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Organizational Culture in Children's Mental Health Systems of Care

by

Jessica Mazza

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science in Public Health
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ABSTRACT

A cohesive organizational culture has been linked to positive outcomes in child-serving agencies, such as improved child-level outcomes and positive organizational climate (Glisson & Green, 2006; Glisson & Hemmelgarn, 1998; Glisson & James, 2002; Hemmelgarn, Glisson, & James, 2006). Although isolated studies of organizational culture have been conducted in individual agencies (child welfare and juvenile justice), no study has examined the organization culture of successful, holistic systems of care that involve the coordination of multiple agencies, such as child welfare, juvenile justice, mental health and education. Data collected from the three system-of-care sites selected for participation in *Case Studies of System Implementation* was analyzed for themes using the Atlas.ti qualitative software package. The analysis was conducted through the framework of Schein's model of organizational culture. For each site, examples of artifacts, values, and assumptions were identified. The artifacts at sites were closely related to the articulated values of the organizations. Findings also suggest that there are underlying components to the organizational culture of system of care, including system of care values and principles, collaboration, willingness to change, and leadership. Results also showed that local context affects organizational culture. Suggestions for future exploration into these hypotheses are provided.

Chapter 1

Introduction

Severe Emotional Disturbance & Systems of Care

Epidemiological studies have shown that approximately ten percent of children will be diagnosed with a severe emotional disturbance (SED) (Kutash, Duchnowski, & Friedman, 2005). A SED diagnosis is given to a child when there is a DSM-diagnosable disorder of a sufficient duration (typically one year) and that the disorder results in significant functional impairment of multiple domains (Kutash, Duchnowski, & Friedman, 2005). A “system of care” is described as an organizational philosophy that is meant to create and provide an integrated, community-based service array to children with SED and their families (Stroul & Friedman, 1986, 1994). Systems of care involve the coordination of multiple child-serving agencies in the treatment of children with SED and their families. These agencies frequently include mental health, child welfare, juvenile justice, and education. Successful systems of care have been found to improve the structure, organization, and availability of children’s services, less is known about the factors that guide successful system development to establish effective system implementation.

Research and Training Center Study 2: Case Studies in System Implementation

The Research and Training Center for Children’s Mental Health at the Louis de la Parte Florida Mental Health Institute offers empirical support to systems of care implementation in order to improve services for children with SED. As part of these

efforts, *Case Studies in System Implementation: Holistic Approaches to Studying Community-based Systems of Care* was designed to identify strategies that local communities undertake in implementing community-based systems of care. The study examined six systems of care which were selected through a national nomination process. The six sites selected were: Placer County, California; Region 3 Behavioral Health Services, Nebraska; the state of Hawaii; Santa Cruz, California; Westchester County, New York; and the Dawn Project, Indiana. These sites were selected due to their accomplishments in serving youth with SED and their families through the establishment and sustainability of their systems of care. They were also selected for the varying contexts of their systems in order to provide variability in case sampling. Data collection included key stakeholder interviews, observations, document reviews, and survey ratings of the local factors identified as critical to successful implementation. For the analysis in this project, three of the sites will be examined for organizational culture: Region 3 Behavioral Health Services, Nebraska; Santa Cruz, California; and Westchester County, New York. These sites were selected for their variability of local contexts.

Organizational Culture

In the process of qualitative data analysis, themes of organizational culture emerged as important factors in system implementation. Although many nuanced definitions of the construct exist, organizational culture can essentially be defined as the artifacts, values, and assumptions collectively held and utilized by a group of people in a specific organization. Edgar Schein proposed a model of organizational culture that divides culture into three levels: artifacts, values, and, basic assumptions (1985). Artifacts are the most visible elements of an organization's culture and can include

symbols, language, physical space, and dress. Values are those articulated statements that are shared by an organization's members. Assumptions are the basic underlying notions that drive all other elements of organizational culture. Positive organizational culture has been linked to successful service delivery in child-serving agencies, such as juvenile justice and child welfare (Glisson & Green, 2006; Glisson & Hemmelgarn, 1998; Glisson & James, 2002; Hemmelgarn, Glisson, & James, 2006).

Study Aim

To date, organizational culture has not been examined in systems of care, where multiple child-serving agencies collaborate to provide coordinated service and support to children with SED and their families. This project will explore the qualitative data collected at each of the sites for themes of organizational culture. Schein's model (1985) will be used as the conceptual framework to examine the organizational culture of three systems of care that participated in *Case Studies of System Implementation*.

Chapter 2

Literature Review

Serious Emotional Disturbance

A review of the prevalence research indicates that approximately 20% of children have a mental disorder worthy of a DSM-IV diagnosis, and approximately 10% of children have SED (Kutash, Duchnowski, & Friedman, 2005). Friedman, Kutash, and Duchnowski have estimated the prevalence of children with a serious emotional disturbance ranges from 9% to 19% (1996).

In various studies, researchers have found that only *one* in every four children with SED have received professional mental health services during their most recent period of having a disorder, and only one half of children with SED have ever gotten mental health services (Costello, Mustillo, Keeler, & Angold, 2004). This is a staggering gap in the provision of services.

The amount of functional impairment experienced by children with SED is quite severe. Research has suggested children and youth with serious emotional disturbance also suffer in other domains of functioning (Friedman, Kutash, & Duchnowski, 1996). Negative outcomes are often associated with SED, which can include the psychological, social, and educational domains (Friedman, Kutash, & Duchnowski, 1996).

The extent to which SED affects a child's well-being, along with the impact to a family, can be severe. Many youth with severe emotional disturbance have problems transitioning into adulthood, and these outcomes create a great social and financial strain

in the community. The gravity of the impairments which accompany SED can be successfully addressed by a system of care.

Systems of Care

“A system of care is an adaptive network of structures and processes, and relationships grounded in system of care values and principles that effectively provides children and youth with serious emotional disturbance and their families with access to and availability of services and supports across administrative and funding boundaries” (Hodges, Ferreira, Israel, & Mazza, 2006b).

The concept of a “system of care” is described as an organizational philosophy that is meant to create and provide an integrated, community-based service array to children with serious emotional disturbance (SED) and their families (Stroul & Friedman, 1986, 1994). Systems of care emerged from the idea that children with SED and their families often have multiple needs from various service sectors (such as special education, juvenile justice, mental health, and child welfare) and that these children would be best served by a coordinated array of services to meet these multisystemic needs (Anderson, McIntyre, Rotto, & Robertson, 2002). The concept of systems of care began to emerge in 1984 when the Child and Adolescent Service System Program, (CASSP) was created (Kutash, Duchnowski, & Friedman, 2005). This program had the explicit goal of helping various communities develop systems of care for children with SED and their families (Kutash, Duchnowski, & Friedman, 2005). The foundation for systems of care, as outlined by Stroul & Friedman in 1986, developed out of the early CASSP efforts. The role of a system of care is to improve the quality and effectiveness of care necessary to treat children with SED through a community-based approach.

Stroul and Friedman describe the services in a system of care as being “organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families” (1986). Although the system of care philosophy was operationalized in 1986, little is known about how the various components of the system of care interact to create and sustain a properly functioning system (Hernandez & Hodges, 2003). Systems of care have positive outcomes on the structure, organization, and availability of services for children with SED and their families (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). Systems of care were developed with the purpose of meeting the mental health needs of children and youth with SED and their families (Lourie & Hernandez, 2003). The coordination of multiple agencies may cause conflicts of organizational identity within the system of care, and is worth investigation.

Further, there are certain values and principles of systems of care that may relate directly to the study of organizational culture. To gain a better understanding of how these components might contribute to the organizational culture of specific systems, a brief description of each of these universal traits of systems of care follows.

Shared Values

One of the most critical ideas of importance in a community-based system of care is that of shared values. Values should be shared by system stakeholders, and incorporate the values of a system of care as outlined by Stroul and Friedman (1994). These values include services centered around the child and the family, and the incorporation of the specific strengths of each child and the family into interventions. Further, the values of the system should include community-based services, and the community should be

considered critical in the design and provision of services. Of further importance, the services provided by the system of care should be culturally competent (Anderson, McIntyre, Rotto, & Robertson, 2002). Shared values are frequently identified as an important aspect of an organization's culture (Schein, 1985, 1990, 2004).

Leadership

It is important to remember that leaders in a system of care generate shared values of the system (Anderson, McIntyre, Rotto, & Robertson, 2002). Leadership has consistently emerged as a critical factor in system of care implementation (Hodges, Ferreira, Israel, & Mazza, 2006b; Mazza, Ferreira, Hodges, Israel, & Pinto, 2006; Meyers, 1985; National Implementation Research Network, 2005). Relationships exist among these leaders across the system, from service agencies to families, to state and local governments (Anderson, McIntyre, Rotto, & Robertson, 2002). Although the factors which make a good leader may vary, strong leaders in a system of care should be focused on the values of the system and the connections which occur inter- and intra-agency. Leadership is strongly tied to the cultural mores of an organization (Schein, 2004).

Collaboration

Perhaps at the heart of a successful system of care is collaboration. It requires system stakeholders to share in the responsibilities of a system of care and also to hold steadfast to a commitment to propel and improve the system (Anderson, McIntyre, Rotto, & Robertson, 2002). Systems of care require a collaborative process in both their development and sustainability (Chorpita & Donkervoet, 2005). Human collaboration helps to guide the provision of

appropriate, community-based services. At the heart of system collaboration is the idea that if leaders and stakeholders of the system coordinate and focus their efforts, various agencies will be able to provide multi-systemic services to the children and families in need.

