Indiana System of Care Phase II: A Case Study of Development, Implementation, and Evolution

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FoCuS: Supporting partnerships among families, communities, and schools through collaboration engagement, and research.
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Acknowledgements
This study would not have been possible without the support of countless people, including families, along with local systems of care and state agencies. Most importantly, we thank the staff of the Indiana System of Care (IN-SOC) for allowing us to conduct this study and make the connections needed to collect the necessary data for this report. Likewise, we are indebted to the people who took time to interview with our team. We also wish to thank Indiana University and the IU School of Education for its support. Finally, the idea for this study emerged out of collaborative research being conducted with One Community One Family and the relationship it has with the Indiana Division of Mental Health and Addiction.

The Indiana University Families, Communities and Schools (FoCuS) team strives to improve its work. We thank you for your interest in this project and welcome your questions and suggestions.


Executive Summary
The IN-SOC Phase II study aims to better understand the gaps in the Indiana System of Care (IN-SOC) structure that were identified within Phase I of the study, titled, Indiana System of Care: A Case Study of Development, Implementation, and Evolution. Phase I indicated several positive findings and a few challenges primarily related to items that were to be addressed in year two of the grant. The Phase I study found that the IN-SOC team positively influenced family and youth “voice,” exhibited or established a strong culture of caring leaders, and demonstrated progress regarding cultural competency. Areas of needed improvement included workforce development, service gaps, and funding and finance issues to ensure long term sustainability.

Phase II of the study also focused on the developmental progress of IN-SOC using two frameworks: “community readiness,” as studied by Behar and Hydaker (2009, 2012), and the use of the “most underutilized strategies” along with “state and community partnerships” as studied by Stroul & Friedman (2011). Following a mixed methods case study design, multiple sources of data were utilized: (1) ten interviews with state, agency, and local leaders as well as family, caregivers, youth, and community members involved with IN-SOC; (2) documents review, and (3) survey responses. Analyses results yielded six main findings:

1. **IN-SOC is meeting its goal of implementing family-driven, youth-guided services and expanding family and youth involvement at the state level.**
   Although Behar and Hydaker (2012) considered Family & Youth as Partners as one of the “least ready” and lowest ranking areas within the participating sites in their study, both Phase I and Phase II of the IN-SOC studies indicate Family & Youth as Partners as one of the strongest areas at the state level. However, more work is needed at the local levels.
2. **IN-SOC has made progress in expanding its partner and provider networks.**
   Network of Local Partners was another low-ranking cluster in the 2012 Behar and Hydaker study; however, IN-SOC has demonstrated improvement in the area of Network of Local Partners, beginning in late 2016 to present, especially at the state level.

3. **IN-SOC continues to cultivate leaders and champions, though new challenges have emerged.**
   Although the interviewees in the Phase I study emphasized there were champions at both the state and local level who fostered a high performing team atmosphere, new challenges were identified in Phase II, such as a loss of influential SOC leaders, resulting in gaps and challenges.

4. **IN-SOC is incorporating the system of care approach in monitoring protocols.**
   IN-SOC has incorporated site reviews, quality improvement audit data—particularly in the area of cultural and linguistic competency—and will collect data which includes working with the Family and Social Services Administration (FSSA) using Medicaid data. This is with the intent to analyze and identify disparities in individuals’ access to and utilization of mental health services.

5. **IN-SOC is improving the cultural and linguistic competence of services.**
   With the hiring of the Cultural Linguistic Coordinator, these services are continuing to grow. However, the need is still great as many counties have not yet received training in this area.

6. **IN-SOC is working toward developing a broad array of services, evidence-based practices, and more natural supports to bolster sustainability efforts.**
   IN-SOC has made progress in incorporating evidence informed approaches for families, partners, and staff. In addition, it is fostering grass-roots approaches to services to better ensure long-term sustainability.

**Limitations.** Obviously, given the nature of this study, caution is urged in how the findings from this report are interpreted and used. The research team suggests considering this report as a starting point for further conversation. As such, readers are reminded that there are important limitations to this study. First, data collection was small, limited in scope, and fairly subjective. Purposeful sampling was used as part of an effort to interview people who would have the necessary experiences to provide useful information. The researchers also recognize the possibility that not all stakeholder perspectives were represented in our study processes and therefore, while unlikely, making it possible that a different group of respondents could have produced a different set of findings.
Introduction

The first phase of the Indiana System of Care study, titled, *Indiana System of Care: A Case Study of Development, Implementation, and Evolution*, focused on the preliminary strategies and progress of a statewide level system of care (SOC) structure within the Indiana SOC expansion initiative to sustain state and local SOCs. Phase I of the study sought to understand key steps of the new initiative. Components identified included building local governance, establishing an evaluation subcommittee, collaborating with partners, and incorporating the SOC values and principles into practice. See Table 1 for recommendations from Phase 1.

Several gaps in the SOC structure were also identified in Phase I, including: the development of family and youth voice, specifically at the local level; advancing and deepening the workforce development subcommittee; addressing cultural competency and disparity challenges; identifying and addressing service gaps, particularly effective, intensive services throughout Indiana; continuing to build a strong internal culture of caring leaders; and proactively addressing funding and finance issues to ensure long term sustainability.

Phase II of the Indiana SOC study sought to address the gaps that were identified within Phase I of the study, including a deeper focus on “unconventional” SOCs—sometimes thought of as more naturalistic approaches (e.g., nonprofit, neighborhood, or faith-based entities); collaborations with new partners; and sustainability plans. Unique to Phase II is an added examination of the developmental progress of IN-SOC in terms of its “community readiness,” as articulated by Behar and Hydaker (2009, 2012), and the use of the “most underutilized strategies” along with “state and community partnerships” as described by Stroul & Friedman (2011).

Theoretical Framework

The purpose of the IN-SOC Phase II study was to gain a clear understanding of how IN-SOC engages in efforts to expand and improve statewide health, mental health supports, and accessibility for young people and their families. To accomplish this goal, the research team worked with stakeholders to develop a useful mixed methods framework that would guide the study. This resulted in the decision to use the Phase II project to examine the developmental progress of IN-SOC through the lens of two well-known frameworks: “community readiness” (Behar & Hydaker, 2009, 2012) and the increased use of “most underutilized strategies” (Stroul & Friedman, 2011). Behar and Hydaker’s (2009, 2012) SOC community readiness framework examined factors considered to be most essential in developing SOCs, including areas considered to be “least ready” but key to deeper involvement and expansion of SOCs. The research team primarily focused on these least ready elements within the IN-SOC expansion work.

Framework 1: Community Readiness

As suggested by Behar & Hydaker (2012), the process of assessing community readiness is an essential and informative step in SOC implementation. They asserted that:

The concept of “community readiness” offers an important contribution to improving the planning and implementation process for communities. Being able to understand what factors are important to the successful implementation of a
system of care should help communities assess their own strengths and weaknesses and address the areas of weakness. (p. 15)

Table 1. Recommendations from Phase 1

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<td>1.</td>
<td>Improve access to effective behavioral health and other supports statewide, including, but not limited to: wraparound, integrated health care, mobile crisis and acute inpatient resources, paying particular attention to rural areas.</td>
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<td>2.</td>
<td>Develop a sustainability plan for wraparound using multiple funding streams along with the development and sustainability of local SOCs.</td>
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<td>3.</td>
<td>Increase monitoring of and remain responsive to disparities based on socio-economic and geographic factors, gender, race, ethnicity, language, and legal status.</td>
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<td>4.</td>
<td>Increase robust discussions about identifying gaps, opportunities, and prioritization of services and have youth and family involved in these topics in meetings throughout the state.</td>
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<td>5.</td>
<td>Actively address the dearth of child psychiatrists, psychologists, and masters licensed professionals.</td>
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<td>6.</td>
<td>Develop the proposed sustainability plan that will go beyond the grant for local and state SOCs.</td>
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<td>7.</td>
<td>Ensure that a pipeline of effective leaders is available who are committed to continuing the strong culture of care that has developed over the last several years.</td>
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<td>8.</td>
<td>Provide a specific and ongoing focus on access to services, supports, and infrastructure in rural areas.</td>
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<td>9.</td>
<td>Address the need for better representation from the Department of Education, juvenile and corrections agencies, as well as from the State Department of Health and Medicaid.</td>
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<td>10.</td>
<td>Involve more colleges and universities to promote the concepts associated with SOC, wraparound, and other evidence-based practices.</td>
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<td>11.</td>
<td>Continue to ensure all partners are at the table, comfortably connected, and fully engaged.</td>
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Using multidimensional scaling and cluster analyses, Behar and Hydaker designed a community readiness assessment scale which included 109 statements rated on a five-point scale from “least ready” to “most ready.” To determine community readiness, their assessment was conducted with a broad array of national experts drawn from 24 of 27 newly federally-funded systems of care communities across the United States who participated in the planning. The study was designed to further the understanding of community readiness and gathered data from 506 stakeholders who participated in the study, including project leaders, staff, partner agencies, parents, youth, community leaders, and others. These 109 statements were organized into eight clusters and rated by site representatives according to importance and difficulty of implementation. “The resulting information has identified the concepts that the participants believe to be central to readiness and are the most important and easiest/most difficult to implement” (Behar & Hydaker, 2012, p. 5). The following were rated on a scale of one to five, with one being least ready and five being most ready:

- Collaboration 3.51
- Accountability 3.44
- Evaluation 3.39
- Plan to Expand Services 3.39
- Leadership 3.35
- Shared Goals 3.25
- Network of Local Partners 3.21
- Family & Youth as Partners 3.13

The “least ready areas” (in bold above) include 1) Shared Goals; 2) Network of Local Partners, with specific focus on “non-traditional” partners, such as, advocates, community leaders, and volunteers; and, 3) Family & Youth as Partners. As summarized by Behar & Hydaker (2012), these least ready cluster areas indicate “the next steps, deeper steps, in the collaborative process will require strengthening and broadening local partnerships with agencies, providers, families and youth” (p. 28).

Through Phase II, we examined the extent to which IN-SOC has progressed in its efforts to address the “least ready” cluster areas in order to understand where IN-SOC stands in comparison to the “ideal” that the authors established within a panel of national experts in the area of community readiness.

Framework 2: Underutilized Strategies

The second framework used in the Phase II analyses was drawn from the “most underutilized [SOC] strategies” defined by Stroul & Friedman (2011). By examining strategies that have been found to be underutilized in other SOCs (i.e., those strategies that could have been used but were not used extensively for expansion purposes), the research team observed the extent to which the underutilized strategies identified by Stroul and Friedman have been implemented within IN-SOC. Specifically, the research team explored if these strategies were currently being implemented in IN-SOC, and, if so, to what degree and with what impact.
Stroul and Friedman (2011) listed the **most effective strategies as well as those found to be most underutilized** by the nine states selected for inclusion in their study due to the significant progress made in their statewide system of care expansion. The study included a total of 52 interviews that were conducted with stakeholders from Arizona, Hawaii, Maine, Maryland, Michigan, New Jersey, North Carolina, Oklahoma, and Rhode Island. The participants were asked to identify: 1) which strategies were used; 2) to assess the effectiveness of those strategies; and 3) to provide specific examples of how the particular strategies were used. Interviewees were also asked to make overall judgments about the strategies they believed to be the most effective. As a result, **several strategies were identified as underutilized—strategies that could have been used but were not used extensively** for expansion purposes in the sample of states. Stroul and Friedman (2011) concluded that these **underutilized strategies have the potential to advance expansion efforts**. Stakeholders were also asked to identify challenges and barriers to expanding systems of care. Two barriers stood out as major concerns across states: “fiscal crises with accompanying budget cuts” and “changes in administration that could potentially result in policy changes” (p. 80). Other significant challenges included “insufficient buy-in and financing from other child-serving systems,” “lack of a children’s mental health workforce trained in the system of care approach,” and “loss of federal funding and accompanying supports for systems of care” (p. 80). These challenges create complexities within SOCs that make it difficult to understand the true impact SOCs are having within communities.

