes both in the same treatment plan. They are delivered in a variety of settings, including some detention facilities and prisons but also in mental health and court settings in the community. Generally, sexual offenders are required to remain far away from potential child victims. Some are compelled to follow parole or probation requirements including frequent reports to probation officers, court counselors and others. Some are also required to take medication that is intended to reduce their risk of re-offending. Some are required to take it in the presence of people the courts have designated to supervise their full compliance with medical and legal requirements.

Approaches to intervention with this population vary. Some are tied to the principles of applied behavioral analysis; others are more like 12 Step responses that deal with the wrong impulse and whatever triggers it as a condition to be proactively avoided across a life span. Talk therapy of various types has been useful to many as have combined cognitive and behavioral strategies.

Experts in this field, along with people trying to be experts in this field, have recommended everything from hypnosis to exercise (not to disparage either) to stop criminal sexual behavior. For system designers, the important thing is to make the best informed choices possible, collect data to measure what works and what doesn't and plan to offer what is found to produce the best results in the future.

It is not the purpose of this Curriculum to evaluate or suggest approaches to address criminal sexual behavior. It is, instead, to give supervisors a context in which to understand this part of systems of care.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Supports for Education

Note: Although adult consumers often pursue various types of education, systems of care theory and thinking focuses mainly on children and young adults when it comes to education. When older consumers seek educational support, it is mainly available through vocational rehabilitation, occupational therapy and coaching.

Education is the right of every child from early intervention programs and elementary school through high school, regardless of disability. For some, the right to continue their education extends through early adulthood. In order to participate fully in and benefit from educational activities, a number of students need a variety of supports.

The first educational option for most students is the public school system. Many young people who are unable to participate in public school on their own can do so if resource people are available to help them meet their needs. Some need physical assistance to turn a page, write an answer or participate in classroom discussion. Others need emotional or behavioral support. Still others need a quiet, structured space where they can learn, someone to talk to when things are tough and people to help them remain medically able to be in school.

Special education is an entitlement program aimed at including as many children as possible in neighborhood schools. Students who are eligible for special education are served in regular classrooms, sometimes with support and other times without it. They are served in resource rooms located in neighborhood schools, in day treatment settings within and outside of mainstream schools and in settings that cater to students who have special needs, often related to psychiatric illness, emotional disturbance, medical and behavior problems.

Children and young adults have the right to receive education in the least restrictive environment in which their needs can be met. That's why planners usually start by considering the local school as option number one. If that environment, even with individualized support, does not support learning and academic achievement, the next choice may be a resource room used part or full time. The most restrictive environments for education are usually day treatment and partial hospital programs, some affiliated with hospitals or residential treatment programs, some freestanding. They may also be either public or private, the latter typically funded with public school district money and sometimes privately funded by family, faith, community or cultural organizations.

In terms of what participants in educational services get, the key things to look for are good results, academically and otherwise, for students to be engaged in school and to make progress. Students should be both comfortable and safe. These outcomes are achieved when students' needs are met through individualized educational plans (IEPs).

In some communities, alternative schools are also available. They are used to serve very different populations from one area to another. Some focus on educating pregnant and parenting children, others on children who are truant, or youth who are dealing with drug and alcohol abuse issues. Some alternative schools are options children and families can select. Others are mandated by courts and other community authorities.

English as a second language – ESL – programs are also part of local educational resources. Even small communities are seeing the need to help young people who have come from all around the world master English. There are large districts in which students speak as many as fifty different languages. In some, students speak more than one hundred languages, further emphasizing the need for these programs.

An issue to consider, especially for parents, is whether or not adequate services are available to parents to walk them through the IEP process, make sure they know their child's rights and to help them get the right plan for their child. In most areas, advocates are available to assist parents who want their help. Some are paid, some are volunteers. For complex situations, attorneys are sometimes available to assist students and parents. All of them have special training in federal regulations and are prepared to advocate for the rights these children and families are guaranteed.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Services for Children and Families Involved in Protective Services

Services for families and children involved in protective services work best when they are individualized and designed to help people keep children safe and well. This is true for both mandated and voluntary participants. Families enter the protection system for a wide variety of reasons. There is one common theme: the safety of a child is at risk. Systems of care have to provide a varied and comprehensive array of options to respond to the circumstances that compromise or potentially compromise the safety of each child involved.

The things families sometimes need to keep children safe include:

- A system that triggers reports that certain children are at risk
- Well trained investigators
- Courts that balance the child's right to be with parents, the parents' rights to raise their child and the importance of the child's safety
- Practitioners, across the board, who are aware of how children react to being removed from their homes, even when they are not safe in them.
- Resources to help parents learn how to best care for their children across a wide continuum of life areas: health care, supervision, nurturance, education and more
- Resources to help parents learn safe discipline, anger and stress management, communication skills and whatever else they may need to reduce any risk to their children
- Services and supports to address parents' issues with mental illness, addiction, disability and anything else that impedes their ability to safely raise their children
- Effective ways to help people secure and maintain adequate housing, employment, food, transportation and meet other basic needs

Because some children must be removed from their homes to ensure their safety, systems of care include kinship care and foster care, the most common forms of alternate family care. Kinship care, including the resources represented by non-blood kin, is the first choice for children who need placement. Kinship care is more likely to be available when systems of care invest in it and find ways to proactively help extended families and close friends provide it. It's likely that more families would be able to care for children in their extended families if they had enough financial and other forms of support to make it work.

Kinship and foster care are essential resources for abused, neglected and dependent children. They are, however, often under-funded and not adequately resourced. Unless addressed, this capacity issue results in more expensive placements that may be distant from the child's original home.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Protective Services for Adults

Although abuse and neglect of the elderly and people who have developmental or other disabilities is (sadly) nothing new, reports about it are becoming more frequent. Systems of care have responded by extending their expertise in investigations and interventions to this vulnerable population.

The abuse and neglect of people with disabilities and older people runs a wide gamut. It can be accidental neglect triggered by a lack of information and resources or by conflicting responsibilities. It can be deliberate murder by starvation or physical abuse that the victim is threatened by the perpetrator not to report. Often, the victims are terrified enough of further injury to comply with the threats and so, remain silent and continue to be victimized.

Reports on this type of abuse and neglect come from family homes, nursing homes and different levels of skilled and unskilled health care facilities. Most people have heard of older people who have dementia dying after wandering off when they were not adequately supervised and monitored. In a number of important cases, proprietors of these facilities and their employees have been held legally accountable for these tragic circumstances, some given lengthy prison sentences.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

ACT Teams and Related Supports²⁴

Assertive Community Treatment (ACT) is a model of service delivery for adults and young adults who have persistent and chronic mental illness or developmental disabilities. ACT is generally delivered in a team format so that consumers always have a resource person to call. They rely on one central person for normal contact but that person's colleagues are, with the consumer's permission, up-to-date on each consumer's needs and circumstances.

The A in ACT is important – assertive. ACT providers are advocates for consumers. They are generalists who provide counsel, care coordination (aka case management), transportation, treatment and service planning and just about anything else consumers need, including emotional support, crisis back up and a willing listener and sounding board.

ACT services are sometimes associated with programs that offer resources to young adults and adults that provide them with places to hang out. These places are sometimes called clubhouses. They typically provide organized activities, meals, concrete help (warm clothes, hygiene supplies, food and staples, etc.), information, vocational support and more.

²⁴ Training and Treatment Innovations, Inc., Oxford, Madison Heights, Waterford, Saginaw, Flint and Jackson, Michigan

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ACT and related supports are a key part of local systems of care. They meet consumers' needs in ways that allow them to live in their own homes, in their own neighborhoods. Otherwise, many of these consumers would be at risk for institutional care or sometimes, prison.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Residential Treatment

For purposes of this curriculum, residential treatment includes all group, out-of-home care environments: group homes, residential programs, small group living arrangements and so on, excluding facilities that are mainly psychiatric in purpose and function.

Residential treatment was historically the treatment of choice for many consumers. The reasoning behind it included the fact that it was seen as cost effective. The consumers who have traditionally been placed in residential treatment are referred because they worried or even alarmed their families or communities in one or more ways. They may have behaved unusually, made unsafe decisions or hurt themselves or others. Whatever the reason, they were thought unfit or too troubling to live around other people. Still others had disabilities that perturbed their families and the people around them or that left their families and others feeling unable to help them live at home or in the community.

Whatever the specific reason, a decision was reached: these people – both adults and children – need to be somewhere. Once people agreed on that, the efficiency argument came into play: there are a number of these folks so let's put them somewhere together. What people saw was that, for example, one nurse could care for eight people in group care, which was cheaper than having eight nurses help eight different families or consumers live in their own homes. They saw a group of people who

needed a completely safe and well supervised living environment so putting them in one place made sense.

This type of reasoning eventually led to some consumers actually living in congregate care. Fortunately, the role of group care has shifted markedly. Now it is utilized as a strategy rather than a destination. It's not a result, it's a path to a result.

In group care, there are always certain things on which the people in the group must agree, like rules and standards for their conduct with each other and for how they maintain their shared spaces. This means that most consumers in residential treatment have at least some of the same goals. It's an essential part of living in a group without constant upheaval and conflict. No one benefits when the environment is unstable and when what happens is unpredictable. Unfortunately, though, the need to address these group issues detracts from the opportunity to individualize what happens to the people in the group.

Beyond the limited ability to individualize what's offered in the program, there are other issues with the effectiveness of residential treatment, especially in long term placements. Sometimes participants learn new dysfunctional behaviors in residential environments. There are additional concerns with whether or not skills learned in congregate care transfer to and stabilize in the community because of the differences between the treatment environment and the consumer's actual or planned living environment.

Residential treatment is used in some of the following situations:

- To serve consumers who present a danger to self and/or others and can only be served or contained in a residential-type environment
- As a short to medium term crisis stabilization strategy
- To provide treatment for people who have difficulties that are best addressed in a group of people who have or have had similar difficulties
- To deliver a wider variety of services and supports to consumers than they could receive in their normal living environments
- To serve consumers who have no place to live by preparing them to live in less restrictive environments
- To provide intensive training for independence, work and adulthood when limited funds are available

Staff and consumers have to carefully consider what they want to get out of a residential placement prior to selecting a provider. They should consider as they discuss program options, at minimum, the following:

- What is the average length of stay for the program?
- What does the provider say will be achieved by the placement?
- What is the size of the group?
- Who is in the program? Why are they in it?
- How many staff are in the environment with how many consumers during the day? The evening? At night?