Collaboration, however, is more complex in action than it is in simplified theory. There are some threats to collaboration which can prevent the system of care from providing an array of coordinated services. These include personal barriers (such as individual mindsets about how to provide services), systemic barriers (like governmental bureaucracies) and environmental barriers (like the location of services) (Anderson, McIntyre, Rotto, & Robertson, 2002).

Some strategies to meet these challenges might be cross-system meetings, the facilitation of both written and oral communication among system stakeholders, and the creation of an atmosphere that celebrates the success of a system (Anderson, McIntyre, Rotto, & Robertson, 2002). The ability to utilize some of these strategies may relate to the organizational culture of a system of care.

Organizational Culture

The term 'organizational culture' lacks a universal definition. A literature review in 1995 yielded 15 different definitions of the construct (Hudelson, 2004). The term organizational culture has evolved differently in various disciplines, including anthropology, sociology, business management, and medicine (Glisson & James, 2002). It has been noted as a 'fad' among researchers, who saw the term appear in the early 70s in the management literature (Hofstede, Neuijen, Ohayv, & Sanders, 1990).

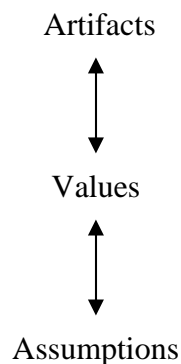
Examining an organization's culture is not unlike the anthropological study of the culture of a foreign group of people. There are *artifacts*, such as language, logos, narratives, products, and style of dress (Schein, 1985, 2004). There are also values, such as those widely-held *beliefs* about what the organization does and stands for. There are also *assumptions*, which guide the behavior and responses of the organization, almost intrinsically. The purpose of organizational culture, similar to a human culture, is to guide the way that a collective group of people responds to internal and external problems.

It wasn't until the 1980s that Edgar Schein conceptualized organizational culture and its components into a frequently cited model of this complex phenomenon (Schein, 1985). His definition of organizational culture, useful in this discussion, is as follows:

“the pattern of basic assumptions that a given group has invented, discovered, or developed in learning to cope with its problems of external adaptation and internal integration, and that have worked well enough to be considered valid, and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to these problems.”
(Schein, 1985, p.9)

Schein incorporated the notions of artifacts, values, and assumptions in a simple model that demonstrated the layered nature of organizational culture.

Figure 1. *Schein's Model (1985)*



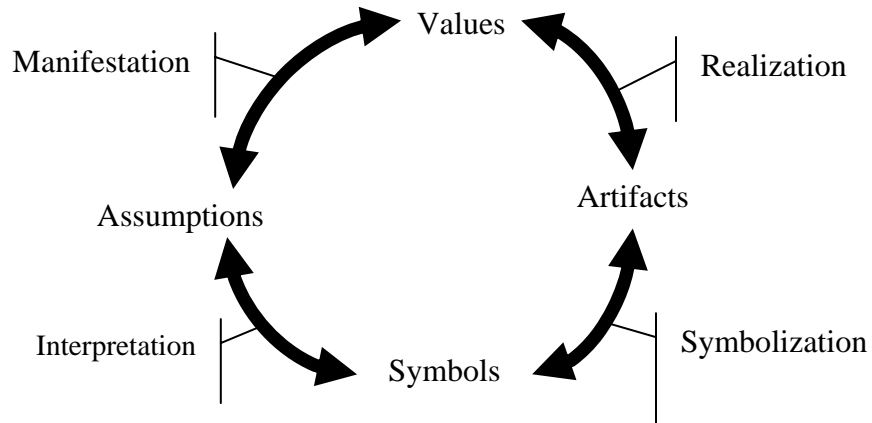
Artifacts lie on the surface, as the visible components of culture. This includes language, the physical environment, technology, art, stories about the organization, publications, and rituals. Artifacts include all of the observable phenomena that is visible in an organization. These are most easily identified, Schein explains, to the outside observer. *Values*, which produce artifacts, are the next group in his hierarchical model. Articulated values are those shared by the organization and are norms and rules that guide behavior in the organization. These are harder to identify within an organization, but are commonly held by most members of an organization. Values are the outgrowth of the *assumptions* of the organization, unspoken rules for behavior that are generally so intrinsic that they are not discussed or easily visible in an organization without thorough investigation. They guide the behaviors and cognition of organizational members. This is the most difficult layer of culture to uncover (Schein, 1985, 2004).

An example of the model's application to a child-serving agency might look like this: the language "family-driven care" is an artifact of the value that families served by the agency should have control of their own service treatment. This value is an assumption of the organization that treatment is most effective when driven by the family.

Schein's model has been criticized by other researchers who find the model too static to explain complex organizational phenomena (Diamond, 1991; Hatch, 1993). The complexities of an organization, it has been argued, cannot apply to such a linear model. For example, Hatch's cultural dynamics model posits two fundamental changes to the model: *symbols* are presented as a new element, and relationships and processes between

the elements (artifacts, symbols, values, and assumptions) are emphasized. The model appears below:

Figure 2. *Cultural Dynamics Model (Hatch, 1993)*



Here, the intermediaries between the elements are the processes which truly guide the expression and manifestation of organizational culture (Hatch, 1993). The model is more process based than Schein's, and Hatch argues that it is the fluid processes that better explain the mechanisms of cultural expression.

Manifestation is the process by which tacit assumptions are transformed into values that are easily recognizable. As evidenced by the two-way arrows, manifestation is also solidified by the recognition of values, which maintain or can even alter assumptions. Hatch proposes that when the values and assumptions of an organization align through the process of manifestation, members experience a positive confirmation of their culture. This is an important part of the model, as like Schein, the cultural dynamics model finds assumptions to be at the heart of an organization's culture. In this model, however, it is emphasized that there is an important reinforcement of the assumptions by the manifestation process.

Realization is the transformation of values into artifacts, which are the visible aspects of culture. This in itself is another important process, as the artifacts of an organization are the most tangible aspects of organizational culture. Similar to the process of manifestation, realization allows for the transformation of values into visible artifacts. The artifacts also help to reinforce the values, as they remind employees of the values held by an organization (Hatch, 1993). As an example, a mission statement displayed on a wall can reinforce the values held by an organization.

Symbolization in the cultural dynamics model is important, as it deals with the concept of symbols not addressed by Schein's cultural model. Here, symbols are "anything that represents a conscious or an unconscious association with some wider, usually more abstract, concept or meaning" (Hatch, 1993, p. 669). Symbols can include logos, stories, slogans, images, architecture, rituals, and charts. Although these are indistinguishable for what can be considered artifacts, the cultural dynamics perspective distinguishes the actual things which are symbols from the ways that these things are created and used by the organization. Therefore, symbolization links the object or artifact to meanings that it is associated with. The artifact must be transformed into a symbol to have any meanings for the cultural objects or events. Classifying something as a symbol highlights the idea that certain artifacts hold more symbolic potential than others.

Sealing the cultural dynamics model is the process of *interpretation*. The notion here is that symbols can be reinterpreted with new meanings into the basic assumptions held by members of an organization. This, Hatch argues, allows for an organization to take symbolized content into the dynamics of an organization's culture (1993).

The particular usefulness of the cultural dynamics perspective is the attention that is given to the actual processes between the levels of culture (artifacts, values, and assumptions). The addition of symbols are only, fundamentally, an abstraction of those artifacts that are being interpreted by members of an organization. The nuance here is that artifacts can be symbols at various times, but only when they are being used to interpret and create organizational culture. Otherwise, they can be simply defined as artifacts (Hatch, 1993). The attention to the processes between levels of culture provides a particularly relevant understanding of the study of organizational culture in complex systems.

Organizational Culture in Child-Serving Agencies

Although organizational culture has been used to study organizations in the private sector since the 1970s, non-profit and social service sectors are just beginning to utilize the concepts (Glisson & Hemmelgarn, 1998; Glisson & James, 2002). As in private businesses, the culture of an agency is useful for determining why some businesses are more successful than others (Glisson & James, 2002). Organizational culture in social service agencies are important, as it has been found to determine the behaviors of workers, which in turn can lead to organizational success (Ashkanasy, Wilderom, & Peterson, 2000). Several studies have recently been used to examine organizational culture in children's mental health services, and results consistently demonstrate the importance of organizational culture in child serving organizations (Glisson & Green, 2006; Glisson & Hemmelgarn, 1998; Glisson & James, 2002; Hemmelgarn, Glisson, & James, 2006).

The definition and model of organizational culture used in these studies parallels the models previously presented in this paper. The authors cite the construct supplied by Rousseau (1998), which states that organizational culture is layered. That is, norms and behaviors are the outside layer that is visible to workers and outside observers, and the inner layers is comprised of those assumptions and values that are intrinsic to norms and behaviors. The model is further defined by Hofstede (1998) who posits that invisible values drive visible behavior within an organization. The researchers using the model use it to reinforce the belief that workers may not be aware that they are internalizing the assumptions and values that are driving behavior (Glisson & James, 2002).

These researchers also differ from traditional organizational culture research in that they support the idea of organizational *context*, which is comprised of organizational culture and climate. Climate refers to workers' perception of the work environment on their performance levels (this includes depersonalization, role overload, and emotional exhaustion) (Glisson & Green, 2006). The researchers combine this with organizational culture to create the 'organizational context' construct. This is important to understand when examining the results of their research studies. While they have shown a connection between organizational culture and success, it is not always separated from the effects of organizational climate.

