



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

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The Indiana University FoCuS team strives to improve its work. We thank you for your interest in this project and we always welcome your questions and suggestions.

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EXECUTIVE SUMMARY

For more than 20 years, the Indiana Division of Mental Health and Addiction (DMHA) has been working at the local level to help communities build coalitions focused on supporting children's mental health services. This report describes a study on the development, implementation, and evolution of a statewide level system of care (SOC) structure within the Indiana System of Care (IN-SOC) Expansion initiative to sustain state and local SOCs. The project used a case study design to uncover and examine systematically gathered information from the program along with several key stakeholders. This report describes some of the attributes of Indiana's unique contexts and offers insights that may be helpful to other communities and groups engaging in similar types of system change and growth, both locally and nationally.

It should be noted that this is not the first attempt to implement SOCs across Indiana but it is the first to develop a state level SOC structure. Prior to this initiative, three previous federal, regional and local CMHI grant projects were implemented, followed by numerous state initiatives including legislation, state start-up funding for SOC development, technical assistance, 1915 c Medicaid Waiver, and a 1915 Medicaid Demonstration grant, to name a few.

Our findings revealed the following:

IN-SOC is committed to youth and family involvement: IN-SOC broadened its focus to all youth and families with mental health and related needs. In addition to broadening its scope of services, IN-SOC has been working to bring youth and family voice to the forefront. Stakeholders noticed the benefits of the youth and family subcommittee and how they are placed at a level of importance. One of the challenges stakeholders would like to see addressed is more robust discussions on identifying gaps, opportunities, and prioritization of services, in addition to having youth and family more consistently involved in discussing these topics in meetings throughout the state.

IN-SOC is working toward improved interagency and cross-sector communication and collaboration (including child-serving organizations and systems, schools and other SOCs): IN-SOC is leading efforts at the state level, via role modeling and helping to sustain interagency collaboration, by ensuring that all have ownership and a reason to be at the table. Sharing resources had been difficult in the past as the partners were more detached from one another and acting in silos. However, this has been improved over the last few years and has helped to sustain services. Deeper involvement from key organizations at state and local levels were mentioned as a need. These include the Department of Education (DOE), Department of Workforce Development, the faith-based community, and other informal supports.

IN-SOC is working to improve access to needed supports and services: One approach to improve access to services, particularly in rural areas, is to provide evidence-based trainings to service providers and others involved in the informal support systems in rural areas. The stakeholders value the cultural and linguistically appropriate services most.

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Although much work is being done to improve access to services, there are still a number of barriers that need to be addressed. As one respondent mentioned, *“Gaps still remain regarding access to effective, intensive community-based services, e.g., high quality wraparound, support, and outpatient services, etc.”* First, service availability varies from county to county, many times with additional service challenges in rural counties. Second, the stakeholders are looking to involve schools and DOE in a more substantive way to access services. Third, the stakeholders see greater community awareness as a way to address the challenges of accessing services. Finally, funding is another issue as community mental health centers that provide many of these services are *“in the midst of business model shifts, especially with Medicaid expansion and the coming of accountable care.”* However, through collaborations at the state and community level, IN-SOC is beginning to slowly move the needle in a positive direction toward better access to services and to protect youth who fall through the cracks in the system.

IN-SOC is shifting attitudes and reducing stigma associated for individuals experiencing decreased mental wellness: Stigma is still there but it is slowly beginning to diminish and stakeholders believe that the Indiana System of Care has helped reduce the stigma associated with emotional behavior challenges. Cultural differences are also related to stigma. As the state of Indiana is becoming more diverse, cultural differences should be considered which might be associated with stigma, disproportionality, and disparities in outcomes.

SOC values and principles are demonstrated through actions and behaviors of the IN-SOC Team: There is a phenomenal team at the state level, however, the concern is that if key leaders leave IN-SOC, how would the mission, vision, and strong culture that has been built continue? *“Who is going to defend and support the work they are doing?”*

Ensuring Sustainability of Indiana’s SOC: IN-SOC is looking to secure funding from several avenues and incorporate a focus on youth with lived experience. Within the next year, there is a plan to include a finance study. Further, local and state SOC’s will be working to develop a sustainable plan beyond the grant that is funding the statewide initiative.

Recommendations

1. Improve access to effective behavioral health services and supports statewide, including, but not limited to, wraparound, integrated health care, mobile crisis, and acute inpatient resources, paying particular attention to rural areas.
2. Develop a sustainability plan for wraparound using multiple funding streams along with the development/sustainability of local SOC’s.
3. Increase monitoring the access to effective services and remain responsive to disparities based on socio-economic factors, geography, gender, race, ethnicity, language, legal status.

EXECUTIVE SUMMARY Continued

4. Increase robust discussions about identifying gaps, opportunities, and prioritization of services and to have youth and family involved in these topics in meetings throughout the state.
5. Actively address the dearth of child psychiatrists, psychologists, and masters licensed behavioral health professionals.
6. Develop the proposed sustainability plan that will go beyond the grant for local and state SOC's.
7. Ensure a pipeline of effective leaders are available who are committed to continuing the strong culture of care that has developed over the last several years.
8. 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.
9. Involve more colleges and universities to promote the concepts associated with SOC, wraparound, and other evidence based practices.
10. Continue to ensure all partners are at the table, comfortably connected, and fully engaged.

It has been exciting for the FoCuS evaluation team to work with IN-SOC as it engages families and collaborates with various agencies. Developing a culture that values collaboration has been a critical component for IN-SOC and is viewed as essential for sustaining continued development in Indiana. Indeed, the IN-SOC team appears to be committed to working with families and youth in addition to creating interagency partnerships across and throughout the state. Promoting and engaging family-driven and youth-guided principles seems to be strengthening these efforts at all levels of the project. In addition, the IN-SOC leadership team is working to reduce stigma that can be associated with having mental health challenges. According to our findings, next steps include the following: develop a deeper focus on family and youth voice; advance and deepen the work force development subcommittee; address cultural competency and disparity challenges; identify and address service gaps in all areas, particularly effective, intensive services in rural areas; continue to build a strong internal culture of caring leaders; and, proactively address funding and finance issues to ensure long term sustainability. Several possible limitations when interpreting the findings of this study are offered. Overall, IN-SOC appears to be well-positioned to continue building a dynamic continuum of services for families and youth, while monitoring appropriate access and confronting disparities based on socioeconomic factors, geography, gender, race, ethnicity, language, and legal status for Indiana youth.

Introduction

This report describes a study of the development, implementation, and evolution of a statewide level system of care (SOC) structure within the Indiana System of Care Expansion initiative to sustain state and local SOCs. This particular study focuses on the *current* SOC expansion grant strategies and progress. Prior to this initiative, three previous federal, regional and local CMHI grant projects were implemented, followed by numerous state initiatives including legislation, state start-up funding for SOC development, technical assistance, 1915 c Medicaid Waiver, 1915 Medicaid Demonstration grant, and more. The vision of the IN-SOC initiative is to connect all young people with supportive adults to increase the potential that children and youth will achieve wellness, engage in their community, and promote wellness for future generations. This research project used a case study design in an effort to create and provide useful information for program stakeholders and is intended to serve as a resource for program designers and evaluators, both locally and nationally. This report presents Phase I of a study that examined why and how the State of Indiana created the Indiana System of Care (IN-SOC), explored some of its early successes, and described what stakeholders envision an effective IN-SOC will look like in 5 years. The investigation focused primarily on gathering and synthesizing the perspectives of various IN-SOC stakeholders, in terms of the project's mission, implementation strategies, and sustainability efforts. This report also describes some of the attributes of Indiana's unique contexts and offers insights that may be helpful to other communities and groups engaging in similar types of system change and growth.

Background

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 systems of care (Huang, Stroul, Friedman, Mrazek, Friesen, Pires, & Mayberg, 2005). 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 with or at risk for mental health or other challenges and their families while creating meaningful partnerships among systems and agencies and, 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).

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) put it this way, "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, in press; 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 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 Manteuffel (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).

Consistent with recommendations for state level leadership, the study described in this report examined the creation and implementation of the recently developed Indiana System of Care Expansion initiative. This study critically examined the perspectives of various project stakeholders in regards to IN-SOC’s mission, implementation strategies, sustainability efforts, and long-term impacts. Specifically, this study sought to: (1) Understand both why and how IN-SOC was created; (2) gain a deeper understanding of the population, agencies, and regions supported by IN-SOC; (3) understand how the integration of SOC values and principles support early successes within the SOC Expansion Strategic Plan; and, (4) explore what stakeholders envision an effective IN-SOC will look like in 5 years. This research also incorporated the unique attributes of Indiana’s contexts that set the stage for IN-SOC.

Method

This study employed a qualitative case study design. A case study is “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). For this study, multiple data collection methods were used to develop a detailed understanding of the case. Considering multiple sources of evidence as well as the strength of the data sources and the extent that logical convergence appears to be occurring across various sources of information, increases validity (e.g., Hitchcock, Johnson, & Schoonenboom, 2016) for case studies (Yin, 1989, 2013). A rich description of the setting and findings is provided.

This study consists of two phases: IN-SOC Phase I Study and IN-SOC Phase II Study. This report describes the Phase I study, which was conducted in 2015 and early

2016. Phase I was developed as follows: The FoCuS research team reviewed the literature, developed a set of questions and research protocol for the study, shared this information with IN-SOC leadership for feedback and approval, and acquired IRB approval. The study included two primary sources of data: (1) Document collection and review in which the research team gathered publically available information related to IN-SOC, including email correspondences, meeting minutes, grant proposals, and other materials, and, (2) semi-structured interviews with identified project stakeholders.

Data analysis from the Phase I interviews will determine the focus and additional data collection of the Phase II study. The FoCuS team will schedule Phase II interviews as needed and continue to gather weekly updates from core project leadership including progress and process challenges, and reflections on the overall project in the form of emails, brief phone calls, and shared journals. Collection of Phase II documents will include all publically available document production associated with IN-SOC (meeting minutes, strategic plans, project reports) that have been developed since the end of Phase I of the study, in addition to other data sources.

Setting

The Indiana Family and Social Services Administration (FSSA), through the State Division of Mental Health and Addiction (DMHA), has been actively working to improve both access to and quality of behavioral and mental health services for Indiana youth and families. The mission of the Indiana DMHA is "to ensure that Indiana citizens have access to quality mental health and addiction services that promote individual, family and community resiliency and recovery." Consistent with this mission, Indiana DMHA has expanded the use of evidence-based practices and adopted a SOC strategy of behavioral and mental health service delivery in Indiana.

For more than 20 years, Indiana DMHA has been working at the local level to help communities build coalitions to support children's mental health services. In 2008, DMHA was awarded a Community Alternative to Psychiatric Residential Treatment Facility (CA-PRTF, Urdapilleta et al., 2012) Medicaid demonstration grant, which focused on the provision of intensive services for youth. In 2012, the 1915(i) PRTF Transition Waiver was implemented, which allowed "children enrolled in the demonstration project to continue receiving the Medicaid home and community-based waiver services provided under the demonstration grant" along with the 2013 SOC Expansion Planning grant, which provided funding to develop a strategic plan (FSSA, 2016b). From these efforts, SAMHSA awarded Indiana a four-year federal SOC implementation grant in 2014, the focus of which is to assist the state in implementing its statewide SOC Expansion Strategic Plan (see Appendix D).

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, 2016a). The vision of IN-SOC is to surround all young people with supportive adults so that they can achieve wellness, engage appropriately with their community, and collaboratively promote wellness for future generations. With this broad, holistic vision in mind, the IN-SOC population of focus is on all Indiana youth who can benefit from whole-community support systems such as SOCs. The core principles include: family driven, youth guided, trauma informed, collaboration, community-based, individualized, strengths based, culturally relevant, and outcomes

based. More detailed information on the setting and background of IN-SOC may be found in the Appendix: IN-SOCs vision (Appendix A) Statewide IN-SOC meetings (Appendix B), IN-SOC Implementation Project (Appendix C), IN-SOC Expansion Grant (Appendix D) and IN-SOC Goals (Appendix E).

Data Collection

Data for this study were collected from (1) primary and (2) secondary sources: (1) Through semi-structured interviews with stakeholders, and (2) documents from IN-SOC leadership. First, the purpose of the semi-structured interviews was to understand why and how the State of Indiana created the IN-SOC; examine the perspectives of various stakeholders related to IN-SOC's mission, implementation, sustainability efforts, and outcomes; and, describe what stakeholders envision an effective IN-SOC will look like in five years. Interviews were conducted via telephone or in person and were scheduled at a convenient time for the participant. Each interview was approximately one hour in length. All interviews were audio-recorded and transcribed for analysis. Second, public documents developed by IN-SOC staff and its partners were utilized, as well as other documentation that stakeholders shared with the evaluation team (e.g., agendas, meeting minutes, websites, grant proposals, etc.). Documents were specifically targeted that would help the researchers create and report an in-depth understanding of the practices of IN-SOC.

Using interviews and document reviews, the study outcomes focus on synthesizing stakeholder ideas and advice to help IN-SOC administration reach its intended goals for the State of Indiana. The study also provides an investigation of the attributes of Indiana's unique contexts and becomes a valuable resource for program design and evaluation, both locally and nationally.

Study sample. The ideal participants were identified by using criterion-based sampling which involved selecting stakeholders to be interviewed who met predetermined criteria of importance (Patton, 2002). First, the research team generated criteria for deciding who should be interviewed for this study (e.g., current or potential partners in the IN-SOC). Next, these criteria were examined for completeness by IN-SOC personnel and stakeholders and then revised by the study team. Using agreed upon criteria, a list of potential interviewees was generated and subsequently finalized by IN-SOC personnel and stakeholders. Nine stakeholders were interviewed who were involved in IN-SOC at various stages of its development and had been involved in different systems, including: Family and Social Services Administration (FSSA), the Division of Mental Health and Addiction (DMHA), Youth MOVE Indiana, Youth & Family Subcommittee, Mental Health America Indiana (MHAI), Indiana Department of Child Services (DCS), Indiana University (IU), Office of Juvenile Justice and Delinquency Prevention (OJJDP), and National Alliance of Mental Health (NAMI).