- How many consumers are discharged to a less restrictive environment?
- How many remain in a less restrictive environment six months after discharge? Twelve months? Twenty four?
- What do the consumers who use the program think about it? What about their families? What about referrers and funders? Who's satisfied? Who isn't?

If answers to these questions are not available, staff and consumers should reconsider using a program. This list is modest in its level of expectation for making information available. Responsible service providers will have all of this information and more.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Psychiatric Hospitalization

Like residential treatment, the purpose and function of psychiatric hospitalization has changed a great deal over the years, especially in the last two decades. While it was once seen as a long term, sometimes lifetime, living option, it is now a brief intervention, triggered by specific indicators and used to achieve defined goals.

The three most compelling features of psychiatric hospitals are the availability of medical expertise, security and resources. In a psychiatric setting, consumers who need psychiatric services have fast access to psychiatric assessment, diagnosis, medication and blood level information and treatment of symptoms for psychosis, delusional states, etc. In well planned psychiatric settings, consumers are secure and completely safe. Everything about these environments is designed to maximize the safety of everyone in them. Well planned psychiatric environments include all of the resource people who might be helpful to consumers: psychologists, social workers, nurse practitioners, nutritionists, occupational therapists, recreational specialists and others in addition to psychiatrists. Front line staff, regardless of their educational

backgrounds, are trained to be effective resource people who focus on consumer safety and well being.

Psychiatric hospitalization is usually considered or utilized for the following purposes, among others:

- Assessment and diagnosis
- Medication trials, adjustments and as a safe place to wait until new medication takes effect so that its impact on consumer safety, comfort and functioning can be assessed and monitored
- Psychiatric crises when consumers have decompensated
- Suicide attempts and persistent, chronic depression that has not responded to community based treatment
- Serious self injury
- Dangerous public or private behavior
- Conduct that endangers others
- Persistent psychotic or manic episodes

With the current emphasis on reducing utilization of psychiatric hospitalization, there is little need for concern about the long term placements seen in the past. In current systems, it can be difficult to get adequate access to psychiatric settings for enough time to help consumers through difficult periods in their illnesses.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Crisis Services²⁵

Crisis services are a new addition to systems of care and where they are available, they have been well received. The most effective ones provide person to person in-home or in-community interaction and support. Many crisis programs have adopted a team

²⁵ New Jersey Partnership for Children, Mobile Crisis Initiative, 2002.

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approach so their crisis response includes two people. That allows the crisis workers to combine their expertise and talk with different members of a household at the same time. It also increases staff safety as they enter potentially volatile and angry situations together because they can back each other up.

Other crisis programs are designed to serve consumers in office locations. In these programs, it's much easier to train and supervise staff. Office-based crisis programs also provide staff with immediate back up as needed and an environment that is more likely safe than not. The downside is that consumers' ability to utilize these programs often depends on the availability of transportation which many consumers don't have.

Still other crisis programs provide telephone support, usually via a toll-free phone number. With the availability of cell phones these days, most people can access telephone support. The drawbacks here are first, the lack of in-person, human-to-human contact and second, the resulting decrease in the amount of information crisis helpers have compared to what they would learn in a face-to-face meeting, especially in the individual's home environment.

In order to be effective crisis programs need:

- A call/email center and a triage process
- A realistic policy on when crisis help will be available, including the time from the request to the time of connection
- To inform people that the service is available and how to access it, including potential consumers, law enforcement, service providers, congregate care and group home workers, courts and court staff, protective services, etc.
- A way to connect crisis helpers with people in crisis, in descending order of probable impact: in-home or community, face to face; face to face in a neutral or an office setting; phone contact
- Maps, directions, safety training, cell phones, information about possible safety risks and where the police are, cars (in most places) and more (if crisis workers go into the community)
- Crisis assessment skills, protocols for interviews or an assessment tool
- Procedures to document all crisis related information, interventions, what was discussed, recommended and decided on
- Tools to evaluate the success of crisis services including consumer satisfaction, the percentage of consumers who are able to remain in their homes because of the crisis service and evidence that their crises decrease in frequency, severity, duration and ultimately, at least some times, are eliminated

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Services for Basic Needs

In most communities, a wide variety of services are available to help people meet their most basic needs. Some are federally mandated and funded so they are available throughout North America (and elsewhere). The availability of other services varies from state to state, province to province and sometimes from one county to another. These services include the following:

- Job training and referral programs that help people learn how to complete applications, interviews, etc. and provide them with job leads
- Income assistance or temporary aid for qualified applicants
- Medical services including prescription medications, vaccinations and allied health care services
- Programs for women, infants and children
- Food stamps and information about community hunger-related resources like food banks, community pantries, meal services, etc.
- Programs that help people pay utility bills
- Child care and early intervention programs
- Emergency housing
- Short to long term housing for homeless people
- Shelters and other supportive services for victims of domestic violence
- Services for elderly people that are offered in both home and community settings
- Services and supports for people who have disabilities
- Transportation assistance

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Drug and Alcohol Treatment

The number of people who need help because of drug and alcohol use, abuse and addiction is exploding. The need extends from children to the elderly and crosses gender, socioeconomic and cultural lines.

The people who need treatment are very different from each other and in response to those differences, there are a variety of treatment options available for people who have the disease of addiction. People can get in-patient or out-patient care, depending on what they can afford or fund through other sources. Some qualify for assistance for periods of months, others for the traditional 28 or 21 days. There are programs that allow parents to bring their children into treatment with them, although not enough to meet the need.

The involvement of family members and friends in treatment has become the norm rather than the exception to the rule. This practice depends on the availability of local treatment options and transportation for people who are part of the lives of those who are in treatment. System designers and planners have to ensure this capacity to deliver a family-based response to people who have drug and alcohol problems.

Recovery is, at least in part, dependent on the availability of post rehabilitation supports and many communities have well developed, effective 12 Step networks that provide it. In some communities, recovering people have built informal social and recreational opportunities to help people stay clean and sober: sports leagues, clubs, dances, talent shows, karaoke and more. These informal resources are as important in local systems of care as formal rehabilitation programs.

Other Addiction Support

If we look honestly at addiction, including addiction to cigarettes, gambling, bad relationships, shopping, sex, food, pornography, the internet and all the rest, nearly every family is touched by the disease. Twelve step networks have been active in these areas, as have rehabilitation programs that specialize in specific types of addiction. They are also important parts of local systems of care.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent	Good			
	Fair	Poor			

Medication Monitoring

As the number of people who use medication continues to increase, especially psychotropic medications, there is a clear need to ensure that it is working as well as possible for the people who use it. This is now an essential part of local systems of care. For many medications, blood testing is the best mechanism for evaluating whether or not they are present in people's blood streams in amounts that allow them to have the effect they are supposed to have.

The frequency of testing varies from medication to medication and less frequently, patient to patient. For some medicines, it's necessary to check blood levels and side effects weekly. Most testing intervals are less frequent.

Medication monitoring is available in clinics and at the offices of prescribing physicians, nurse practitioners and others. Therapists, care coordinators and others involved with consumers who use medication make sure to ask questions and assess the progress of the consumers with whom they work. If they see consumers' symptoms bleed through or notice that they are experiencing difficult side effects, they let them know and help them (if needed) contact the prescribing healthcare professional.

Service Providers	Your Rating		Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?
	Excellent Fair	Good Poor			

Services for People who Commit Crimes

Young Offenders

There are a wide variety of approaches currently available to intervene with young people who commit criminal offenses. What happens to them specifically depends on several factors: the youth's criminal history, the nature of the criminal act, the degree to which the crime hurt others or put them at risk, the youth's response to the arrest and subsequent events, the developmental and mental health history of the youth, the youth's positive record, school history, community involvement and other potentially relevant parts of the youth's life.

Probably the most important current movement in corrections and responses to young offenders is the Restorative Justice movement.²⁶ This practical philosophy directs participants to understand, first, that when young people commit criminal acts, they have broken faith with their families, neighbors and members of their communities. This understanding calls for accountability, a key element in Restorative Justice. The young offender has to take personal responsibility for the criminal act, by serving detention, incarceration or whatever other penalty is considered appropriate. The emphasis is equally and rightly on community safety and the right of citizens to be safe, secure and to have their property protected. Another important element of Restorative Justice is competency development for the youth involved, broadly and effectively, to remediate skill gaps and to make additional criminal activity less likely. Multi Systemic Therapy, MST, (mentioned elsewhere in this curriculum) is another service offered by systems of care for the same young people who are served with the Restorative Justice point of view.

²⁶ Paper Boat Consulting, Madison, Wisconsin and Bazemore, Gordon. (1998) Restorative Justice and Earned Redemption: Communities, Victims and Offender Reintegration. The American Behavioral Scientist. Vol. 41, Number 6, pgs.768-813

A variety of placements are used for young offenders judged unable to be safe or adequately supervised and compelled to behave legally at home. Placement is also used to punish youth and often, to separate them from other youth in their communities who engage in illegal behavior. The placements selected include group homes, residential treatment centers, youth rehabilitation centers and sometimes treatment foster care. The placements selected typically deliver lots of supervision, a structured schedule and opportunities to learn new coping and decision making skills. They also provide clear cut systems of rewards and punishments to teach youth that behavior has consequences that are predictable and under their control by how they choose to behave.

Many systems of care offer community alternatives to young people who have broken the law including probation, intensive probation, house arrest and electronic monitoring, day treatment, after school programs, job corps and mentorship programs.

There are also specialized responses to youth crime that are aimed at serving young people who commit sexual offenses, belong to gangs or engage in other risky behaviors. These include treatment, placement and group and individual therapy.

Adult Offenders

In the adult system, the most common responses to criminal behavior are arrest, indictment, trial and if the person is found guilty, incarceration or in some cases, probation, community service and fines. House arrest is available in some areas, depending on what the offender did and what the offender has done in the past.

There have been innovations, however. In some communities, there are drug courts staffed by judges, prosecutors, public defenders and others who have advanced information about and insight into addiction and everything that goes with it.

Similar efforts in the adult system have focused on people who have mental illness, emotional disturbance or developmental disabilities. Like the so called "drug courts," above, certain judges and others who work with these offenders are knowledgeable about what these disabilities mean and how they affect behavior. They are aware of what medication and related services can do for these offenders and what their limits are. The professionals who staff these courts are also informed about the rehabilitation and recovery supports offenders can access to increase their chances of remaining well enough to serve prison sentences or to participate in halfway house and supervised release programs.