Their research focuses primarily on child welfare and juvenile justice. These agencies are stressful environments, as jobs in these sectors can have high demand with little compensation (Glisson & Green, 2006). Further, these systems are often perceived to be ineffective and often have defensive cultures, due to the many bureaucratic procedures like paperwork, litigation, and defense against public criticism (Glisson &

Green, 2006). These agencies also have low job satisfaction and high turn-over rates, which can contribute to negative climate and culture (Hemmelgarn, Glisson, & James, 2006).

Conversely, positive organizational cultures are more prone to incorporating inventive approaches and innovative technologies (Hemmelgarn, Glisson, & James, 2006). Innovation is always a concern in child serving agencies, as stakeholders strive to produce more desirable outcomes with new services and programs. It has been found that organizational cultures that are flexible and comfortable with taking risks are more successful in adapting these new technologies (Hemmelgarn, Glisson, & James, 2006). The successful adaptation of “soft technologies”, like new mental health treatments, is frequently determined by the organizational culture within which they are implemented. The authors cite evidence-based practices (EBPs) as an example of a soft technology. Evidence-based practices and their incorporation into children’s mental health systems are a current topic of concern in services research (Pinto, Israel, Hodges, Ferreira, & Mazza, 2006). As mental health communities focus on the incorporation of evidence-based practices into existing service arrays, attention should be paid to the cultures in which they are being adopted.

Building on research of adaptation of EBPs by child serving systems, Aarons and Sawitzky (2006) focused their efforts on examining the cultural factors that contributed to the adoption of EBPs. They examined climate and cultural factors from 301 public mental health service providers serving youth and their families. They found that those agencies with more constructive cultures had more positive attitudes towards the incorporation of evidence-based practices into their service array. They identified

constructive cultures as those environments that place emphasis on support, interpersonal relationships, and performance. Constructive cultures are also more likely to support conflict resolution and creative approaches to service delivery and treatment. In contrast, those agencies with less constructive cultures were less likely to foster EBPs introduced into practice. Other studies have confirmed that human serving agencies with less constructive cultures can be closed off to new innovation (Glisson & James, 2002).

In one study, Glisson and Green (2006) studied the effects of culture and climate on access to mental health care for children involved in juvenile justice and child welfare agencies. Social factors that contribute to the referral of children to mental health care can include expectations and attitudes of case managers that work within juvenile justice and child welfare. Glisson and Green hypothesized that these factors would contribute to referral of children to mental health care services. Their sample included 588 children involved in child welfare and juvenile justice case management units across 21 urban and rural communities in Tennessee. Results from the study showed that children being served by units with a ‘constructive’ organizational culture were 11 times more likely to be referred to appropriate mental health services. Their findings suggest that child-serving systems should place effort into building and sustaining constructive cultures. Glisson, Dukes, and Green (2006) found that children being served by case management teams with more positive cultures were more likely to be referred to mental health agencies. This is relevant in that many children being served by such agencies have the need for mental health treatment (Hernandez & Hodges, 2003).

Significance of Study & Research Objectives

The literature shows that a strong organizational culture has been linked to positive outcomes in child serving agencies, such as low staff turnover and increased performance by workers (Glisson & Green, 2006; Glisson & Hemmelgarn, 1998; Glisson & James, 2002; Hemmelgarn, Glisson, & James, 2006). However, organizational culture in systems of care has not been formally researched. Because systems of care require the interaction of multiple agencies, a thorough analysis of organizational culture in systems of care will provide insight into these multi-agency structures.

Although isolated studies of organizational culture have been conducted in these individual agencies (e.g. child welfare, juvenile justice), no study has examined the organizational culture of successful, holistic systems of care that involve multiple agencies such as child welfare, juvenile justice, mental health and education. This study will offer a cross-site comparison of three system of care sites researched in *Case Studies of System Implementation*.

Evidence of the three levels of organizational culture identified in Schein's model will be systematically examined to identify similarities and differences across the system-of-care sites. Evidence of the alignment of each level of culture (e.g. translation of values into artifacts) will also be researched. Results will serve to generate future hypotheses on the function of organizational culture in systems of care.

Chapter 3

Methods

Secondary Analysis (Case Studies of System Implementation)

The purpose of *Case Studies of System Implementation* is to identify strategies that local communities undertake in implementing community-based systems of care and provide greater understanding of how factors affecting system implementation contribute to the development of local systems of care for children with serious emotional disturbance (SED) and their families.

This study assumes that the processes contributing to system development cannot be adequately understood in terms of linear progress toward a goal. Given the complexity of SOCs, the structures, processes, and relationships contributing to system implementation should be studied holistically in order to understand the relationships among factors that support system implementation. To accomplish this, the Case Studies of System Implementation study used a multiple-case embedded case study design (Yin, 1994) to investigate how communities operationalize and implement strategies that contribute to the development of community-based SOCs for children with SED and their families.

A case study design explores a bounded system over time through detailed and in-depth data collection that makes use of multiple sources of information (Creswell, 2003; Stake, 1995; Yin, 1994). Case studies are particularly useful when phenomena are investigated within their real-life context and when the boundaries between phenomena and context are not clearly evident (Yin, 1994). They can be useful in the investigation of

phenomena that are greatly influenced by the overall socio cultural-geographical context, and in studies that intend to provide information about important processes as they evolve over time.

The unit of analysis in a case study design determines how the study relates to a broader body of knowledge. In this study, the unit of analysis is the community-based SOC at participating sites. Each site is the subject of a separate case study, and this study is covering multiple case sites. Specific strategies related to the system implementation factors serve as the embedded units of study within each individual site.

Site Selection Criteria

A national nomination process was conducted to identify established SOCs. This process included the solicitation of nominations through the Children, Youth and Families Division of the National Association of State Mental Health Program Directors, Center Dissemination Partners, Center Advisory Board, Department of Child and Family Studies staff, and an 18-member panel of national experts on well-functioning SOCs. Detailed document review and telephone interviews were used as the basis for final site selection.

Site selection criteria included sites that have identified needs for a local population of children with SED; have a set of goals for this population that were consistent with SOC values and principles; are implementing strategies to achieve progress towards these goals; and have demonstrable outcomes related to achieving those goals. In addition, system stakeholders had to have the ability to reflect on key transitions during system development.

Selected Sites

The study sites were selected via a purposive sampling method. Sites were selected for variance in terms of population density, racial/ethnic composition, and the way in which their systems of care were developed and sustained. The variety of landscapes make the data rich for studying organizational culture in a multitude of contextual settings.

Region III Behavioral Health Care, Nebraska. Region 3 Behavioral Health Services (one of six regions in the state) is a 22-county area, which covers a 15,000 square mile area in rural central/south Nebraska. Region 3 has a population of approximately 223, 143 people. The racial/ethnic composition is 98% white, 2.2% Hispanic/Latino, 0.3% Native American, and 0.2% Black/African-American. The median household income is \$31,867; 12% of all families are below the poverty level; and 16% of children under age 18 are below the poverty level (U.S. Census Bureau, 2000a).

Region 3 began its system of care efforts in 1989 when a new position in each region was created by the state legislature to focus on children's mental health on a system level. In 1997, Region 3 received a 5-year SAMHSA/CMHS system of care grant, which allowed for a strengthening of their service array (Hodges, Ferreira, Israel, & Mazza, 2007). The system of care is a collaboration between the Behavioral Health System and the Department of Child Protection and Safety (a combination of Children Welfare and Juvenile Probation), as well as the Department of Education and the local family organization. Region 3 is currently serving as a statewide system of care model (Hodges, Ferreira, Israel, & Mazza, 2007).

Region 3 Behavioral Health Services was selected for analysis of organizational culture because it is the only rural site sampled. For this site, there are 27 interview

transcripts available for coding, as well as notes from 5 observations that occurred during the data collection process (Fall 2005).

Santa Cruz County, California. Santa Cruz County, California is comprised of 441 square miles and a population of approximately 255,602 people (U.S. Census Bureau, 2000b). The racial/ethnic composition is 75% white, 26.8% Hispanic/Latino (of any race), 3.4% Asian-American, 0.2% Native American, and 0.7% Black/African American. The median household income is \$53,998 and 6.7% of all families are below the poverty level (U.S. Census Bureau, 2000b). Approximately 27.8% speak a language other than English inside the home (U.S. Census Bureau, 2000b).

In 1989, the Santa Cruz County system of care began, when the county received a grant through AB377 (the Children's Mental Health Services Act). This grant provided funding to expand to additional counties the Ventura County System of Care pilot project. Development was further supported by a 5-year SAMHSA/CMHS system of care grant which the county received in 1994 (Hodges, Ferreira, Israel, & Mazza, 2006a). Santa Cruz has been described as a "bifurcated county" (Rosenblatt, Giffin, Mills, & Friedman, 1998). There are notable demographic differences between the north and south sections of Santa Cruz County, which can make service delivery challenging. The south portion of the county is described as having a largely migrant and low income population (Rosenblatt, Giffin, Mills, & Friedman, 1998). A higher Latino population in South County creates a critical need for bilingual staff, although a shortage of bilingual staff is a challenge throughout the county (Hodges, Ferreira, Israel, & Mazza, 2006a).

Santa Cruz County was selected for analysis of organizational culture because of its notable demographic differences. For this site, there are 35 interview transcripts

available for coding, as well as notes from 7 observations that occurred during the data collection process (Fall 2006).