In Stroul and Friedman’s (2011) study, eight strategies were considered to be the **most significant underutilized strategies**:

1. Incorporating the system of care approach in monitoring protocols to monitor compliance with system of care requirements
2. Creating or expanding the use of evidence-informed and promising practices
3. Creating or expanding the provider network
4. Improving the cultural linguistic competence of services
5. Redeploying funds and using data on cost avoidance
6. Increasing the use of state mental health funds, funds from other child serving systems, and local funds
7. Generating support through social marketing and strategic communications
8. Cultivating leaders and champions for the system of care approach (p. ii).

Similar to Behar and Hydaker (2009, 2012), Stroul and Friedman’s (2011) underutilized strategies are those that were not used extensively for expansion purposes but had great potential to advance expansion efforts. Therefore, this was the rationale behind the IU research team choosing these studies to use as scaffolding for Phase II of the IN-SOC expansion efforts. In addition to the underutilized strategies, Stroul and Friedman focus on **state-community partnerships** for expanding the SOC approach. The authors concluded that “without state involvement, the likelihood of sustaining federally funded systems of care beyond the grant-funded period is significantly diminished” (p. 78). The IU research team also explored the crucial role that the state and communities serve in expanding the system of care approach in Indiana.
Finally, gaps uncovered during the IN-SOC Phase I study, along with any new initiatives and strategies started during Phase I, were also explored vis-à-vis the community readiness framework (Behar & Hydaker, 2009, 2012) and most effective and most underutilized strategies (Stroul & Friedman, 2011). Table 2 below provides a synopsis of our findings, which includes quotes from interviewees.

**Background and Brief Literature Review**

In the United States, the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Comprehensive Community Mental Health Services for Children and their Families Program (CMHI) has been a primary funder of SOCs (Huang, Stroul, Friedman, Mrazek, Friesen, Pires, & Mayberg, 2005). As reported in Phase I of our study (Anderson, Ergulec, Ruschman, 2016), historically, SOCs promoted well-coordinated, community-based care for children with serious mental health needs and their families (Anderson, 2000; Stroul & Friedman, 1986; Stroul, Blau, & Sondheimer, 2008). SOCs are defined as effective, community-based services and supports for children and youth and their families with or at risk for mental health or other challenges, while also creating meaningful partnerships among systems and agencies, most importantly, with families and youth (Stroul & Blau, 2010). The SOC model was originally “based on the recognition that traditional service delivery structures and practices have had limited success, particularly for children with serious and complex mental health needs who are involved with multiple child-serving systems” (Stroul, Goldman, Pires, & Manteuffel, 2012, p. 2). However, over the past decade, the SOC concept has broadened dramatically, expanding the focus to a much wider range of children and families, not just those experiencing emotional behavior needs, by assisting communities to build interagency models of prevention and early intervention (Anderson, Ergulec, Cornell, Ruschman, & Min, 2016). At the state level in Indiana, according to project leadership, the purpose of the IN-SOC initiative is “to model and provide leadership, guidance, technical assistance, and policy change at the state level to ensure that a local system of care is available for every child, youth, young adult and their families” (FSSA, 2016).

Since its inception, CMHI has emphasized program evaluation and continuous quality improvement as guides for the development of SOC infrastructure (Sheehan, Manteuffel, Storman, & King, 2008). As such, evaluators and applied researchers have been integral to the development, implementation, and growth of the SOC concept. Blau, Huang, and Mallery (2010) noted, “Improving partnerships between researchers, mental health workers, and consumers will no doubt improve system functioning” (p. 3) and some evidence points to the success of these efforts (Stroul & Friedman, 2011). This design is deliberate in its intention to implement ongoing feedback loops that emanate from the systematic collection of data at child, family, service, and system levels (Anderson, 2016; Sheehan et al., 2008). Further, the flexibility in the SOC framework necessitates that locally available mechanisms structure and facilitate interagency collaboration and coordination (Anderson, Crowley, Dare, & Retz, 2006). On the other hand, SOCs are predicated on the widespread adoption of a common set of values and principles (Anderson et al., 2016). This allows SOCs to emerge and evolve based on a community’s specific needs. As such, SOCs are dynamic and designed to
Table 2. Indiana System of Care Expansion Efforts as Compared to Behar and Hydaker’s Community Readiness

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<tr>
<th>Community Readiness Study</th>
<th>IN-SOC Expansion Efforts</th>
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<td>Behar and Hydaker (2012)</td>
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- Behar and Hydaker’s (2012) SOC community readiness framework in which factors considered to be essential in developing SOCs were examined, along with factors that were considered as “least ready but key” to deeper involvement and expansion of SOCs.

- Study on 24 sites provides a detailed, statistically based description of community readiness described by eight clusters (Least Ready in bold):
  - Collaboration
  - Accountability
  - Evaluation
  - Plan to Expand Services
  - Leadership
  - Shared Goals
  - Network of Local Partners
  - Family & Youth as Partners

- The “least ready areas” indicate that the “next steps, deeper steps, in the collaborative process will require strengthening and broadening local partnerships with agencies, provider families and youth” (p. 28).

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<th>Family &amp; Youth as Partners</th>
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<td>This cluster was the number one “least ready” cluster in Behar &amp; Hydaker (2012). Findings in both Phase I and Phase II of the IN-SOC study indicate that great strides have been made at the state level within the Family &amp; Youth as Partners area, though more work is needed at the local levels. The IN-SOC studies show that, “Having one-third of the board comprised of youth and family is a milestone for the state and the project. Having youth and family input on policy and other important decision making is a considerable improvement within IN-SOC.”</td>
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<th>Network of Local Partners</th>
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<td>Network of Local Partners was another low-ranking cluster in the 2012 study, specifically “non-traditional” partners, such as advocates, community leaders, and volunteers. IN-SOC has demonstrated improvement in the area of Network of Local Partners, beginning in late 2016 to present, especially at the state level. However, struggles in this area continue, especially at the local level: “The IN-SOC board and state partnerships are growing but we need more diversification/representation across all counties.” Some also believe partners at the state level need to grow as, “At the state level, too many [people] just don’t show up.” Surveys indicated that the state needs to recruit and better engage key partners such as the Department of Corrections and Bureau of Development Disabilities Services, among others, which would develop a more effective and sustainable state-wide system.</td>
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<th>Shared Goals</th>
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<td>Both Phase I and II of the IN-SOC study appear to indicate that goals are being shared at the state and local level as well as with partners. One interviewee stated: “One of the things that many of the board members are interested in is improving access to care for youth and families and I think that there have been several subcommittees developed to assist in the development of or into achieving that</td>
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<td>Community Readiness Study</td>
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• The lowest ranking, but most important, cluster in Behar and Hydaker was Family & Youth as Partners. “Non-traditional” partners, such as parents, advocates, community leaders, and volunteers.

References

shared goals. *We have several partners who also share this goal.*” Another stated, “One of the ways that we develop goals is through the enhanced multi-disciplinary team which is separate from IN-SOC. A family member’s perspective included the following: “I am so used to collaboration that when providers sit down at the table I don't care if I sit in as a provider or a parent. I feel like everybody's voice is being heard and we all do have the same goal. We have the same goal of making it easier for families to get them the resources and help they need for their kids.”

• However, there are pockets at the local level in which partnerships have not fully developed or developed at all. At last count, approximately 10 of the 92 counties did not have an active SOC, and therefore did not have a network of partners, and some of the SOCs were still struggling with developing those partnerships. Still, the number of partners and active SOCs has risen sharply since 2015 which demonstrates strong growth in a short period of time and should be celebrated.
Table 2 continued. Indiana System of Care Expansion Efforts as Compared to Stroul and Friedman’s Most Underutilized Strategies / State and Community Partnership Study

| Most Underutilized Strategies & State-Community Partnerships | IN-SOC Expansion Efforts  
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<th>Stroul and Friedman (2011)</th>
<th>As Related to Stroul and Friedman (2011)</th>
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| Stroul and Friedman (2011) focused on SOCs’ adoption of “most underutilized” but key strategies (those strategies that could have been used but were not used extensively for expansion purposes) in addition to “state and community partnership” strategies. The most underutilized but key strategies include:  
- Incorporating the system of care approach in monitoring protocols in compliance with system of care requirements  
- Creating or expanding the use of evidence-informed and promising practices  
- Creating or expanding the provider network  
- Improving the cultural linguistic competence of services  
- Redeploying funds and using data on cost avoidance  
- Increasing the use of state mental health funds, funds from other child serving systems, and local funds | The eight strategies in Stroul and Friedman were those most underutilized in the SOCs they studied. In our IN-SOC study, all eight were in use, some with greater depth than others.  
- (1) Incorporating the system of care approach in monitoring protocols in compliance within the SOC requirements. Stroul and Friedman noted that “the use of monitoring protocols as a mechanism for assessing the implementation of system of care requirements was not identified as a frequently used strategy” (p. 35). IN-SOC, however, has incorporated site reviews, quality improvement audit data, particularly in the area of cultural and linguistic competency, and are developing data dashboards that can be used to communicate SOC health/effectiveness and will collect data which includes “working with FSSA to pull Medicaid data with the intent to analyze and identify disparities in our access to and utilization of mental health services.”  
- (2) Creating or expanding the use of evidence-informed and promising practices: IN-SOC has made progress in conducting regional trainings in a number of evidence-informed practices such as Positive Behavior Interventions and Supports (PBIS), Trauma Informed Practices, Cultural and Linguistic Competency training, and has plans for additional technical assistance (TA) and trainings in the future. Although the state has made headway with TA and evidence-based trainings and practices, there are complications primarily around capacity. In order to improve in this area, more modeling and training needs to occur, particularly training for new SOC Coordinators. Some stakeholders believe that before new programmatic training is developed there needs to be better training and support for the local SOC coordinators: “The support to local systems of care has been an ongoing struggle. The technical assistance needed for local systems is the development and training of the local coordinators. Most of the energy and effort has been spent focused on the development of partnerships and strategic plans without a focus on the coordinators understanding of their role and responsibilities to that system.” And, “There should be much more clarity in aligning the support with the national SOC movement.” |
Table 2 continued. Indiana System of Care Expansion Efforts as Compared to Stroul and Friedman’s Most Underutilized Strategies / State and Community Partnership Study

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<th>Most Underutilized Strategies &amp; State-Community Partnerships</th>
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<td>Stroul and Friedman (2011)</td>
<td><strong>New SOCs as they are developed need more resources around how to do the day-to-day work of SOC coordination.</strong></td>
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<td>• Generating support through social marketing and strategic communications</td>
<td><strong>(3) Creating or expanding the provider network:</strong> This strategy is a compilation of several strategies that have been touched on previously. IN-SOC is working to expand its provider network and has made progress, but is experiencing challenges in pockets of the state, again, primarily around capacity. Expanding the provider network involves deeper relationship building, funding, recruitment strategies, and more TA to more effectively and efficiently service the needs of state and local SOCs. To continue improving youth and family involvement, at which IN-SOC has excelled, “There needs to be a larger entity of youth and family technical assistance to help guide this process. We need to know better how to build that [youth and family] development at the local level. Workforce development is a huge barrier within the social service system. We are struggling to provide a continuum of services from the top tier to the outpatient setting. There are struggles with the rigidity of requirements for wraparound facilitators and the licensing requirements for therapists.” In order to identify the most important workforce issues in Indiana, IN-SOC developed and conducted a Workforce Issues Survey and plans to use data from the survey to develop a proposal to address workforce issues. One approach that has addressed this is funding that comes from Project LAUNCH, a program that focuses on children birth to five years of age. LAUNCH provides funds for TA webinars for early education and other child serving professionals across the state.</td>
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<td>• Cultivating leaders and champions for the system of care approach</td>
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<td><strong>State and Community Partnership strategies</strong></td>
<td><strong>(4) Improving cultural linguistic competence of services.</strong> With the hiring of the Cultural Linguistic Coordinator last year, these services are continuing to grow though the need is still great, as evidenced by one stakeholder: “We need a lot more cultural competency training and development. Really looking at community culture, individual culture, family culture, you know and the disproportionality of the people who are being over served or under severed in the community in various ways.”</td>
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<td>In addition to the underutilized strategies, Stroul and Friedman focus on state-community partnerships for expanding the system of care approach. The authors concluded that “without state involvement, the likelihood of sustaining federally funded systems of care beyond the grant-funded period is significantly diminished” (p. 78). Additionally, the authors noted “the importance of the community involvement in sustaining systems of care and expanding them to other areas” (p. 78).</td>
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**Table 2 continued. Indiana System of Care Expansion Efforts as Compared to Stroul and Friedman’s Most Underutilized Strategies / State and Community Partnership Study**

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- **(5) Redeploying funds and using data on cost avoidance.** IN-SOC is currently collecting data on service use and expenditures, exploring methodologies for reviewing disputes regarding paid claims of Medicaid monies and other initiatives and incentives of Medicare dollars. “We’re working with FSSA to pull Medicaid data with the intent to analyze and identify disparities in our access to and utilization of mental health services.”