The above referenced halfway houses and supervised release programs in some communities are focused on people who have drug and alcohol issues, people who have committed nonviolent crimes, first time offenders, people who were victimized before they became offenders and others based on local priorities and decisions.

Service Providers	Your Rating Excellent Good Fair Poor	Who is eligible?	With whom do they work best?	How do you access it? Who do you contact?

System of Care Worksheet for Supervisors

Strengths of your System of Care	Gaps in your System of Care (including capacity and competence issues)

Most competent providers

Why?

Ideas

Supervisors, Information and Evaluation

Accurate Information: A Supervisor's Quest in Systems of Care

One of the key elements in Family and Person Centered Practice is compassion and one of the ways it's evidenced is in tolerance for every family and every consumer. Practitioners don't evaluate; they listen and help. They don't judge, they join. The approach is, in many instances, unconditional in that service providers and services don't disappear or stop when consumers fail or when what they achieve is less than what had been hoped or expected. An essential part of this service philosophy is the certainty that blaming and shaming consumers in most situations is rude, disrespectful and nonproductive (assuming the absence of illegal or unsafe behavior for which perpetrators must be held accountable).

Competent supervisors make sure that staff understand this and how it influences the way they treat consumers and families. Supervisors have to remember that their employees are not the consumers of the services their organization provides. They can't tolerate in staff what staff are (rightly) expected to accept from consumers and families. Staff are evaluated and to do that, supervisors need information.

When staff fail, acknowledgement of failure is often part of whatever corrective action is taken to address their mistakes. This requires the supervisors who are responsible for implementing and documenting those corrective actions to make judgments. They have to make them with accuracy rather than optimism and those judgments depend on information.

Skilled supervisors understand that service providers in systems of care, including themselves and their employees, are not permitted to fail repeatedly. Services are supposed to work and barring obvious examples from the mandated systems (that many resent), people who receive them are supposed to be satisfied with them. It's impossible for supervisors to determine if services are working or if consumers are satisfied with them without information.

Service providers work in a marketplace and there is nothing unconditional about it. The capacity to help consumers achieve measurable results and to be satisfied with the services that helped them achieve them is the only business plan worth considering. It's also the right thing to do.

Many supervisors who implement Family and Person Centered Practice have to deal with the fact that families and consumers often ask their staff for recommendations on which programs they should select to augment what they are already getting. They want information about which providers are successful at what, what percent of the time. Unless providers make their outcome data available, both consumers and staff are left without the information they need to support a choice of one program over another. Even when providers make outcome data available to consumers and other

stakeholders, there is often no way to evaluate how the information is gathered, analyzed and presented. Even when the methods for data collection are specified, supervisors have to remain aware that the information provided may be influenced by marketing priorities rather than pure scientific curiosity.

This is not meant as an indictment of service providers but rather as part of a cognitive framework supervisors may use to think about what providers do, how well they do it and with what results. Ideally, the condition of the local system is everybody's responsibility and the information people need to make good choices is reliable, accurate and available. If you supervise staff in these circumstances, congratulations. If not, the following means of becoming and staying well informed may prove helpful.

Finding and Gathering Information

Service Plans

One of the most valuable ways for supervisors to understand what other providers do is to review the service plans they generate for consumers and families they serve collaboratively with those organizations. Supervisors can help staff assess how well or poorly the actions of their colleagues in these organizations and the strategies summarized in service plans reflect the cornerstone values of Family and Person Centered Practice. The following service plan review questions are intended to provide supervisors with an organized format they can use to teach staff how to learn more about what other programs in their communities actually provide.

Is the plan community-based?

- Where is the consumer or family living?
- Where is the consumer or family working? Learning? Worshiping? Socializing?
- Where is the consumer or family getting needed help?
- Does the family or consumer have relationships with neighbors or others nearby? Does the plan address these relationships (if necessary)?

Is the plan individualized, focused on outcomes and needs driven?

- How many measurable outcomes are listed in the plan? Are they consistent with what others who know the family and consumer report that they want? With the consumer's probable comfort level?
- How many clear need statements are there? Are they stated as needs rather than program or service statements?
- How alike are the plans generated by the provider for other consumers? How different are they?

Is the plan comprehensive?

- How many life domain areas are included, stated or implied? (Even if life domain terms are not specifically used, are a variety of life areas addressed?)

Is the plan strength-based?

- Are strengths listed?
- How many?
- Are the strengths reported significant (e.g., “Her faith is her lodestone” versus “She’s willing to accept services”) and specific enough (e.g., “He loves to play cards with his three best friends” versus “He gets along well with peers”) to be useful in strategy development?
- How many of the strategies listed are based on specific strengths?

Is the plan culturally competent?

- Do the planning processes ensure that people can communicate effectively in their most comfortable language?
- Is the consumer’s or family’s culture mentioned?
- How many of the strategies listed reflect that/those culture/s?

Is the plan consumer/family driven?

- Is the consumer or family asked who they’re related to, or is there a formula or a definition that recognizes blood kin only? Are they able to include friends, partners and non-blood kin?
- Have the confidentiality procedures and releases of information been proactively resolved?
- Were friends and family members included if that was what the family or consumer wanted? Excluded if that was what was wanted instead?
- Are their names, addresses and phone numbers available (so they can be included)?
- How many strategies are based on relationships with the friends and family members included by the consumer?
- Are the outcomes consistent with the consumer’s or family’s choices?
- Does the plan reflect the family’s or the consumer’s ideas about what they need?

Staff Reports

Having a talkative staff – even just one! – has both pros and cons. When it comes to getting information about how collaborating providers operate, it’s a plus. Supervisors must filter this type of information in keeping with what they know of their employees’ personal biases, relationships and agendas. Still, reports from employees remain a useful tool in understanding a local system of care.

Supervisors should also factor in how dramatic or stoic employees tend to be as they tell their stories. What is a minor incident at court for employee #1 may sound like the

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O.J. Simpson trial when employee #2 reports it; for employee #3, a mad dash after a consumer in trouble may sound like a typical day at work while the exact same day may end with employee #4 crying in your office.

Staff reports about other providers' mistakes are usually pretty easy to get. This is not as much a comment about staff as an observation about how most people tend to behave at work: they complain. Sticking simply with "normal" human behavior at work, many supervisors have rightly concluded that their employees are generally pretty good at reporting what other people are doing wrong.

In these reports, supervisors should get a factual description of what actually happened and should do so as briefly as possible. It's important to let people talk but equally key to limit the amount of gossip that's acceptable in the workplace. Supervisors will have to maintain that balance proactively.

Direct Observation

Most supervisors end up observing at least some of the behavior of front line staff who work for other organizations. Many also observe supervisors, managers and other senior people as they work and interact with others.

Supervisors may want to observe for the following across an organization's levels, from front line to executive staff:

- Collaboration: Do they seem willing to work with others? Do they seem to value collaboration? Do they operate well as members of a team?
- Relationships: Are they polite? Do they treat everyone with compassion and respect? Are they prompt?
- Communication: Do they listen to others? Are they able to say things in ways that are clear to service recipients and others outside of their own organizations?
- Reliability: Do they do what they're supposed to do? What they say they will do?
- Participation: Are they focused on the matter at hand and engaged with the people who are present? Are they helpful in how they participate in planning and other activities?
- Advocacy: Are they advocating for consumers and families or advocating for the needs and goals of their programs? Are they effective and well informed advocates? Are they able to be politely assertive on behalf of consumers when other professionals push for a plan or strategy that doesn't suit them?
- Honesty: Do they tell the truth to families, consumers and other participants in planning processes, court, meetings, etc? Are they clear about what they may keep confidential and what they may not?

Complaints and Problems

Every service provider receives complaints and every service provider has problems. This is a human business staffed by humans so issues will come up. It's normal.

With that said, supervisors should note if and when an organization has a lot of problems, more than seems normal given the nature of this work. Even more important, how do representatives of the organization handle disagreement? Problems and complaints? Do they really listen to what people think has gone wrong or do they respond defensively? Do they apologize or make excuses? How far do they go to right a wrong? Are they more invested in proving that their point of view is the most correct or in building relationships with consumers?

Consumers' and Families' Reactions

Consumers typically have a favorable reaction to service providers who treat them and serve them in keeping with the definitional elements of Family and Person Centered Practice. In this model, staff are usually seen as welcome resource people who deliver what consumers and families need and want consistently, reliably and with respect. Good service providers tend to get along well with consumers.

On the other hand, providers who are unable to forge positive bonds with consumers may be exhibiting a pattern of behavior that is contrary to the principles of Family and Person Centered Practice. An employee may not work well with a particular consumer. That happens to all service providers occasionally. Supervisors should pay attention when organizations employ staff who don't relate well to consumers lots of times or overall. Do these employees receive coaching? Do they improve as evidenced by reports from consumers and families? If they fail to improve, are they replaced?

Competence

Supervisors can evaluate the competence of service providers in many ways but the best place to start may be in how their employees respond to complicated and unanticipated events, both "live" and proactively. Some consumers are seen as challenging to service providers. This may be because of the complexity of their circumstances or because of their difficult or hostile behavior. Some consumers are considered challenging to serve because of who is involved with them, sometimes formal resource people and other times, informal resource people. Sometimes it's because the consumer wants something that isn't available, can't be funded easily or will be unpopular with authorities and other stakeholders.

If the staff of an organization exhibits the ability to remain calm and keep working towards positive solutions in these situations, that's a good sign that the organization is invested in competence. Equally revealing, when staff of an organization engage in crisis and safety planning for people who have complex needs, that organization is responding competently to complexity.

Some consumers as well as some judges, social workers, parents and other stakeholders are easy to relate to, talk to and engage. Others are testy, angry and bitter. This spread of character traits exists across all of the people who fill every role in local systems of care. Anybody can get along with pleasant consumers and stakeholders. Organizations need competent staff to be in the trying relationships that test everybody and make those relationships work regardless of how difficult it is to do so.

Stars

One way to tell how an organization works is to see who its leaders select as or allow to become stars. Watch who they send to public forums and community meetings and who gets promoted. Supervisors can learn a lot about what an organization considers important by paying attention to these decisions.

It's a good sign when provider organizations recognize effective, talented employees. When supervisors instead see staff they consider shallow, less skilled or lacking in compassion promoted to leadership roles, there may be reason to be concerned about how an organization is operating.