Westchester Community Network, New York. Westchester County, New York is 1,295 square miles and is the county located north of New York City. Westchester County is an urban population of approximately 920,000 people (U.S. Census Bureau, 2000c). The Westchester County Community Network has community networks in ten communities around the county, including Eastchester, Lakeland, Mount Vernon, New Rochelle, Peekskill, Port Chester, Whites Plains, and Yonkers. The racial/ethnic composition is quite diverse in the different communities located within the county. Overall, Westchester County is approximately 15.6% Hispanic/Latino, but some of the communities lie far from this number (Portchester is approximately 50% Hispanic/Latino, while Eastchester is only about 5%). There is a burgeoning Hispanic/Latino population in many of the communities served by Westchester County (Hodges, Ferreira, Israel, & Mazza, 2006a).

Westchester Community Network has its early roots in the first community network meeting, held in Mount Vernon in 1978. In 1989, the county received a small New York State grant to develop a coordinated system of care for children with SED and their families. System of care work continued to grow in Westchester County through the nineties. In 1999, Westchester County received a 5-year SAMHSA/CMHS system of care grant in order build upon their work with SED youth and their families (Hodges, Ferreira, Israel, & Mazza, 2007c).

The Westchester Community Network was selected for analysis of organizational culture because of its urban population and grassroots development. For this site, there

are 38 interview transcripts available for coding, as well as notes from 7 observations that occurred during the data collection process (Summer 2007).

Data Collected

The investigation used a multiple-case embedded case study design to investigate how communities operationalize and implement strategies that contribute to the development of community-based systems of care for children with SED and their families. Case study data was collected using semi-structured interviews with administrators, managers, direct service staff and families; direct observation; document review; and a review of aggregate outcome data. A brief description of these methods follows.

Documents were used to provide organizational-level data related to system implementation as well as system-of-care development in a historical context. Documents included materials related to goals and intent of the system, legislative history, regulations or guidelines, budget justifications, monitoring reports, annual reports, and reports of accomplishments.

Factor brainstorming and rating were conducted in order to identify local factors believed to be critical to system-of-care implementation. Local system implementation factors and definitions were identified by stakeholders at each site using a Factor Brainstorming Exercise with key system leaders prior to on-site data collection. A Factor Rating Exercise was then used to validate the locally identified system implementation factors by a broader group of system stakeholders. The survey was a rating of the identified factors on a five-point scale with regard to both their importance and effectiveness in local efforts to develop systems of care.

Semi-structured interviews were conducted in person and by telephone for the purpose of understanding personal perceptions and beliefs about the process of system-of-care implementation and the role of the identified implementation factors in local system development and their relationship with one another. Interviews lasted 1 hour and were held at a time and place that was convenient for the interviewees, and sites assisted in identifying the key people to be included in the interview process. All interviews have been professionally transcribed.

Observation of service delivery structures and processes were conducted for the purpose of observing aspects of system implementation in action. Direct observations were coordinated with naturally occurring agency and community meetings. Each researcher attending meetings or observations took field notes on the processes and actions.

Analysis

All narrative data collected were analyzed for themes using the Atlas.ti qualitative software package (Scientific Software Development, 1997). The analysis was conducted using the framework of Schein's model organizational culture. Interview transcripts served as the primary data source, with supplementation of other data (locally-identified implementation factors, documents, and observation data) for triangulation. For each site, examples of artifacts, values, and assumptions were identified. Evidence of the alignment of the three levels of culture were examined. The following table outlines the operational construct of each of those levels.

Table 1. *Construct Matrix*

Artifacts	Visible structures and processes <i>Examples:</i> Language, narratives, logos, artwork, physical structure, publications
Values	Shared, articulated beliefs that stakeholders deem critical to system functioning or service delivery
Assumptions	Tacit rules that guide behavior and decision-making

Atlas.ti allows for analysis that can be done in an iterative process, and facilitated the development of emergent codes as the analyses were conducted. The analysis involved independent review and coding of the data by the investigator, as well as the identification of themes that were common across sites. The Atlas.ti software allows for multiple levels of analysis that can be conducted in an iterative fashion and allows the coding of data into identified categories, and the ability to add comments that are linked to specific passages, codes, or families of codes. The initial coding schemes were guided by the constructs of Schein’s organizational culture model (artifacts, values, and assumptions). Additionally, the use of Atlas.ti facilitated the development of additional codes as the analyses are conducted. Themes and patterns emerging from the data were identified. Any emergent themes were reapplied to the data set for further analysis, utilizing a systematic comparison method for ensuring that new data is accurately coded (Strauss & Corbin, 1998). The researcher will give attention to the rigor and quality of data analysis. For the purpose of establishing construct validity, the triangulation of data will be used to build explanations through convergent evidence. An additional member of the RTC Study 2 research team trained in qualitative data analysis offered a spot-check

of classification of the data, and any adjustment of coding schemes were made to insure the validity of the data.

Chapter 4

Results

Because of the research questions and data collection methods used in *Research and Training Center Study 2: Case Studies of Implementation*, the results of this study on organizational culture are presented through the lens of the implementation factors identified at each site. For the purpose of presenting the results, the implementation factors that were related to the values of the system were identified as the organizational culture values for each site.

Factor Methodology

For *Case Studies of System Implementation*, locally derived system implementation factors were generated by key stakeholders at each participating community through a factor brainstorming process that was conducted prior to onsite data collection. The brainstorming process was used to both identify and define critical factors in local system implementation. The research team worked closely with key system leaders via conference calls and reviewed documents to identify the factors considered critical in developing the system of care. Key stakeholders then provided definitions for these locally identified factors.

A ratings exercise was subsequently used to validate the locally identified system implementation factors by a broader group of system stakeholders. Interview participants were asked to complete a mail-in questionnaire in which they: 1) validated each factor and its definition, 2) noted the importance of each factor in the establishment and/or sustainability of the system, 3) rated each factor in terms of ease/difficulty of

implementation, and 4) rated each factor in terms of effectiveness of the system in implementing the factor. Therefore, each definition was agreed upon by a larger group of respondents. For all sites, there was strong agreement for all definitions.

Using the factor definitions, the research team first grouped the system implementation factors into categories according to their primary role in system functioning. The factors can be clustered into four categories as shown in Table 2. These clusters are a result of an early framework that was developed to analyze results of the case studies (see Hodges, Ferreira, Israel, & Mazza, 2006).

Table 2. *Roles of Factors (Hodges, Ferreira, Israel, & Mazza, 2006b)*

4 Roles of Factors	Definition
1. Facilitating System Values	Those factors that are related to the intrinsic philosophy that is fundamental to the system of care.
2. Facilitating System Goals	Those factors that are broad-level goals that direct the SOC and bring it under the control of a single plan.
3. Facilitating System Information	Those factors that are related to the availability of feedback to system stakeholders
4. Facilitating System Structures	Those factors that are related to specified roles, responsibilities, and authorities that define organizational boundaries and enable an organization to perform its functions.

For the purposes of this analysis, factors that facilitate system values served as identified values in the analysis.

The table below summarizes the values identified at each site. For a full list of factors and definitions, please see Appendix B. Each value-based factors at each site was reviewed for corresponding artifacts and assumptions. A profile of the organizational culture at each site is presented.

Table 3. *Identified Values at Research Sites*

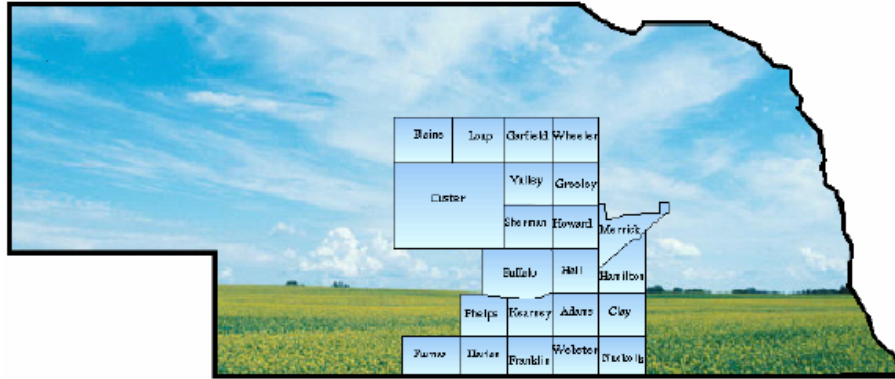
Region 3 Behavioral Health Services Site Profile

Research Site	Identified Values
Region 3 Behavioral Health Services	Collaboration Family and Youth Participation Leadership Responsiveness to Change Shared Vision
Santa Cruz County	Cultural Competence Interagency Collaboration System of Care Values Willingness to Change
Westchester Community Network	Community Organization Model Courage to Change Leadership Shared Values and Goals

“That’s our culture. Because of our ruralness, we don’t have everything, so we have to depend upon others to help each other. In times of struggle, nobody even thinks a second time to go help a neighbor out, or going across the state to help somebody. We can’t have everything...we have so limited resources, we pull our resources together. That’s how come it looks good.”

- Family Member, Region 3 Behavioral Health Services

Figure 3. *Region 3 Services Map.*



The image above is a logo found on Region 3’s publications. It outlines the 22 county region of Nebraska that is covered by their services. The background in this picture reflects the landscape in which services are provided. Region 3 covers 15,000 square miles in the south central part of the state, with a population of approximately 223,143 people (U.S. Census Bureau, 2000a). This designates the region as a rural population, which is reflected in this logo.

Suggested artifacts, values, and assumptions of the organizational culture in Region 3’s system of care summarized in Table 4. For each value, the implementation factor related to that value will be discussed, followed by the artifacts and assumptions related to each implementation factor.