- **(6) Increasing the use of state mental health funds, funds from other child serving systems, and local funds.** One way IN-SOC has incorporated this strategy is by utilizing the federally funded Temporary Assistance for Needy Families (TANF) program to fund Parent Cafes in 34 Indiana counties to help with youth and family development. In addition, 18 local coordinators are funded through the State Psychiatric Fund.

- **(7) Generating support through social marketing and strategic communications.** Social marketing is a gap that needs to be addressed as mentioned by survey participants: “Social marketing for System of Care has not been overly present.” And, “Social marketing is also something I am not sure if we are doing well at. Is there Facebook, etc. that helps to promote our messaging?”

- **(8) Cultivating leaders and champions for the SOC approach.** The interviewees in the Phase I study were in agreement that there is a phenomenal team at the State level, and many emphasized there were champions at both the state and local level who foster a high performing team atmosphere. However, from Phase I of the study to Phase II, shifts occurred within the leadership team at the state level which seemed to elicit new challenges. As stated in the IN-SOC site visit presentation, the “loss of three influential SOC team members created period of loss and shifting of responsibilities to fill in the gaps.” Still, in both Phase I and Phase II, several stakeholders attribute the success of engaging family and youth to champions in some key positions who influence other members of the subcommittee. “I think we have some key people on the youth and family
| Most Underutilized Strategies & State-Community Partnerships | IN-SOC Expansion Efforts  
|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Stroul and Friedman (2011)                                 | subcommittee that are very invested... They have empowered others to speak up, speak their mind, and throw things out there to forge partnerships with all the rest of us.”  

**State and Community Partnership Strategies**

Much like Behar & Hydaker’s Network of Local Partners, Stroul and Friedman’s focus on the importance of State and Community Partnerships as a way to build long-term sustainability, especially once the funding cycle ends. One key community partnership within IN-SOC that interviewees referred to as a good illustration of natural supports or grass-roots efforts is the Lutheran Foundation. Its focus is to “foster strategic partnerships in support of effective approaches to solutions addressing unmet community needs.” (The Lutheran Foundation, n.d.). Conversely, regarding community partnerships, an interviewee mentioned, “there are pockets at the local level in which partnerships have not fully developed.”
evolve in response to new knowledge, evaluation findings, and changing state and local contexts (Anderson & Cornell, 2015).

Given these complexities, it was not unexpected that as part of the national CMHI evaluation, Stroul and Mantuelfel (2008) stressed that state agencies are crucial for providing both leadership and resources in sustaining local SOC initiatives within a given state. The authors recommended that state level implementation strategies include: “(a) incorporating the approach in policy documents, plans, guidance, regulations, and contracts with providers; (b) implementing long-term financing strategies; (c) establishing partnerships across child-serving agencies; (d) implementing new services statewide; (e) providing training and TA; (f) removing barriers in policy, regulations, and financing identified by communities; (g) and monitoring compliance with the approach and evaluating outcomes” (Stroul & Friedman, 2011, p. 5).

Method

The Phase II study employed a mixed-method case study design. Broadly, a case study methodology, that incorporated aspects from both qualitative and quantitative traditions, was implemented to allow for “an exploration of a bounded system or a case (or multiple cases) over time through detailed, in-depth data collection involving multiple sources of information rich in context” (Creswell, 1998, p. 61). Multiple data sources help to increase the validity of the interpretation by confirming or sometimes rejecting findings from one source of data with other sources of data (Yin, 1989).

Similar to Phase I, the Phase II study primarily utilized key stakeholder interviews and document analyses as data sources. Phase II additionally included information from hard copy and online surveys, used to elicit input from a wider range of stakeholders regarding the success and challenges of the SOC expansion in Indiana. The goal was to gain a better sense of where IN-SOC stands in terms of its work to improve statewide health needs for youth and families.

Data Collection and Study Sample

Data for this study were collected primarily through semi-structured interviews with ten state, agency, and local leaders, including representatives of family, caregiver, and youth groups, along with various community members involved with IN-SOC. In addition, public documents created through IN-SOC and its partners, as well as other documentation that stakeholders shared with the evaluation team (e.g., agendas, meeting minutes, websites, and presentations) were used. Further, in collaboration with IN-SOC partners, the research team developed and distributed a survey (see Appendix B) to elicit assessments from a wider range of stakeholders. A hard copy of the survey was distributed during the IN-SOC governance board meetings in April and August of 2017. A modified version of the survey was also distributed online after the IN-SOC statewide conference in June, 2017 (see Appendix C).

Purposive sampling techniques (Merriam & Tisdell, 2015; Patton, 2015) were used for the interviews. The research team generated criteria for deciding who should be invited to be interviewed (e.g., current or potential partners in the IN-SOC). The criteria were examined by IN-SOC personnel and stakeholders, revised by the study team, and finalized. Twelve potential interviewees were invited via email, with ten agreeing to participate. Interviews were conducted via telephone and were scheduled at a convenient
time for the participant. Each interview lasted approximately forty minutes to one hour in length. All interviews were audio-recorded and transcribed for analyses.

Secondly, public documents developed by IN-SOC staff and its partners were utilized in addition to documents that stakeholders shared with the evaluation team. Documents were specifically targeted that would help the researchers create and report an in-depth understanding of the practices of IN-SOC.

**Data Analyses**

Consistent with case study design, data triangulation was employed by using multiple sources of evidence (interviews, documents, and surveys), aimed at corroborating findings (Patton, 2002). Specific aspects of the data analyses are described in the following sections.

**Interview Analyses**

All interview recordings were transcribed and analyzed independently by two researchers. Using the qualitative analysis software, Dedoose, each interview transcript was imported into the program. Dedoose was chosen for its simple user interface and ability to allow multiple researchers using Mac or PC systems to simultaneously collaborate (Talanquer, 2014). Dedoose also calculates the percentage of agreement among multiple coders along with inter-rater reliability coefficients.

Following a theoretical/deductive thematic analysis approach (Braun & Clarke, 2006), the researchers attempted to fit the data into a pre-existing coding frame. The pre-existing codes were derived from the Stroul and Friedman (2011) study, the Behar and Hydaker (2009, 2012) study, as well as gaps found in Phase I.

To become familiar with the data, the coder first read through the data set at least once, after which the formal coding process began. After the data were initially coded, the analysis re-focused on the broader level of themes rather than codes (Braun & Clarke, 2006), which “involves sorting the different codes into potential themes and collating all the relevant coded data extracts within the identified themes” (p. 89). All themes were subsequently revised. For example, if there were not enough data to support a theme, that theme was eliminated. After all themes were revised, they were used to craft the content of the study. By gathering all the content coded “family and youth voice,” for example, Dedoose enabled researchers to read back-to-back all interviews related to that content. It was an important process of the analysis, as it enabled a complete representation of a given content area.

**Document Analyses**

In addition to interviews, document analyses were conducted (Bowen, 2009). Documents were analyzed after the interview data analyses and the themes generated from the analysis were used as a framework to deductively analyze the documents. New themes were generated when the document data did not fit the pre-determined themes. Documents from IN-SOC were also used to support the findings of the study.

**Survey Analyses**

Similar to the interview analyses, a survey was developed utilizing themes based on the Stroul and Friedman (2011) and Behar and Hydaker (2012) studies. As it was not
feasible to interview all stakeholders, the survey was designed to gain the perspectives of a broader range of stakeholders regarding IN-SOC’s progress and development. The hard copy survey included seven areas of focus. First, we asked the role of the participant serving on the IN-SOC team; for the remaining items, the participants were asked to rate six statements according to importance. Each statement required participants to rate at both the local and state levels on a five-point Likert scale, ranging from “strongly disagree” to “strongly agree.” The online survey, which was provided at the annual statewide Indiana Systems of Care Conference, was slightly modified. A “neither agree or disagree” option was added and the online survey primarily focused on state-level assessments whereas the hard copy survey focused on both the local and state level.

The hard copy survey was provided to stakeholders who attended quarterly statewide governance meetings in April and August of 2017, with 28 participants completing the April survey and 30 completing the August survey. The April respondents included 11 family members/caregivers, 10 state SOC members, along with some local SOC members, SOC coordinators, partners, subject matter experts, and youth. Some respondents selected more than one role option. The August survey included 17 state SOC members, 13 local SOC members, 10 family members/caregivers, as well as SOC coordinators, subject matter experts, partners, young people, and those in the Other category (respondent rates less than 10 are not listed).

The online survey was offered to approximately 250 participants of a pre-conference session primarily designed for SOC members and SOC coordinators, which took place the day prior to the June 2017 System of Care Conference. The survey was completed by 46 participants garnering an 18.4% response rate. The online survey respondents included 15 SOC coordinators, 15 local SOC members, state SOC members, partners, family members/caregivers, subject matter experts, and young people. To preserve anonymity, additional details about survey respondents are not provided.

Findings

Analysis of the in-depth interviews, documents review, and surveys revealed six main findings related to new initiatives, ideas, or strategies that emerged after the Phase I study, including a deeper focus on natural supports, new partners, and the development of unconventional SOCs. Each finding involves several subcategories that more fully explain the corresponding finding and includes quotes from interviewees to illustrate central findings through the voice of the study participants (Anderson, et al., 2016).

1. IN-SOC is meeting its goal of implementing family-driven, youth-guided services and expanding family and youth involvement at the state level

Comparing Behar and Hydaker (2012) with the findings of IN-SOC Phase II, it is clear that IN-SOC has been a strong model for the local SOCs in terms of giving primacy and voice to the value of family voice and choice. Several stakeholders found the incorporation of family-driven and youth-guided principles to be exemplary within the state governance entity. The stakeholders especially mentioned the involvement of the youth and family subcommittee in decision-making processes.

Indeed, the IN-SOC Governance Board currently has 27 voting members with eleven of the seats held for youth and family member representation. Interviewees noted that having one-third of the board comprised of youth and family is a milestone for the
state and the project. For example, every policy that the IN-SOC Governance Board passes is first voted on by the Youth and Family Subcommittee (YFS). IN-SOC leadership also requested that the YFS review and approve the self-assessment tool, Systems of Care Implementation Survey (SOCIS), to ensure it included family-friendly language.

Having youth and family input on policy and other important decision-making is a considerable improvement within the IN-SOC project. All the interviewees remarked that they were impressed by the level of success that the state has had in authentically engaging and literally giving voice to youth and families within this subcommittee.

One interviewee mentioned, “The Youth and Family Subcommittee is coming along splendidly. We’re so happy to have the youth and family there [and the] families are also really grateful.” Most stakeholders agreed that the state has done an excellent job of demonstrating youth and family inclusion while at the same time staying sensitive to limitations regarding their knowledge of the system. Another interviewee stated that an approach IN-SOC takes to ensure youth and family are comfortable at the subcommittee and governance meetings is to curtail or completely discontinue the use of acronyms during meetings—an idea that was generated by a family member. The board agreed and adopted this practice, making it a point to not use acronyms so that family and youth can readily understand what is being discussed. For example, instead of saying DMHA, it would be stated as Division of Mental Health and Addiction. These small steps allowed families to feel more comfortable within the team and, having a better understanding of the topics, participate more fully.