Analytic Strategies

Consistent with case study design, data triangulation was employed through the use of multiple sources of evidence (i.e., interviews and documents). The goal of triangulation was to corroborate findings (Patton, 2002). Data gathered for this study were analyzed sequentially: First, interview data were analyzed; followed by documents. The purpose was to use findings from the document reviews to strengthen and support the findings from the interview data.

Interview analysis. All interviews were digitally recorded and transcribed

verbatim. Using the qualitative analysis web-based platform, Dedoose, each interview transcript was imported into the application. Dedoose was chosen because it is easily accessible via the Internet, has a simple user interface, and allows multiple researchers who can use either Mac or PC systems, and work from different locations, to simultaneously collaborate on the same project (Talanquer, 2014). Dedoose also facilitates the calculation of percentage of agreement among multiple coders and calculates inter-rater reliability coefficients. It offers a unique opportunity for research teams to not only carry out team-based analytics, but to interactively train other coders in the use of qualitative methods.

Data analysis in this study started with reading and rereading all transcriptions of the set of recorded interviews (Stake, 2006). Each transcript was read by the project manager, who had also conducted the interviews, to identify preliminary themes from the data that aligned with at least one of the research questions. To make the analysis process more transparent, after the first round of coding the following process was utilized:

1. Using the objectives laid out within the IN-SOC study protocol, a skeletal infrastructure was developed. In this step, the research team approached the study objectives as deductive assertions.
2. For each study objective, at least one pre-assertion was developed. A pre-assertion was an initial 'statement of finding' that was generated, revised, and eventually confirmed by the research team.
3. As the team progressed in the analyses, additional assertions were added to the findings as they emerged from the data.

After the researchers developed the first set of pre-assertions, two researchers next separately coded two interviews, using Dedoose. They then met and discussed all discrepancies until reaching an agreement about the coding. While analyses were occurring, these processes were also discussed with a third researcher who had a deep understanding of the coding process and some experience with IN-SOC, as well as with the Project Coordinator involved with the IN-SOC project.

After agreement about coding was reached, the team next used the Dedoose Training Center to build and maintain inter-rater reliability. First, the expert coder created a training session that was designed to train other coders from the team. During the testing session, the trainee is blind to the work that was done by the expert. After session completion, results provide a Cohen's Kappa coefficient of code application, as well as specific information about where the 'trainee' and 'expert' agreed and disagreed. When Cohen's Kappa coefficients were calculated with two separate coders, values were between .80 and .90, which is considered to be excellent agreement by Cicchetti (1994), Fleiss (1971), Miles and Huberman (1994), and Landis and Koch (1977). After the training sessions, coders were each assigned two to three interviews to code. A final coding check was made by another researcher and then loaded into Dedoose. The analysis process was participatory and iterative, continuing until no new information about the primary research questions was derived. Code categories were refined as subsequent data gathered. Coding differences were resolved through discussion.

As a result, the team generated several assertions that captured the codes and themes supported by the data (Erickson, 1986). To do this, the research team used Erickson's (1986) method of analytic induction, which is based on the researchers' repeated reading of the data as a whole, who then arrive at a set of credible assertions.

“Assertions are statements that the researcher believes to be true based on an understanding of all the data” (Smith, 1997, p. 80). To establish credibility for each assertion, the trustworthiness of the assertions was checked by seeking both disconfirming and confirming evidence in the data. All of these processes were discussed among the research team while analyses were occurring and, if needed, an experienced researcher provided a check of the coding scheme and emerging findings, which also provided an opportunity for fine-tuning.

Document analyses. In addition to interviews, document analyses were conducted which “involves skimming (superficial examination), reading (thorough examination), and interpretation” (Bowen, 2009, p. 32), combining content analysis and thematic analysis. Content analysis is used to organize information into categories related to the study’s purpose. In this process, meaningful and relevant passages of documents are identified and separated from that which is not pertinent (Bowen, 2009; Corbin & Strauss, 2008; Strauss & Corbin, 1998). In this study, documents were analyzed after interview data was analyzed. Thus, the themes generated from the analysis of the interview data were used as a framework to deductively analyze the study documents. When document data did not fit the pre-determined themes, new themes were created. The use of predefined codes or themes is common when document analysis is supplementary to other research methods, such as in this study (Bowen, 2009).

Documents were also used to support the findings of the study. Mismatches such as when identified themes did not appear to be supported by data or when different opinions about how to analyze ambiguous data from source documents between researchers were treated as discrepancies. These processes were iterative and continued until all discrepancies were resolved and no further new information appeared to be forthcoming from data collection or analyses. Only when all the evidence from the interviews and documents created a consistent picture of initial and ongoing development, implementation, and evolution of the Indiana System of Care, were the researchers satisfied that the processes of data collection and analysis were complete. That said, the research team acknowledges that this report presents thinking at a specific point in time, using a specific and limited dataset. In other words, please consider this report a ‘work in progress.’

Findings

Analyses of the data for this study yielded six key findings or assertions that are related to the initial and early development, implementation, and evolution of IN-SOC. Each assertion includes several subcategories that more fully explain the corresponding finding. The order of assertions is based on our interpretation of the apparent relative importance, based loosely on how often each was referred to in the interviews. We point out that this order should be considered tentative because the assertions tended to be closely connected to each other. For example, the theme *youth involvement* was found in multiple assertions. The table below includes the assertions, the key points to each assertion, and how each links to the IN-SOC and SOC principles. The sections following the table are organized by the assertions that include quotes from the interviews and are provided to illustrate central findings through the voice of the participants in this study.

Assertions	Key points	Link to primary principles of IN-SOC
<p><i>A strong sense of youth and family involvement</i></p>	<ul style="list-style-type: none"> • Youth and family subcommittee • Youth MOVE Indiana • Voices of individuals with lived experience • Working Together Works • Barriers for youth and family involvement 	<p><i>Collaboration.</i></p> <ul style="list-style-type: none"> • Professionals respect the families they are working with along with their opinions and families seem to respect the professionals. Stakeholders believe this sense of trust between two parties is crucial when working with people experiencing mental health challenges. <p><i>Strengths based.</i></p> <ul style="list-style-type: none"> • Consider the strengths of the individual/family along with the strengths of the community and leverage these to overcome issues and barriers rather than blaming the individual/family. <p><i>Family Driven.</i></p> <ul style="list-style-type: none"> • The idea that families are equal partners in the decision making; that IN-SOC ensures its staff listens to youth and families regarding their challenges and take into consideration their solutions and ideas. <p><i>Youth Guided.</i></p> <ul style="list-style-type: none"> • Having youth and families at the table. • Hiring youth with lived experience. <p><i>Individualized.</i></p> <ul style="list-style-type: none"> • Understanding and focusing on individual situations and needs to create positive outcomes.
<p><i>Interagency and cross-sector communication and collaboration</i></p>	<ul style="list-style-type: none"> • Modeling and leading by example • Sharing resources and improving partnerships • Monitoring progress • WrapSTAR- improving the quality of wraparound • Local level success • Challenges with interagency collaboration • A need for deeper involvement from 	<p><i>Interagency Collaboration.</i></p> <ul style="list-style-type: none"> • All agencies and entities are working together to truly collaborate to come to agreement on how to generate positive outcomes. • Ensuring that all partners have ownership and a reason to be at the table. • Focusing on all youth and families with mental health and related needs. Believing that all people fall on a continuum of mental health needs, some more complex than others. <p><i>Community based.</i></p> <ul style="list-style-type: none"> • It takes the full community and the primary stakeholders within the community to

	key organizations at state and local level	create successful outcomes for families and youth.
<i>Access to needed supports and services</i>	<ul style="list-style-type: none"> • Cultural and linguistically appropriate services • Barriers to services • Education • Community awareness • Access to effective behavioral supports statewide • Funding and shift in business practices 	<p><i>Outcomes Based.</i></p> <ul style="list-style-type: none"> • Finding the gaps. How IN-SOC makes a concerted effort to identify and address gaps, be they cultural linguistic, lack of resources, or other gaps. <p><i>Culturally relevant.</i></p> <ul style="list-style-type: none"> • Providing culturally diverse services to ensure all family and youth receive needed service and support. <p><i>Community Based.</i></p> <ul style="list-style-type: none"> • Improved knowledge of available resources to develop better accessibility to those resources. • A way to address the challenges of accessing services.
<i>Attitudes and stigma associated with individuals experiencing decreased mental wellness</i>	<ul style="list-style-type: none"> • Increased awareness of these issues • Creating safety nets and prevention • Having sufficient resources • Marketing and social media efforts • Considering cultural differences • Changing the language 	<p><i>Strengths based.</i></p> <ul style="list-style-type: none"> • Focusing on all youth and families with mental health and related needs. Believing that all people fall on a continuum of mental health needs; some more complex than others. <p><i>Trauma informed.</i></p> <ul style="list-style-type: none"> • Taking into account how either an individual or an entire community can be affected by trauma.
<i>SOC values and principles are demonstrated through actions and behaviors of the IN-SOC Team</i>	<ul style="list-style-type: none"> • Embedding quality relationships • Collaboration and individualized approaches • A phenomenal team at the State level 	<p><i>Collaboration.</i></p> <ul style="list-style-type: none"> • The importance of having champions who foster a high performing team atmosphere. • All agencies and entities working together to truly collaborate to come to agreement on how to generate positive outcomes. • Ensuring that all partners have ownership and a reason to be at the table. <p><i>Community based.</i></p> <ul style="list-style-type: none"> • It takes the full community and the primary stakeholders within the community to create successful outcomes for families and youth.
<i>Sustainability of Indiana's SOC</i>	<ul style="list-style-type: none"> • Grants • Sustainability through youth with lived experience 	<p><i>Outcome based.</i></p> <ul style="list-style-type: none"> • Working together and strategizing around positive outcomes that all agree upon.

Table 1: Summary of assertions

Assertion 1: IN-SOC is committed to youth and family involvement.

Findings indicate that IN-SOC is committed to creating a culture of inclusiveness that ensures family and youth participation at all levels of the system of care including planning, decision-making, policy development, outcomes monitoring, and process improvement. Interviewees were clear that one of the core values driving a successful system of care is building respectful partnerships that result in the solicitation and inclusion of youth and family voice and participation in all levels of decision making. Moreover, although the grant project for IN-SOC was focused on youth with serious emotional disturbance (SED) ages 5-21, IN-SOC has broadened this focus to include all youth and families with mental health and related needs. This shift was viewed by study participants as indicating a major philosophical advancement. As one interviewee commented, “...at this point we are really looking at all children and families and making sure that they have support and access to the resources they need to be healthy and have healthy life styles. And so we broadened it. When we first started, we were really just looking at specific wraparound programming.”

Likewise, IN-SOC has been working to make youth and family voice central to the project. Respondents noted that youth and family involvement in IN-SOC has been slower to start than hoped because, “the mental health systems aren't as developed and it is sort of a new concept to be supportive of the families not just of the clients, or consumers...” At the same time, however, stakeholders clearly agree that youth and family must be involved as equal partners in decision making if IN-SOC is going to reach its full effectiveness. To make this happen, IN-SOC is addressing several items that are described next.

Youth and family subcommittee. The common goal for youth and family engagement, expressed by interviewees, was for widespread engagement that extended to the governance of each local SOC. Further, IN-SOC is modeling this expectation through its *Youth and Family Subcommittee* at the State level. The purpose of this subcommittee is to disseminate influential ideas about how communities can work together, along with family and youth, to focus on ensuring that mental health supports are available for all. Regarding youth and family membership at the board level, one interviewee said, “we have changed our board membership to include youth and families. And we allowed the flexibility that it does not have to be same youth and family every time. And so it is a true partnership, it is through participation. We are not just “talking membership,” which I think is sometimes where you start, but really getting into those conversations around how this can benefit those youth and family. So we really get true commitment on their behalf and I think the change that we’re modeling is why youth are still coming to the table.”

Stakeholders reported that they have noticed the benefits of youth and family subcommittee: “We were really partnering with families; it really was about the family's voice and choice. The families were really driving the car.” Others expressed being impressed by the progress being made towards the full participation by youth and family members. Recently IN-SOC implemented a formal policy that illustrates this commitment: “nothing gets to IN-SOC without first going through the youth and family subcommittee.” The youth and family subcommittee meets on the same day as the quarterly governance board meeting. In fact, the subcommittee meets prior to the full board meeting so they can review and provide input to agenda items that will be

discussed at the board meeting.

The IN-SOC Governance Board currently has 27 members and nine of the seats are held for youth and family member representation. Interviewees noted that having one-third of the board consist of youth and family is a milestone for the State and the project. This is the first time that youth and family were clearly in a formal position of providing input on policy and other important decision making. In terms of next steps, one interviewee suggested that an orientation be provided for youth and family board and committee members to ensure that folks “*feel like they are capable advocates and they aren't just sitting there, and maybe listening to people talk in ways they may not understand.*” As the youth and family subcommittee evolves, the intent is that it will offer input, ideas and feedback related to all SOC policy development and implementation. In addition, IN-SOC wants to have youth representatives from across SOCs in Indiana, participating on all child serving systems and support structures in the state, such as juvenile justice, LGBTQ community, youth with lived experience, and more.