Chit chat and "buzz"

Supervisors should make sure they know how the local rumor mill operates, who is a part of it and what people are saying. This often proves to be useful information about what is going on in the system even if it isn't 100% true. Perception drives systems of care to a degree, whether or not it's accurate.

As long as supervisors sort what they hear carefully and use the information they hear (in what are essentially rumors) judiciously, they will likely benefit from keeping their proverbial ears open.

Emails and memos

Memos and emails are better markers than the above mentioned "buzz" for how organizations operate because they have been documented, recorded and shared with others. They can't be retracted and can be forwarded to countless people. When a service provider writes something that seems inappropriate, even clueless, there is good reason for concern. The child protective services worker who shares in writing that "Here's how it works: these are bad parents and they make bad decisions so we make the decisions and if they don't like it, we take the kids." may not be able to assist in family reunification. That individual may be jeopardizing the success of a service plan, the outcome of a court hearing or the reputation of an agency. The worker who feels alright about writing that "In this family, they all steal so prison is just a matter of time." may not understand Family and Person Centered Practice at all.

In both examples, it's disconcerting enough that the workers think like this. It's worse that they apparently don't know when they are embarrassing themselves and their organizations publicly, especially in writing and most especially, in email (which can easily end up anywhere).

Note to Supervisors:

What if people in your local system of care are gathering information like this about your staff and your program? It's never a bad idea to keep a close eye on the part of the system closest to you: your staff, your team.

What Supervisors Need to Know

As stated repeatedly in this volume of the *Supervision Curriculum for Family and Person Centered Practice*, supervisors need accurate information. They need to know about what their programs are doing and how they are functioning. The information supervisors need is not typically available to them unless they design systems to collect it and make both the information collection systems and the data they produce part of the services they supervise.

This is not intended to imply that supervisors become researchers (unless they want to). Supervisors are more likely to be consumers of research rather than researchers. For them, evaluation is a tool they need to do their jobs well. It has to be practical and simple, though, and specific to the programs or services they and their employees are implementing.

The following are areas of interest that many supervisors have in common:

What is going on right now, today?

This is always a priority for supervisors and it's a question that can't be answered without multiple types of information. Here are just a few things that are part of the answer to a simple "What's up?" for supervisors.

First, starting with consumers who participate in the program:

Who is in the program today? Who is coming in and who is leaving?

Supervisors have to make sure that the number of consumers their employees serve matches the expectations set in their budgets, by their licenses and by regulation. For some, it's a question of keeping numbers up and for others, it's the exact opposite. To manage a team's activity, a supervisor has to know census numbers on a daily basis.

Change is often difficult for consumers to manage. Admission to and discharge from a service or program represents change. That's why supervisors monitor these – and other – transitions. For some consumers and for some programs, a little extra attention applied in a timely fashion may ease reactions to change.

Where are the consumers today?

For many service providers, knowing the exact location of consumers is an important factor in treatment or service planning as well as in safety planning. Are they at home, safely occupied? Are they facing workplace issues that should be managed proactively? Are they in an environment that could trigger dangerous behavior? All of these questions represent information supervisors need to know.

If the service provided is intended to help consumers live in their communities, the number who are managing it is important information, as is the number who are in congregate care or far from home. If the consumer is in congregate care, current thinking is that placement should be as brief as possible so supervisors in those environments have to focus on discharges as much as they do on admissions.

Having this information also allows supervisors to keep track of the changing environments in which consumers live and whether they are more or less restrictive over time, another key piece of information on how a program is functioning.

What are they doing? How are they doing?

Supervisors want to know whether or not the families or consumers they serve are engaged in positive activities that further their plans and prospects. People can't grow and prosper in a vacuum. It's therapeutic for most consumers to have something each day to which they can look forward.

Most supervisors in Family and Person Centered Practice are interested in making sure the people they serve are able to work, socialize, worship and participate in hobbies, activities and so on. They also need to know if the consumers they and their staff serve are as healthy as possible, across a number of areas. If they have disabilities, supervisors need to monitor whether or not their needs are being met in whatever ways work best for them.

Service recipients should see the supports they receive as helpful and the staff as responsive and respectful. Supervisors can't train or mentor staff without knowing if staff and services are seen this way.

If consumers are trying to remain clean and sober or avoid dangerous behavior, supervisors need to know who – in their program – is managing or succeeding at those goals and who is not. Overall, what supervisors are responsible to ensure is that consumers are doing as well as possible and without ongoing information, they can't fully assume that responsibility.

What is happening to consumers?

This is where the Critical Incident Reporting System (Supervision 301) comes in handy and designed correctly, will meet a multitude of information needs.

Supervisors who use *The Supervision Curriculum for Family and Person Centered Practice* are advised to think in terms of using their Critical Incident Reporting

systems to report positive, negative and dangerous events, census information and transitions. Supervisors should also use the Critical Incident Reporting System to triage events so that consumers and staff understand which events are minor or routine and which are major.

The Critical Incident Reporting System is an important supervision tool as well. It allows supervisors to focus on whether or not staff are helping consumers reduce negative incidents and increase positive events.

The Critical Incident Reporting System helps supervisors do two other important things. First, it identifies what events must be reported and documented on what timelines (major = immediate report, minor = by noon the next day, for example). Second, it triggers the reporting and documentation of events of significance in others around the consumers, when the consumers have identified them as part of their families, friendship networks and support systems.

Supervisors also need to be able to answer the same and similar questions about the employees who report to them:

Where are the staff?

Every supervisor in every business has to answer this question, if not daily, then at least once in a while. Supervisors need to know who is ill, who is on vacation, who is taking a half day off, who has a sick family member and who is on leave. Many supervisors also have to know who is blowing off work or has for whatever reason, failed to show up.

For community based staff in Family and Person Centered Practice, supervisors develop strategies to confirm in accountable ways that staff are where they're supposed to be during their working hours (whatever those hours may be). In programs that don't require full time office attendance due to field work, staying informed about that field work becomes an important priority (see "Remote" Supervision, Supervision 101).

It's helpful to have detailed information about employees' plans for each day. Most supervisors require staff to report their planned schedules in advance and update them quickly when plans change. There are numerous electronic methods to do this that have other positive, by-product effects: the capacity to sign-up for times to interact with colleagues and others in the workplace, the ability to reach people so their safety can be assessed and more. These are the best tools for monitoring staff location and activities and they are affordable and easy to learn. With that said, there are also paper schedules that can be updated by phoning an identified support person when plans change.

There are routine but important events staff attend that supervisors may want to be informed of in advance so they can support their employees to be prepared and to perform well. Court hearings and conflict resolution meetings are examples of this

type of event. It may be helpful to require employees to report these events as soon as they are scheduled.

What are the staff doing?

A key supervisory function is to hold employees accountable for doing their jobs. This means supervisors need accurate and up-to-date information about their employees' activities.

There is discussion in The Supervision Curriculum: Supervision 101 and Supervision 301 about why supervisors need to make sure employees are doing what they are supposed to do. This is not intended to criticize honest employees who are reliable reporters of their day-to-day efforts on behalf of consumers and families.

While optimism about people in general and employees specifically is an important part of supervision, it can't replace checking on what they are actually doing. Have your employees be specific on their schedules in terms of what they are doing. HVs – which for many translates to home visits – isn't enough information for supervisors. Instead, "1:30 – 3:00, HV with Eric J, finish resume" and "3:30-4:30, Meet Sari at Walker Public Library, teach her to use Google" is much more useful because it allows supervisors to follow up which they are not just entitled but required to do.

When issues arise about how much time employees are engaged in specific activities, supervisors need yet another type of information. Time studies can be an important management tool. Time studies require employees to document exactly what they are doing at brief intervals – like every fifteen minutes – for several days. Time studies are not often popular with employees. Still, the information collected is useful in budget planning and other areas. A time study, for example, revealed that staff were spending a fifth of their time driving consumers around. If that's what the program intends, the information confirms that staff are acting as they need to. Other programs may use the same information to justify hiring a driver to increase billable hours for employees who can bring in needed revenue.

What results are consumers achieving?

What is each consumer achieving?

Most if not all programs that offer services from a Family and Person Centered perspective are intended to help consumers achieve important changes. In individualized programs, consumers will be working on whatever they choose. In others, consumers will be working on achieving results that match the purposes of the programs in which they participate: job outcomes for job programs, educational outcomes for school programs, safety outcomes for protective services and so on.

As stated previously, programs are supposed to work. They are supposed to help the people who participate in them achieve specific results. Some of the results are general, for example, to manage a disability as well as possible so a person can be

with his family, work, socialize and participate in life. Others are very specific: to be financially independent by working at least X hours each week; to keep a child safe by doing A, B and C (the specific requirements approved by Protective Services and the court); to successfully complete Articles of Probation 1, 2 and 3. Some service recipients choose the outcomes they'd like to achieve. Others are required to achieve results specified by courts and other mandated entities.

Supervisors should focus on what consumers and families want to or have to achieve in order to develop direct, practical measures of how programs are working. Whether or not the intended results are achieved allows supervisors to evaluate their employees' competence as well as their program's functioning.

It's not difficult to get this information reported if treatment and service planning processes and formats are designed to prompt it. Supervisors can then follow up in either individual or group supervision or both to monitor consumers' progress and how effectively the strategies in their written plans are working.

What results does the program help all or most participating consumers to achieve, overall?

Many supervisors find it useful to measure how their programs are doing overall, across participating consumers. What they measure and how they measure it varies with what each program offers. Across programs however, two types of measurement remain consistent: the results consumers want to or are compelled to achieve by virtue of receiving the service or participating in the program and the degree to which they are or are not satisfied with the services they are receiving or the programs in which they are participating.

Developing Outcome Evaluation Systems

Outcome evaluation is about determining whether or not a program has achieved what it set out to achieve. Outcomes can be consumer specific or reflect program accomplishments across consumers. Outcome evaluation differs from process evaluation in a significant way. Outcome evaluation is about did we get where we set out to go while process evaluation is about how we get to the outcome – Did we do what we said we would do?

Program specific outcome evaluation systems do not have to be very complicated. The keys to developing an effective system for a program or service include:

- A clear definition of each outcome to be measured, clear enough that most people who read it, hear it or observe it agree on whether or not it has been achieved.
- A simple, straightforward method to get staff to collect and provide the information needed.
- A reliable way to summarize the information.

- A plan to use the information to improve the program.