Another important aspect was that the YFS modeled this process to other SOCs by conducting their meetings in different locations around the state. This allowed local communities and regions to gain a sense of what it might be like to include youth and families in local SOC meetings. As an incentive, families involved in the subcommittee meetings who were voting members received a small Youth and Family Stipend for attending. The intention behind the stipend was to encourage families to attend and participate in the meetings. One of the members of the subcommittee stated, “The Youth and Family Subcommittee is very empowering. I am always amazed how people change after they come to a couple meetings and how all of the sudden they start [participating] and they’ve got opinions. It’s just amazing to me….I love it.” However, the YFS is currently working to identify a sustainability plan for funding Youth and Family Stipends as “the level of youth and family engagement and involvement at the state SOC level creates a financial challenge in regard to grant year-4 funding for Youth and Family Stipends” (IN-SOC site visit presentation).

Two key entities that have served an important role in ensuring youth and family involvement at the state level are the nonprofit organizations Youth MOVE (Motivating Others through Voices of Experience) and NAMI (National Alliance on Mental Illness). Each includes Indiana chapters within national organizations. Youth MOVE Indiana is a national youth-led organization with five chapters in Indiana. Its focus is to improve services and supports for youth, bring about positive change, and serve as youth advocates in the areas of mental health, addiction recovery, LGBTQ, juvenile justice, and suicide prevention (Youth MOVE Indiana, 2013). Youth MOVE has a strong presence on the YFS and IN-SOC Governance Board and ensures that a local SOC is available for all youth. Through events, dialogue, and open meetings, the Indiana chapter provides
technical assistance and advocates for policy change at the state level. Representatives of Youth MOVE are also engaged in the Indiana Suicide Prevention Advisory Council and monthly Indiana Public Policy meetings.

Through education and training programs, NAMI Indiana supports and advocates for people living with mental illness. The nonprofit is a youth and young adult peer support provider, offering a one-week paid training course for young adults who wish to provide peer support to others. Trainees learn skills to professionally support someone living with mental health challenges or substance use disorders. In addition, NAMI provides cross training to “increase the capacity to positively influence behavior health systems” (NAMI Indiana, n.d.).

1a. Key individuals on the youth and family subcommittee. Several stakeholders attribute the success of engaging family and youth to those they view as champions in key positions who are highly invested and carry influence with other members of the subcommittee. As an example, one interviewee voiced her appreciation with the YFS, stating:

*I think we have some key people on the youth and family subcommittee that are very invested. They have empowered others to speak up, speak their mind and throw things out there to forge partnerships with all the rest of us, and I think that’s great.*

As aforementioned, most stakeholders are pleased with the YFS at the state level. However, some of the interviewees acknowledged concerns at the local level as they believe most local SOCs still do not include family involvement. As one interviewee stated, “*The youth and families in local SOCs are attending the meetings in various forms but they have not reached the point where they really begin to build a subcommittee, except in Ripley County. *” Further, a stakeholder at the state level believes that part of the challenge

*really lies on us [the state] because as a state System of Care, we’re focusing on our state youth and family subcommittee and we really haven’t begun to build a process for people to have that kind of training [at the local level].*

Based on the document analyses and findings from the Phase I Study (Anderson et al., 2016) and within the Phase II study, it is clear that IN-SOC has deep involvement in the area of family and youth as partners. Indeed, IN-SOC has been found to be strongest in family and youth involvement at the state level, an apparent anomaly compared to the Behar and Hydaker study results. However, according to Phase II interviewees and findings from the surveys, there is still work to be done in order to improve local family and youth subcommittees and overall engagement of youth and families, primarily at the local level. One plan being discussed at the state level is to create a local Youth and Family Subcommittee leadership training. Training could be provided every quarter at the state level within different regions which will help support participants in starting their own youth and family subcommittees at the local level.
2. IN-SOC has made progress in expanding partner and provider networks

“Expanding the provider network for the expanded array of services and supports” is categorized as an underutilized strategy in Stroul and Friedman’s (2011) study. Although underutilized, the participants in the 2011 study who did expand their provider network found it to be an effective strategy. As reported in the Stroul and Friedman study, communities and states continue to struggle with workforce issues and “expanding provider networks can be an effective approach for addressing workforce needs, creating the capacity to provide the broad array of services and supports that is characteristic of the system of care approach, and offering meaningful choices to families and youth” (p. 76).

IN-SOC’s role in expanding the partnership and provider network includes bringing together different system partners, such as stakeholders, state agencies, or state funders, so that they have an opportunity to hear first-hand what other agencies are experiencing and what their needs are. The stakeholders of IN-SOC found a critical growth of unique partnerships throughout Indiana. One interviewee defines the purpose of this network:

_The purpose of having that infrastructure is so that children and youth who have mental health concerns in the state of Indiana have access to the right kind of services when they need them. Families can be empowered to really work their own strengths, you know, by the strengths of the systems around them to help their young people achieve what they really need to achieve to make their lives better._

One interviewee stated that IN-SOC’s intent is to “connect with every system that may have kids or youth who have mental health concern or are at risk for mental health concerns.” These partners include, but are not limited to, the Department of Education, The Commission on Improving the Status of Children (CISC), early childhood education, juvenile and corrections agencies, Indiana Department of Health, and Medicaid.

The results of the online and paper surveys taken in April, June (online), and August indicate that the majority of the respondents believe they are a valued partner in the Indiana System of Care both at state and local levels. In the April and August surveys, 65% of respondents either agreed or strongly agreed with the statement of “I feel like a valued partner in the Indiana System of Care” at the local level. At the state level, 61% either agreed or strongly agreed (Table 4).

Although the June online survey response at the local level was similar to the April and August paper survey response (67% agreed or strongly agreed to the same statement at the local level), the state-level responses were markedly different, with only 36% stating they agreed or strongly agreed they were valued partners (Table 5).

The difference in the response level between the paper and online survey may be due to the natural reticence that occurs when providing feedback with colleagues seated nearby. Respondents may also feel pressure to quickly provide responses, thus not allowing for reflection. Online surveys, on the other hand, allow ample time for individuals to reflect and prepare responses. Online surveys also provide more confidentiality thus allowing people to express challenges without fear of retribution.
Table 4. April, August survey responses for “I feel like a valued partner in IN-SOC”

<table>
<thead>
<tr>
<th>April &amp; August</th>
<th>“I feel like a valued partner in the Indiana System of Care”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local (Mean= 4.0)</td>
<td>![Bar Chart]</td>
</tr>
<tr>
<td>State (Mean= 3.9)</td>
<td>![Bar Chart]</td>
</tr>
</tbody>
</table>

1=Strongly disagree  2=Disagree  3=Neither agree nor disagree  4= Agree  5= Strongly agree

Table 5. Online June survey responses for “I feel like a valued partner in the IN-SOC”

<table>
<thead>
<tr>
<th>June</th>
<th>“I feel like a valued partner in the Indiana System of Care”</th>
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</thead>
<tbody>
<tr>
<td>Local (Mean= 3.8)</td>
<td>![Bar Chart]</td>
</tr>
<tr>
<td>State (Mean= 3.2)</td>
<td>![Bar Chart]</td>
</tr>
</tbody>
</table>

1=Strongly disagree  2=Disagree  3=Neither agree nor disagree  4= Agree  5= Strongly agree

Another rationale for the difference in online response at the state level is that there appears to be a greater level of frustration at the state level as compared to the local level. Although there has been a tremendous effort to improve partnerships and collaboration at the state level with the intent to expand the provider network, the challenge is that “not all these partners at the state level...have good connections back at the local level.” Thus, the stakeholders agreed that involving different partners varies especially when in rural communities as some of these organizations may not be involved in every county. As one of the respondents in the online survey commented, “Too many small communities have very weak SOCs and need much more support and direction. Some do not have a strong Mental Health commitment” (Online survey). In addition, the partners’ level of involvement differs in each community. For instance, some of the interviewees mentioned that Department of Child Services (DCS) is very active in their
local SOCs, but not within other SOCs. Similarly, not every county has involvement from the early childhood education sector. Additionally, the Center for Substance Abuse Prevention (CSAP) and its activities differed from community to community. Also mentioned was the varied involvement of primary health care in each county, where “some places it's done very well and some places it's not done at all.” Stakeholders believe that the state should recognize these issues. Moreover, the expansion of services and partnerships has been mentioned as a need. One of the respondents of the online survey wrote:

*It feels like services are still pretty siloed. It would be great to see more partnerships and services expanding into areas where there currently aren’t. We are always short of practitioners in our county and find it difficult to get families involved since most work and cannot get time off to attend meetings.*

Regarding local partners in the April and August IN-SOC paper-based surveys, the results showed that respondents were split nearly equally from the low end, middle, to the upper end of agreement on the survey statement: “All needed partners are attending and involved with the Indiana System of Care.” 30% of the respondents disagreed or strongly disagreed; 31% neither agreed or disagreed; and 39% either agreed or strongly agreed with the statement. At the state level, the majority of the respondents were more satisfied with the statement, as 21% either disagreed or strongly disagreed and 47% either agreed or strongly agreed (Table 6).

Table 6. April and August survey responses for “All needed partners are attending and involved with the Indiana System of Care”

<table>
<thead>
<tr>
<th>April &amp; August “All needed partners are attending and involved with the Indiana System of Care”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local (Mean = 3.0)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>State (Mean = 3.2)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
</tr>
</tbody>
</table>

1=Strongly disagree  2=Disagree  3=Neither agree nor disagree  4= Agree  5= Strongly agree

Similar to the paper survey, the online survey included the question, “All needed partners are attending and involved with the Indiana System of Care” and the results showed that the majority of respondents (52%) either disagreed or strongly disagreed with this statement and 29% either agreed or strongly agreed with the statement (Table 7). Again, the difference in results between the online and paper-based surveys may be
that respondents are more willing to be critical in an online, anonymous survey as opposed to completing a paper survey in a room sitting next to colleagues. Another likely explanation may be that more SOC coordinators and staff members were involved with the online survey since it was geared for SOC coordinators and members who attended the June conference, as opposed to the paper survey which included more partners, family members, and youth respondents, thus highlighting the challenges at the state level.

*Note: the online survey did not offer the option of providing a separate response for the state and local levels with the exception of one question.*

Table 7. June (online) survey responses for “All needed partners are attending and involved with IN-SOC”

<table>
<thead>
<tr>
<th>June</th>
<th>“All needed partners are attending and involved with the Indiana System of Care”</th>
</tr>
</thead>
<tbody>
<tr>
<td>General (Mean= 2.8)</td>
<td>![Survey Responses Graph]</td>
</tr>
</tbody>
</table>

1=Strongly disagree  2=Disagree  3=Neither agree nor disagree  4= Agree  5= Strongly agree

To increase partnership among organizations and local SOCs, one interviewee suggested having “more conversations from the state level on the benefits of developing and supporting your system coordinators, not overtasking them. Not, you know, burning them out, not giving them caseloads, those types of things.”

The interviewees also discussed organizations that should be involved but either currently are not or not to the degree that they need be. Some of the organizations mentioned include: Bureau of Developmental Disabilities (BDD), Office of Juvenile Justice and Delinquency Prevention (OJJDP), Juvenile Detention Alternatives Initiatives (JDAI), Indiana Department of Correction (IDOC), Department of Child Services (DCS), Indiana Minority Health Coalition (IMHC), Department of Early Childhood, Department of Health, Office of Medicaid, Policy, and Planning (OMPP), and individuals from police and law enforcement (Table 8). The agencies that were listed most often as needing to become involved were BDD and agencies focused on juvenile justice or law enforcement. A few mentioned faith-based and non-profit organizations along with individual townships or counties that needed to participate. One survey participant wrote, “I think we could always work more closely with IDOE, although much progress has been made! I would also like for us to work even more closely with BDD.”
An interviewee stated the importance of connecting with these coalitions as:

*They can serve as gatekeeper in a good sense of the word. If there's a community that's hard to get into, that's hard for folks to know how to relate to, then that coalition can serve as the gatekeeper for them, model how it is that they can get involved, and help facilitate it happening as well.*

They also want to see these agencies as partners given the agencies are both state-wide organizations and within many local communities.