Table 4. *Region 3 Results*

Artifacts	Values	Assumptions
Co-location; “paycheck”	<i>Collaboration</i>	Required for success in rural environment.
“Three-legged stool”	<i>Family & Youth Partnerships</i>	Critical to system success.
The Chili Story.	<i>Leadership</i>	Required for the shared vision; everyone is a leader.
All stakeholders able to articulate a shared vision.	<i>Shared Vision</i>	SOC principles benefit children and families.
Adapting the EICC from the ICCU	<i>Responsiveness to Change</i>	There is no other way to function.

Strikingly, the rural culture of the area is very much reflected in the organizational culture of the system of care. The values identified in the factors created by Region 3 were: *Collaboration, Family & Youth Participation, Leadership, Shared Vision, and Responsiveness to Change*. The consequences of providing services in a rural environment are reflected in many of the values of Region 3, specifically in the articulated value of collaboration.

Collaboration in Region 3 is evidenced by an established level of trust, and stakeholders have developed networks across all service sectors, engage in collective problem solving, and share resources across system partners. Data indicate that stakeholders share a genuine commitment to collaboration and what it means. Stakeholders within Region 3 stressed the uniqueness of the rural/frontier landscape, and stated that there is a frontier attitude in which providers must work together and support each other in order to be successful. Therefore, the rural landscape serves as an impetus for system partners to sustain collaboration.

“Collaboration” was identified by key stakeholders as a factor critical to system implementation. The definition created by stakeholders describes the nature of Collaboration in Region 3:

“*Collaboration* is described as a process that involves relationships and partnerships with families, providers, child/family service entities and other leaders. It is characterized by a commitment to shared vision, and mission and support by all participants to system of care objectives. Collaborators have mutual respect for one another’s roles and responsibilities. They leverage, share and maximize resources and also share responsibility and accountability. Collaboration involves a commitment to learning and providing educational opportunities for system partners.”

The strongest evidence of collaboration in Region 3 is found in their physical structure. In Region 3, staff from various agency partners are co-located. As one supervisor stated while discussing the coordination of services among various agency partners, “We are all housed together, we’re all on the same floor. And I think that helps the rapport. I think it’s important to house them together. That way you can just develop those relationships better.” This quote reflects the notion that co-location as an artifact is not only evidence of collaboration, but a perceived facilitator as well.

Several stakeholders discussed collaboration of agency partners as being so effective that the only notable difference between employees was the signature on their paycheck. This common theme reflects the depth to which collaboration in Region 3 has been established. “You wouldn’t know the difference between the staff except who signs their paycheck,” stated one administrator. This was similarly echoed in statements such as “The only main difference [between workers] is the paycheck,” and “what we wanted it to look like that was so integrated that no one would know who worked for who, that the only difference was their paycheck.” This common phrase and use of the language reflects the value that the collaboration of agency partners is clearly evident in Region 3. The collaboration of agency partners is so successful, they are not distinguished as separate agency partners, but as a cohesive group.

One stakeholder described collaboration as “a mindset of participants and facilitators.” This reflects the tacit assumption that guides stakeholders to collaborate. Further assumptions found in the data indicate that there is also the belief that “most partners understand the importance of collaboration in a rural environment with few resources, both financial and in services.” The assumption that is that the rural landscape

serves as an impetus for system partners to value collaboration and to ensure its sustained success. Region 3 has indeed created structural changes that have strengthened collaboration, like the co-location of staff from various agency partners. The assumption is that the system must continually strive for collaboration, since it is required in this rural region with scarce resources.

The definition of “Collaboration” provided by system stakeholders describes it as “a process that involves relationships and partnerships with families, providers, child/family serving entities and other leaders”. One of the most striking values in Region 3 is that of empowerment of families and youth within the system. More than facilitating family/youth voice in the clinical process, data indicate that family and youth are viewed as critical to system functioning. This is evidenced by the active involvement of family members that serve on boards at all levels of the systems, a strongly active family organization (Families CARE) and a youth-run advocacy organization (YES) that is involved both locally and on state and national-boards. Families CARE has been an equal partner in the system from the beginning.

“Family and Youth Participation” was identified as a critical factor to system implementation. This was the definition created by key stakeholders describes Family and Youth Participation in Region 3:

“Family and Youth Participation is described as an important process through which the roles families and youth are integrated within the system. In these roles, family and youth participants are involved in all critical aspects of the system including service delivery, planning, implementation, and evaluation. Families and youth are values as participants in the system and their involvement allows other stakeholders to understand the importance of family voice, choice, and leadership in the organization. Family and youth participation is facilitated by a strong family organization. The expressed goal of family and youth participation is family driven/youth guided care.”

‘Four stakeholders mentioned ‘the three-legged stool’ in semi-structured interviews. According to a program administrator, stakeholders understand the legs of this stool to be, “The family, Health and Human Services, and Region III” (Health and Human Services is a system partner). Interview data further indicated that for Region 3 stakeholders maintaining this balance is important, specifically as it concerns the family. “This stool is not going to stay up right if one of the legs goes,” voiced one respondent. One system administrator echoed this sentiment: “And the three legged stool will not be level if you have someone with a lot more knowledge than the others have.” Data indicates that the concept of the ‘three-legged stool’ and the understanding that one of the ‘legs’ is the family organization demonstrates how deeply embedded the value of family and youth participation is in Region 3.

The assumptions underlying the value of family and youth participation in the system was reflected in both interviews and factor ratings data. Most system stakeholders truly believed that family and youth are crucial to the system’s functioning at multiple levels, from the clinical service level. “Implementation of services depends on the family,” responded one stakeholder in the factor ratings exercise. This was echoed in another sentiment by another respondent, “Nothing happens without the family.”

On an even broader level, the assumption of the benefits of family and youth participation in the system goes beyond the provision of clinical services. There is the idea that “commitment to voice and choice for family is critical to system success.” This data implies that stakeholders in Region 3 have a shared belief in the importance of family and youth participation at a system level. Evidence at all three levels of Schein’s

model (artifact, value, assumption) suggests that this value is well embedded in the organization's culture.

Evident in a discussion of family and youth participation is the leadership provided by family and youth within the system. As discussed in the review of the literature, leaders in a system of care help to cultivate the values of the system (Anderson et al., 2002). Relationships exist among these leaders across the system partners (Anderson et al, 2002). This is important, as leadership is invariably linked to the cultural values of an organization (Schein, 2004).

In Region 3, data indicate that there are exemplary leaders across all system partners and they are described as passionate, strong, and possessing a shared vision.

“Leadership” in Region 3 was described as:

“A process that supports a strong and shared vision among empowered stakeholders including agencies, families and providers. Leadership is based on a strong commitment to the values, goals, and mission of the system of care and a belief in the system's ability to achieve results. Leadership facilitates the sharing of authority and responsibility, and it fosters a vision for the future and understanding of how to get there. Leadership is characterized by all system stakeholders accepting and having power to carry out their responsibilities.”

In Region 3, the narrative/myth called “The Chili Story” illustrated how the system leaders came together in the state capitol and came up with the idea of implementing a system of care in Region 3. As one system leader stated, “We came up with this...*(chuckles)*...great idea over the 50 cent cup of chili at the state capitol.” This story extended to other stakeholders in the system, who use it to cite the leaders coming together to form their system. Although this story is often cited, not all system members know much about it. One partner in the family organization stated, “I don't think I've

ever heard the full chili story. I heard reference to it once.” What is evident from interview data is that “The Chili Story” is a narrative that allows stakeholders to link the beginning of the system to the leaders in a familiar way. It also reflects the value of collaboration and shared vision within the system.

Some of the assumptions around leadership are found in other values of the system, which is consistent with Schein’s idea that leadership within an organization is critical to enforcing shared values in that specific culture (Schein, 2004). For example, in Region 3, leaders were identified as the “main champion to bring others to the shared vision,” and play an invaluable role by “helping all stakeholders understand the shared vision.” This is also evident in the local definition of leadership, in that it is described as ‘a process that supports a strong and shared vision among empowered stakeholders.’

Another assumption of leadership within the system, identified in their definition, is that it is ‘characterized by all system stakeholders accepting and having the power to carry out their responsibilities.’ This assumption translates to all system stakeholders feeling capable of holding positions of leadership or make leadership decisions. Data indicated that processes of ensuring that all workers have an opportunity to sit on the leadership board for a period of 3 months demonstrates that this behavior is enforced by system processes and is part of Region 3’s culture.

Leaders were identified as playing an invaluable role by “helping all stakeholders understand the shared vision” of Region 3. This shared vision is synonymous with many of the original federal CASSP principles and have been fortified and supplemented over time to include an emphasis on cultural competence and family/youth-driven care. This trend is tantamount to the system of care movement on the federal level. Region 3 started

its system of care efforts while recipient of a CASSP grant, so it is not surprising that these are retained in the vision of the system. Stakeholders described the shared vision of Region 3 as:

“A strong desire to achieve better outcomes for children and families that is based on a common belief that system of care principles will benefit children and their families. This shared vision also includes building upon modes of services delivery that are aligned with system of care values and principles including access to community-based services throughout rural and frontier regions of the system, implementation of promising practices and evidence-based care, and using the wraparound approach to deliver services and supports. Stakeholders describe a determined effort to communicate this vision.”

Overall stakeholders are able to articulate a shared vision, and they demonstrate their self-awareness of this value. “We can all mouth the shared vision and know that it’s really what we all want to do. We want to create something that makes it better for children and families. We’ve all got that shared vision.” Evidence of this vision was not found in other agency documents or available data. However, system of care values and principles are present in more specific ways, including the emphasis on family-driven care within the Region.