The following steps provide supervisors with a simple way to develop an outcome evaluation system for the services or programs they supervise. The exercises that follow the steps may be helpful to further their abilities to design informative systems

Step 1 Decide what outcomes you want to measure

- Look at referral trends. Who is referred can be a direct and accurate measure of what referrers want consumers to achieve in the program when they refer them.
- Ask service recipients what they want to achieve by participating in services.
- Examine consumers' actual plans to determine what might be priority outcomes for families and consumers.
- Look at the top priorities of referring systems: What are typically their specific concerns? What outcomes are each referring system chartered or mandated to achieve?

Step 2 Describe the priority outcomes in ways that groups of people understand and can agree.

- Define each outcome in terms of how it looks; what has or should be produced by the plan/s?
- Does it sound a certain way? Is frequency an issue? What about duration? Intensity?
- Is it specific enough that 10 people, representing 10 different points of view, would agree on whether or not it has been achieved?
- Be clear. Avoid buzz words and jargon; use language that allows people to understand what you're measuring.

Step 3 Assess what your program already monitors, how it is monitored and how well it measures the defined priority outcomes.

- What data has already been collected? When? How? By whom?

- Are there information gathering systems in place that could be adapted to collect information about the defined outcomes?

Step 4 Determine how to initiate collection of new information that relates to key outcomes.

- Whenever possible, build on pre-existing structures.
- Keep it simple. Complicated data collection methods produce unreliable results.
- Make it as convenient to collect the needed information as possible.
- Listen to the staff who work in the trenches of your program. Find out what they can easily do in terms of collecting information and what they consider unfair burdens on their time.

Step 5 Construct an information collection system based on what you learned in Steps 1 through 4.

- What tools will staff need to collect the desired information?
- Will they need training? If so, what training will they need? How will they get it?
- What, if any, motivational support will boost the likelihood that staff will collect and report information accurately and on time?

Step 6 Try it out.

- How will you find out how staff are doing as they implement the evaluation system?
- Does the information you receive from the evaluation system make sense?

Step 7 Put it into practice.

- How will the evaluation/information collection system be maintained?
- How will the evaluation/information collection system be improved as experience with it provides important insights?

Step 8 Use the information.

- To whom will the information be reported?
- With what intended result?
- In what format will the information be presented?

Priority Outcomes: Systems and Examples

Education Programs:

How many young adults graduate from high school, and how many do not?

How many take the G.E.D. and how many pass it?

How many high school graduates go on to complete at least one semester or term of college? How many of these students earn a degree?

How many high school graduates go on to complete one or more semesters or terms of post-high school education (other than college)? How many of these students graduate from post-high school education?

Child Welfare Programs:

How many children are found to lack one or more of the basic elements of a safe lifestyle (legally defined as sufficient nutrition, shelter, adult supervision, reasonable discipline, access to health care, etc.)?

How many child abuse investigations are conducted? How many children are removed from their homes and placed in out-of-home care pursuant to or in response to investigation results?

How many of these placements disrupt and require removal and another placement? How many of these children are placed with relatives or non-blood kin? How many are placed in foster care with strangers? How many go into other types of placement and what types of placements do they enter?

How many children are reunited with their legal guardians within six months of their removal? During this same period, how many additional children are removed from their homes?

For how many children are permanency plans established?

How many are available for adoption? How many children are adopted? (If you decide to monitor adoptions, make sure that they and other, less formal permanent family arrangements are tracked. For many families involved in kinship child-rearing arrangements, adoption - with the accompanying termination of parental rights - is not desired or necessary since the child is already considered a family member in good standing.)

Programs for Young Offenders:

How many juveniles are arrested? Of these, how many are charged with misdemeanors? How many with felonies?

How many offenders are ordered to perform community service? Of these, how many complete their assigned community service successfully? How many remain free of arrest for one year or more after completing community service?

How many offenders are put on probation? How many complete it successfully? How many remain free of arrest for one year or more after completing probation?

Of the number of juveniles charged with illegal acts, how many are sent to detention or another secure setting for at least 30 days? How many remain free of arrest for one year or more after completing placement?

Mental Health Programs:

How many consumers are successfully served by local community mental health resources (i.e., remain within their communities)? How many consumers have to leave their communities to get needed help?

Of the consumers who are served in congregate care, how many remain stable (i.e., out of congregate care) for X number of days, weeks, months following discharge? How many of these consumers receive community-based services?

How many consumers are determined to be eligible for medication monitoring, ACT participation or clubhouse membership? Of those eligible, how many attend regularly (i.e. more than half the times scheduled or as indicated in their treatment or service plans)?

Health Programs:

How many babies are born? How many of them survive the first year of life?

How many mothers in the community give birth? How many mothers-to-be are seen by health care professionals at least three times before their babies are born?

How many babies are born drug-exposed?

How many children under the age of 18 have received 5 or more recommended inoculations?

How many people in the community smoke cigarettes?

How many sexually active people in the community have been screened for sexually transmitted diseases? How many are successfully treated?

Financial Assistance Programs:

How many families earn a livable wage of at least \$XXX? How many do not?

How many months do people remain on public assistance? How long have people typically received it in the past (i.e., X years ago)?

How many people work X hours per week and remain over federal and state definitions of poverty? How many people work X hours per week and are under the poverty definition?

Of the people who work, how many receive health benefits from their jobs? How many do not?

Developing an Outcome Evaluation Systems Exercise

Part 1: Specifically define the following outcomes in ways that represent priorities in your program and other programs in your system of care. Include a description of how exactly you will measure whether or not each outcome has been achieved.

1. *Completes a secondary education.*
2. *Is reunited with parents or other family caregivers.*
3. *Behaves legally.*

4. *Remains clean and sober.*

5. *Manages mental illness successfully.*

6. *Is financially independent.*

7. *Delivers healthy infants.*

8. *Manages disability/serious medical problems successfully.*

9. *Raises children who are safe and healthy.*

10. *Receives needed supports at home and within the community.*

Part 2: For the outcomes you defined in Part 1, respond to the questions below as specifically as you can.

Outcome 1: *Completes a secondary education.*

What information will you collect?

How will you collect it?

Who will collect it?

How will the information be utilized?

Outcome 2: *Is reunited with parents or other family caregivers.*

What information will you collect?

How will you collect it?

Who will collect it?

How will the information be utilized?

Outcome 3: *Behaves legally.*

What information will you collect?

How will you collect it?

Who will collect it?

How will the information be utilized?

Outcome 4: *Remains clean and sober.*

What information will you collect?

How will you collect it?

Who will collect it?

How will the information be utilized?

Outcome 5: *Manages mental illness successfully.*

What information will you collect?

How will you collect it?

Who will collect it?

How will the information be utilized?

Outcome 6: *Is financially independent.*

What information will you collect?

How will you collect it?

Who will collect it?

How will the information be utilized?

Outcome 7: *Delivers healthy infants.*

What information will you collect?

How will you collect it?

Who will collect it?

How will the information be utilized?

Outcome 8: *Manages disability/serious medical problems successfully.*

What information will you collect?

How will you collect it?

Who will collect it?

How will the information be utilized?

Outcome 9: *Raises children who are safe and healthy.*

What information will you collect?

How will you collect it?

Who will collect it?

How will the information be utilized?

Outcome 10: *Receives needed supports at home and within the community.*

What information will you collect?

How will you collect it?

Who will collect it?

How will the information be utilized?

Process Evaluation

Sometimes supervisors aren't content to wait and see what outcomes each – and all – plans produce. They prefer, instead, to figure out which aspects of each plan probably predict the achievement of their priority outcomes. Sometimes it's easy to see what predicts positive results and equally easy to keep track of those elements. Real estate managers believe that the type and location of their ads leads to the success or failure of their sales efforts so they monitor those ads. Managers in companies that manufacture cars believe that training and maintaining skilled employees helps their companies produce attractive, functional vehicles, so they monitor staff training, motivation and support. In both cases, responsible supervisors look at the outcomes – properties sold and automobiles manufactured - but also pay close attention to the process variables – content and location of advertisements and education and support of employees – to “tweak” improved results. They determine which processes or elements in their work have direct influence over whether or not the outcomes they want to produce are achieved and adjust them to increase the chances that they will ultimately succeed. This is called process evaluation and it is an important adjunct to outcome evaluation. It allows supervisors to focus on the processes – or variables – in their programs that are most likely to produce the desired outcomes.

The following steps provide a vehicle for supervisors to design program-specific process evaluation systems. They don't have to wait to see if their priority outcomes are achieved in their programs; they can push the processes that seem most likely to influence outcome achievement.

Process Evaluation Examples: Outcomes and Possible Predictive Variables

These examples revisit the work done in previous exercises on outcome evaluation systems

Outcome: *Completes high school*

Predictive Variables:

- Number of days in school/number of school days
- Number of available supports for acceptable behavior/number of students who exhibit problem behavior and need that support
- Available supports for acceptable academic progress/number of children who have failed one or more classes as sophomores or juniors and need those supports

Outcome: *Children are reunified successfully with parents or other caregivers*

Predictive Variables:

- Number of in-person visits and other contacts with family members
- Number of chances per month to work on relationships in a therapeutic environment
- Number of the parent's or caregiver's basic needs (e.g., safety, shelter, etc.) met that directly address the unmet needs that caused the removal

Outcome: *Behaves legally*

Predictive Variables:

- Consistent implementation of legal consequences
- Time spent participating in activities aimed at developing new skills and competencies
- Direct evidence of remorse in action (through participation in community service and other required activities)

Outcome: *Remains clean and sober*

Predictive Variables:

- Number of times per month the individual accesses sobriety guidance of any kind
- Number of days each month during which the individual participates in sober social activities

Outcome: *Manages mental illness successfully*

Predictive Variables:

- Number of days in the community/number of days in the period examined
- Each utilization of community resources
- Number of blood or urine screens that indicate appropriate use of prescribed psychotropic medication/total number of screens
- Number of days with satisfying human interactions/number of days monitored

Outcome: *Achieves financial independence*

Predictive Variables:

- Number of job preparation activities attended/number of job preparation activities available
- Number of people finding safe and stable child care arrangements so that they can work/number seeking safe and stable child care
- Number of people who find reliable transportation to jobs/number trying to find reliable transportation to jobs

Developing Process Evaluation Systems

Remember, process evaluation is about determining if what was to be done by program staff was actually done.

The following steps are presented as a guide to develop a simple process evaluation system for your program. The same principles that govern outcome evaluation system design apply to process evaluation: keep it simple, clear, and easy to use.