2a. **Enhanced multi-disciplinary team.** Some stakeholders also mentioned “enhanced multi-disciplinary teams” which is separate from IN-SOC. This team is a collaborative group across state agencies that meets monthly to discuss how to address gaps in the systems. Typically, meeting topics include: “*children who are involved in multiple systems and how some children have fallen through the cracks.*” They examine and discuss the reasons these situations occur along with prevention measures to avoid recurrence.

2b. **Challenges with providers.** A challenge that was mentioned by a few interviewees was persuading providers to see the value of collaborating with IN-SOC. As one of the interviewees stated, “*We have the same goal of making it easier for families to get them the resources they need and the help they need for their kids,*” and continues, *A lot of our providers don't really understand that it's about people working together, and when people work together it saves every agency a lot of money.*” Thus, the stakeholders want the providers to take a more active role in IN-SOC and become more engaged.

In addition, a few stakeholders mentioned having numerous empty seats for voting members at the IN-SOC governance meetings. The interviewees would like to see state-level service partners and providers who are on the board take a more active role.
and become more engaged in the process. Along with this, the collaboration among current SOC partners and providers was found to be a challenge in certain aspects. For instance, sharing data across state agencies has been an issue in the collaboration. The stakeholders see “sharing data” as important because they think that they cannot “make significant impacts in services until we [they] share data across state agencies so we can we know that we are assessing the landscape accurately.”

3. IN-SOC continues to cultivate leaders and champions, though new challenges have emerged

The Stroul and Friedman (2011) and Behar and Hydaker (2009, 2012) studies found that new leaders must be identified and prepared at state and local levels. Stroul and Friedman (2011) assert that states and communities must cultivate champions who are able to communicate convincingly about the system of care approach and have sufficient influence to make a difference… As a strategy for expanding the system of care approach, states may wish to consider how best to identify such champions, how to cultivate them as advocates for systems of care, and how they can best help with expansion efforts. (p. 78)

The findings of our study revealed that the components that will help partnerships grow and flourish are relationships that are developed or maintained in addition to having champions in strategic or influential positions. Building strong relationships and having champions, especially in key positions, are two components which tend to influence how an organization becomes a good partner. For example, one interviewee mentioned that the relationship building with a champion within the Department of Education (DOE) fostered a strong partnership within IN-SOC, whereas before DOE was only nominally involved. Another interviewee mentioned the Safe Support School Model, in which the state DOE is engaging in the idea of social-emotional learning and safe space, is considered “a really amazing step that Indiana is really pushing,” because it is believed that, “if we are going to make major shifts in our health care model and our value system in Indiana, it’s going to happen in our schools and it’s going to happen in our health care system, that’s where are all the kids are.”

The interviewees in the Phase I study were in agreement that there is a phenomenal team at the state level, and many emphasized there were champions at both the state and local level who foster a high performing team atmosphere. As one interviewee mentioned, “we’ve just been blessed that we’ve found the right people at the right time that want to do the right thing.”

Conversely, from Phase I of the study to Phase II, shifts occurred within the leadership team at the state level which seemed to cause new challenges to emerge. As stated in the IN-SOC site visit presentation in April 2017, “Losing three influential SOC team members created a period of loss and shifting of responsibilities to fill in the gaps.” Although challenges can occur with any system change, interviewees reported specifically experiencing a perceived shift in values regarding communication and collaboration: “There seems to be some new challenges with regard to communication and those sorts of things,” which was of particular concern as these were areas that were in high standing in Phase I of the study.

Even though some stakeholders stated the shifts created some challenges, they also mentioned that the leadership team made efforts to listen to feedback and take
suggestions into account to make the leadership transitions smoother. As one of the interviewees noted, “it's taken all of us a little bit of adjustment time to get used to the new way of doing things.” In sum, the leadership transitions brought new challenges, as is sometimes expected when changes in leadership occur within organizations.

4. **IN-SOC is incorporating the system of care approach in monitoring protocols**

In the Stroul and Friedman (2012) study, the researchers found that “the use of monitoring protocols as a mechanism for assessing implementation of system of care requirements was not identified as a frequently used strategy” (p. 35). IN-SOC has started to develop data dashboards which provide data reflecting child and adolescent mental health and wellness in Indiana. The purpose of creating data dashboards is to bring a variety of sources together to assist partners and the community in making data-driven decisions. IN-SOC has also been working on collecting data, which includes “working with FSSA to pull Medicaid data with the intent to analyze and identify disparities in our access to and utilization of mental health services.”

4a. **Social marketing.** Stroul and Friedman (2011) found that social marketing was rarely identified as an important strategy for expanding SOC services but could be very effective in expanding the awareness of SOC services. Their study suggests spreading the word about the mental health needs of children and the value of the SOC approach to address these needs by crafting messages “that are clear, powerful, and tailored to specific audiences. Social marketing campaigns and publicly educating others are needed to reach important audiences” (p. 77).

In Phase I of the IN-SOC study, we found that the stakeholders see greater community awareness via social marketing as one way to address the challenges of accessing services. They see it as their job to ensure that the community understands all avenues in which youth can access services within their community. To create community awareness regarding available programs and services, the local governance boards are in discussion on how the use of social media can help in this matter. Further, stakeholders view social media as a way to create community awareness to address stigma. During IN-SOC Phase I, one of the plans mentioned by stakeholders was to develop a quarterly *INSOC News* newsletter which would provide a way to “educate, inform and share kudos” state-wide and reach local SOCs. The intent was to share successful ideas that others around the state might wish to pursue. At the time of this writing only one issue of *INSOC News* has been published, though there are plans to release another issue soon. Survey respondents also commented that the IN-SOC website can be improved and used as a communication tool between state and local SOCs as “communication to local SOC coordinators is challenging. Posting key documents and progress reports on the IN-SOC website in one place for coordinators would be helpful.”

All the interviewees in this study, however, believe that social marketing has been one of the key challenges for IN-SOC. They also believe that, if done well, social marketing could have a strong impact. As one interviewee stated, “[Using social media] for social marketing is where we should be moving towards because that is the avenue where most people are connected... but I don't think we've gotten to that point yet.” Another interviewee explains, “The more that we have the opportunity to talk about the system of care and explain what it is and help people understand how they can be a part
of it, I think that we’ll continue to move forward and continue to keep that trajectory going.”

It was found that the term “social marketing” has various meanings to stakeholders. Some of these meanings include: public service announcements and brief segments that are sent out via a listserv; brief videos; radio clips; newsletters; and blog posts that can be shared with the local SOCs which can be customized and sent to their local communities. Social marketing could also include a YouTube channel, or a state Facebook or Twitter page. The majority of the interviewees do not consider the IN-SOC webpage posted on the DMHA website as social marketing. As one of the survey respondents commented, it is “very difficult to locate any website for IN-SOC. I only found the IN-SOC Facebook page. Would suggest a Twitter account that is routinely updated with IN-SOC happenings. Facebook could be used as well but it targets an older audience.”

Social marketing has also been seen as an important piece of information sharing. One of the challenges that the stakeholders note is that in Indiana, “people don’t know where to go to get the help, or where to go just to find out where they need to go... We have a lot of phone calls from those wanting to know about resources.” For instance, one survey respondent mentioned, “I never could find any information on the statewide pre-conference event at all. The website really could have been done better.”

Another challenge with the social marketing and information sharing in rural counties is that many families do not have reliable Internet connection and some of the families may not be able to read. Thus, the state and local groups need to develop other means to get the word out in rural areas. The state admits that “having an identified Social Marketing position would have made rolling out a robust marketing plan easier had we known then what we know now.” Instead, the state is working with the FSSA marketing team and an external marketing agency to develop a plan to update the website, in addition to planning and developing approaches to meet the social marketing goal. Currently, individuals are using their private Facebook pages for updates and to broadcast and share meeting information.

4b. Network of local partners. Similar to the Stroul and Friedman (2011) findings on expanding the provider network, the Behar and Hydaker (2009, 2012) studies found that the “Network of Local Partners,” particularly “non-traditional” partners, such as neighbors and churches, are key to expansion. This was also verified within the IN-SOC interviews. In the Behar and Hydaker (2009, 2012) study, the participants rated the “Network of Local Partners” as highly important, but also as one of the more difficult items to implement.

The IN-SOC stakeholders at the local level stated that it has been a priority to involve more natural supports regarding the “Network of Local Partners,” as this will offer infrastructure supports once the project moves out of its funding cycle. The findings from the June survey echo this claim. The “Support to local SOC” item was found to be one of the areas most in need of change or improvement within IN-SOC (Figure 1).
Likewise, workforce development is another component that IN-SOC has acknowledged it needs to address. Developing natural supports continues to be a challenge within IN-SOC, with the exception of a few counties that have been successful in engaging faith-based organizations or other nonprofits. Most stakeholders stated that they do not have faith-based groups as partners in their local area. As one of the respondents from the survey suggested, “If it isn't already happening, workforce development efforts should be taking place at state and private universities, churches, and other organizations. The need to serve youth and families only seems to be rising and we will continue to need to increase the workforce.” In contrast, a few counties are on a positive trajectory in this area, as one stakeholder stated:

*Dearborn County has so many churches involved it's amazing to me. And I wish we could get that... I wish we could get a great connection. I think that would be the most outstanding thing in the world. Because faith-based people, that's where a lot of people go when something happens. They go to talk to the preacher, they go talk to a priest, and that's the whole thing. If I knew how to get them [faith-based organizations] in, believe me I would.*

4c. **Training and Technical assistance.** In the Stroul and Friedman (2011) study, training was found to be a vital expansion strategy in all the states within the study. However, in general, training on effective practices has not been used systematically as a strategy by the states studied in the 2011 research. Similarly, we found challenges with training and workforce development in the IN-SOC study. In Stroul and Friedman’s study, the researchers found that communities and states continue to struggle with workforce issues. However, in states that reached out to a broader range of providers, it
was found to lead to a larger number of service providers on a fee-for-service basis, which was one of the key approaches.

The TA coordinator at the state level within IN-SOC is supporting SOC involvement by providing technical assistance and training and development for local coordinators, local systems of care, local collaborations, and working with state partners. In Phase I of the study, it was discussed that the main responsibility of the TA coordinator was to provide local SOCs with the training and resources needed for each community to develop a local SOC infrastructure and begin development and implementation of their own strategic SOC expansion plan. To do this, the training and technical assistance has focused on how to build collaboration, formalize collaborations, foster stronger community engagement, understand the various systems in place, and begin to identify strengths and gaps in those systems.

In addition, the TA coordinator mentioned in an interview that the TA position provides:

training development, which is focusing more on adaptive work (which requires a change in values, beliefs, behavior) such as creating constructive dialogue, conflict resolution practices, and how to cultivate safe space, which help make IN-SOC stronger and build the dynamics of the actual System of Care.

As has been reported in Phase I (Anderson, Ergulec, & Ruschman, 2016), with the advent of hiring a TA coordinator, much progress had been made in contacting local youth-serving, faith-based, or other entities, developing and expanding local SOCs in nearly all 92 counties in Indiana.

In Phase I, it was reported that the TA coordinator was the linchpin, working with different local SOC governance to identify a person in each community who will “help them develop their local SOC.” Respondents generally viewed this as a challenging but important role, because the TA coordinator is constantly scrutinizing needs and barriers that are unique to each county. And as one interviewee put it,

As a state, we're not telling [the counties] how to do it. We're not giving them a recipe; we give them guidance. We've got a policy on how to develop things but we then look to them and say “here's the core elements we're expecting. How are you going to develop your governance so that it functions within those loose parameters?” On the other hand, local SOCs mentioned the need of “more focused technical support [at the local level]. There should be much more clarity in aligning the support with the national SOC movement. New SOCs as they are developed need more resources around how to do the day-to-day work of SOC coordination.