Youth MOVE Indiana. What started as a small advisory board in May 2012 is now a local chapter of one of the leading national youth-led organizations in the country devoted to improving services and systems for youth. Youth MOVE (Motivating Others through Voices of Experience) is a youth-driven, youth-guided organization that serves as one of IN-SOCs partners. Its primary goal is to improve “services and systems that support positive growth and development by uniting the voices of individuals who have lived experience in various systems including mental health, juvenile justice, education, and child welfare.” Its mission reads: “Youth MOVE Indiana strives to inspire and strengthen the voice of youth and make a difference through education, empowerment, and support. We will advocate for positive change in youth-serving systems.” Its vision reads: “We, the members of Youth MOVE Indiana, will work towards positive and progressive change surrounding the areas of adolescent mental and physical health in our community, our nation, and our world. Our goal is to prevent discrimination, promote acceptance, and change negative societal perceptions that affect today’s youth. We will take the initiative to empower new generations to stand up, speak out, and be fearless” (Youth MOVE Indiana, 2013).

Youth MOVE is funded through a grant from the DMHA, and has youth representatives on both the Governance Committee and the Youth and Family Subcommittee. Although not a direct service provider, Youth MOVE does provide a voice for young people who have been involved in the mental health, juvenile justice, and other systems. These young people have lived experience and “recognize the importance and power of youth voice and choice” and “strive to help other youth feel free to be themselves.” (FSSA, 2016c). Youth MOVE advocates for and provides critical input into the change process that is happening at the state level, ensuring that the needs and voices of the youth are known and understood. Youth involvement within IN-SOC has become embedded in several ways through Youth MOVE’s work and other involvement at the state level. One interviewee voiced, “*so just as you would say we need to reserve a slot for an educator and for a veteran and for someone involved in the judicial system, we made sure we were there to say we need to ensure there is a spot for youth voice representation.*”

An example of the Youth MOVE effort to advocate for young people is the Working Together Works program. The purpose of Working Together Works, a program

developed through Mental Health America, Indy, is to ensure that Indiana develops a collaborative strategic plan, shares resources, and engages in cross-training to increase the capacity to positively influence behavioral health systems. It also aims to change and improve behavioral health outcomes for persons in recovery from serious mental illness and/or substance use disorders for youth, young adults, and family members of children with serious emotional disturbances (IAIC, 2015). Youth MOVE sends representatives to these meetings to provide input and ideas. In addition, representatives also participate on the Indiana State Suicide Prevention Advisory Council and are helping to develop the structure of the council.

Barriers to youth and family involvement. Interviewees also discussed some of the barriers to youth and family involvement that face the full implementation of IN-SOC. Respondents noted that in the past, discussions followed a similar theme, *“They [family members] have to be trained and they have to stop complaining and they have to be educated about the system. They have to learn to communicate better.”* Now, stakeholders want to see more discussion about identifying gaps, finding opportunities, and prioritizing services to ensure full youth and family involvement in meetings at both the state and county levels. A key insight in this regard was expressed by one respondent: *“There needs to be a separate discussion about the providers and policymakers kind of dragging the families and youth along. I think it [needs] to be the other way around.”*

Assertion 2: IN-SOC is working toward improved interagency and cross-sector communication and collaboration (including child-serving organizations and systems, schools, and other SOC).

The interagency collaboration efforts occurring within IN-SOC have been growing and evolving over the past few years and have gone through several distinct phases. Efforts appear to have first begun with wraparound and then continued with the CA-PRTF grant in 2008. It was at this time when agencies and systems really began discussing SOC values and how to implement them as they relate to interagency cooperation and collaboration. In 2012-2013, partnerships coalesced further when discussions at the state level focused on how to authentically collaborate through governance boards, committees, collaborative grant projects, and partnering agencies.

Early forays into interagency collaboration began with cross-system initiatives to address specific challenges and formal commissions preceding the advisory board. Currently, there is representation from multiple agencies throughout the state that are all involved in cross-departmental meetings (see Appendix B for more information about local and statewide collaborative meetings).

IN-SOC focuses on sustaining these interagency collaborative efforts by first ensuring that all parties feel ownership for the goals and objectives and have a clear reason to be at the table. IN-SOC leadership has focused on building healthy and productive cross-system relationships, viewing them as critical to not only ensuring sustainability of these efforts, but to achieve lasting, effective outcomes. As one interviewee conveyed, having *“more formal structure causes people to interact more.”* Below we describe some of the specific ideas and ways respondents mentioned or described how IN-SOC is nurturing interagency collaborations.

Modeling and leading by example. Interviewees described how IN-SOC is leading at the state level via role modeling and encouraging the local SOC to collaborate with the state and with one another to build effective SOC locally and statewide. Two

statewide groups provide oversight to this work: The IN-SOC Governance Board and the Youth and Family Subcommittee. The members of these two groups vote on policy, implement evaluations, monitor progress, and share process improvement ideas. Each county has been asked to identify one person who will serve as key contact or *SOC Coordinator* for their local SOC and participate in a monthly conference call. The purpose of these calls are to model collaboration and disseminate information, discuss and revise processes, and share ideas and structures that local SOCs might utilize in their own communities. To encourage full and authentic collaboration, the IN-SOC board is working to broaden the representation of board members. As one interviewee said, *“The original advisory group that oversaw wraparound services became our governance board.”* They now realize this board needs to diversify to stay relevant, effective, and serve as a model for the county SOCs.

IN-SOC has hired a technical assistance coordinator (TA), who was described by one interviewee as having his “feet on the ground” in communities throughout the state. Indeed, with multiple agencies collaborating in several counties, the TA coordinator is 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 looking at 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?”*” As of spring 2016, the TA coordinator had identified and was able to connect with the key contacts in each of Indiana’s 92 counties. However, while all SOC coordinators have been identified, some are nonresponsive. Currently, local SOC activity and development has been reported in approximately 72 counties. Still, folks saw this as a breakthrough for the state: *“That was a big undertaking.”* Respondents also noted the importance of these efforts, recognizing that there are many more counties, agencies and individuals who are aware of and talking about SOCs. The goal of agencies being able to provide more comprehensive services statewide is now seen as achievable.

Sharing resources and improving partnerships. When interagency collaboration is working well, it *“allows for partnerships, true partnerships, to happen.”* For example, FSSA has now combined its programming with the Department of Child and Family Services (DCS), so that DCS has access to certified and approved providers. These practices, in which key partners are sharing resources at the state agency level, appear to be among the important reasons these partnerships are developing and will be sustained. As one interviewee explained, *“It is because we are sharing resources, sharing funding, and we are collaborating using our personal resources, our personal experiences. And that really continues to bring people to the table.”*

Although sharing resources had been difficult in the past when stakeholders were more detached from one another and acting in silos, the landscape in Indiana has changed and improved over the last few years. As one interviewee stated, Indiana went from nothing to, *“trying a home and community based waiver.”* In fact, Indiana was only the fourth state to implement this for children with serious mental health illnesses. Participating in the pilot waiver program prepared Indiana to successfully implement a

related five-year Medicaid grant to demonstrate that intensive community based services could provide an alternative to residential treatment, sustaining or improving functioning. As a result, a plan was developed to sustain intensive community based programs through multiple funding streams and the development of sustainable SOCs. Furthermore, the state now sets aside part of the Medicaid money to help move children from state hospitals and Psychiatric Residential Treatment Facilities (PRTFs) to intensive community based services coordinated through high quality wraparound teams within the community. Although funds are not yet being placed into a *funding pool* (e.g., blended funding for blended services), money is now being used for the wraparound service model, with DMHA providing trainings and certification for wraparound. The State is also working with the wraparound evaluation and research team from the University of Washington, Portland State University, and University of Maryland. *“All of that is supporting a service package that Medicaid funding mapped for the state plan 1915i amendment and the use of state money for children who don't qualify for that [along with] the money follows the person.”*

Monitoring Progress. In the spring of 2015, IN-SOC initiated the *Evaluation Sub-committee*, which meets every other month. The goal of the committee is to develop and implement an evaluation process for the state and local communities. An emphasis has been placed on using existing information from multiple sources and required data for the federal grant as part of the basis to monitor and sustain the state’s SOC development and quality improvement process. This committee is also charged with continuously reviewing the internal progress of the IN-SOC project. Through this committee, the state hopes to exemplify and model the evaluation process that it would like to see replicated at the local level. As one respondent stated, the exciting part will happen when everyone meets to examine the data and folks can say, *“here's our contribution to our outcome and now let's look at it as a whole.”*

WrapSTAR – improving the quality of wraparound. The Wraparound Structured Assessment and Review (WrapSTAR) (WERT, n.d.) is a comprehensive tool that monitors the fidelity of wraparound services and necessary supports and services (e.g., the full infrastructure of a SOC, organizational readiness, including the support from the wraparound facilitator; their supervisor; their clinical director; the CEO; as well as how fully the wraparound team is connected with the system of care, and availability of related services). The impetus of WrapSTAR occurred when, early on, the state found a number of gaps in wraparound support systems. At that time, six SOCs decided to examine and overcome this challenge. As a result, the WrapSTAR system allows SOC teams to use their data to increase fidelity, develop needed infrastructure to support improved fidelity, thereby improving outcomes for youth and family. The first cohort of Indiana WrapSTAR sites included six local or regional SOCs. The IN-SOC team plans to *“market this process to all of our other agencies that are doing high fidelity wraparound.”*

Early Successes with Collaborations at the Local Level. Our analyses uncovered examples from various local SOCs indicating that IN-SOC was having influence on the local level for improving mental health supports. For example, when the board of one local SOC discussed the collaborative efforts to infuse mental health services into their school system, one interviewee noted, *“the mental health providers are not just there to help kids get an education -- they're there to help with the focus of, ‘how*

can we help this kid with this life.” In addition, this respondent continued, the county has multifaceted services so *“they’re talking about substance abuse, mental health needs, what’s going on in your home with their parents, they’re looking at how it is being approached.”* Moreover, they not only have connected education and mental health services in the schools, which is really a difficult accomplishment due to the unique dynamics between the two systems, but, *“they funded it locally so their community agencies have gotten together and found funding themselves for this effort, which is really the ultimate goal we’re trying to get to.”* This is a great accomplishment for a local county to build sustainability with local support. Another interviewee put it this way, *“It’s great to start things at a state level but then we have to figure out how we are going to sustain that locally.”* In addition, findings suggested that these efforts are making a difference for local families. An interviewee remarked, *“it’s making their education system better because their kids are getting some of their needs met. They feel like -- even when you talk to the different agencies and you talk about how does it feel with these kids getting these services in school -- you can tell that it’s making a difference for those kids. It’s making a difference with their families.”*

An important byproduct of these efforts is that local governance boards continue to grow as stakeholders and potential stakeholders become interested in being a part of a successful team. In one local SOC, the first time the TA coordinator attended a board meeting, there were 6 or 7 folks in attendance. After the TA provided several educational sessions on the system of care principles and the work that IN-SOC was engaged in around the state, participation grew to 36 attendees and included community influencers such as judges and prosecutors. One person put it this way, *“the language began to change the way they look at their work, and challenged the way they think about their work, and how they think about the relationships with provider/consumer.... So it’s really kind of dynamic.”*

Another interviewee discussed challenges that two neighboring counties were facing: *“They had some obstacles and had meetings where they have to drive a lot to go to meetings”* where they were *“repeating information over and over again and all the same people are at the same meetings talking about the same kind of kids.”* These folks let their contact at the state know about these barriers and that local stakeholders wanted to change the situation. The IN-SOC contact helped them group all the meetings together into one day. The result was a reduction in driving time and less redundancy of having the same information repeated. This also allowed participants to go deeper in their conversations. *“Now because the meetings are [more comprehensive] and we are all together, things are really getting into much more substance within the conversations.”* In addition, they can include representatives from DCS, the prosecutor’s office, the local judge, local law enforcement and education. And most importantly, not only are all of these agencies there, each brings its own interests and focus: *“When you have these short meetings, you can only go so far. They never really got to the point of realizing some of the challenges they were facing because they couldn’t get deep enough in the conversation to get to those challenges.”*

Such changes are core to well-functioning systems of care, allowing multiple agencies to work together, both locally and on a state level. In addition, IN-SOC is able to collaborate with and offer individualized services to meet the needs of each county. As one interviewee pointed out, the changes in the way meetings and collaborations are

structured have really changed the dynamics: *“When we're able to challenge the way things are done and find a way to do it more efficiently and effectively, that meets everybody's needs. It makes them want to promote more collaboration and more integration of their resources and services so it's really a great example.”* Not unexpectedly, the efforts related to improved collaboration and individualization match the intended goal of IN-SOC, which is to “establish a mechanism for communication and coordination between state and local SOC and generate SOC involvement among local decision makers, which will result in increased participation in expansion planning and implementation, developing interagency agreements and care management entities and assistance with SOC monitoring” (IN-SOC goals).

Challenges with interagency collaboration. Stakeholders also described some of the challenges related to these efforts. For example, findings indicated that some stakeholders want to see the rural communities better represented. Others noted that they want to see more involvement and increased awareness about the IN-SOC project across the state, so that *“every organization, every service provider, every hospital, every small practice, every family therapist, everyone in the community who provides mental health services should be aware and become more involved.”* Respondents also agreed that local community groups should be more actively involved and connected, to ensure that all relevant groups in each community have a better understanding of the resources that are available to them. It was clear from the findings that people believe the ultimate goal for interagency collaboration is to develop this kind of involvement at the state level, then implement it at local levels. Ultimately, and as a result of these efforts, every county should have its own youth and family advisory council and governance board, and further, their county board representative should be involved at the state level in order to share the strengths and needs of their local community with the larger group. Even though IN-SOC is making headway to ensure that all SOC coordinators or key contacts are engaged and actually participating, some of the stakeholders still see this as a challenge that will require persistence from the state for the foreseeable future.