One assumption of valuing a shared vision is embedded in the locally-generated definition itself. The definition describes a shared vision as being “based on a common belief that system of care principles will benefit children and their families.” There is also the assumption that “the shared vision is commonly understood by various levels of staff and stakeholders within the system of care.”

Responsiveness to Change was grounded in the values and beliefs of the system. A general feeling within Region 3 is that change is an ongoing process, and they are never finished with building the system. Responsiveness to Change was identified as:

“as innovation as well as the willingness to adjust planning and implementation based on the system’s experiences. Innovation is reflected in the ability to combine models and try new approaches to service delivery and system design. The flexibility to adjust planning and implementation is created by the availability of constant feedback and the willingness to take action on feedback given. Processes that support constant feedback include meetings at all levels and across all parts of the system and 360° feedback loops. This responsiveness includes being open to changes that provide funding opportunities.”

One salient example of an artifact in Region 3 for a responsiveness to change was a new effort to curtail the needs for costly, deep-end services. One program in the array of services provided by the Region is the Integrated Care Coordination Unit, a specialized intensive wraparound program for wards of the state. Based on positive success and cost savings created by this program, system stakeholders realized that a similar type program could be implemented for those youth *at-risk* of becoming wards, a growing number of youth in Region 3. Stakeholders used funds to implement the Early Intensive Care Coordination program to prevent children from becoming state wards, and data showed this program’s ability to divert out-of-home placements for those children and youth at risk of being removed from the home. This is one example of how the program used strategic planning to create and respond to changing needs, in an effort to respond to “what works” and applying it to programs in order to serve a broader population.

Responsiveness to Change was described by stakeholders as an understanding that this was ‘the way they do business.’ This was reflected in such quotes as “I just don’t know how else you do things,” said one stakeholder. “That is so much a part of our lives,” said another, “We don’t even think about that.” A value like Responsiveness to

Change was identified as one of the stronger elements of Region 3’s culture. One stakeholder noted, “This is our culture, we are not satisfied unless we are asking ‘What if?’ and then willing to change based on results and data.” So here, Responsiveness to Change closely fits with Schein’s description of an assumption, an unspoken rule for behavior that is deeply intrinsic (Schein, 2004).

Santa Cruz County Site Profile

“It is more of a culture that’s created this ability to operate in this kind of way. And I think that culture is a combination of the size of our community. The actual culture of Santa Cruz County. It really is a culture. We’ve got people who think similarly and have shared values.”

- Child Welfare Administrator, Santa Cruz County

Santa Cruz County, California is comprised of 441 square miles and a population of approximately 255,603 people (U.S. Census Bureau, 2000b). The racial/ethnic composition is 75% white, 26.8% Hispanic/Latino (of any race), 3.4% Asian-American, 0.2 Native American, and 0.7% Black/African American. Approximately 27.8% speak a language other than English inside the home (U.S. Census Bureau, 2000b). Santa Cruz has been described as a “bifurcated county”, which means that there are notable demographic differences between the north and south portions of the county. ‘South County’ has a largely migrant and low income population (Rosenblatt, Giffin, Mills, & Friedman). This higher Hispanic/Latino population creates a critical need for bilingual staff and culturally competent services. This need is highlighted by *Cultural Competence*, one of the values of the organizational culture of the system of care.

Suggested artifacts, values, and assumptions of the organizational culture of Santa Cruz County’s system of care are presented in Table 5.

Table 5. *Santa Cruz Results*

Artifacts	Values	Assumptions
Collaboration with Hispanic organizations; literature in Spanish; training and education on cultural issues.	<i>Cultural Competence</i>	Critical because of the high Hispanic population.
Emphasis on understanding ‘language and dialects’ of various agencies; collaborative efforts.	<i>Interagency Collaboration</i>	Necessary to seamlessly integrate services for children and youth
“At home, in school, out of trouble”.	<i>SOC Values</i>	Accepted as an underlying core value to keep children in the community.
Continuous development and system expansion.	<i>Willingness to Change</i>	Change is required for sustainability.

The values identified in the factors created by Santa Cruz County system stakeholders were: *Cultural Competence*, *Interagency Collaboration*, *System of Care Values*, and *Willingness to Change*. The value most affected by local context is that of *Cultural Competence*, which highlights the system’s struggle toward serving the local population.

Cultural Competence was described by respondents as a “core value of our system...that is supported on all levels of program design and implementation.” In the 2005-2006 fiscal year, approximately 45% of the youth being served came from Hispanic/Latino families. Maintaining the value of cultural competence was not without its challenges, as stakeholders described the difficulty of the implementation. “It requires relentless attention and ongoing education,” noted one respondent. Cultural Competence was described as:

“a core value of the System of Care, manifesting in strategic interagency processes to promote culturally relevant and sensitive services at all levels of the system. It includes an evolving focus on underserved and inappropriately served populations, and a responsiveness to changing populations, including specific change-efforts in key departments.”

The evidence of cultural competence is widespread in Santa Cruz County. For one, brochures and pamphlets across systems are widely available in Spanish. Training in cultural competence has risen from 26% to 84% of employees attending in the last five years, suggesting a strategic focus to the value of cultural competence. Other structures that have been created by stakeholders, which include strong efforts in outreach and engagement to Hispanic youth and families. These include the development of alternate pathways to care, which involve Hispanic community-based organizations rather than the formal public system, and with which Hispanic families may be more comfortable and engaged. These artifacts demonstrate that the Santa Cruz County system of care is committed to increasing their capacity to serve those of other cultures, and that this commitment is visible in tangible artifacts (documents in Spanish, outreach materials) and also systemic structures (partnering with Spanish-speaking organizations to provide alternate “entrances” to the system for Hispanic families that might otherwise avoid involvement in the traditional mental health system).

Underlying the value of cultural competence is the idea that in order to serve the local population, the system must be open to idea of culturally sensitivity and appropriateness. Stakeholders indicate that “there is always more to do” in terms of increasing cultural competence, and that “it requires relentless attention and on-going education.” This is evident through the ongoing training and efforts to serve minority youth in the system. Overall, cultural competence is an ongoing effort by stakeholders,

who must support this value because of the high percentage of minority youth in the system.

The value of Interagency Collaboration was, for the purposes of *Case Studies of System Implementation*, originally categorized as a factor related to system goals, not values. Upon examination of factors for inclusion of this analysis, the definition was re-analyzed for its content. Interagency Collaboration has been chosen as a factor related to system values, which is evident in the definition through the use of shared values, agency language, and a “willingness to learn” in the definition created by agency stakeholders.

The definition is as follows:

“Interagency Collaboration is described as the formal and informal System of Care processes that are key to Santa Cruz County's system development. Interagency collaboration promotes both structured and organic communication and embodies the willingness to learn and seek information about different child-serving agencies. Elements of interagency collaboration include shared values that are based on well-developed cross-system knowledge and are tied to community need. Interagency collaboration promotes joint training and strategic planning ventures. Interagency collaboration and commitment are constantly renewed through changing leadership. This collaboration recognizes that the various "dialects" or languages of agency reform are often consistent with each other, allowing reform efforts from mental health, Juvenile Probation, Child Welfare, and Special Education to be mirrored and supported by agency partners. This collaboration helps achieve the seamless integration of reform efforts within participating System of Care agencies.”

A thorough review of Santa Cruz documentation uncovers several examples of interagency collaboration, with a specific attention to understanding other agencies. Examples of inter-agency retreats are available through these documents, which are attended by various agency partners in an effort to learn more about one another and collaborate more efficiently. Respondents also emphasized the importance of setting aside personal ego. One common phrase cited in interviews was, “Leave your egos at the

door.” When agency partners come together, they focus on setting aside ego and promoting collaborative actions in order to serve youth and families. This commitment to interagency collaboration was evident at multiple levels of the system, from the administrative to the services level. These artifacts included jointly pursuing and administering grants to fund innovative services, creating cross-disciplinary service teams, co-locating staff across sectors, and creating opportunities for joint problem solving when differences in values or responses to families differed across agencies.

For Interagency Collaboration, the assumption is that it is “what we signed on for when we established our system of care, we spend a great deal of time meetings and working at integration,” according to one administrator. This quote reveals that there may be a tacit agreement by stakeholders to work together. Similarly, one theme emerging from the data was that this type of collaboration “is just the way things get done.” The assumptions underlying collaboration include “shared values” (as stated in the definition), as well as the “willingness to learn”, which is further suggested in the idea that different agency partners learn each others “language” or “dialect”, in an effort to improve collaboration. This evidence suggests that Interagency Collaboration is deeply entrenched in the Santa Cruz County system of care.

The system of care in Santa Cruz is guided by system of care values that bring various agency partners together to achieve their goals. As stated by one stakeholder “most people know and accept this as an underlying core value.” The definition created by stakeholders contains language that is reflected across their system of care [emphasis original]:

“System of care values is described as the shared mission adopted across partner agencies to support the original mission of keeping children

and youth *at home, in school, out of trouble*. In addition, the values incorporate new initiatives such as the Mental Health Services Act and Child Welfare Reform which focus on keeping children and youth *safe and healthy*.”