Step 1

For each outcome you've defined for your program, generate one or more process variables that are likely to influence whether or not each outcome is achieved.

Step 2

Check with potentially relevant literature, available data and your own experience to determine how well or poorly the process variables you listed above actually influence results.

Step 3

Design reliable methods to collect data and to determine whether or not the selected variables have occurred or are occurring.

Step 4

Make sure that the needed information is collected consistently and reliably. Look first at what information is already routinely collected in your organization, and whenever possible, build on that.

Step 5

Examine the collected process information in reference to the outcomes you're also measuring to see if your guesses about what predicts success or failure were accurate.

Step 6

Adjust your design, as indicated by the results of Step 5.

Step 7

Determine how to use the process evaluation data to improve your program's performance as it relates to the achievement of specific outcomes.

How pleased are people with what we do?

Programs and services are supposed to help consumers live the lives they want to live. Some services are supposed to keep children and vulnerable adults safe and others help people get effective treatment for addiction. Other programs are supposed to help participants get decent jobs or provide families the resources they need to raise children who have disabilities at home.

Consumers are supposed to be satisfied with the services they receive, sometimes even pleased: how the staff treat them, how well or poorly they are heard, the degree to which their needs are met, whether or not service providers hang in there when they are most needed and more. On top of that, other stakeholders, like funding, referral and regulatory agencies and courts, must also be satisfied because they too are consumers of services, although in a very different way.

Whether or not consumers and other community stakeholders are satisfied with services is an important thing for supervisors to know. They may need to find ways to learn how satisfied or dissatisfied people are with their programs unless they already have adequate access to this information (for example, an active evaluation component in their organizations or local systems).

It's important to factor in the difference between how consumers respond to services in which they voluntarily participate and those in which they are required to participate. This is not to say that consumers aren't satisfied with mandated services and the workers who provide them. It's a tribute to both service providers and consumers that many of them engage in mutually respectful, useful relationships even when consumers are not participating voluntarily. Still, people are more likely to be satisfied with something they want than they are with something they don't.

It's also important to remember that consumers and families are more satisfied when the services work for them than they are when they don't work. The participant in the job program who has a reasonably okay job will be happier than the participant who

doesn't. The consumer who has an accessible apartment and a vehicle adapted to her use is satisfied because she now lives independently despite her disability. The consumer who is still waiting for the modified apartment and vehicle is, understandably, less satisfied.

Who do we ask if they're satisfied?

- *Are families and consumers satisfied with our program?*

It's not difficult to get answers to this question on an ongoing basis. The strategy is to ask consumers, choose one or more ways to do it and see what works best. Many supervisors and others train consumers or former consumers to be evaluators so that other consumers are more likely to feel comfortable talking to them about their satisfaction. Others use written or electronic means to measure satisfaction that allow respondents to remain anonymous. Both methods can be helpful since some consumers are leery about complaining even when they would like to because they fear reprisal.

- *Are staff at the organizations that refer consumers to your program and fund or require their participation in the program satisfied?*

People in positions to refer consumers to programs do so because they have found at least one reason to respect a particular program. It may be because of a favorable impression made by one or more of an organization's employees or a positive report from a consumer. Referrers also favor programs that are committed to serving consumers through difficult times without summarily discharging them. They also take into account what programs make every effort to include consumers who need their help rather than including only a narrowly defined "model" consumer. There are many important reasons for supervisors to work on organizational integrity and satisfying referrers and funders is one of them.

- *Are the courts and other governmental agencies and entities satisfied with the program?*

As noted above, organizational integrity is a big factor in whether or not stakeholders who represent government and courts will be satisfied with your program. Public agencies and courts hold the mandated responsibility for what happens to and what is expected from many consumers. They can subcontract it but never delegate it legally. Because of that, they favor organizations that keep consumers, family members and communities safe. They most respect the providers that ensure that their mandates are responsibly and accountably achieved.

- *Are other stakeholders satisfied with the program?*

This is at least partly a measure of how the managers and staff of a program interact with other service providers and community organizations. Service providers who are polite and respectful to colleagues leave them more satisfied than those who behave arrogantly. Collaboration is built on the awareness that

many minds are often better than one, particularly when situations are complex and challenging. Program staff who work with others in keeping with that awareness make good impressions on their colleagues, so those colleagues are more likely to be satisfied with the program the collaborative staff represent.

Sample Questions for Evaluating Satisfaction

- Do staff do what they say they will do?
- Do they treat people with courtesy and respect?
- Are staff helpful? Do they change what they do to accommodate consumers' needs?
- Do staff collaborate with consumers, families and other participants when they work together?
- Are staff prompt? Do they show up when they say they will?
- Do staff communicate clearly? Can people understand what they say?
- Are staff meeting consumers and others in their homes, communities or wherever else they are needed?
- Are staff truthful with consumers and others?
- Are staff adequately prepared for planning meetings, court and other key events?
- Do staff return phone calls and emails promptly?

Developing Evaluation Strategies for Local Systems of Care: A Planning Guide for Supervisors

Follow the prompts listed below and practice "walking through" the steps to develop both outcome and process evaluation systems for your community.

Part 1: Outcome Evaluation

- (1) List 5 outcomes that you believe are important to people in your community. These can reflect the work of any agency, school or organization.





- (2) Check your list. Are the outcomes you listed defined specifically enough that most people will understand them and easily agree whether they have been achieved or not? If not, go back and edit them until they are.
- (3) For each outcome that you defined, indicate exactly how you'll confirm whether or not it's really a community priority, and how you will collect information on whether it has been achieved. Look first to information that is already being collected and build on that. Remember, keep it simple and avoid duplicative efforts that will only frustrate participants.

Outcome	How to confirm that it is a priority	Information collection strategies
(1)		<ul style="list-style-type: none"> • • • •
(2)		<ul style="list-style-type: none"> • • • •

Outcome	How to confirm that it is a priority	Information collection strategies
(3)		<ul style="list-style-type: none"> • • • •
(4)		<ul style="list-style-type: none"> • • • •
(5)		<ul style="list-style-type: none"> • • • •

(4) For at least 5 information collection strategies you listed in Step 3, who will be involved in implementing each one? What preparation, training, or support will they need?

Information Strategy	Who	Preparation
1.		
2.		
3.		

Information Strategy	Who	Preparation
4.		
5.		

(5) How will you make sure that the information collected is accurate and reliable? As you answer this question, think in terms of specific policies and procedures that will support the integrity of the evaluation process.

(6) How will you maintain consumers' confidentiality (as required by HIPPA) as you collect information?

(7) Determine how to use the information as follows:

Who are your primary audiences?

What will you report to them? How will you do it?

How will you use the data from your outcome evaluation system to support continued system or care development and improvement?

Part 2: Process Evaluation

- (1) For each outcome you listed and defined, what process variables will you track to enhance your ability to produce success?

Outcome	Process Variables
	- - -
	- - -
	- - -
	- - -
	- - -

- (2) What data will you collect to assess the status of the process variables you identified above? Who will collect the information? How will it be collected?

Process Variable:		
Data to be collected	Who will collect it?	How will they collect it?

Process Variable:		
Data to be collected	Who will collect it?	How will they collect it?

Process Variable:		
Data to be collected	Who will collect it?	How will they collect it?

Process Variable:		
Data to be collected	Who will collect it?	How will they collect it?

Process Variable:		
Data to be collected	Who will collect it?	How will they collect it?

(3) What training, supervision, and support will be needed to optimize the reliability and accuracy of the data collected?

(4) How will the data be analyzed?

(5) How will it be presented? To Whom? With what ends in mind? Complete the chart that follows.

Data	Audience	Purposes

(6) How will you ensure that your procedures, methods and conclusions are valid?

Informal Resources in Systems of Care

Informal resource people and community supports are central to implementing Family and Person Centered Practice. They represent what is often a rich yet untapped source of practical assistance for people in need.

The most important resource people are the family members and friends consumers choose to include in their daily lives and sometimes their service plans. Other informal resource people include 12 Step sponsors, advocates, leaders and allies in faith, people who are dealing with similar circumstances and anyone else who can help.

Community supports can be equally helpful. They may include girl scout troops, Big Brothers/Big Sisters, other volunteer mentors, sports programs, community centers, support groups, food banks and more.

This section of Supervision 401 deals with these two aspects of working with informal resources: recruiting and working with informal resource people and volunteers and helping consumers access community supports.

Resource People

Supervisors are encouraged to consider the format that follows as a way to think through how they might connect with volunteer resource people. It will provide them with opportunities to model and teach this skill to staff so they learn how to include these resource people on behalf of families and consumers.

As mentioned throughout this curriculum, consumers can refuse to include informal resource people in their plans and their lives.

Finding, Including and Keeping Volunteers: A Checklist for Supervisors

1. List the types of people who best match the consumers you and your staff serve: Ethnicity/language? Skills? Personal attributes? Remember, you will normally be looking for at least several types of resource people at any given time. These are your primary audiences – the actual resource people you want to recruit.

Example: Women (especially mothers) who are in recovery from drug addiction for at least three years and who participate actively in community 12 Step resources.

Example: People who speak both English and Vietnamese.

Example: Male mentors who can engage and inspire young men to stay in school and out of trouble.

-
-
-

2. For each type of volunteer you listed above, jot down the names of people who might know a few or a lot of members of the primary audiences you identified above. These people are your secondary audiences, who can be approached to help you recruit or get access to your primary audiences.

Example: Staff, consumers and others in recovery; the director of the local day treatment/rehab program

Example: The Vietnamese Buddhist Association, the University Asian Student Union

Example: Fraternities, the faith community, athletic leagues

-
-
-

3. Are there any local groups that have values and missions that are similar to yours and those of your organization? How might they be approached to help?