Communication and competition issues between the partners were some of the other challenges mentioned during the interviews. One interviewee said the communication currently tends to be on the surface level and does not yet go deep enough, stating, *“I'm sure that there's probably partnerships out there that we just don't know about because we don't really take the time to find out the kinds of projects that other agencies are working on and how our work coincides and how we can partner. Some of it has to do with competition.”* This person continued, *“When it comes to organizations – nonprofits- they're competing for the same sorts of grant money...So, the whole being able to get beyond competition is very hard.”*

In terms of collaboration, one interviewee categorized the concept of the collaboration spectrum into a loose collaboration and a tight collaboration. In a loose collaboration, there tends to be more competition and little communication versus a tighter collaboration where there's more trust, collaboration, and integration of planning, programs, and funding. In Indiana, this person noted, *“There's probably very, very, few SOC's that have a very tight collaboration and most fall somewhere in the middle.”* Thus, this appears to be an area in need of improvement.

Need for deeper involvement from key organizations at state and local levels.
Education. Many of the stakeholders noted that Department of Education has not

fully bought into the system of care concept yet. One interviewee stated, *“I don't think it's because they disagree with the concept or oppose the concept. I think it's simply just a matter of education and the board and its current collaborators really creating the right message and the right incentives for them to come.”* In fact, the interviewee believes there are other reasons why certain agencies are not yet at the table. *“I think that there are other initiatives and issues that are bubbling under the surface. You know, for example, you might look at disproportionality in suspension and expulsions in the education system, there is coalition that is working on that. That might be a lever for system of change that would force DOE to say ok what's going on with this SOC stuff, we really need to participate in this. That hasn't happened quite yet.”*

However, IN-SOC recently has a new member from the Department of Education who will be more involved with the SOC. This was seen as promising by a number of the stakeholders. In addition, several interviewees discussed how the collaboration with DOE and school districts would open up new possibilities and opportunities. Further, although many of the interviewees agreed that, until recently, education had not really been at the table, one interviewee noted how local communities have been trying to work with their local school districts to understand and meet the needs of students with mental health issues in the schools. One example can be seen at *The Crossing*, an alternative Christian school, which has almost 30 schools in the central part of the state and has plans to expand throughout the state.

Local governance boards around the state are trying to better connect with their local education systems. Our data suggest that these conversations are occurring throughout the state. These needs challenge IN-SOC, since creating an approach on the state level that is relevant for Marion County as well as smaller communities is a difficult if not impossible task, something that might not be welcomed in the local communities. The goal of avoiding “top-down” approaches is a key feature of IN-SOC. The idea is to support local efforts to make connections with local education systems. One interviewee stated that *“It would be better if the school keeps and attends to the kids who are falling through the cracks.”* However, these must be collaborative efforts that also involve mental health and juvenile justice. The goal is that local SOCs can say, *“here's what we think and here's where we can provide support....”* These are conversations that are in various stages throughout the state.

Several interviewees also pointed out that a partnership with DOE and school districts would help address some of the behavioral issues that are experienced by children who have mental health problems. For example, one respondent described the use of positive behavioral interventions and supports strategy (PBIS) that has been used at some Indianapolis Public Schools (IPS) with considerable success. However, as another respondent noted, sometimes the PBIS is *“not integrated with the school, the school often will have a contract with the community mental health center to provide services on site and sometimes those two things aren't integrated very well.”* Additionally, *“there are also programs that focus on reducing suspension and expulsions at some schools that provide interventions for kids and keep them in school instead of being suspended but could use some sort of follow-up with a mental health professional.”* These and other approaches that are designed to support youth in the education setting with mental health issues are of great interest to IN-SOC stakeholders.

Faith-based community and other informal supports. Stakeholders noted that

churches, synagogues and other places of faith offer assets that could and should be tapped. One interviewee described how training leaders from the faith community in SOC approaches would help local communities to create and sustain a continuum of services for young people with mental health needs. This also could open up more opportunities to address needs and build the capacity for ensuring that the strategic plan isn't limited, as this would involve a way of adding and utilizing informal supports to address challenges.

Another interviewee discussed the need to involve and better support early childhood professionals to build the capacity for prevention and earlier intervention when problems arise with children and their families. These efforts need to include proactive prevention strategies that will intervene in challenging behavior well before children get to an age where the behavior, if left unchecked, is more difficult to address. Indeed, prevention and early intervention are key to reducing the need for special education, child welfare involvement, and referrals to juvenile justice.

Respondents also clearly indicated the need for better representation from juvenile and corrections agencies, as well as from the State Department of Health and Medicaid. One interviewee expressed excitement about the Juvenile Detention Alternative Initiative JDAI initiative in Indiana that will provide alternatives to placing youth in detention (DYS: JDAI, n.d.). Another respondent noted that SOCs are preventative and responsive to the needs of youth and family, and are therefore well positioned to help with this work.

On the other hand, financial circumstances were seen as one of the biggest potential barriers for interagency collaboration throughout the state of Indiana. As an interviewee noted, it is *"kind of that chicken or egg thing."* If financial incentives were available, then agencies that are not really involved currently, would likely become involved. As stated by one interviewee, *"in the [strategic] plan there's a lot of discussion of developing braided, blended, shared funding streams to provide services; but it's a heavy lift to really get that stuff in motion."*

Assertion 3: IN-SOC is working to improve access to needed supports and services.

Many of the approaches for improving access to services have either been implemented within the last year or are in the process of being implemented. Our findings indicated that respondents believe a good approach for improving service access, particularly in rural areas, is by providing evidence-based trainings to service providers and others involved in providing support systems. *"There has been a big push from the Department of Child Services and DMHA to provide training for specific evidence based practices for all types of issues from trauma related issues to the needs of young children and their parents across the state."*

Though still in the development phase, IN-SOC partners, DMHA, and Indiana University are in the process of creating a process to identify which youth are receiving evidence-based practices (EBPs). Participation in EBPs has been linked to routine assessment data and access to outcome management reports is being developed. The goal is to have a better idea of the distribution and use of evidence-based practices, have an understanding where the gaps are, how well trainings are working in terms of addressing these gaps, and the impact on outcomes for children, youth, and their families. The initial timeline for releasing the first assessment outcome reports was October 2016.

IN-SOC is also exploring telemedicine and asking questions such as, to what extent is this method effective? And, how will it be paid for if incorporated? As

mentioned, workforce development is one key item that interviewees believe will help address service gaps, particularly in rural areas, as well as developing methods to recruit and employ qualified people at a good wage. It was clear the respondents' view the efforts of IN-SOC to address the *revolving door syndrome* that exists in Indiana, and is especially important for rural communities, as important to the future of the state.

Cultural and linguistically appropriate services. IN-SOC recently hired its first statewide cultural linguistic competency coordinator. This coordinator is a DMHA employee, hired through the SOC implementation grant, to work at the state level. One respondent noted this person is also a "feet on the ground" person. Stakeholders see this position as greatly needed, representing a big shift for the state as it explores, *"how are we as a community looking at the unique cultures and needs of our families, how are we addressing disparities and outcomes."*

This role also meshes nicely with IN-SOC's specific goal to provide culturally and linguistically appropriate services. To do this, one stakeholder pointed out the gradual approach that IN-SOC has taken related to cultural competency, utilizing the following steps: introduce the idea of what culture is, work through personal value orientations regarding cultural diversity, observe how cultural dynamics play out within collaborations, and then discuss the dynamics from a community perspective. One interviewee said the approach was one of determining *"what the strengths are, what the challenges are, what some of the solutions are to improve the situation. And to include all people, not just the dominant group, but to include all people no matter what marginalized group they're a part of, to start to get them to see things from that perspective and then we can slowly, over time, start to get deeper into the issue of cultural diversity and inclusion."*

Barriers to services. Although much work is being done to improve access to services, there are still a number of barriers that need to be addressed. Service availability and quality vary from county to county; there are services in some counties that aren't necessarily available to those in rural communities. For example, acute crisis services for kids, as one interviewee mentioned, are still lacking in counties which causes families or caregivers to drive to another county to access a hospital with an acute psychiatric bed for a child. Thus, *"sometimes what you'll see is that kids end up in the juvenile justice system instead"* due to lack of services provided in the rural counties. Another example is respite services, as this is typically not available in many counties in Indiana due to a lack of providers. The good news is that Medicaid pays for these services; the bad news is that there aren't enough providers to offer these services in many Indiana counties. The other issue related to providing services *"has been the needs of children who have co-occurring developmental and mental health concerns."* As one interviewee reported, there are limited services for youth with dual or more mental health challenges. However, IN-SOC has enhanced the state's multi-system assessment tool to better identify those needs.

Education. Having the child's education at the forefront of services is one of the long-term goals that one interviewee mentioned, stating that children's *"education, rather than it being an afterthought, it needs to be front and center."* Currently, IN-SOC is working to involve schools and DOE in a more substantive way. One interviewee shared the following example: *"Some of the remedies we see with kids is that they are placed in residential facilities and removed from the home because of their behavior."*

Then what if that child, especially a child with an IEP (Individualized Education Plan or Program) or 504 (prohibits discrimination against public school students with disabilities and provides accommodations or modifications for the student), needs to be evaluated? For one, could any part of that decision be based upon the child's ability to participate in everyday living, including school, then maybe some of that decision could be funded by education. But as it is now, [the youth] is placed outside of the home for 3 months or 4 months or maybe 6 months. When they return home, schooling may not have occurred at the facility, or at least not at a quality level." Which means all that time and learning has been lost.

Since IN-SOC works with all children and youth, including "*marginalized groups, disenfranchised groups,*" cultural relevance was the one of the principles that the stakeholders see needs more attention throughout the state. In addition, several stakeholders mentioned that they would like to see an increased focus on disproportionality. As one stated, "*African American kids are underrepresented in the mental health system and over represented in the juvenile justice system.*" Thus, there is a need for champions and decision makers from the African American and Latino communities.

Workforce development. Behavioral workforce issues are also being discussed. The lack of enough child psychiatrists, psychologists, and masters licensed professionals was recognized by the legislature, creating a time-limited program to forgive student loans for behavioral health professionals. Challenges in recruiting and retaining behavioral health professionals statewide, especially in rural areas, lead to the development of a new workforce development subcommittee.

IN-SOC's training and evaluation partnership with University of Washington and University of Maryland, which focused on developing high fidelity wraparound, increased the awareness and value of partnering with higher education. One interviewee discussed how better workforce development could be achieved through partnerships with more universities, stating, "*with that subcommittee I think, if not from evaluation but workforce development, that there are some things that hopefully our academic partners could do to help develop new professionals and help to sustain those who are out there.*" In fact, one of the IN-SOC sub-committees has already started expanding their work to include more colleges and universities; to promote the concepts associated with SOC, wraparound, and other evidence based practices. This would likely create connections with recent graduates to offer support and provide skill development for the existing workforce. The overall goal is to grow and support a stronger workforce of quality providers to serve families and youth.

Funding. Funding was another persistent concern expressed by study participants. Many interviewees noted the need for more and better access to services for youth and families. Part of this worry appeared to stem from changes occurring in community mental health centers throughout the state. It is these centers that provide many of the services for youth and families in Indiana and currently they are "*in the midst of business model shifts, especially with Medicaid expansion and the coming of accountable care. Whereas in the past sometimes it was hard for families to get kids services because they didn't have a payment mechanism already in place, [now] the centers are kind of scrambling to figure that out now as the system shifts from payment for service to accountable care.*" On the other hand, through the ongoing collaborations

at state and community levels, IN-SOC has been able to better provide access for young people in need and protect youth who are at risk of falling through the cracks in the system. One interviewee put it this way, *“there were just lots of cracks in the system or places where kids could fall through and not be able to access services.”* Some respondents noted how the concerns with limited access in community mental health are quite similar to the challenges youth with mental health challenges experience in schools. Young people are struggling academically and *“the education system will push that kid out. Only he hasn't done anything to end up in the court system and he hasn't really been identified for him to end up in the mental health system. So this kid falls through the gaps in the system.”* In order to address these kinds of gaps, IN-SOC is providing additional support through programs such as wraparound, the Community Alternative to Psychiatric Residential Treatment Facility (CA-PRTF) grant (FSSA, 2016b), Children’s Mental Health Initiative (CMHI) (Indiana Department of Child Services, 2016), and Child Mental Health Wraparound (CMHW) (FSSA, 2016d) *Note: the five-year Medicaid demonstration grant ended 9/2012 with a sustainability plan. The transition PRTF 1915c Medicaid waiver is for youth still enrolled in demonstration grant, Money Follows the Person (MFP), 365 days following PRTF or SOF; CMHW, CMHI. In addition, PRTF Transition and MFP are ending.*

Community awareness as one approach to addressing access barriers. The stakeholders see greater community awareness as a way to address the challenges of accessing services. They see it as their job to make sure the community understands all of the places where youth can enter services in their community. As one individual stated, *“how can we come together and create one entry point for all those services?”* In order to reach people in the community and create community awareness, the local governance boards are talking about how to use social media to help people understand what services and programs are available. This kind of awareness is not only informing youth and family but also all the stakeholders in the community and various people who are providing these services.

Assertion 4: IN-SOC is shifting attitudes and reducing stigma associated for individuals experiencing decreased mental wellness.