Laying the groundwork for the development of new SOCs was a critical component in Phase I. However, given the next level of training and technical support that needed to be accomplished, new challenges emerged, primarily around capacity, to conduct these trainings in a timely manner to ensure fidelity throughout the state. The following quote shows the technical assistance challenges:
There's very inconsistent communication on the TA side. We used to have technical assistance that was outside of the division of mental health and addictions, it was contracted to another agency, and there were multiple coaches, multiple states, or multiple technical assistance coaches that would come out and meet with you regularly and they covered the entire state. But asking one person to cover the entire state regardless of their education experience, is really just a tall task.

A number of interviewees recommended, “They need more. One person covering the whole state is not enough, especially with this kind of role and this kind of system change that they're hoping to model. I think that's been a major challenge in my eyes.” One of the survey respondents recommended training “SOC leaders in logistics of how to make a local SOC functional and effective.”

Another goal in Phase I was for the TA to work with the cultural and linguistic competence coordinator to “assist with development of technical assistance plans for each local SOC to ensure inclusion of cultural and linguistic competence, and continuously assess the technical assistance needs of local SOC governance structures as it relates to cultural and linguistic competence.” This is one of the key components that was believed to develop buy-in at the local levels. Beyond this, it was expected that the TA would assist by providing resources, education, and support as local SOCs begin to address the goals and objectives related to finance and social marketing.

IN-SOC leadership discussed the idea of building a cross-system technical assistance center in Indiana. Given the difficulty associated with meeting the needs of 92 counties with only one person responsible for this task, the plan was to bring other resources and supports together. With the development of a TA center, IN-SOC leadership plans to look at all the system partners, engage in discussing collaboration issues from various systems, and determine how they can provide TA training and development together. This state-level, state-wide cross system engagement and training provided for local communities is seen as a challenge that IN-SOC will need to address. As a first step, IN-SOC has created an online TA request form where the state monitors requests from partners.

Further, stakeholders would like to see “more technical assistance opportunities.” One interviewee stated that they need someone on the team who is “able to develop the coordinators.” With technical assistance, IN-SOC is making strides in having all coordinators work together and collaborate. Although the experienced coordinators may not struggle as much as the new coordinators, they state they are still not getting the technical assistance they need. Several stakeholders mentioned that the coordinator trainings “are happening half way into the grant cycle for new coordinators” and several months after new coordinators were hired, or they “email and request technical assistance” and do not receive a timely response or no response to their requests, indicating a need for additional TA coordinators if the state wishes to meet its training and TA goals. One response to the online survey sums up this issue: “I am fairly new to [name of agency]. I am unaware of the purpose of the SOC and its agenda has not been made clear as a new person to this environment.” Similarly, another survey respondent commented, “I feel uninformed about the role of the SOC. I do not know the goals and challenges presented. [The IN-SOC statewide conference] is a monthly meeting I was to
attend as an employee in my position.” The stakeholders assert these frustrations are primarily due to capacity issues—not having enough people working on the technical assistance aspect within IN-SOC. One technical assistant “covering the whole state is not enough.” In order to solve these challenges, IN-SOC is currently refining a peer-mentoring (“Buddy System”) process to assist in networking and support for local system coordinators (IN-SOC site visit presentation).

As aforementioned, not immediately offering the initial trainings for the new coordinators in the system caused numerous challenges. As one stakeholder noted, “By then, people who are brand new coordinators are lost and, like, ‘I don’t know what to do.’ I think that was one of the biggest challenges.” Thus, the stakeholders hope to see more people hired in this area and believe this will also foster better communication channels so that they can have their requests and questions answered in a more reasonable timeframe.

The other topic mentioned during the interviews related to the technical assistance was regional trainings. As one of the interviewees stated:

"The local people are preparing everything for regional trainings instead of the state preparing them, and that's taking away from the work, you know, the time that I would need to be doing work for my actual own county. I'm preparing agendas and setting up regional trainings because they have this new training structure, but really, I should be writing grants and looking for additional blended and braided funding for my own county."

In addition, a few interviewees reported that the SOC coordinators are being told when the trainings will take place without getting input from them regarding the best time that would work for their region. This adds to the level of stress and sense that the SOC coordinators are not being valued as they were in the past.

In sum, the stakeholders would like to see more technical assistance provided to the local system of care coordinators and “help them understand engagement, what that looks like in engaging stakeholders at the local level.” It was found that even though the stakeholders think that communication and collaboration at the state level has improved, they still see a challenge translating this at the local level to ensure the local partners understand what the state intends to do.

At the state level, several interviewees mentioned they would like to see trauma informed training offered for parents as they are “going through traumas everyday with their kids.” Another training mentioned by the interviewees was the Crisis Intervention Teams (CIT) as it provides a safer environment for families and youth. In addition, they would like to see more mental health first-aid for providers. With only one TA, this will be a difficult goal to reach.

One of the findings of this study is the improvement of the youth and family involvement at the state level. A suggestion in the survey comments may help to better improve this involvement at the local level: “There needs to be a larger entity of youth and family technical assistance to help guide this process. We need to know better how to build that development at the local level.”

Youth MOVE Indiana (Youth MOVE Indiana, 2013), one of the organizations that serves on the IN-SOC governance board, provides a three-hour suicide awareness
training. It is a Continuing Education Unit (CEU) credentialed, evidence-based training and considered to be “wonderful” by a few stakeholders. One of the interviewees mentioned that she would like to see the youth who work in Youth MOVE step into the role of trainers, so “they could bring youth voice to the table” but also so that:

These youth, many of whom struggle with mental health problems, anxiety, addiction issues, and can’t function in a traditional work environment, [could have] a career path where they could operate independently, they can work when they want to, and they can do something they can feel good about.

Interviewees believe this approach could help expand training options and help other youth who are experiencing similar mental health struggles.

4d. Workforce development. Implementing workforce development mechanisms was found to be an important key in both the Stroul and Friedman (2011) and Behar and Hydaker (2009, 2012) studies, to “provide ongoing training, technical assistance, and coaching to ensure that providers are prepared to offer effective services and supports consistent with the system of care approach” (Stroul & Friedman, 2011, p. 2). In Phase I of the study, we found that partnerships and contracts with universities, state staff, and SOC communities have all been helpful in developing a workforce that is trained and prepared to work within the SOC framework. In addition, in Phase I, IN-SOC had planned to create a new workforce development subcommittee.

In Phase II, we find that a workforce development subcommittee was created which focused on issues impacting the SOC workforce. The subcommittee determined a list of eight concerns that were developed from the results of a survey that was implemented. Despite these efforts, one of the interviewees stated that “there was a workforce development subcommittee, but they could only go so far. We tried to get some expansion on for the Indiana Professional Licensing (IPL) board and their requirements were problematic.” Similarly, one of the online survey respondents wrote, “In spite of having a committee, the state [IN-SOC] has done little to improve workforce development. The IPL creates even more challenges to an already difficult situation.” In addition to the workforce development subcommittee, IN-SOC has two work groups that are “looking at how do we deal with mental health in the schools which looks at workforce as well as services and supports.” There is also a group, which at the time had been working for six months, “looking at the challenges with co-occurring diagnoses, primarily children with mental health and DD or autism spectrum.” In the upcoming months, IN-SOC plans to develop a report with “solid recommendations.”

In a similar vein, the April and August surveys revealed that “workforce development” received the lowest rating among the areas in which IN-SOC is doing well at the state level (Figure 2). Regarding areas that need to be improved or changed within IN-SOC, workforce development received the highest rating at the state level, closely followed by social marketing (Figure 3).
Interviewees expressed their concerns with the state of the workforce development goal. For instance, one interviewee said, “Because a lot of what we do is based out of Indianapolis, the needs of smaller communities and rural communities don’t get addressed as adequately as you would hope.” Respondents believe that workforce development is a general challenge for the state and local SOCs. For instance, as one interviewee explained, the pay level is not commensurate with the challenges and
stressors that go along with the profession, which lead to recruiting problems in finding qualified and quality-minded individuals for positions such as SOC coordinators or wraparound facilitators. In addition, several stakeholders reported that rural areas present an even deeper challenge as they are “all competing within different agencies for the same people whether it’s the Department of Child Services, probation, mental health, education, we’re all competing for the same people and we don't have a great pool to choose from.”

Related to workforce development, several interviewees mentioned they typically assume added responsibilities outside their typical work responsibilities. A future concern is that, once the funding cycle ends, even more responsibilities will be added to the current staff, potentially causing the quality of work to suffer. Although this does not seem to be directly related to workforce development, it has a significant impact on the work being conducted.

A critical issue and ongoing challenge of IN-SOC’s workforce development is the high amount of turnover within the SOC field. One interviewee mentioned that there should be an outline with criteria for hiring coordinators: job descriptions; templates; trainings; and more. As the interviewee stated:

*The state needs to put something out to kind of outline, ‘here's what your basic job should look like and here's what your basic day should look like,’ because we found that that is where most of the coordinators get stuck.*

Criteria such as this would also be helpful for the local SOCs, as would a description of the skills and qualities that a good system of care coordinator should have:

*Making sure that they have those interpersonal skills, that they know how to engage stakeholders, how to facilitate meetings, helping them understand how to write, what is their elevator speech, because if you can't sell this in a couple minutes, then you're going to lose people right up front.*

With these systems in place it would likely help with the hiring and retention process. One stakeholder sees developing local coordinators as an important process because without this, they are not going to have a sustainable SOC. The challenges with workforce development was summarized by one of the interviewees:

*It's a big struggle to get people who match the [background] criteria that the state has and then once we do get those people approved, to get them trained based on the schedule that the state puts out... There's never enough people to provide the services for the amount of people who need them.*

One of the online survey respondents captured the challenges by stating:

*There are struggles with the rigidity of requirements for wraparound facilitators and the licensing requirements for therapists. Social marketing for System of Care has not been overly present. The support to local systems of care has been an ongoing struggle. The technical assistance needed for local systems is the*
development and training of the local coordinators. Most of the energy and effort has been spent focused on the development of partnerships and strategic plans without a focus on the coordinators understanding of their role and responsibilities to that system.

An idea was posed by one interviewee regarding the workforce challenge: to have trainers or seasoned SOC staff provide informational sessions at local middle schools and high schools to discuss job opportunities in the field of human services. To take this idea further, it was suggested that mentoring programs be developed for high schools and college students to support them to get into these fields and shepherd them through, ensuring a greater success rate.

The issues mentioned within the workforce development area are primarily related to the dearth of quality workers within the system. The other issue is a financial challenge. As one of the interviewees reported, “If they had more resources financially, they'd be able to invest in more people.”

5. IN-SOC is improving the cultural and linguistic competence of services

The increased diversity and need for Cultural and Linguistic Competence (CLC) is an important piece of the SOC development. The Stroul and Friedman (2011) study found that “activities are under way in [the states they studied] to enhance the cultural and linguistic competence of their services although these activities were generally not defined as strategies for expanding the system of care approach” (p. 76). One of the most significant underutilized strategies found in Stroul and Friedman’s (2011) study was improving the cultural and linguistic competence of services. Thus, they suggest “a next step in system of care implementation is to demonstrate that cultural and linguistic competence will improve outcomes and, ultimately, support system of care expansion” (p. 76).

Stroul and Friedman (2011) found that reducing racial, ethnic, and geographic disparities in service delivery was recognized as an important goal but was not generally defined as a strategy for SOC expansion. Similarly, our conversations with the IN-SOC stakeholders showed that having cultural competency services have been recognized as a goal. The stakeholders agree that more cultural competency training and development is needed. Incorporating culture-specific services in their service array, recruiting culturally diverse providers, and training were some of the items discussed by interviewees.