Group	Contribution	Approach Strategies
<u>Example:</u> the ONALA club (created in a NA/AA collaborative process)	Lots of recovery support in the Women's Network that meets at the ONALA club	Have a female employee go to an open meeting and ask for volunteers (not during or as part of the meeting) over coffee
<u>Example:</u> The Associations listed in Step II	They have volunteer translators in both organizations	Call and make an appointment with both groups
<u>Example:</u> 100 Black Men	Advocacy work for boys and young men	Request a meeting
•	•	•
•	•	•
•	•	•

4. For each primary and secondary audience you have identified, list strategies that might be effective for recruiting them

Primary Audience	Recruitment Plan
1. Women in recovery	<ul style="list-style-type: none"> • Distribute fliers at community centers and daycare centers • Have recovering staff reach out to friends in the program • Find a way to pay child care and transportation costs for volunteers
2. English/Vietnamese translators	<ul style="list-style-type: none"> • Prepare electronic and paper brochures to describe your need for help in both languages • Distribute them in Asian stores and to Vietnamese clubs (email lists)
3. Male mentors	<ul style="list-style-type: none"> • Try to get on local cable show that focuses on urban issues and minority youth

	<ul style="list-style-type: none"> • Address men's community groups • Meet with the owner of the boxing gym
4.	<ul style="list-style-type: none"> • • •
5.	<ul style="list-style-type: none"> • • •
6.	<ul style="list-style-type: none"> • • •

Secondary Audience	Recruitment Plan
1. Child protective services workers Public health nurses	<ul style="list-style-type: none"> • Ask about successful consumers who have completed CPS involvement and may be willing to volunteer • Make posters and fliers available for them to distribute
2. Vietnamese business owners	<ul style="list-style-type: none"> • Stop by and visit
3. The Association of African American Churches The Black Student Union	<ul style="list-style-type: none"> • Address a meeting • Make fliers available • Address a meeting • Make fliers available
4.	<ul style="list-style-type: none"> • • •

Secondary Audience	Recruitment Plan
5.	<ul style="list-style-type: none"> • • •
6.	<ul style="list-style-type: none"> • • •

5. Find out about and list local standards for your community as they relate to volunteers:

- Background checks and screening

- Informing volunteers about consumers who need their help that reflects full compliance with HIPPA standards

- Training on how to connect with the people who need volunteers and how to successfully support them

- Instruction on the environments in which they may volunteer and whether or not volunteers will be alone with consumers

- Support and advice for volunteers as they interact with consumers

- Communication with parents and guardians (when children are connected with volunteers) and with the organizations for which they volunteer

- Documentation, if any is required, to report what happens each time volunteers get together with consumers

6. What could disqualify a potential volunteer? Are there exceptions or procedures that address special circumstances?

Community Resources

Supervisors are equally encouraged to help staff locate and access the resources that are available to consumers and families in their community. These resources may not be well publicized due to limited funding but they are available to those who seek them out. Supervisors who are well informed about community support efforts can provide practical support to their employees as they learn to connect consumers with these resources.

In the following format, supervisors are prompted to identify how staff and consumers can access community resources. They are also prompted to think about financial and implementation aspects of working with informal support resources.

This format may also be used with staff, especially at staff meetings, to allow them to show off what they know and be resources for each other and the consumers they all serve.

Finding the Informal Resources in Your Community

For each of the following services and supports that may be needed by a consumer, estimate how much the service would typically cost in your community if the consumer or someone on behalf of the consumer is required to purchase it. Next, determine how to access each as an informal service on behalf of consumers and identify any barriers, resource issues or procedures that may impede consumers' access to the service, if there are any.

Service/Support	Typical Cost?	What has to be done to access it?	Barriers/Impediments
A Thanksgiving dinner			
A bicycle			
A divorce			
A break from the kids			
Sports or exercise equipment			

Service/Support	Typical Cost?	What has to be done to access it?	Barriers/Impediments
Help with utility bills			
School supplies			
Help for victims of criminal acts			
A week's worth of non-perishable food			
A Girl Scout uniform			
Work clothes for new members of the work force			
A prom outfit			

Service/Support	Typical Cost?	What has to be done to access it?	Barriers/Impediments
Recreation and exercise activities for seniors			
A birthday party			
Help in a crisis			

Supervisors and Money

Systems of care run on a number of levels but one of them is always financial. Systems of care were once marketplaces that allowed professional service providers to select and purchase service options for consumers who needed help. In modern systems of care, consumers shop for themselves instead.

Somewhere in your county, there is money. It's in public agencies, governmental entities, foundations and benevolent associations. It's in lots of different places. Knowing where it is, what it's for and how to get it makes supervisors more effective.

When you listen to people talk about money for Family and Person Centered Practice, it often sounds like there isn't any, at least not for consumers and providers of community-based services. Counties and states end up spending a lot of their money to purchase "beds", placements and other categorical services.

In some areas, this practice has existed for so long that it's become an expectation, almost an entitlement, for traditional service providers. In many communities, these traditions persist and begin to carry the weight of law or regulation, although they are neither. Everybody knows how it works and what to expect. People become complacent which often lowers their expectations for real system change and improved practice.

Family and Person Centered Practice includes and represents newer service models, most of which are community-based. They don't have long funding histories. It's important that they are well defined and marketed effectively so consumers and stakeholders know about them. Even more important, stakeholders need to know who these programs serve best and what they do, exactly. An emphasis on the results they produce – outcomes – is a helpful way to describe them. It's also useful to describe how they can replace or augment other service options. Supervisors and other managers shouldn't be hesitant to describe what their services and programs produce and what they cost. They may also compare their costs with the costs of other programs.

The following format lists areas in which supervisors need specific answers to questions about money. Supervisors are advised to use this format as a guide to learn more in order to be a resource to staff and consumers.

Find out how your community functions in the following areas:

Flexible Funds

Is there flexible money in your community? Which organizations include it in their budgets? What or whom is it for?

If not, what funding sources tend to be the most flexible?

What do you have to do to access flexible dollars?

How long does it take to get flexible funds, from the request to receipt of the funds?

Whose approval do you need and in what form?

Are there any set rules or limits? Expectations with which to comply?

What documentation is required?

Fiscal Practices

If you, or your staff, are purchasing something to help a consumer meet a need, do you...

- Get estimates?
 - How many?
 - Are you required to take the lowest?
 - Do you average estimates?

- Get a purchase order?
 - How do you do that?

- Use a contracted or approved provider?
 - Which providers are currently approved?
 - What do they provide?
 - How are they paid?

- Contract with a new provider?
 - How do you do that?

- Get a check cut?
 - How do you do that?
 - How long does it take?

- Use petty cash?
 - How do you do that?
 - How long does it take to get it?
 - What, if any, are the rules and expectations for accessing petty cash?
 - How is it to be documented?
 - How and by whom is it approved or not?

What does it cost? Who pays for it?

Find out the average cost and the cost ranges of the widely available services listed below. If you offer the service, use your cost in your calculations. Next, call several providers of each service, visit their websites or read their literature so that you can begin to get an idea of service costs and cost ranges. You may also get cost and cost range information from whoever is responsible for purchasing lots of each type of service. For each one, find out which organizations and funding sources usually fund it.

For a Child:

Service	Duration	Cost Range	Average Cost	Funding Source
Foster care	90 days			
Treatment foster care	30 days			
Detention	5 days			
Emergency shelter	2 nights			

Service	Duration	Cost Range	Average Cost	Funding Source
In-home services	12 weeks*			
Residential treatment	1 month			
Community based behavior services	*			
Therapy	10 sessions			

* figure this in whatever units (sessions, hours, weeks, etc.) are commonly used in your area

For an Adult:

Service	Duration	Cost Range	Average Cost	Funding Source
Psychiatric evaluation	1 interview plus the report			
Psychiatric hospital	7 days			
Individual out-patient therapy	12 sessions			
Weekly blood test for medication levels	4 weeks			
Ambulance trip	40 miles			
Day treatment	6 weeks/30 days			
Job skills training	6 weeks			
Drug/alcohol detox and rehab	28 days			

For Newer Services:

Service	Duration	Cost Range	Average Cost	Funding Source
Weekly one-on-one mentoring	2 hours/ week for 9 months			
Resource Coordination (aka case management)	4 hours/ month for 6 months			
40 mile round-trip transportation to weekly activity, driver, gas, etc.	4 times/ month			
Job coach	4 hours/ day; 5 days/week for 6 weeks			
Wraparound facilitation	First 4 weeks			
Emergency housing	1 week			

Collaboration and Systems of Care

In local systems of care, service providers that are concerned about making sure both formal services and informal supports are available to the consumers they serve often come together to develop or further develop a system of care that reflects local needs and priorities. Members of these collaborative community groups should include people who represent completely informal community responses to human needs as well as people who are paid to provide formal services.

They also include consumers and their families, relatives and friends. Some community groups are formally structured; others more loosely. Some are created to implement legislative priorities,²² some to reflect state/provincial visions of improved help for consumers who need it.²³ Still others are “grass roots” responses to the drive to improve circumstances for people dealing with challenging issues.²⁴

These groups and the efforts they make are the best resource most communities have to create a system of care that responds adequately to local needs. It’s a fact that local systems of care matter to a number of people. It’s equally true that those people have different roles and different needs around developing a local system. Some provide services, some receive them. Others fund them and others measure them. The only way to build on all of their points of view is to bring them together as equals and find consensus among them.

This isn’t easy. There are a number of conflicting opinions involved and a number of people who are convinced that theirs is the only really legitimate point of view. It’s not easy to bring these disagreeing people together and help them find out where they actually can and do agree but there’s no other way to design a local system of care. It’s a frustrating but necessary process.

Most collaborative community groups recruit supervisors to participate in their system of care design efforts because they need the practical, up-to-date information supervisors can provide. Despite their busy schedules, supervisors in programs that provide Family and Person Centered Practice should participate in these collaborative groups. Without their voices and input, newer, community-based services may not be developed to their full potential and with sufficient capacity to meet community needs.

²² Children’s Mental Health and Social Services Collaboratives, Minnesota; the Comprehensive Services Act, Virginia

²³ Michigan Interagency Family Preservation Initiative, and London Wraparound, Ontario, Child and Adolescent Local Area Networks, Illinois

²⁴ Communities Collaborating to Develop Wraparound in Ontario

Collaborative community groups can...

- Allow easier and increased access to formal services that address consumers' unmet needs.
- Provide greater, in depth access to informal resources that can meet consumers' needs, even needs that endure over time.
- Offer a level of cultural competence that is not often reached when only professional service providers, who may not fully reflect a community's diversity, are included.
- Bring together a wide variety of skills, talents and specialties.
- Reduce and prevent duplicative efforts.
- Build networks of mentors, respite providers, recreation coaches and other volunteers who can directly address the needs of local consumers.
- Combine already existing dollars across service modalities so that services for consumers are fairly and jointly funded.
- Find additional resources and new funding sources that allow service recipients maximum flexibility and choice.
- Make decisions collaboratively and establish local consensus on the missions, values, shape and implementation of the local system of care.
- Help everybody involved stay accurately informed about what other participants have to offer.
- Encourage support/resource people and staff to coordinate their efforts for families they share.
- Accurately reflect the voices of participants from all walks of life.