Stakeholders believe that IN-SOC is helping to reduce the stigma associated with emotional and behavior challenges through its efforts to spread awareness of these issues. This finding was corroborated by our document analyses which examined some of the initiatives set forth by the governance board via the strategic plan. Specifically, portions of the strategic plan focus on creating safety nets and prevention. Prevention is being created by educating and training supportive adults to create safe spaces and opportunities for youth to talk about their feelings, emotions, and mental health. The idea is to move beyond focusing solely on mental health providers and educate as many people as possible. One interviewee put it this way, *“There is a continuum there that if there were services available for people across the entire spectrum, if we tackled this from a mental health perspective instead of a disease state perspective, then we could really make some progress.”* The goal of the IN-SOC is that sufficient resources should be invested at every level of the continuum so whatever the services and supports that are needed by the family or child, they can be accessed.

At the state level and within many of the counties, numerous anti-stigma campaigns along with other approaches to address stigma are addressing ways to confront

and combat it. The IN-SOC strategic plan also includes marketing and social media efforts to reduce stigma. One interviewee remarked that the overall goal is *“to be able to address stigma, and to not address it as a mental health stigma, but basically to help folks understand that mental health is on a continuum like other health-related needs.”* In addition, respondents noted that the way people think about stigma is starting to evolve. For example, it is becoming increasingly likely that people won’t *“have a problem saying, ‘yeah, I have ADD or I have some form of autism’ and their friends accept that about them.”* Respondents also pointed out that these shifts in thinking are at least in part due to the general public becoming more aware of and educated about mental health. Many interviewees viewed improved social marketing and widespread educational initiatives as most responsible for these changes. The numerous anti-stigma campaigns both at the state level and in many of the counties are starting to have a positive impact. The media was viewed as having the capacity to create both negative and positive views of mental health. One respondent illustrated this point by saying, *“all of the instances of shootings where it’s claimed that the shooter has some sort of mental illness.”* On the other hand, media can and has been utilized to educate people in ways that help reduce stigma.

In addition to the youth who have been identified with a mental health issues, there are other youth who are *“sitting in the back of a schoolroom with negative symptoms and aren’t talking about it, and have no place to go [to address the problem].”* More attention should be given to youth who have yet to be identified or may just need some support in the short term.

Cultural differences can also contribute to stigma. As the state of Indiana is becoming more diverse, cultural differences should be considered which might be associated with stigma. For example, with the large Burmese community in Indiana, stigma might differ based on people’s values and views, so even though the rest of the state may not be aware of certain types of stigma, it can be alive and well in certain cultures, especially when it comes to depression and suicide. As one interviewee stated, *“the SAMSHA Annual Survey found that Indiana had the lowest level of access to care for youth with major depression.”* The same interviewee claimed that Indiana has a higher rate of suicide for adults and youth than other states. However, respondents agree that the attitudes towards stigma are beginning to shift. Youth are more open to share their struggles and problems and adults are starting to accept that mental health is a part of the full spectrum of health.

Given this, the language, mood and conversations are changing with people across the board. Whether it is nationally known spokespersons or everyday people, there is a realization that *“we need to start talking about this differently.”* And, with the work of Youth MOVE around advocacy, awareness and involvement in policy changes, the stigma should continue to dissipate. Yes, stigma is still present but it is slowly beginning to diminish. Interviewees mention that they have wrestled with this widespread problem at the state level and believe IN-SOC has done a good job initially to address stigma in their strategic plan by acknowledging a need for mental health for *all*.

Assertion 5: The SOC values and principles are demonstrated through actions and behaviors of the IN-SOC Team.

Some interviewees expressed concerns that if a few key leaders leave IN-SOC, how would the mission, vision and strong culture that has been built carry on? *“Who is*

going to defend and support the work that they are doing?”

Embedding quality relationships. One of the leaders is taking the following approach to ensure a quality-based and sustainable culture: *“...we needed a team at the state level that is not dependent one person so when [someone] chooses to move on, what has been built will be sustained. And that is my number one personal goal because we have worked too hard and we have seen too many positive changes in our system for myself or some other person to leave and have it all fall apart. I think that is something within our culture that we are trying to create. These concepts get embedded within our work and how we do things becomes our way of doing things as oppose to what that one person said was a good idea.”*

Collaboration and individualized approaches. One of the challenges that was addressed through utilizing collaboration and individualized approaches was the need for prosecutors to attend multiple rural meetings that repeated similar information on similar youth challenges. One person stated *“I go to six one-hour meetings a month and talk to the same group of people about the same group of kids”* which is not a very effective nor efficient approach. The TA discussed this problem with the local SOC team and incorporated collaborative values and individualized approaches to discuss *“their culture, their community culture, which is culturally competent kind of way to approach it.”* This process allowed the team to articulate and better understand what the obstacles were and the TA helped to unlock the obstacles via dialogue and problem solving at the local level. Through collaboration and individualized methods, they were able to approach obstacles in a way that was comfortable for everyone: *“they all feel better about their work, they feel like they’re getting more accomplished, so it really just completely changed the dynamic... I mean completely.”*

The interviewees were in agreement that there is a phenomenal team at the State level. Although the SOC values and principles have been illustrated throughout each assertion within this study, the following are some additional examples that demonstrate those values and the importance of having champions who foster a high performing team atmosphere:

- “Probably one of the most dynamic teams I have ever worked with anywhere. [Our supervisor] has done a tremendous job of gathering together a group of talent and very experienced people so that leadership/vision in communities across the state is quite dynamic. I think we're going to affect and change the way all the systems operate and we will continue to collaborate and find things to fix.”
- “How we look at youth families, those partnerships -- I can see it changing wherever I go. We want more youth and families at our tables. Those visionary principles and values affecting all those communities everywhere we go.”
- “There is an influence of mid-level champions and executive agencies that push the agenda forward and are really creative with ways to codify programs and initiatives outside of themselves.”
- “Through the work since I’ve been here, I’ve realized that a lot of things are changing and people are coming together, people are having different conversations and we have identified SOC contacts in all 92 counties in the state which is huge growth from where we were.”
- “The level of commitment to these SOC and governance boards and these principles and values are probably higher than I’ve ever seen and I think it's going

to continue to grow. I think juvenile justice is really getting behind it, education is starting to come around, across the board... I think Indiana is really going to hit it out of the park as a state. We're really going to achieve that level of real collaboration, real cultural competence and trauma informed."

- "We have a JDAI initiative here in Indiana, which is a juvenile detention alternatives initiative and that's a juvenile justice initiative that's trying to look at how they can come up with alternatives for kids in detention and so one of the greatest things about SOC is that it, by nature is preventative, it's responsive because we're responding to needs for people but we're also trying to talk about, as a community, how can we gather together and be preventive? How can we get ahead of this, before the kids reach this place? It's empowering those kids and empowering them to say "hey, we partner with Youth MOVE national" and saying how can we help give these kids a voice?"
- "One of the things that was really impressed upon me was how this wasn't just a principle value, they were really *doing* these principles and values. They were really partnering with families; it really was about the family's voice and choice."

The IN-SOC team has embraced honesty, openness and has demonstrated a welcoming approach to new ideas that have encouraged creativity within the team, allowing the team and partners to challenge status quo, and think differently about how to better serve youth and families. As one stakeholder reported, they are not afraid to speak their truth whatever that may be. Moreover, their strategy of positioning people in roles where their strengths can best be utilized has been instrumental in building a culture of inclusiveness and success.

Assertion 6: Ensuring Sustainability of Indiana's SOC.

"In order for this to be sustainable, it can't be a state program that's kind of pushed down, it has to be something that's grassroots; it grows up. So we're looking at building those local governances so that they're self-sustaining, so that they have their own strength. There's a good communication between the local governance and the state governance. And that those two are working well together, to meet needs and to review data and outcomes and come up with solutions, challenges."

Sustainability typically conjures up funding, however, it also involves wide-spread adoption of programs, processes, and services throughout the state at all levels. Regarding funding, some stakeholders believe there are still funding silos that need to be addressed and plan to have the finance committee tackle that head on. Although funding and sustainability efforts will be discussed more in-depth in Phase II of this study, the FoCuS research team wanted to add a few salient points in Phase I.

A few interviewees mentioned community agencies that have accessed local funding on their own to fund certain efforts, which is one key goal of being a sustainable organization. *"Every community can't just expect the state to write checks. It's hard to keep something sustainable when the money comes from the state because: Is that money always going to be there? It's great to start things at a state level but then we have to figure out how we are going to sustain that locally."* As mentioned before, if financial incentives were available, perhaps agencies that are not currently fully involved, may become involved.

Grants. As mentioned at the beginning of the study, the various grants received

were instrumental in helping communities build coalitions to support children's services. The purpose of the Federal SOC Expansion Planning grant from the Substance Abuse Mental Health Services Administration (SAMHSA) is to develop a strategic expansion and sustainability plan for systems of care statewide. These grants are key to building sustainability and improving access to and the quality of integrated behavioral health services and resources for youth and families in Indiana. Through this grant and the innovative approach of the IN-SOC team and partners, this focus has expanded to children of all ages and their families with the intent to ensure that they have support and access to the resources they need to be healthy.

Sustainability through youth with lived experience. Several interviewees discussed the importance of hiring youth with lived experience. "Lived experience" refers to those who have first-hand experience with various systems or services, e.g., juvenile justice, foster care, etc. In order to expand the youth and family involvement, the lived experience position was written into IN-SOCs sustainability plan. This position is a crucial piece in building sustainability throughout the state as those with lived experience can more authentically connect with youth, families and partners partially due to understanding the context and challenges that youth and family face and how to address those challenges through past experience.

Future Goals for the IN-SOC

When looking at the future and what is hoped for or expected, there were several responses from interviewees. Many of these expectations are already in place within a few of the SOC's, it's a matter of replicating these in all 92 counties:

- Widespread youth and family engagement within each of the local SOC's
- Better outcomes for youth and families with approaches to measure those outcomes
- Governance boards that include powerful state level influencers, especially in the political arena, as a more effective approach to addressing needs and outcomes and attracting new funding to the state
- Become more aware of criminogenic risks and the factors within these risks and develop programs
- Minimize the disparities between the dominant groups and the marginalized groups in the society
- Improved mental health and general health
- Less youth and families in the criminal justice or child welfare system
- Development of an online database that all partners and families could use and have better access to services throughout Indiana
- State agencies (DCS, DMHA, DOE, Medicaid, etc.) to collaborate creating true blended funding
- Incorporating families and youth as equal partners
- Interventions starting at a younger age with the hope that incarceration rates would decrease.

Discussion

It has been exciting to see the work of the IN-SOC team, working with families and collaborating with multiple agencies as the IN-SOC model has been developed and rolled out. Developing a culture that values collaboration has been a critical component for the leadership team and is viewed as essential for sustaining the developmental

process in Indiana. Indeed, the IN-SOC team appears to be committed to working with families and youth by promoting and sharing family-driven and youth-guided principles and the collaboration efforts to date seem to strengthen these ideas and goals. In addition, the team is working to reduce the stigma that can be associated with having mental health challenges. According to our findings, next steps include developing a deeper focus on family and youth voice; advance and deepen the work force development subcommittee; address cultural competency and disparity challenges; identify and address service gaps, particularly effective, intensive services in all areas with particular attention to rural areas; continue to build a strong internal culture of caring leaders; and, proactively addressing funding and finance issues to ensure long term sustainability. Overall, IN-SOC appears to be well positioned to continue to build the continuum of services for families and youth, while monitoring appropriate access and confronting disparities based on socioeconomic factors, geography, gender, race, ethnicity, language, and legal status for Indiana youth.

Although several challenges were mentioned by interviewees, it was clear from the findings that the first year of this project was focused primarily on collaboration, building local governance, and establishing an evaluation subcommittee, the majority of which have been accomplished. Results noted that there are still gaps that remain with access to effective, intensive community based services (i.e., high quality wraparound, support, and outpatient services) and behavioral health supports (i.e., wraparound, acute inpatient, and crisis) statewide. The research team notes that the need for these kinds of services and supports, particularly in rural areas, is not uncommon and can be found nationwide.

Respondents in this study noted that better representation from the Department of Education, juvenile and corrections agencies is needed, as well as from the State Department of Health, and Medicaid. However, several respondents also pointed out that the involvement of these systems is beginning to occur. For example, one interviewee expressed excitement about the Juvenile Detention Alternative Initiative (JDAI) initiative in Indiana, that will provide alternatives to placing youth in detention. Another respondent reminded us that SOC's are preventative and responsive to the needs of youth and family, and are therefore well positioned to help with this work.

As mentioned previously, financial circumstances were seen as one of the biggest potential barriers for sustaining interagency collaboration throughout the state of Indiana into the future. Findings from this study clearly indicated that development and sustainability of the local SOC will depend on multiple funding streams. As an interviewee noted, it is *"kind of that chicken or egg thing."* If financial incentives were available, then agencies that are not involved currently would likely become involved. As stated by one interviewee, *"in the [strategic] plan there's a lot of discussion of developing braided, blended, shared funding streams to provide services; but it's a heavy lift to really get that stuff in motion."*

Developing the behavioral health workforce in Indiana has also been a struggle. The lack of child psychiatrists, psychologists, and masters licensed professionals was recognized by the legislature, creating a time-limited program to forgive student loans for behavioral health professionals, were all viewed as potential barriers that need to be confronted. However, it is encouraging that the challenges in recruiting and retaining behavioral health professionals statewide, especially in rural areas, have already lead to

the creation of a new workforce development subcommittee. It will be important to follow the work of this committee and how it plans to address this challenge in the next few years.

IN-SOC's training and evaluation partnership with University of Washington and University of Maryland, which have focused on developing high fidelity wraparound, was seen as increasing the awareness and value of partnering with higher education. One interviewee discussed how improved workforce development could be achieved if partnerships are created with more universities, stating, *“with that subcommittee I think, if not from evaluation but workforce development, that there are some things that hopefully our academic partners could do to help develop new professionals and helping to sustain those who are out there.”* In fact, one of the IN-SOC sub-committees has already started expanding their work to include more colleges and universities in an effort to more widely promote the concepts associated with SOC, wraparound, and other evidence based practices. This would likely create connections with recent graduates and support skill development of the existing workforce. The overall goal of which would be to grow and support a stronger workforce of quality providers to serve families and youth.