DMHA led the development of a Health Disparities and CLC Task Force in 2016, which has achieved an approved CLC Policy and a Draft Strategic Plan for Culturally and Linguistically Appropriate Services (CLAS) Standards and CLC Implementation. This includes language regarding compliance with CLC training standards which were added to the DMHA contracts it has with providers. Questions to gain information about language spoken in the household were also added to DMHA’s Data Assessment Registry Mental Health and Addiction (DARMHA) database and to the DCS intake form.

One individual within IN-SOC who is knowledgeable in cultural competence mentioned there were plans to include families and youth in trainings focused around poverty, disability, and culture. “The United Way does poverty simulations and I’ve been advocating that the SOCs get connected with those trainings and put on a poverty simulation of their own.” The plan is to engage families and youth by allowing their
stories to be heard, sharing their experiences, and engaging them to become a part of the work and trainings that IN-SOC promotes. Eventually, the goal is to “teach them about how this all works, how they can be involved and what they can do to advocate for themselves to help to create change within the system.” Involvement of families and youth has been seen as an especially important step “when you are dealing with communities that are more isolated, they're more marginalized” because it is a way of exchanging information; the families and youth can then take that information and share it throughout their community. It was mentioned within at least one interview that, in Indiana, working with refugees or immigrants needs improvement, as this population would be considered as some of the more marginalized or isolated groups.

6. IN-SOC is working toward developing a broad array of services, evidence-based practices, and more natural supports to bolster sustainability efforts

Stroul and Friedman’s (2011) study found that “less activity was reported for implementing evidence-informed practice than for creating or expanding a broad array of services, care management, and an individualized approach—the essence of a system of care since its beginning” (p. 76). However, the importance of interventions that have empirical support has increasingly been emphasized.

Our findings from the Phase I study (Anderson, et al.) revealed that one of the goals stated in the IN-SOC expansion strategic plan is related to services and supports. It reads as “All young people can take advantage of the right resource/service ‘at the right time in the right way.’” In order to reach this goal, one of the strategies is to “implement evidence-based practices (EBP’s) based upon identified need, with a continuous quality improvement process (e.g., identify local needs, identify and include EBP’s for promotion and prevention)” (FSSA website, n.d.). This is consistent with the stakeholders’ thoughts as they believe that a solid approach for improving service access, particularly in rural areas, is to provide evidence-based trainings to service providers and others involved in providing support.

Stakeholders in the local areas talked about the lack of accessible resources in their communities. It was mentioned that they are “really struggling with the intellectual disability and developmental disability folks that we work with” and stated that the resources are not available in many smaller communities. Trying to find avenues to support the aforementioned youth and families is considered to be very difficult. One interviewee remarked that perhaps this is due in part to the lack of involvement from key agencies within IN-SOC or of those agencies not being involved to the degree that would better support the needs of these communities—that the state needs to work on:

...pulling the right people to the state. The Bureau of Developmental Disabilities and Medicaid are two key agencies that are not currently at the table and we need them to help to support us and pay for those services, or we can't provide them.

The stakeholders in the local areas also mentioned issues they are facing with access to acute and residential hospitals. For example, many of the acute hospitals do not accept clients with autism as this population is not considered appropriate as an acute case. However, one interviewee mentioned that “those kids are in crisis and we have nowhere for them to go. Even kids with Medicaid are having a hard time getting into
acute hospitals lately.”

In order to address the issues with the acute hospital crisis, IN-SOC has considered “mobile crisis units.” The stakeholders think that mobile crisis units would work in an urban area but are not sure how effective this might be in rural areas due to the time it takes to travel from rural areas to a hospital or service provider. “If a kid is in crisis, the time it takes to get someone into a hospital can take six or seven hours. And by the time you get them there, the crisis is over.”

Several interviewees mentioned The Lutheran Foundation, a nonprofit and member of the Lutheran congregations in northeast Indiana’s Allen County, as a “grassroots” or “unconventional” SOC. Its focus is to “foster strategic partnerships in support of effective approaches to solutions addressing unmet community needs” (The Lutheran Foundation, n.d.). A new service the Foundation provides is LookUp Indiana. LookUp is “a compassionate initiative designed to provide mental health information and reduce the stigma associated with these serious health issues. By connecting those in need with life-saving resources, The Lutheran Foundation desires to deliver community-wide hope and healing” (LookUp, n.d.). Valid challenges found in both Phase I and Phase II of the IN-SOC studies is that many people do not have easy access to information about mental, emotional, and behavioral health services and do not know where to turn for help. Thus, some of the stakeholders believe LookUp Indiana is the future of providing improved access to health care and should be replicated throughout Indiana and in other states. As one interviewee stated, “It's really frustrating that as a young person I can go to any city in the world and be able to find a sushi bar near me but I can't find [health care] services in my home state.”

6a. Sustainability. Ensuring sustainability of Indiana’s SOC was one of the goals stated in Phase I of the study. The stakeholders interviewed in Phase I reported that there are still funding silos that need to be addressed and IN-SOC planned to have the finance committee address this, among other finance-related concerns. Although sustainability was IN-SOC’s goal for 2017, the research team was not able to garner much information on the progress of this goal.

Items mentioned in IN-SOC documents regarding sustainability goals include, “Partners in the SOC creatively braid and blend funding from multiple sources and stakeholders to provide the most effective, appropriate, and comprehensive system for all children regardless of payer” (Indiana system of care strategic expansion priorities, 2017). IN-SOC’s desired goal is the “creative use of funding and resources including integrating SOC strategies with block grants and other healthcare reform efforts” (IN-SOC handout, 2017) which would assist state and local SOCs to provide broad array of services and supports. However, a few of the local stakeholders mentioned that they need more clear information and explanation at the state level about the sustainability plans. For instance, one survey respondent stated:

*I think the state has done a great job obtaining the federal grant and creating positions at the state level with these funds. However, the local SOCs feel left out and disconnected from the state plans at this point. We do not seem to have a role regarding the future development of SOCs. It feels very much like a top down*
situation as opposed to collaboration. Nothing about us without us should also be the philosophy of the IN-SOC as it relates to the local SOCs.

Another online survey respondent mentioned that “there is also no actionable sustainability plans or suggestions for local SOCs.” In addition, the stakeholders discussed sustainability concerns once DMHA funding ceases. As one of stakeholders explains, sustainability is an area that needs to be communicated to the full IN-SOC team more clearly:

One thing that's confusing to me is sustainability. I know that they have a finance plan cut out on the state level but the communication surrounding that is kind of inconsistent. We were initially told we would have two year grants and then we were told we wouldn't have renewals. Then we received our request for proposal (RFP) for a second year, again without any clear explanation and it was very much like a “we don't know yet,” and then all the sudden here's your RFP, you have 5 days or 7 days to fill it out and respond. So, I think as far as their sustainability plan, we don't really know if or how they're going to continue to sustain it especially when we're not given an explanation on that. So, I think, that again comes back to the clear communication.

One approach to sustainability, focused on the youth and family subcommittee that IN-SOC leadership is currently exploring is a model from the state of Delaware on the role of family-run organizations within SOCs:

We did get a lead through the state of Delaware. Does the youth and family subcommittee become a family run agency or organization within Indiana? The Delaware organization (Delaware Family Voices) funds their peer mentoring and I guess they also have a state plan that supports paying for that. We'll spend the next year really trying to pull [ideas] together with help from the TA network. So we have things going on but nothing has been written up, there's no formal document stating that this is the sustainability plan. That should happen this year.

As reported in Stroul and Friedman’s study, “creating or improving financing mechanisms and using funding sources more strategically to support the infrastructure and services comprising systems of care” is a strategy to support expansion of the system of care approach (p. 10). Under this specific strategy, Stroul and Friedman found that the process of “redeploying, redirecting, or shifting funds from higher cost to lower cost services to finance infrastructure and/or services and support expansion of the system of care” is underutilized although it has proven effective in some of the states (p. 11).

6b. Future Hopes. There were several responses from interviewees regarding the future of SOCs in Indiana and what is hoped for or expected. Many of these expectations are already in place within some of the local SOCs; it’s a matter of replicating within all 92 counties. Needs include:

- Better partnerships with the local hospitals, like acute and residential hospitals
• Ways to support people with co-occurring mental health and IDD challenges
• Funding for mobile crisis, that would promote overall health, mental health, family stability, which in turn would create very few out of home placements
• Solving issues related to workforce development
• All 92 counties having an active system of care with local coordinators in each county
• Utilizing data and reports more effectively
• Growing in the area of prevention and the promotion of the emotional well-being of youth
• More individuals in the technical assistance area to develop the system of care coordinators
• Growing both parent-peer support and youth-peer support models across the state
• Decreasing the number of tasks that come from the state level as those tasks take crucial time away from the local community work

Discussion

Using a mixed method case study design for the IN-SOC Phase II study, the research team explored gaps that were identified in Phase I of the IN-SOC study, and also included new initiatives, ideas, or strategies that were instituted post-Phase I. Additionally, the team utilized two studies as a theoretical backdrop through which to explore developmental progress of IN-SOC in terms of its “community readiness” (Behar & Hydaker, 2009; 2012), and the use of both “most underutilized strategies” and “state and community partnerships” (Stroul & Friedman, 2011). To achieve this purpose, multiple sources of data were utilized, including (1) interviews with state, agency, and local leaders, including representatives from family, caregiver, and youth groups, along with various community members involved with IN-SOC; (2) documents review; and (3) survey responses. Data analyses suggested six main findings. The first indicates that IN-SOC is meeting its goal of implementing family-driven, youth-guided services and expanding family and youth involvement at the state level. The second suggests that IN-SOC has made progress in expanding partners and provider network. Third, IN-SOC appears to be cultivating leaders and champions for the system of care approach, though new challenges have emerged. Fourth, analyses indicated that IN-SOC is incorporating the system of care approach in monitoring protocols. The fifth finding suggests that IN-SOC is improving the cultural and linguistic competence of services. Finally, IN-SOC appears to be creating or expanding the use of evidence-informed and promising practices. While the findings as a whole are promising, challenges have emerged that need to be addressed and overcome.

Behar and Hydaker. When considering the findings for the IN-SOC expansion efforts based on the Community Readiness framework (Behar & Hydaker, 2009, 2012), three factors seem to warrant further discussion. First, Behar and Hydaker (2012) considered Family & Youth as Partners as one of the “least ready” areas in the sites participating in their study. Moreover, Families & Youth as Partners component was found to be the most difficult to establish within SOCs. However, in both Phase I and Phase II of the IN-SOC studies, Family & Youth as Partners was indicated as one of the strongest areas at the state level, though more work is needed at the local level. The IN-SOC study shows that having one-third of the IN-SOC Board comprised of youth and
family is a milestone for the state and the project. Likewise, having youth and family input on policy and other important decision-making is a considerable improvement within IN-SOC.

The second point that seems to be worth additional consideration is the *Network of Local Partners*, another low-ranking cluster in Behar and Hydaker’s (2012) study; specifically, “non-traditional” partners, such as advocates, community leaders, and volunteers. In our study, beginning in late 2016 to present, IN-SOC seems to be demonstrating improvement in the area of Network of Local Partners, especially at the state level. However, struggles in this area appear to be continuing more acutely at the local level with a few exceptions. While some participants reported that the IN-SOC Board and state partnerships are growing, findings also suggest that more diversification/representation is needed across all counties. Some stakeholders also indicated that partners at the state level need to keep evolving, as stated in this quote, “at the state level, too many [people] just don’t show up.” For instance, surveys indicated that the state needs to recruit and better engage key partners such as the Department of Corrections and Bureau of Development Disabilities Services, among others, which would develop a more effective and sustainable state-wide system.

There are also pockets at the local level in which partnerships have not fully developed or developed at all. At last count, for example, approximately 10 of the 92 counties did not have an active SOC, and therefore did not have a network of partners; with some of the SOCs still struggling to develop such partnerships. However, it is encouraging to reiterate that the number of partners and active SOCs has risen sharply since 2015, demonstrating strong growth over a short period of time; something that needs to be acknowledged and celebrated.