The artifact most tied to the system of care values are examples of language used by system stakeholders in the interview process. Without prompting, most agency partners reflected their work back to the idea that children and youth should be “at home, in school, and out of trouble”. The phrase is on agency brochures and around staff offices. It is evident from interview data that this phrase is clearly repeated and understood by staff, who attempt to link their work with children and families to the goal of keeping kids in the community safe in the home, in school, and out of trouble with the law. As stated on administrator, “We try to infuse those values with our staff... early on they coined the phrase ‘Keep kids at home, in school, out of trouble.’”

Also, agency partners are thoughtful about how these values tie in with system action. One probation officer stated, “We’ve moved away from the institutional response but really try to have a series of graduated responses that are in the community with keeping the kid *at home* [emphasis added].” Similar quotes reflect that these goals guide services for children and families.

System of Care Values are accepted as a fundamental core value of the system. One program manager stated, “These values exist throughout the system. We really believe in the mission—both clinically at the services delivery level and fiscally at the administrative level.” Many stakeholders responded similarly, stating that system of care values “incorporate the entire system,” but that they “need constant maintenance to keep all agencies collaborating.” The data indicate that the values of system of care are

present in Santa Cruz, and stakeholders are cognizant of system goals when designing services within the system of care.

Connected to system of care values in Santa Cruz was the value of Willingness to Change. One program manager stated, “With the core belief in system of care, being flexible and having a ‘whatever it takes’ philosophy keeps us going.” This flexibility is described in the stakeholder definition of Willingness to Change:

“*Willingness to Change* is described as the creativity, flexibility, and ‘whatever it takes’ attitude of staff in providing the best care possible within a ‘wraparound philosophy’ focused on family needs and strengths; continuous development and system expansion, including a focus on practical application of system of care values and principles; maintaining adequate supervisory and support structures to keep the System of Care robust and vibrant; and incorporation of new literature and training on Evidence-based Practices and reform principles within participating agencies.”

The documentation and processes in Santa Cruz are indicative of a culture that changes and adapts to local needs. One previously mentioned example is that of training on cultural competence, which they have increased to meet the ever-increasing needs of serving Hispanic youth and families. In interview data, administrators noted that they continuously search for funding opportunities and work across departments toward achieving system change.

Stakeholders in Santa Cruz felt there was a “shared understanding of the importance of change” and also that “it is second nature.” The assumption of the willingness to change is that being creative and flexible allows providers to provide ‘the best care possible’ (from the definition). Another assumption underlying this willingness is that the various collaborating agencies in Santa Cruz are open to the idea of system of

care values and the ‘whatever it takes’ attitude. “All agency cultures demand it,” said one policy maker in Santa Cruz. Again, the Willingness to Change in Santa Cruz appears deeply entrenched in their organizational culture, allowing stakeholders to respond to varying changes in community needs.

Westchester County Community Network Site Profile

“We liked the community organization piece because it led to natural cultural competence. If you’re gonna build something in a community, it’s gonna have the people in it...ideas in it that reflect that community.”

- Administrator, Westchester County Community Network

Westchester County, New York is 1,295 square miles and is the county located north of New York City. Westchester County has a population of approximately 920,000 people (U.S. Census Bureau, 2000c). The Westchester County Community Network has community networks in ten communities around the county, including Eastchester, Lakeland, Mount Vernon, New Rochelle, Peekskill, Port Chester, Whites Plains, and Yonkers. Each of these communities is diverse, in terms of racial/ethnic composition, income, and community priorities for children’s mental health.

Suggested artifacts, values, and assumptions of the organizational culture of Santa Cruz County’s system of care are presented in Table 6.

Table 6. *Westchester Results*

Artifacts	Values	Assumptions
The network structure	Community Organization Model	System must be adapted to various community context.
Narrative of the leader who started the first network; Family members as leaders.	Leadership	Leadership should be shared.
Strength-based at all system levels.	Shared Values & Goals	Necessary to drive the system, but not universal yet.
Various responses to local challenges and issues.	Courage to Change	Stakeholders agree to face challenges together.

This diverse urban landscape is similarly reflected in the structures and culture of the system of care. The values identified in the factors created by the Westchester Community Network were: *Community Organization Model*, *Courage to Change*, *Leadership*, and *Shared Values and Goals*. Providing services across a diverse county are reflects in many of the values of the Westchester County Community Network, and the community organization model strongly reflects the response to this local diversity.

Westchester County's community model can be seen as a response to the local context. The system of care structure includes ten separate community centers that function within a county that has many diverse needs. This structure allows the system to respond to problems and challenges at the community level. More than a structural design, inherent in this model are several values critical to the system, including the belief that the community is responsible for responding to these needs. It was defined as:

“The *Community Organization Model* is central to Westchester County's system of care. It refers to a strong belief that the community has responsibility for its children and families, and that communities, organized at many levels including the Network level, are key to the success of children and families at high risk/high need. “Wraparound” and all of the other system of care concepts are built on this framework. While the Network model is Westchester's “creative step,” it is based on this underlying belief in the power of community and although the model had been replicated elsewhere, it is truly unique to the system of care in Westchester County.”

The very physical structure of the system of care is a manifestation of value of community organization. There is an ongoing engagement of all partners in community-based problem solving around specific issues. Anyone is able to call a network meeting (at one of the ten community centers around the county), which creates flexibility in response to local concerns. This organization around local networks allows system

stakeholders to be responsive to small sectors of the county that have very different needs. An example of this local problem solving is that of fire-setting youth within a particular community, in which the local community partners were able to mobilize quickly to assess and then address the issue with additional training, services, and supports. Partnering with the local fire department to address fire-setting issues with youth illustrates a strong example of this community organizing. The example of the response to fire-setting youth is evidence of the value of community organizing. This is directly tied to the belief reflected in the definition of Community Organization Model, that “the community has responsibility for its children and families”.

A few assumptions underlie this value of community organizing. The first is the assumption that the system must be adaptive at the community level, given the stark demographic differences between communities within the county. As stated in the definition, the assumption is that “communities, organized at many levels including the network level, are key to the success of children and families.” This assumption is perhaps the most fundamental to the system of care, as it creates the culture and structure necessary for the system to operate.

The other assumption embedded in this value is that of community responsibility. As cited in the definition, it “refers to a strong belief that the community has responsibility for its children and families.” As one administrator noted, “Community organizational is really saying to an entire community, ‘You’re all responsible.’” This was a consistent sentiment throughout all levels of the system, with one case manager remarking, “We’re all responsible. I feel we’re all responsible in making it work.” As

evidenced by these data, this assumption of community responsibility is held by system stakeholders across levels of authority.

The Courage to Change in Westchester County was closely tied to values apparent in the Community Organization Model. The definition of Courage to Change strongly involves the notion of the community facing challenges together. The definition for Courage to Change is as follows:

“Courage to change refers to willingness to “take the system to the next level” and collaborate with one another to effect change, being unafraid to speak openly and honestly about what does or does not work. It also involves taking steps backward or “stopping the action” when necessary. Partners make an implicit agreement to face challenges together, take risks to achieve goals, and support one another throughout the process. Having the courage to change means willingness to create new solutions and think “outside the box.” They share a belief that the system is a dynamic process and that it must change and grow to be vital. Data is used to refine the issues, engage families in the process, bring together system partners, and foster the growth and development of the system in order to bring about needed change.”

Artifacts for this value include, as evidenced in the definition, the use of data to bring system partners to the table. One salient example was that of truancy at one of the communities. Community data showed that truanancies were high in this community, specifically because it was not reported until a high number of truanancies was reached for a particular student. A large community network was called, in which community members, system stakeholders, and school representatives came together to change the way in which truancy was reported by the schools. The data further indicated that this helped to resolve the issues of high truanancies. Many stakeholders through interviews cited this as a narrative example of a community coming together to create change. The artifacts that indicate that the Courage to Change is closely tied to the Community

Organization Model, as the system responds to challenges and changes in an organized manner.

For Courage to Change, the data indicated that it was a constant process, and inherent in the definition is the agreement of stakeholders to face challenges together. The Courage to Change was cited by stakeholders as “what makes the system work” and a “constant process”. An assumption is also found in the definition of the value, as “an implicit agreement to face challenges together, take risks to achieve goals, and support one another in the process”. This indicates that at its very basic level, the Courage to Change is an implicit value of the Westchester Community Network.

In the Westchester Community Network, the value of leadership was striking in that the notion of leadership is shared across agencies and systems. More importantly, data indicate that families participate in this shared leadership. Leadership in Westchester is defined as:

“Leadership within the Westchester Community Network began with one charismatic leader who exhibited energy, a sense of purpose, and the ability to communicate well. This leader strategically hired some like-minded people, and this core group, which continues to exist, became a leadership “think tank.” Leadership within the system is based its vision, on shared principles and values, and continues to communicate a sense of purpose and future possibilities. The leadership in the county is enthusiastic, energetic, and pragmatic and strongly believes that leadership must be shared across agencies and systems. This shared leadership is identified, recruited, and supported on every level and from every system.”

The definition of Leadership pointed to one “charismatic leader”, and stakeholders were quick to articulate stories about this leader at the creating of the first of the ten community networks in Mount Vernon. A sentiment reflected in interviews was that “it was her vision and connections that really started the whole process.” Despite the

focus on this one leader, data indicates that leadership is shared and accessible. The processes in Westchester indicate that leaders are brought up through the system-stakeholders in leadership positions provide narratives of working at the ground level as case managers.

Another clear notion of the culture of leadership that was often articulated by case managers and line level staff is that of family members as leaders. This is also a visible structure. At family meetings, family members are positioned at the “head of the table” which makes it visible that they are not merely participants in the process, but are leading it. “Sometimes, being a professional, the families look to us as leadership,” noted one case manager, “but I look at the families as leadership. Because they know the real needs of their family and they have been doing it, and they will continue to do it when we’re gone. Sometimes they may not think so, so it’s up to us to encourage and promote that.” Observational data indicates that these processes are evident at the child and family level.