Collaborative Community Groups: Who?

When **only** gatekeepers for formal services are included in community collaborations, access to formal services improves. But that's all.

When gatekeepers for informal resources are included, community members' access to the vast wealth of supports they represent increases.

When consumers who have complex needs are included, everyone else involved is more likely to be polite, responsive, informed and compassionate. Their presence creates a needed **behavior trap** as staff who used to chat about consumers and families, sometimes disrespectfully, rethink and change how they act and how they speak. All told, everybody becomes more polite, more respectful and more concerned about the consumers' right to privacy.

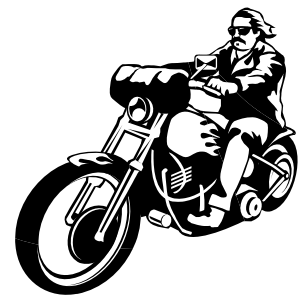
Community groups benefit from the participation of consumers, decision makers, administrators, managers and workers active in:

- Child and adult protective services
- Mental health

- Early childhood education, schools, colleges and universities
- Child welfare
- Health care and medical services
- Court
- Law enforcement
- Domestic violence shelters and service providers²⁷
- Developmental disabilities
- Vocational rehabilitation and job programs
- Economic support and food stamps
- Parks and recreation
- Occupational, physical and other therapies
- Drug, alcohol and other services related to addiction
- Government
- Hospices and related services
- And more

Collaborative community groups also benefit from the inclusion of people who are and who are active in:

- Adult and child recipients of services and people close to them
- Businesses
- Civic groups
- Faith organizations
- Recovery
- Service clubs
- Motorcycle/biker clubs²⁸
- Sororities and fraternities
- Volunteer organizations
- Cultural associations
- Neighborhood leagues
- Sports
- Arts: dance, music, theatre, sculpture, crafts, etc.
- Food banks
- Block watch
- Political clubs
- Investment clubs
- Other informal resources



²⁷ Candy Taulton, Michigan Victim Assistance Academy, Family Counseling and Children's Services

²⁸ Jae Guetschow, State of Michigan, Lenawee County

Decisions for Collaborative Community Groups²⁵

- Is anyone missing from the group? Any resources missing that help consumers meet their needs?
- Who will be eligible to participate in each program in the local system of care?
- Who can recommend a child, adult or family for inclusion in a program or service?
- What exactly constitutes a referral to the programs in the local system? Can one referral be used by all the programs? Can a single referral access the entire system of care?²⁹
- Will the collaborative group have a role in determining that a consumer will be accepted into the system or will that be up to each participating program?
- Will the group have a role in reviewing treatment plans? Approving them? Funding them?
- How will disagreements among programs participating in the system of care be resolved?
- How will consumers' grievances be addressed? Should the collaborative group have a role?
- How will the participating programs and services be monitored? Measured? What exactly are the differences between one program and another?
- Will the group define a few common outcomes that are important to local people and collect data that measures progress on these priorities?
- How will the collected data be used to inform consumers and stakeholders about progress?
- How will capacity for facilitation and coordination of resources (sometimes called case management) be increased to the level needed?

²⁵ Neil Brown and Patricia L. Miles, Brown Miles, Inc., Portland, Oregon and Columbus, Ohio, Numerous published and non-published writings, 1994-present and The Community Partnerships Group, 1995, McMurray, PA

²⁹ "No wrong door," Community Solutions, Fort Worth, Texas

Collaboration and Your Community: A Worksheet for Supervisors

Find out the following:

- Are there any groups in your community that facilitate collaboration and the development and/or expansion of the system of care?

- What does/do the group(s) (above) do?

- Who is on it (them)? Names and roles -

- Who is not part of the group/s but should be? How can they be approached, invited, and included? (don't forget consumers, families and informal resource people)

Missing Resource People	Plans for Inclusion

- Talk to at least three colleagues, families or other contacts in communities other than your own. Learn how the other communities designed their system of care and what the plusses and minuses of their decisions have been. Ask about collaborative community groups. Note anything you discover that may be useful to your community and prepare to describe it to your local collaborative group/s.

Sales, Persuasion and Supervisors

If supervisors want to expand the implementation of Family and Person Centered Practice in their communities, key people will have to be convinced that it will benefit consumers and families and that it will be fiscally prudent. Supervisors are advised not to wait until decision makers, justly and rightly, purchase their services. They and their staff are not exempt from convincing people – selling them on the idea – that what they offer has real value. Try these tips to increase your chances of successful persuasion.

- Help people see how they will benefit – personally, professionally and otherwise – from making Family and Person Centered Practice services and programs available to local consumers and families.
- Think outcomes. State clearly what your program is designed to produce, in terms that are easy to understand, transparent and measurable.
- Use simple words that reflect globally important outcomes: safety, happiness, an education, a decent job, satisfying and peaceful relationships, etc. Make sure people see that individualized, community-based services provide the surest path to achieve these outcomes for many consumers.
- Observe the people you wish to convince. What could they get out of expanding access to Family and Person Centered Practices? What could they avoid? Is it possible that people would be grateful to them? Make fewer angry phone calls? How can you use what you observe to persuade them?
- Remember, at all times, this isn't about criticizing particular supervisors who embrace "old school" service values and their programs and employees; it's about the people you seek to bring on board. Persuasion requires the persuader to focus on decision makers, not on themselves. No personal feelings allowed!
- Ask yourself, what might alienate this person? What can supervisors and staff do to reduce the chances that they will set off negative reactions in people when they need positive responses?
- Forget (temporarily) justice. Leave the "shoulds" out of it and deal with the attitudes of the people who must be persuaded. To be effective salespersons, supervisors have to focus on results, not what a truly fair response to both their programs and persuasive efforts might be.
- Supervisors should carefully consider what words they are using in their efforts to persuade. They should make a deliberate effort to use words that attach easily to the needs and mandates that are important to those they seek to bring on board. If a protective services worker or a probation officer hears a

supervisor talk specifically about child safety and community safety, that supervisor is halfway there.

- Don't give up. Supervisors should change their approaches until they find ways to convince decision makers to support Family and Person Centered services.

Examples of Persuasive Approaches

Think carefully, before trying to persuade anyone to choose your program, about exactly which words best communicate to each individual. Think about what their issues are and adjust your approach to reflect and include those issues.

For the Therapist:

Our program isn't therapy but it's therapeutic for many participants. Many therapists are involved in the treatment plans for the consumers we serve with great benefit to them. I hope that you'll find a way to participate and share your insights without betraying the confidence of your client. We can help this consumer achieve important outcomes if we work together.

For the head of the child welfare system, a political appointee:

Good Morning Ma'am/Sir, I'm here to offer some suggestions that I believe will help families safely raise their children, produce good value for the taxpayer's dollar and keep your picture off of the front page of the newspaper in yet another critical article.

For the judge who is worried about recidivism:

Your Honor, I believe - and I've seen the evidence over and over again – that we can help people meet their unmet needs and sever their connection with your court positively and effectively. I understand that the decision is yours. I just want to, hopefully, give you a few more tools to get it done and our program can be one of those tools.

For the adult consumer:

Our service isn't exactly a program like the programs you may have participated in before. It's a way of helping consumers achieve their own goals and live their lives as they decide. We're here to find out what you want, not to tell you what we think, advise and have available. It's your life, after all, and you're in charge of it.

For the desperate parent who is requesting long-term placement for a child:

I have no idea how you've managed to cope with your level of stress for so long. I'm not sure if I could do it, if I had to. If you want, I'd like to tell you about what we offer. It may make at least a few of your days a little easier, especially since it's getting more difficult to get long-term placements.

For the job program worker:

Our program helps consumers focus on outcomes, which for programs like yours means jobs. Simply placing people in work environments hasn't produced stable employment for many who have special needs. If we can discover their strengths, locate their resource people or even find resource people to mentor and assist those who are isolated, more consumers will achieve financial independence and sustain it over time.

For the child who has seen it all:

Look, whatever happens, you probably won't like it. I don't even blame you for that. Still, we can talk about a way to get you on track that's not too stupid. It can even get people off your case. Let me know if you want to hear about it. Otherwise, it'll be business as usual and you know all about that.

For the school principal:

I know it's tough to treat one child differently than the rest, especially in a classroom setting. Other children –and parents– react to that. Still, the more an Individualized Educational Plan (I.E.P.) really fits a student, the better the result. I'm here, not just to help meet this child's needs, but to find out what his/her teachers need to help him/her achieve the goals on the I.E.P.

For the protective services worker:

It doesn't always seem logical, but individualized plans that help people who have been abusive and/or neglectful build on their strengths are the single best hope for protecting vulnerable members of our society. If we can't find the strengths of perpetrators and partner with them, vulnerable children and adults will die. Our program does just that and we do it with a clear focus on safety. We work from strengths but we're realists. We understand the risks and you can count on us to plan for them and keep you well informed.

For the care coordinator, aka case manager:

People in your position have to be flexible. There's no way to reliably predict what consumers need in order to address whatever they face. In our program, we push everyone to be flexible because the plans we help our consumers and colleagues design meet consumers' needs rather than just list referrals to different providers. We try to keep our emphasis on what the consumers we serve need even when services to meet their needs are not readily available. When we work together, flexibly, we can help people meet their specific, individual needs creatively and more of them will succeed.

Telling People About Your Program or Service

You will need to define and describe what you and your staff offer repeatedly, to lots of different people who have very different concerns. For the list below, analyze how your program could best be described.

Person/Role	Important points to make	Relevant Illustrations
Parent advocate		
Judge		
Discharge planner in a congregate care facility		

Person/Role	Important points to make	Relevant Illustrations
Director of the Boys and Girls Club		
Social worker at domestic violence shelter		
Congregate care and group home staff		
Teacher		

Person/Role	Important points to make	Relevant Illustrations
Probation officer		
Attorney		
Adult consumer		
Public Health nurse		

Person/Role	Important points to make	Relevant Illustrations
Brother/sister of a child consumer		
Hospital social worker		
Grandpa & Grandma		
Guardian Ad Litem		

Person/Role	Important points to make	Relevant Illustrations
Spiritual leader		
Agency administrator		
Psychiatrist		
Business leader		

Person/Role	Important points to make	Relevant Illustrations
Specialist concerned with developmental disabilities		