Similarly, the third area was *Shared Goals*, another cluster that was ranked low in Behar and Hydaker’s (2012) work. However, findings in both Phase I and II of the IN-SOC Study appear to indicate that goals are being shared at the state and local level and at the state, local, and partner levels. For example, some interviewees stated that one area many of the board members were interested in was improved access to care for youth and families. Thus, several subcommittees were developed to assist in the development of or achieving that shared goal. Similarly, one family’s perspective highlighted that they were so used to collaboration that when providers from various organizations sat with family and youth, regardless of the role, everyone felt their voices were being heard and believed all parties were moving in the same direction regarding goals.

**Stroul and Friedman.** In comparing the IN-SOC expansion efforts to Stroul and Friedman’s (2011) work, “Most underutilized but key strategies” and “State and community partnership strategies” appear to be worth some additional reflection. The eight strategies listed by Stroul and Friedman (2011) were those most underutilized in the SOCs they had studied.

In our IN-SOC study, all eight were in use, some with greater depth than others. The first strategy was incorporating the system of care approach in monitoring protocols in compliance within the SOC requirements. Stroul and Friedman (2011) noted that “the use of monitoring protocols as a mechanism for assessing implementation of system of care requirements was not identified as a frequently used strategy” (p. 35). IN-SOC, however, has incorporated site reviews, quality improvement audit data, particularly in the area of cultural and linguistic competency, and is developing data dashboards that can...
be used to communicate SOC health/effectiveness and will collect data, which includes working with FSSA to pull Medicaid data, with the intent to analyze and identify disparities in individuals’ access to and utilization of mental health services.

The second strategy is creating or expanding the use of evidence-informed and promising practices. IN-SOC has made progress in conducting regional trainings in a number of evidence-informed practices such as Positive Behavior Interventions and Supports (PBIS), Trauma Informed Practices, Cultural and Linguistic Competency training, and plans for additional technical assistance (TA) and trainings in the future. Although the state has made headway with TA and evidence-based trainings and practices, there are complications primarily around capacity. To improve in this area, more modeling and training need to occur, particularly training for new SOC coordinators. As the findings revealed in the IN-SOC study, some stakeholders believe that before new programmatic training is developed there needs to be better training and support for the local SOC coordinators.

Creating or expanding the provider network is another important strategy that is a compilation of several strategies which have been touched on previously. IN-SOC is working to expand its provider network and has made progress but is experiencing challenges in pockets of the state, again, primarily around capacity. Expanding the provider network involves deeper relationship building, funding, recruitment strategies, and more TA to more effectively and efficiently service the needs of state and local SOCs. There have been some struggles with the rigidity of requirements for wraparound facilitators and the licensing requirements for therapists. To identify the most important workforce issues in Indiana, IN-SOC developed and conducted a Workforce Issues Survey and plans to use data from the survey to develop a proposal to address workforce issues. One approach to address this involves funding that comes from Project LAUNCH, a program focusing on children birth to five years of age. LAUNCH provides funds for TA webinars for early education and other child serving professionals across the state.

The next strategy is focused on improving cultural linguistic competence of services. With the hiring of the Cultural Linguistic Coordinator, these services are continuing to develop, though the need still appears to be great. It was also noted that IN-SOC is looking at community culture, individual culture, family culture, and the disproportionality of the people who were being over- or under-served within the community.

As for the redeploying funds and using data on cost avoidance strategy, IN-SOC is currently collecting data about service use and expenditures, exploring methodologies for reviewing disputes regarding paid claims of Medicaid monies and other initiatives and incentives of Medicare dollars. “We’re working with FSSA (Family & Social Services Administration) to pull Medicaid data with the intent to analyze and identify disparities in our access to and utilization of mental health services.”

Regarding the strategy of increasing the use of state mental health funds, funds from other child serving systems, as well as local funds, one way IN-SOC has incorporated this strategy is by utilizing the federally funded Temporary Assistance for Needy Families (TANF) program to fund Parent Cafes in 34 Indiana counties to help with youth and family training and development. In addition, 18 local coordinators are funded through State Psychiatric Funds.
Still another strategy involves generating support through social marketing and strategic communications. Social marketing is a gap that needs to be addressed, as mentioned by survey participants in both Phase I and II of the IN-SOC study. Specifically, more structure and development will be necessary to effectively utilize social marketing, starting at the state level, so that the local levels have a model from which to work. Similarly, some respondents wondered whether social marketing actually helps to promote their messaging; another indicator that more development in this area is needed.

The final most underutilized but key strategy for SOCs as noted by Stroul and Friedman (2011) was cultivating leaders and champions for the SOC approach. The interviewees in the Phase I study were in agreement that there is a phenomenal team at the state level, and many emphasized there were champions at both the state and local level, all fostering a high performing team atmosphere. However, from Phase I to Phase II of the IN-SOC study, shifts have occurred in the state level leadership team, which seems to have created some new challenges in this area. For example, and as was noted in the 2016 IN-SOC federal site visit presentation, the loss of three influential SOC team members created a period of loss and shifting of responsibilities to fill in the gaps. Still, in both Phase I and Phase II, several stakeholders attribute the success of engaging family and youth to champions in some key positions and people who influence members of the subcommittee by empowering others to authentically use their voice and to forge partnerships.

Beyond the eight most underutilized but key strategies just discussed, the IN-SOC study also included state and community partnership strategies. Much like Behar and Hydaker’s (2009) Network of Local Partners, Stroul and Friedman (2011) focus on the importance of State and Community Partnerships as a way to build long-term sustainability, especially once funding has diminished. Interviewees pointed out areas at the local level in which partnerships had not fully developed. Conversely, interviewees also referred to a few key communities in IN-SOC as illustrations where natural supports and/or grass-roots efforts were taking hold, including Dearborn County and The Lutheran Foundation in Allen County. Both counties are developing strong strategic partnerships to address community needs and can serve as models moving into the future.

**Limitations.** Obviously, given the nature of this study, caution is urged in how the findings from this report are interpreted and used. The research team suggests considering the report as a starting point for further conversation. As such, readers are reminded that there are important limitations to this study. First, data collection was small, limited in scope, and fairly subjective. As noted, purposeful sampling was used as part of an effort to interview people who would have the necessary experiences to provide useful information. The researchers also recognize the possibility that not all stakeholder perspectives were adequately represented in our study processes and therefore, while unlikely, making it possible that a different group of respondents could have produced a different set of findings.
References


Behar, L. B., & Hydaker, W. M. (2009). Defining community readiness for the implementation of a system of care. *Administration and Policy in Mental Health and Mental Health Services Research, 36*(6), 381


Appendix A

Interview Questions: IN-SOC Phase II

1. What is your name, your job title and the agency you work for (if applicable) and the role you serve with the IN-SOC team?

2. What is your overall understanding of IN-SOC’s role and mission?

3. Do you feel like a valued partner with IN-SOC? Please explain. In what ways do you think this partnership could improve?

4. Do you see evidence of shared goals between your agency/your role and the goals of IN-SOC? Please explain.

5. What kind of support and training are youth being provided so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation? Provide some examples. Are there ways this could improve?

6. What is at least one area where IN-SOC is excelling? What is at least one area that still needs work? Please provide examples.

7. What about support for families? What kind of support is being provided? Are there ways this could improve?

8. Can you tell me about the parent/caregiver participation on the advisory board? Please provide an example regarding their input on the design and implementation.

9. Can you also talk about any training(s) that have been provided to parents/caregivers to help them feel more confident advocating for themselves and others in the community?

10. To your knowledge, does IN-SOC provide any financial or other support for family involvement? If so, please describe.

11. Can you tell me about the level, quality and growth of partnerships between IN-SOC and community organizations such as faith-based groups? How do you see their place in IN-SOC development?

12. We know that more recent partners of IN-SOC included the Department of Education (DOE), juvenile and corrections agencies, Department of Health, and Medicaid. Who is still missing? Tell me about the progress IN-SOC made to address the need for better representation from these partners? How about additional partners?
13. How does IN-SOC ensure that everyone, including community partners, leaders, families, and youth, understand and share the principles and values of IN-SOC?

14. Please discuss the issues as well as successes about wraparound. What has IN-SOC done to improve wraparound?

15. How has the access to services in rural communities improved and what further needs to be addressed? What are the additional steps IN-SOC has taken in this area and still needs to take? To what extent does expanding the system of care approach statewide reduce geographic disparities? How have recent grants helped the access in rural communities?

16. How is the community being made aware of potential services? For what purposes has IN-SOC used social marketing? What kind of support has IN-SOC generated through social marketing and strategic planning? Other than creating awareness, how has social media been used? Is there an individual or individuals who work on social media or does everyone participate to further social media efforts?

17. Can you talk about the unconventional or unique local SOCs? Why and how have they emerged? How do you consider them as an SOC?

18. What is your vision for the future of IN-SOC? If you look five years down the road, what do you hope will be accomplished?
Appendix B

Indiana System of Care Assessment Survey

Dr. Jeff Anderson’s Families, Communities, and Schools team (FoCuS) at Indiana University-Bloomington, is continuing to gather data as part of its 2017 study, *Indiana System of Care: A Case Study of Development, Implementation, and Evolution - Phase II.* The FoCuS team would like to provide brief surveys at various System of Care meetings to quickly assess how the Indiana System of Care expansion is progressing.

The survey should take less than 5 minutes to complete; once finished, please return this form to the person designated to collect the survey. As always, let Dr. Jeffrey Anderson (jander2@indiana.edu), Nancy Ruschman (nruschma@indiana.edu), or any member of the IN-SOC leadership team know if you have questions, comments, or concerns. We thank you for taking time to complete this survey.

Date: ___________, 2017

Please indicate your assessment of the progress being made by the Indiana System of Care by answering the questions or circling the appropriate number on the scale below. Please feel free to add comments under any of the listed questions.

1=Strongly disagree   5= Strongly agree   If unsure, mark N/A

1. What is your role on the Indiana System of Care team? (mark all that apply)

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<th>Role(s) on Indiana System of Care Team</th>
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<tr>
<td>Youth</td>
<td>Local system of care member</td>
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<td>Partner</td>
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<tr>
<td>Subject matter expert</td>
<td>Other:</td>
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2. I believe The Indiana System of Care is improving as planned:

Local Level: 1 2 3 4 5  State level: 1 2 3 4 5

Please explain (optional):

3. All needed partners are attending and involved with the Indiana System of Care:
4. Name a partner or two you think should be invited into the Indiana System of Care at the state or local level.

5. I feel like a valued partner in the Indiana System of Care (please answer for both state and local levels)

   Local Level: 1 2 3 4 5       State Level: 1 2 3 4 5

   Please explain (optional):

6. Mark to the left the areas you believe that the Indiana System of Care is doing well (mark all that apply or write in additional options).

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   Please explain (optional):

7. What areas would you like to see the Indiana System of Care improve, change, add, etc.? (mark all that apply or write in additional options).

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   Please explain (optional):
(All conference-related questions have been deleted)

State Questions

26. Would you like to provide feedback regarding the Indiana System of Care development as a state?

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27. What is your role with systems of care? Select all the apply.

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28. I believe the Indiana System of Care is improving as planned.

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29. All needed partners are attending and involved with the Indiana System of Care.

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30a. I feel like a valued partner in the Indiana System of Care at the **state level**.

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30b. I feel like a valued partner in the Indiana System of Care at the *local level*.

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31. Please select the areas you believe that the Indiana System of Care is doing well at the state level. *Select all that apply.*

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32. Please use this space to explain or comment on the area(s) you selected.

33. What areas would you like to see the Indiana System of Care improve, change, or add at the state level? *Select all that apply.*
Youth and family involvement

Workforce development

Partnerships

Social marketing

Sustainability

Support to local System of Care development

Other - Please describe:
  

34. Please use this space to explain or comment on the area(s) you selected.

35. Please use this space to provide any other comments or feedback about the progress made by the Indiana System of Care development as a state.