While the findings of this primary report are indeed exciting, the potential challenges and barriers that face IN-SOC as it moves into the future also reminds us that the hard work is not over, and in many ways, is just getting started. However, the stakeholders and other partners are clearly vested in these efforts. They understand that better collaborations can lead not only to better outcomes but also to earlier interventions and, ultimately, prevention. Partners agree that it is critical for all communities to partner with families and help young people.

It has been our pleasure to observe IN-SOCs important work and we are honored to be invited to stay involved as external researchers and work with this team to see what happens next in Phase II of this study.

Recommendations

Although several recommendations for next steps are offered, we simultaneously acknowledge that IN-SOC has already started implementing most if not all suggestions:

1. Improve access to effective behavioral health services and supports statewide, including, but not limited to wraparound, integrated health care, mobile crisis and acute inpatient resources, paying particular attention to rural areas.
2. Develop a sustainability plan for wraparound using multiple funding streams along with the development/sustainability of local SOCs.
3. Increase monitoring the access to effective services and remain responsive to disparities based on socio-economic factors, geography, gender, race, ethnicity, language, legal status.
4. Increase robust discussions about identifying gaps, opportunities, and prioritization of services and to have youth and family involved in these topics in meetings throughout the state.

5. Actively address the dearth of child psychiatrists, psychologists, and masters licensed behavioral health professionals.
6. Develop the proposed sustainability plan that will go beyond the grant for local and state SOC.
7. Ensure a pipeline of effective leaders are available who are committed to continuing the strong culture of care that has developed over the last several years.
8. Provide a specific and ongoing focus on access to effective services, supports and infrastructure in rural areas.
9. 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.
10. Involve more colleges and universities, to promote the concepts associated with SOC, wraparound, and other evidence based practices.
11. Continue to ensure all partners are at the table, comfortably connected, and fully engaged.

Limitations

Before concluding, we describe several important reasons for being cautious when interpreting the findings of this study. First, because purposeful sampling was used in this study, it is possible that all stakeholder perspectives weren't adequately represented in the data. For example, if some specific group of stakeholders was systematically excluded from participating in the study, it might be reasonable to speculate that the resulting data would be skewed. However, we remind the readership that respondents were invited to be interviewed because they had met a set of pre-established criteria. Furthermore, by asking each participant during interviews who else should be interviewed for the study, additional evidence was obtained that our study sample was adequate. Even so, it is always possible in interview research that another group of interviewees may have produced a different set of findings. We also acknowledge that this research was conducted with one state level initiative, making any generalization to similar initiatives unclear. Although the design used in this case study was not intended to be generalizable, being able to fully describe the *counterfactual* of complex projects like IN-SOC may be not realistic. Moreover, without a comparison group, these kinds of designs remain highly susceptible to multiple, serious threats to validity (Shadish, Cook, & Campbell, 2002). In this work, however, we are reminded of Foster and his colleagues (2007) who suggested that consensus about the effectiveness of these kinds of projects will likely only emerge as the evidence from numerous site-specific studies is compiled and examined.

And, indeed, many communities are attempting to build similar state and regional structures of support for coordinated children's social services because of the challenges associated with serving youth with needs that extend beyond distinct systems (Anderson

& Cornell, 2015). As was clearly documented in this study, IN-SOC is predicated on a set of core principles (Stroul & Friedman, 1986) and a common philosophical foundation. Thus, it is possible that other communities that are adhering to these values and principals may have similar experiences in building state and regional system of care models. Therefore, we conclude that the findings of this study may be instructive to others planning similar endeavors.

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Appendix A
IN-SOC's Vision (directly copied from FSSA website)

MISSION: To model and provide leadership, guidance, technical assistance, policy and change at the state level to ensure that a local SOC is available for every child, youth, young adult and their families.

VISION: All young people, surrounded by supportive adults, achieve wellness, engage in their community, and together, promote wellness for generations to come.

POPULATION OF FOCUS: Young people with mental health and related needs. We believe that all young people have mental health needs that would benefit from the support of the entire community.

IN-SOC DEFINITION: The local and regional community takes responsibility for building a comprehensive system that leads to sustainable success for youth and families. The system is characterized by:

- Respect, compassion and values throughout the system;
- Efforts to be responsive and tailor effective services and supports to the unique, whole person;
- Services and supports are created and maintained based upon community data by multiple, varied stakeholders who work in committed, visible partnerships characterized by honest communication, a shared philosophy and approach and shared resources;
- The community recognizes that stakeholders responsible for the creation and maintenance of the system include youth and families; and
- A community-based infrastructure plans, coordinates, implements and sustains the system through accountability, evaluation and quality assurance.

SOC PRINCIPLES:

- | | | |
|-----------------|-------------------|-----------------------|
| • Family-Driven | • Community-Based | • Trauma-Informed |
| • Youth-Guided | • Individualized | • Culturally Relevant |

Appendix B

Monthly, bi-monthly and quarterly local and state meetings (personal email)

IN-SOC Governance Board: This meeting takes place quarterly and the members include a diverse representation of the state. It is our state-level governance board and meets quarterly. There are 34 voting members and quite a few that attend as non-voting members. Meeting is facilitated by Josh Sprunger (NAMI).

Local SOC Subcommittee: This is a subcommittee of the state-level governance board (IN-SOC governance board). It is comprised of the local SOC coordinators in each of Indiana's local systems of care. They meet monthly to gather information from the state (to distribute to stakeholders in their local communities) and to bring issues/concerns to the state if there are issues that the state needs to address. Meeting is facilitated by Jayme Whitaker (SOC Technical Assistance Coordinator) and Lisa Stewart (SOC Grant Director).

Youth and Family Subcommittee: this is a subcommittee of the state-level governance board (IN-SOC governance board). It is a diverse representation of youth and families. The role of this board is to review and approve all policy, process, data, etc. that is brought before the IN-SOC Governance Board. This group eventually will be responsible to assist us in spreading efforts to increase youth and family engagement in the local SOC consortiums. This meeting is facilitated by Jayme Whitaker (SOC Technical Assistance Coordinator).

SOC Evaluation Subcommittee: this is a subcommittee of the state-level governance board (IN-SOC governance board). It is a diverse representation of the state and is focused on review of outcomes and data related to Indiana's SOC. It meets every other month and reports back to the IN-SOC Governance Board. This meeting is facilitated by Betty Walton (SOC Grant Evaluator).

Workforce Development Subcommittee: this is a subcommittee of the state-level governance board (IN-SOC governance board). It is a diverse representation of the state and is focused on review and identification of workforce issues impacting the effectiveness of Indiana's SOC. They meet semi-monthly. This meeting is facilitated by Gina Doyle (Children's Quality Improvement Site Coach Team Leader).

The following meetings are supporting meetings for the IN-SOC committees and the SOC Grant:

SOC Evaluation Team: This meeting consists of the SOC grant evaluator (Betty Walton), SOC Research Specialist (Karel Kalaw) and SOC Grant Director (Lisa Stewart). It is a weekly meeting designed to facilitate communication and coordination of efforts for the SOC grant outcomes and evaluation activities associated with the grant.

System of Care Implementation Grant (SIG) Team: This monthly meeting consists of state representation and provides oversight for the SOC grant activities (goals, projects, budget, outcomes, process improvement, etc.). (Personal email from IN-SOC staff).

Appendix C
INDIANA SYSTEM OF CARE IMPLEMENTATION PROJECT

Indiana Division of Mental Health
and Addiction Substance Abuse and
Mental Health Services Administration
Center for Mental Health
Services
U.S. Department of Health and
Human Services

ANNUAL PROGRAMMATIC PROGRESS REPORT

(Reporting Period: September 30, 2014 –
September 30, 2015)

Project Number: SM061647

Project Name: Indiana System of Care Implementation

Submitted by: Lisa Stewart, Indiana SOC Grant Director

I. KEY STAFF CHANGES:

Indiana's vacant Technical Assistance Coordinator position was filled on June 15th by Jayme Whitaker. The vacant Cultural and Linguistic Competency Coordinator position was filled by Brenda Graves-Croom on August 17. A final interview was completed that culminated in a job offer to Karel Kalaw to fill the vacant SOC Research Assistant position in September (she will be on staff in October). All of the positions noted are planned positions documented in the approved SOC Implementation Project. No additional key staff position changes are anticipated. Job descriptions and resumes have been attached.

II. PROJECT/PROGRAM NARRATIVE:

A. Description and explanation of changes, if any, made during this 6-month period affecting the follow:

- i. Goals and objectives*
- ii. Projected timeline for project implementation*
- iii. Approach and strategies proposed in the initially approved and funded application*

The goals and objectives for this project have not changed in the first year; and the project is on track and anticipated to be completed as indicated in the strategic SOC implementation plan.

B. Report on the progress relative to approved objectives, including progress on evaluation activities; and summary of key program accomplishments to date and list progress.

Indiana's SOC Implementation project is based upon meeting objectives in seven

(7) key categories. Progress during this reporting period towards meeting those objectives is as follows:

- 1. Collaboration Objectives:** *Child serving agencies and stakeholders build relationships around a shared vision. They partner within a formal structure and culture and are held accountable to co-create, implement and evaluate SOC's. The SOC Governance Board is the State-level SOC structure.*

The State SOC Governance Board meets quarterly and continues to provide oversight and leadership for Indiana's system of care (SOC). The development of a process for communication between local and state-level system of care that includes the initiation and approval of all SOC policy was adopted in the last year. The board members continue to evaluate the representation of its voting members and is in the process of developing a member matrix to evaluate the representation of the board and as it applies to the desired representation that is document in the board's policy. To assist the state in ensuring a wide representation of strengths in the voting membership, the board approved a policy for filling vacant voting positions on the board (which include submission of an application to the Governance Board and Youth and Family Subcommittee for review). A regularly scheduled web-based/teleconference meeting for the Local SOC Coordinator Subcommittee (includes representation of a local SOC coordinator from all 92 counties in Indiana) continues to provide a forum for sharing State information, receiving SOC development and providing feedback on local SOC expansion efforts. The Technical Assistance Coordinator has developed a quarterly *In-SOC Insights* newsletter that will be used to share information, successes and announcements with local SOC's. The first newsletter will be distributed in November.

- 2. Values Objectives:** *SOC values are infused throughout the state and local SOC's. Additional values are defined and agreed upon by local stakeholders. Values guide the process, services, supports and outcomes of the SOC's.*

Youth and Family Engagement: Indiana's SOC is grounded upon creating a culture of inclusiveness for family and youth participation in all levels of SOC planning, decision-making, policy implementation, monitoring and process improvement. Indiana believes one of the core values driving a successful SOC is building respectful partnerships with families—resulting in the solicitation and inclusion of youth and family voice and participation at all levels of decision making. The Youth & Family Sub-Committee, was established to ensure solicitation and inclusion of youth and family voice and participation at all levels of decision-making within Indiana's system of care structural development and expansion. The sub-committee is responsible to attain the following objectives: 1) Establish protocols and oversight for youth and family member recruitment on the Indiana System of Care (IN-SOC) Governance Board; 2) Ensure youth and family voice solicited in all IN-SOC Governance Board decisions; 3) Determine what training, mentoring and/or other supports or considerations (e.g., rights, confidentiality,

compensation, etc.) are required to encourage and sustain active youth and family participation and membership on the Youth & Family Sub-Committee and the IN-SOC Governance Board; and 4) Advocate for and support youth and family inclusion and voice in local/regional SOC. The subcommittee has developed a draft policy defining youth and family partnership in Indiana's SOC, including processes for subcommittee membership, role and expectations, stipends for youth and family participation in SOC meetings; member orientation and development training, and subcommittee role in the state-level leadership for local SOCs. The attendance at the subcommittee has continued to increase and there were 8 voting youth/family members at the State Governance Board quarterly meeting in August (nearly meeting the State Governance Board policy that 1/3 of the board voting membership be youth/family representatives). Two significant facts regarding Indiana's Youth and Family Subcommittee include: 1) the subcommittee facilitator is an *Individual with Lived Experience*; and 2) all proposed state-level SOC policy, State Governance Board Member Requests and Proposals for the grant's SOC Development Funds must be reviewed and approved by the Youth and Family Subcommittee prior to moving on to the State SOC Governance Board for final vote and approval—thus ensuring full partnership and inclusion of youth and family in all of Indiana's SOC expansion activities and initiatives. The efforts of the state-level Youth and Family Subcommittee policy is to provide a blueprint for local SOCs as they determine how best to engage and include youth and family representation in their SOC boards and community activities. The Technical Assistance Coordinator is providing education and technical assistance (TA) support to local SOCs stakeholders as they begin working towards increasing youth and family engagement in their SOC expansion efforts.

Cultural and Linguistic Competency: Indiana welcomed a Cultural and Linguistic Competency (CLC) Coordinator to the SOC Grant team late in the year. This individual will be responsible for the infusion of cultural and linguistic awareness, inclusion and competence within Indiana's SOC. The CLC Coordinator has the responsibility for assisting leadership, management, staff, families, youth, contractors and all other system partners in ensuring culturally and linguistically competent practices in all aspects of the system of care. This position serves as the content expert and facilitates the organizational development process to accomplish these goals: 1) Promote Cultural and Linguistic Competence among children's behavioral health entities within Indiana's SOC, both locally and state level; 2) Work with state and local constituents to assess organizational compliance with CLAS standards and develop action plans to include technical assistance and training as deemed necessary; 3) Review, modify and update Indiana's strategic plan for SOC as it pertains to cultural and linguistic competence; 4) Outreach to families and youth from racial, ethnic and linguistic minority communities and assure their engagement with and participation in implementation of strategic plan; 5) Maintain coordination and collaboration with other entities addressing issues of cultural and linguistic competence at a local, state, regional and national level; 6) Review, analyze and interpret statewide data and trends, policies and procedures, in order to make recommendations for community or statewide programs to meet the

mental health needs of individuals who are of minority populations; 7) Evaluate state, regional and national information concerning outreach to, and service access for minority populations and make recommendations for change as necessary; 8) 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; and 9) Develop and facilitate training activities to address the technical assistance needs of local and state SOC efforts as it relates to cultural and linguistic competence.

3. Services & Supports Objectives: *All children youth and young adults have access in their communities to effective and appropriate services and supports to promote positive mental health and address related needs.*

Indiana's initiatives to help local communities ensure youth and family access to the services they need includes providing funding to community providers to implement evidenced-based practices, supports and resources that are needed to fill gaps in services and supports. In the last year, Indiana has funded \$7.5 million for schools to implement, expand or sustain a Positive Behavioral Intervention & Supports (PBIS) program to impact challenges found in the school system. Additionally, through the SOC Development Fund (supported by the grant's discretionary funds), Indiana has awarded \$75,000 in grants to local communities to implement service programs or trainings that impact the mental health of children, youth and families, including: 1) Development of youth and parent facilitated support groups in Allen county; 2) Expansion in Indiana's SOC Conference (a state-wide conference hosted by One Community One Family for providers, youth and families); 3) Youth Mental Health First Aid certification training for providers in Adams and Wells County; 4) Hiring assistance for a Parent Consultant to increase family engagement in Elkhart county; and 5) Consultation resources to implement Improving Practice and Creating Trauma Informed Systems (IMPACTS) in Fulton, Miami and Cass Counties. Efforts to develop a cross system definition of services and supports consistent with SOC values (e.g., access, peer support, natural supports, formal services, etc.) and development of a state-wide assessment of services gaps/needs and creation of a resource map/road map of resources, services and supports for youth, families and community stakeholders will be addressed in the next year with support from the State SOC Governance Board and the Youth & Family Subcommittee.

4. Workforce Objectives: *Indiana has a well-staffed workforce that is competent and trained in their own disciplines. The system offers training across disciplines and agencies in common topics including IN SOC vision, mission, values and principles. The members of the workforce contribute to a system that provides appropriate services and supports with a shared SOC approach in multiple environments.*

Indiana has developed a rough draft of the SOC Implementation Toolkit intended

to provide education, resources and technical assistance to guide SOC expansion and implementation at the local level. The toolkit provides a roadmap with tools, examples and descriptions of important implementation components to support local SOC coordinators in expansion and implementation initiatives within their local SOC community. Additionally, Indiana's Workforce Development Subcommittee was created in August and has begun to examine workforce needs. In September, the group submitted an updated Wraparound Facilitator Supervision policy with a more clearly defined definition of the criteria needed to supervise wraparound facilitators providing high-fidelity wraparound services in the state. This group will continue to facilitate work in the state to address other SOC workforce goals and objectives over the next year. Additionally, DMHA has provided \$207,000 in state funding to sponsor provider training (through a contract with ASPIN) in the following evidenced-based programs: 1) PCIT (Parent Child Interaction Therapy) (Train the Trainer and Therapy level trainings); 2) Strengthening Families; 3) CBITS (Cognitive-Behavioral Intervention for Trauma in Schools); Youth Mental Health First Aid Train the Trainer; 4) and SPARCS (Structured Psychotherapy for Adolescents Responding to Chronic Stress).

5. Finance Objectives: *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.*

Additional actions directed at meeting the objectives in this category will begin this year, guided by the State SOC Governance Board and Youth and Family Subcommittee. The Technical Assistance Coordinator will be assist by providing resources, education and support as local SOC's begin to address these goals and objectives.

6. Social Marketing Objectives: *Raise awareness, and change behavior and public perception around mental health and related needs. Everyone working with young people understands and is committed to promoting mental health as a part of overall health for all people and the community.*

Additional actions directed at meeting the objectives in this category will begin this year, guided by the State SOC Governance Board and Youth and Family Subcommittee. The Technical Assistance Coordinator will be assist by providing resources, education and support as local SOC's begin to address these goals and objectives.

7. Local Governance Objectives: *Effective, dynamic and sustainable local partnerships are developed that include shared responsibility for local SOC creation, implementation, and evaluation so that every child, youth and young adult has access to the services and supports they need.*

To assist local SOC infrastructure development, Indiana continues to provide State-funded dollars in the form of grants for communities to support a local SOC

coordinator and provide the county with an opportunity to participate in a WrapSTAR initiative that evaluates and provides feedback on the local SOC and their provision of high-fidelity wraparound services to youth and families. The purpose of funding is to further develop local SOCs through increasing diverse community partnerships; training local Governance members; improving communication and information sharing between local and state stakeholders; and collecting and analyzing community data in order to provide guidance to improve outcomes for children, adolescents, youth and families receiving services through their local SOC. To provide an opportunity for peer support, networking and education for local SOC leaders, the Technical Assistance Coordinator provided training and development for the Indiana's local SOC coordinators via a Local SOC Coordinator Development day that focused on Why SOC; Trauma Informed Care, System Change & Collaboration and the IN-SOC (State) and Local SOC Partnership Roles. The Technical Assistance Coordinator has been working in the field providing education and TA support to local SOCs and identifying who the local SOC Coordinator and other key stakeholders are in the state. A TA plan has been developed this year, intended to provide local SOCs with the training and resources needed for each community to develop their local SOC infrastructure and begin development and implementation of their own strategic SOC expansion plan.

Indiana's SOC Evaluation Team continues to be active in developing its team and planning activities to tackle the following core objectives: 1) To assist the Indiana SOC state and local partners in collecting and using information to support the implementation of Indiana's SOC Strategic Plan; 2) Create a culture of data-informed policy planning, progress monitoring, and improvement in State and local SOC development to support statewide access to effective services and support for families and their young people with mental health needs; and 3) Act as an advisory group for the required national SOC grant evaluation. Participation in the meetings has been statewide and diverse. Participants include families, youth, SOC staff, wraparound facilitators, state agencies, advocates, other child service agencies, and academics. A combination of in-person meetings with conference calls have been used; future meetings will include the use of in-person meetings and a webinar format to facilitate sharing information, enhance communication, and support interactive meetings.

C. Description of difficulties/problems encountered in achieving planned goals and objectives including:

- i. Barriers to accomplishment*
- ii. Actions to overcome difficulties.*

At this stage in the SOC Implementation project, Indiana has not identified any barriers to accomplishing the planned goals and objectives. While the goals will be met within the project timeline, some of the objectives and strategies are starting later than anticipated due to the fact the key SOC grant staff were not hired and on-board until six (6) months or later into the grant.

D. Report on milestones anticipated with the new funding request.

Indiana spent the last year focusing on filling the vacant positions on its SOC Grant team and building a strong infrastructural foundation for collaboration between state and local SOCs, development of an evaluation team and engagement of family and youth in state-level SOC building and expansion. The activities in the first twelve (12) months of the SOC Implementation project have positioned Indiana for achieving the following milestones in the next year of the project:

1. Launch of the Indiana SOC Toolkit that was created to assist community stakeholders in creation and expansion of their local SOCs.
2. Local SOCs will report success at engaging and involving youth and family in all SOC activities and initiatives, using the state model for the Youth and Family Subcommittee as a standard or example to guide the process.
3. Indiana will have developed a standardized system to gather data on access, appropriateness of services and outcomes to identify disparities with regard to race, ethnicity, sexual orientation, geography and economic status.
4. A communication plan for mental health wellness as part of overall health will be developed at the state-level in preparation for assisting local SOCs in doing the same.
5. Indiana will have developed a plan to examine and monitor shifts in workforce and the changing priorities of providers to understand causes of turnover, change in workload and challenges to efficiency in serving youth and families.
6. The State-level SOC Governance Board voting membership will be aligned with the member representation outlined in the board policy.
7. Indiana will adopt and support a plan for engaging youth and partnerships that facilitate the development of local Youth MOVE affiliates across the state.

Appendix D
IN-SOC Expansion Strategic Plan



Division of Mental Health and Addiction

402 W. WASHINGTON STREET, ROOM W353
INDIANAPOLIS, IN 46204-2739
317-232-7800
FAX: 317-233-3472

Indiana Strengthening Our Communities (IN-SOC)
Supporting Our Youth In Their Communities
Indiana System of Care Expansion Strategic Plan

MISSION: To model and provide leadership, guidance, technical assistance, policy and change at the state level to ensure that a local SOC is available for every child, youth, young adult and their families.

VISION: All young people, surrounded by supportive adults, achieve wellness, engage in their community, and together, promote wellness for generations to come.

POPULATION OF FOCUS: Young people with mental health and related needs. We believe that all young people have mental health needs that would benefit from the support of the entire community.

IN-SOC DEFINITION: The local and regional community takes responsibility for building a comprehensive system that leads to sustainable success for youth and families. The system is characterized by:

- Respect, compassion and values throughout the system;
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- Services and supports are created and maintained based upon community data by multiple, varied stakeholders who work in committed, visible partnerships characterized by honest communication, a shared philosophy and approach and shared resources;
- The community recognizes that stakeholders responsible for the creation and maintenance of the system include youth and families; and
- A community-based infrastructure plans, coordinates, implements and sustains the system through accountability, evaluation and quality assurance.

SOC PRINCIPLES:

- Family-Driven
- Community-Based
- Trauma-Informed
- Youth-Guided
- Individualized
- Culturally Relevant

• Collaboration

• Strength-Based

• Outcome-Based

IN-SOC EXPANSION STRATEGIC PLAN

Category: COLLABORATION - Child serving agencies and stakeholders build relationships around a shared vision. They partner within a formal structure and culture and are held accountable to co-create, implement and evaluate SOC. The IN-SOC board is the State-level SOC governance structure. ***Desired Outcome:*** Implementing strategies to *achieve the following goals will ensure coordination and collaboration across all child and youth serving agencies, providers and programs.*

- ***Goal 1:*** State leaders commit to an “our children” approach with collective responsibility.
 - *Strategy 1:* Engage new partners (e.g., Residential community; Health department; Dept. of Correction; and Dept. of Ed). [**Timeline:** Year 1]
 - *Strategy 2:* State leaders engage to understand what young people need and where they fall through the cracks. [**Timeline:** Ongoing Year 1-4]
 - *Strategy 3:* Leaders are working together proactively to create a model and guide for local SOC that promotes community resilience. [**Timeline:** Ongoing Year 1-4]
- ***Goal 2:*** SOC approach/values and vision are infused into agencies’ language, partnerships, policies, and training.
 - *Strategy 1:* An SOC Return on Investment message with supporting data is created to justify involvement in local and state SOC. [**Timeline:** Year 1]
 - *Strategy 2:* Engage State leaders in a SOC approach and vision; and gain commitment to a process of implementation. [**Timeline:** Year 1]
- ***Goal 3:*** State and local SOC have a feedback loop to ensure implementation of SOC at the local level and support at the State SOC level is compatible.
 - *Strategy 1:* State-approved Access sites are promoted at state and local levels to provide access to the services for all young people within their own community. [**Timeline:** Ongoing Year 1-4]
 - *Strategy 2:* SOC subcommittee provides evaluation feedback on local SOC implementation progress and challenges (e.g., ensure that annual report to the State from local SOC includes outcomes). [**Timeline:** Ongoing Year 1-4]
 - *Strategy 3:* State provides information to local SOC (e.g., IN-SOC board offers quarterly newsletter). [**Timeline:** Ongoing Year 1-4]
- ***Goal 4:*** System change efforts across state agencies are brought to the SOC table to inform, engage and co-create.
 - *Strategy 1:* Decision-making leaders from all child and youth serving state agencies are active members of the IN-SOC board (e.g., Review and refine IN-SOC board purpose; Determine number of members and type of members; Define responsibility and expectations of members). [**Timeline:** Year 1]
 - *Strategy 2:* Youth and families make up a significant percentage of IN-SOC board members. (e.g., Youth and families are recruited and supported to participate on board; providers with lived experience are recruited).

- **[Timeline:** Year 2]
- *Strategy 3:* Map current system change strategies to show relationship and identify gaps. **[Timeline:** Year 2]
- *Strategy 4:* Senior leaders that report to directors have opportunities to communicate, compare, and coordinate. **[Timeline:** Ongoing Year 1-4]

Category: VALUES- SOC values are infused throughout the state and local SOCs. Additional values are defined and agreed upon by local stakeholders. Values guide the process, services, supports and outcomes of the SOCs. ***Desired Outcome:***

Implementing strategies to achieve goals will lead to: (a) services are delivered in a family-driven, youth-guided, and culturally competent way; (b) Family and youth with diverse backgrounds are involved in planning, implementation and outcome measurement strategies; and (c) Training and TA support fidelity to SOC.

- ***Goal 1:*** Families are full partners in clinical care and system building.
 - *Strategy 1:* Create state definition for families as full partners in SOC. **[Timeline:** Year 1]
 - *Strategy 2:* Family involvement is supported financially and logistically through policy. **[Timeline:** Ongoing Year 1-4]
 - *Strategy 3:* Educate, train, mentor and support family members to participate in SOC (e.g., Review existing training for families; Recruit family members and providers with lived experience as family members to participate; Support family advocacy infrastructure in a comprehensive way). **[Timeline:** Year 1]
 - *Strategy 4:* Provide training and TA to providers and administrators to partner with families (e.g., seek promising curricula). **[Timeline:** Year 2]
- ***Goal 2:*** Youth MOVE-iN provides a voice, organized framework and guides a youth movement at state and local levels.
 - *Strategy 1:* Establish state-local infrastructure of Youth MOVE-iN (e.g., Define model of Youth MOVE-iN organization, engage partners and youth across systems as part of the movement; Remain consistent with Youth MOVE National categories as youth transition from *Youth to Youth Advocate to Advocate for Youth to Supportive Adults*—and they mentor and guide others as they develop). **[Timeline:** Year 4]
 - *Strategy 2:* Create Youth MOVE-iN local affiliates (e.g., start with established local SOC). **[Timeline:** Year 4]
 - *Strategy 3:* Recruit youth participants (e.g., use established models of recruitment - what helps, what harms, determine support needed). **[Timeline:** Ongoing Year 1-4]
 - *Strategy 4:* Provide training, TA and support for youth to engage meaningfully and sustainably in SOC. **[Timeline:** Ongoing Year 1-4]
- ***Goal 3:*** SOCs are reflective of and responsive to those they serve; they are community-based, sensitive to diversity and culturally and

linguistically competent.

- *Strategy 1:* Services and supports are available close to home. [**Timeline:** Year 1]
- *Strategy 2:* Gather data on access, appropriateness of services and outcomes to identify disparities with regard to race, ethnicity, sexual orientation, geography and economic status. [**Timeline:** Ongoing Year 1-4]
- *Strategy 3:* TA and training is offered to ensure all youth and families have access, appropriate services and positive outcomes —regardless of race, ethnicity, sexual orientation geography or economic status (e.g., offer training on CLAS standards; Map current CLC training and organizational efforts; Provide basic training at state and local levels on CLC and eliminating disparities). [**Timeline:** Year 3]

Category: SERVICES AND SUPPORTS- All children youth and young adults have access in their communities to effective and appropriate services and supports to promote positive mental health and address related needs. ***Desired Outcome:*** *Implementing strategies and achieving goals will ensure that youth and families can access a full-array of services and supports, including case management and outreach evaluation services.*

- ***Goal 1:*** All young people can take advantage of the right resource/service “at the right time in the right way”.
 - *Strategy 1:* Ensure access to an array of services and supports based on identified need (e.g., coordinate with other efforts to assess state and local resources, services and supports; identify gaps in, or lack of access to resources, services and supports; create plan to fill them). [**Timeline:** Year 1]
 - *Strategy 2:* 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). [**Timeline:** Year 1]
- ***Goal 2:*** SOC Services and Supports have a state definition.
 - *Strategy 1:* Develop cross system definitions of services and supports consistent with SOC values and principles (e.g., define natural supports; define formal services; define access; define peer support). [**Timeline:** Year 1]
 - *Strategy 2:* Identify necessary elements to have an effective SOC. [**Timeline:** Year 1]
- ***Goal 3:*** Young people who receive services have someone to help them move through the system.
 - *Strategy 1:* Create resource map/road map of resources, services and supports. [**Timeline:** Year 3]

- *Strategy 2*: Increase support for young people and families to connect with resources, services and supports (e.g., understand barriers (including cultural barriers) to connection). [**Timeline**: Year 3]
- *Strategy 3*: Youth MOVE-iN maps and provides information about available resources. [**Timeline**: Year 3]

Category: WORKFORCE- Indiana has a well-staffed workforce that is competent and trained in their own disciplines. The system offers training across disciplines and agencies in common topics including IN SOC vision, mission, values and principles. The members of the workforce contribute to a system that provides appropriate services and supports with a shared SOC approach in multiple environments. ***Desired outcome:*** *Implementing strategies to achieve goals will ensure Indiana’s workforce is sufficient in size and competence to provide needed services; and that training and technical assistance is available to facilitate ongoing learning, coaching and practice improvement for Indiana’s workforce; and support fidelity to SOC values and principles.*

- *Goal 1*: A competent workforce is recruited, retained, and has access to professional development.
 - *Strategy 1*: Financially support new graduates in clinical internships (e.g., understand Medicaid policy on reimbursement for interns obtaining experience in provider agencies; Policy supports graduate development). [**Timeline**: Year 2]
 - *Strategy 2*: Examine shifts in workforce and the changing priorities of providers to understand causes of turnover, change in workload and challenges to efficiency. [**Timeline**: Year 1]
 - *Strategy 3*: Use incentives to increase number of professionals (e.g., understand workforce need, population need, and provider resources). [**Timeline**: Year 4]
 - *Strategy 4*: Extend provider reach through use of technology (e.g., understand tele-health options and potential application in the state). [**Timeline**: Year 3]
 - *Strategy 5*: Professional development is available, accessible and cost effective to maintain license and certification and career development. [**Timeline**: Year 4]

- *Goal 2*: The Indiana work force has access to on-going training and TA intended to result in providers increased capacity to provide current, appropriate and effective care to all young people in an SOC environment.
 - *Strategy 1*: Include SOC and EBP training as requirements for licensed foster parents, Bachelor-level providers, degreed professionals and continuing education (e.g., understand training currently offered). [**Timeline**: Year 2]
 - *Strategy 2*: Training is available to certify peer specialists for family members and youth (when available) using competencies accepted in the field. [**Timeline**: Year 1]
 - *Strategy 3*: Create IN SOC implementation toolkit to include SOC

- values, CLAS standards, disparities, family-driven, youth-guided training and a roadmap to guide implementation. [**Timeline**: Year 1]
 - *Strategy 4*: Cross-system Training and TA on topics such as trauma, integrating primary care and mental health, co-occurring disorders, adolescent addiction, and transition is available statewide. (e.g., identify current topics, create resource list of trainers for topic and EBPs). [**Timeline**: Year 2]
 - *Strategy 5*: Local SOC leaders form a network of support (e.g., consistent, scheduled opportunities for peer support among local SOC leaders). [**Timeline**: Year 1]
- **Goal 3**: An in-state training and TA network supports the workforce.
 - *Strategy 1*: Have a dedicated, paid person to understand workforce needs and available training and TA resources (e.g., survey workforce about training needs; evaluate effectiveness of training and TA). [**Timeline**: Ongoing Year 1-4]
 - *Strategy 2*: Create in-state network of trainers and TA providers; and have capacity to manage logistics. [**Timeline**: Year 2] (e.g. conduct training on IN SOC vision, mission, implementation toolkit)
 - *Strategy 3*: Provide consistent and statewide standards for competency and the reimbursement of training and TA providers. [**Timeline**: Ongoing Year 1-4]

Category: FINANCE- 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. ***Desired Outcome:*** *Implementing strategies and achieving goals will ensure sustainability of Indiana’s SOC. Creative use of funding and resources, including integrating SOC strategies with block grants and other healthcare reform efforts will assist state and local SOC to provide a broad array of services and supports utilizing combined resources across multiple agencies, funding streams and stakeholders; adapting the approach to IN and its local communities.*

- **Goal 1**: Creative financing ensures access and capacity to meet the needs of all young people.
 - *Strategy 1*: Braid and blend local and state funds through the SOC to meet service needs of youth and families (e.g., State partners agree on shared outcomes to ensure effective use of funds; coordinate projects and share resources across state agencies; develop and manage a multi-agency fund to support MENTAL HEALTH and addiction services for young people; enact policy around sharing data across the state to show cost effectiveness, create agency expectations for local SOCs to braid and blend funds). [**Timeline**: Ongoing Year 1-4]
 - *Strategy 2*: Local communities develop flex funds. [**Timeline**: Ongoing Year 1-4]
 - *Strategy 3*: TA supports local financing plans. [**Timeline**: Year 2]

- Goal 2: Maximize external resources (federal, foundation, local, block grants, etc.).
 - *Strategy 1*: Formal contracts across systems support efforts to secure external funding opportunities for SOC. [**Timeline**: Ongoing Year 1-4]
 - *Strategy 2*: Consistent review of external opportunities and pursuit of those that might align with and sustain SOC. [**Timeline**: Ongoing Year 1-4]
- Goal 3: Financing supports local system infrastructure development.
 - *Strategy 1*: Training and TA supports financing plans to sustain local SOC (e.g., collect data to support efforts). [**Timeline**: Year 2]
 - *Strategy 2*: Effectively inform and support change agents (champions within the communities advocating for and supporting SOC expansion, including creative collaborations to ensure funding of local SOC efforts) within local SOC communities (e.g., identify at least one change agent in each community). [**Timeline**: Year 1]

Category: SOCIAL MARKETING- Raise awareness, and change behavior and public perception around mental health and related needs. Everyone working with young people understands and is committed to promoting mental health as a part of overall health for all people and the community. ***Desired Outcome:** Implementing strategies and achieving goals will assist the State in its wide-scale adoption of SOC, reduce stigma in accessing mental health, substance abuse and preventative services and support, and promote social inclusion of those affected by mental health challenges and increase partnerships and SOC values and principles.*

- Goal 1: Public understands that mental health wellness is integral to overall health.
 - *Strategy 1*: Public Service Announcements (PSAs) educate public around mental health wellness in health care and other settings (e.g., develop message; address stigma intentionally normalizing mental health for all people). [**Timeline**: Year 2]
 - *Strategy 2*: Develop communication plan for mental health wellness as part of overall health (e.g., develop message (own the “mental health” term); use multi-media approach; create materials to be offered in community environments). [**Timeline**: Year 1]
- Goal 2: State uses one SOC language.
 - *Strategy 1*: Creatively reach new audiences (e.g., identify audiences; locate link to refine message to audience). [**Timeline**: Year 1]
 - *Strategy 2*: DMHA website offers materials and other resources for promoting SOC values and positive mental health wellness message. [**Timeline**: Year 1]
- Goal 3: Promotion of positive mental health and prevention takes place in all environments where young people are.
 - *Strategy 1*: “Caring for your mental health” strategies developed for all young people in all environments (e.g. culturally adapt messages and strategies to reach a diverse audience). [**Timeline**: Year 4]
 - *Strategy 2*: Youth MOVE-iN supports youth to engage in strategic sharing for social marketing and advocacy. [**Timeline**: Year 1]

Category: LOCAL GOVERNANCE- Effective, dynamic and sustainable local partnerships are developed that include shared responsibility for local SOC creation, implementation, and evaluation so that every child, youth and young adult has access to the services and supports they need. ***Desired Outcome:*** *Implementing strategies and achieving goals will establish a mechanism for communication and coordination between state and local SOC and generate SOC involvement among local decision makers, which will result in increased participation in expansion planning and implementation, developing interagency agreements and care management entities and assistance with SOC monitoring.*

- **Goal 1:** Educate, support, implement and evaluate local governance to make it real.
 - *Strategy 1:* Local SOCs identify and collectively support a SOC coordinator for implementation management. [**Timeline:** Year 1]
 - *Strategy 2:* TA and training supports the creation and development local SOC infrastructure. [**Timeline:** Year 2]
 - *Strategy 3:* Local partner agencies identify the benefit of involvement in local SOC. [**Timeline:** Year 4]
 - *Strategy 4:* All State leaders create expectations that local leaders will participate in local SOCs. [**Timeline:** Year 1]
- **Goal 2:** There is a meaningful feedback loop between state and local community.
 - *Strategy 1:* Local SOCs submit annual reports on progress and outcomes from community efforts. (e.g. local SOCs understand implementation and reporting expectations) [**Timeline:** Ongoing Year 1-4]
 - *Strategy 2:* Local outcomes lead to policy change at the state level that will support continued local SOC expansion and sustainability. [**Timeline:** Year 4]
- **Goal 3:** Create a peer network among leaders of local SOC governance.
 - *Strategy 1:* Identify local individuals and agencies experienced in system development. [**Timeline:** Ongoing Year 1-4]
 - *Strategy 2:* Develop opportunities for peer support, networking and education for local leaders. [**Timeline:** Ongoing Year 1-4]

Appendix E
About Indiana's System of Care

“A State priority intended to assist communities in reaching this goal is an expansion of evidence-based practices and the adoption of a System of Care (SOC) strategy to behavioral and mental health service delivery in Indiana” (FSSA, 2016a). Since this is IN-SOC's stated and intended long term goal, one of our intentions with this study is to examine the goals of IN-SOC, including immediate, short-term (1-3 yrs.) and long-term (5-7 yrs.). In addition to IN-SOC's recent intended short and long term goals, the perspectives of various stakeholders on IN-SOC's mission, implementation strategies, sustainability efforts, and long term impacts will be provided. By synthesizing stakeholder ideas and advice, the outcome of the study focuses on helping IN-SOC administration reach its intended goals for the State of Indiana. The State's overall, long-term strategic goals to improve its SOC include the following (directly copied from the website):

- “Develop and endorse a single, statewide definition and application of a comprehensive, effective, SOC for youth and families in Indiana.
- Establish a state-level SOC governance board, including statewide representation, which will ultimately provide the leadership, policy recommendations, and technical assistance needed to support communities in developing and sustaining their local SOC.
- Decrease barriers to service delivery and the feeling of service silos for families trying to access mental health treatment services for youth in their communities.
- Increase the availability and utilization of evidenced-based practices to promote positive youth and family outcomes.
- Increase cultural and linguistic competency in service delivery and reduce disparities in access, service use, and outcomes.
- Identify and fill gaps in service and additional behavioral health needs for all youth.
- Increase provider and agency accountability to the youth and families served.
- Increase the number of and access to local family and peer support groups and programs within communities.
- Develop a comprehensive evaluation plan to monitor outcomes and SOC progress in order to create a feedback loop for system and performance improvement.
- Create an integrated approach to mental illness and substance abuse treatment, prevention, early identification and intervention services and programs.
- Link Indiana's behavioral health initiatives with SAMHSA's Trauma and Justice Recovery Support and Health Reform Strategic Initiatives.” (FSSA, 2016a)