The assumption uncovered for leadership is that “there is a very broad view of leadership” and that leadership is “shared”. Another critical assumption noted by system stakeholders is that leadership should be responsible for developing and fostering both Courage to Change and Shared Values and Goals. “I think the Courage to Change comes from the leadership,” noted a school advocate in the Westchester County Community Network. “Leadership has to create those shared values and goals,” noted one administrator. Again, this is consistent with the notion that leadership is responsible for creating and disseminating cultural mores (Anderson, 2002; Schein, 2004).

The Shared Values and Goals of the Westchester Community Network were found by stakeholders to be “apparent pretty much on a daily basis.” The definition of

Shared Values and Goals articulated by system stakeholders goes beyond traditional system of care philosophy to place emphasis on strength-based approaches, as well as “social justice goals”, defined as the goal of helping children and families succeed within their communities. The definition was described as:

“The System of Care in Westchester County is based on a slowly and carefully built shared vision which is grounded in core values and articulated across partners. In the Westchester Community Network, *Shared Values and Goals* are collectively agreed upon, clearly articulated, and take continuous effort. A constantly restated values base provides continuity of mission across agencies, providers, and communities that includes commitment to individualized care and serving children and families within the community. The values base is aimed at meeting social justice goals—the success of youngsters who would not otherwise achieve success—and includes strength-based approaches to both families and systems.”

The most strongly visible artifacts related to this value evidenced the value of “strength-based”, which was evident, as stated in the articulated value, at all levels of system implementation. The system is genuinely strength based, in that partners’ strengths are identified and utilized to best serve children and families within the county. At family and team meetings, the strengths of the families are clearly posted on large pieces of paper that adorn the walls during family meetings. At the training site for wraparound case management, posters on the wall remind employees that the strength of the family should always be articulated before problems. At system-level meetings, the first thing shared by members are successes. Strikingly, at meetings observed by the research team, leaders present at the meeting reminded system members dealing with a particularly challenging issue, “We celebrate the small successes.”

Many stakeholders reported in interviews that the shared values and goals were among the most important factors of system implementation. Shared values and goals

were described by respondents as “the heart and soul of the work” and provide a “road-map” of the system. The data indicates that the shared values and goals of the system truly are shared, and the assumption is that even though “they’re not universal yet,” according to some interview respondents, “the values base is becoming more common across systems on federal, state, and county levels.”

Chapter 5

Discussion

Schein's Model of Organizational Culture

Schein's model of artifacts, values, and assumptions allows us to understand some key components of organizational culture in children's mental health systems of care. This model adequately explains organizational culture in systems of care, and fits the data that were analyzed. The model explains some of the components and processes of organizational culture in systems of care, but fails to explain all of these phenomena. Primarily, it fails to explain the processes of a value being manifested in an artifact, or how assumptions emerge as values.

The model explains that artifacts both reflect and reinforce the values in the system of care. A salient example of this was in Region 3, where the co-location of staff and acknowledgement that the only difference between staff members of various agencies was who signs the paycheck. These artifacts, while demonstrating a reflection of the value of collaboration, serve to reinforce the value. Another example of artifacts reinforcing the values is that of the phrase "At home, in school, out of trouble," the oft quoted mission statement of Santa Cruz County. This phrase reflects the values of the system, but also reinforces the mission as system stakeholders hear or see the statement.

These examples serve to highlight the usefulness of organizational artifacts, as systems can create structures and processes that are reflective of their core values. Co-location is more than just evidence of collaborative relationships, but serves as a strategy to nurture collaboration. It is a strategic process that helps to strengthen this value. In

the example of Santa Cruz's training on cultural issues, while an artifact of the value of cultural competence, targeted training serves as a concrete strategy to increase stakeholder's capacity to perform work in a culturally competent manner.

Given that structures and processes were created by stakeholders that reinforce system values, their role as organizational artifacts should not be overlooked. Although they may not fall into what might be considered a cultural artifact (like language, artwork, or logos), these structures are created to reinforce an organization's values.

Language as an artifact was highly available in the data. Although this may result in part because of the nature of narrative data (interview transcripts, self-report, observations), language may be critical to transmit complex values within an organization. Santa Cruz County, as an example, places a great deal of emphasis on the understanding of interagency 'language' and has determined the study of agency lingo a precursor to their value of effective collaboration.

The question remains, however, do assumptions and values have to translate into strongly defined artifacts? Although many of the artifacts in this study 'fit' with the value, identifying or aligning an artifact with a specific value could be challenging. Artifacts, as described by Schein, are the easiest elements of culture detectable by an outside researcher, and some of the examples found through the analysis of these data include examples that were harder to uncover (language in interviews, survey data). The most difficult values to align with artifacts are those that are described as "the heart and soul of the work" or "just the way we do things". Things like system of care values, responsiveness to change, and leadership seem to exist on a level that's closer to assumptions, those tacit rules that guide behavior in an organization.

Using this model to uncover data on organizational culture in systems of care allowed for the discovery of common elements at the three sites. Generally, the assumptions and values were most common across sites, with artifacts being highly variable across sites.

Other Models

Schien's model, though multidirectional, is not very dynamic. This makes it more difficult to place in the context of a system of care. Other models are more dynamic, and focus more on the processes on how an assumption translates into value, and how values are then observable as artifacts (see Hatch, 1994).

Another possible approach to the analysis of the organizational culture at all three of these system of care sites could be informed by Joanne Martin's three perspectives of organizational culture (1992). The *integration* perspective of organizational culture is the idea that the system members are focused on shared values and are relatively homogenous within the system of care culture. If the integration perspective were to hold true, then members of the various child-serving agencies within a system of care would share the values of a system of care, regardless of their parent agency. This perspective would hold for these long-standing system of care sites, but perhaps not a community that was just beginning to integrate agencies. For this type of environment, Martin's *differentiation* perspective might hold true: that there are many differences in organizational culture, and the beliefs that are espoused by stakeholders would not be strongly evidenced by any cultural artifacts.

Cross-Site Themes

The common themes that emerged around the notion of organizational culture were strong at these three sites. Cross-site analysis revealed evidence of pervasive cultural values at all three.

A few strong findings emerged from the data that warrant further exploration. The examination of systems of care via Schein's model, (artifacts, values, assumptions) lead to a deeper understanding of the organizational culture of systems of care. The following five hypotheses were generated from cross-site analysis of the data. Any of these findings can and should be further investigated in relation to organizational culture in systems of care.

1. System of care culture is based on the values and principles created by Stroul & Friedman (1986; 1994)

All sites identified a value-based implementation factor specifically related to the values and principles of a system of care (*Shared Vision* in Region 3, *System of Care Values* in Santa Cruz, and *Shared Values* and *Goals* in Westchester). Furthermore, other value-based implementation factors have embedded in their definitions system of care values and principles as outlined by Stroul and Friedman (1994). For example, in Region 3, the definition of *Family and Youth Participation* is driven by the goal of “family/driven/youth guided care”, which is an explicit system of care value. In Santa Cruz, *Cultural Competence* describes another system of care value. In Westchester, *Leadership* is based upon “shared principles and values.”

Although this finding is not surprising, since systems of care are supposed to be based on system of care values and principles defined by Stroul and Friedman. that outline these systems, the results indicate that they are present in system of care culture.

Also, this follows Schein's idea that shared values are frequently identified as an important aspect of an organization's culture (Schein, 1985, 1990, 2004).

2. System of care culture includes a willingness to change.

All of the study sites defined a factor related to change, which included a specific willingness to change the system in the face of challenges or growing needs (*Responsiveness to Change* in Region 3, *Willingness to Change* in Santa Cruz, and *Courage to Change* in Westchester County). Despite differences in titles, factors at all three sites identified a "willingness" of system stakeholders to create change. Further, the assumptions underlying this concept of change were identified as 'second nature' and there was 'no other way' to do system of care work. The concept of change at these sites was reflective of their adaptability to various local contexts, including population, issues of concern, and funding demands. Of all of the findings related to organizational culture, 'change' appeared to be the most inherent and tacit for system stakeholders.

3. System of Care culture is adapted to local context

One of the most striking findings is that of the research sites' ability to adapt to varying contexts. This includes how organizational culture at the system of care sites reflects the needs of each community. Systems of care are supposed to be 'community-based', with services and decision making resting at the community level (Stroul & Friedman, 1986, 1994). The adaptation of local context is strong evidence that the systems investigated for this study are grounded within their communities.

For Region 3, the value of *Collaboration* was identified as critical for success within a rural/frontier environment. This is not to say that collaboration is not a value in the other systems, but was explicitly tied to the rural culture of the Region. Due to a lack

of resources and manpower in this community, the need to share resources was found to be critical. In Santa Cruz, *Cultural Competence* was a value with strong roots in the community. In a system where more than 25% of the local population is of Hispanic origin, and approximately 45% of youth served in the system are Hispanic origin, cultural competence is critical to access and appropriateness of services. Again, cultural competence was not exclusive to Santa Cruz (Westchester County also does extensive work in adapting services to fit with cultural needs of their population), but was found to be most evident in their organizational culture.

In Westchester, the *Community Organization Model* was the value most closely tied to the context of their system of care, as the county has varying communities with sharply different population needs. The ten “networks” across the county served populations with vastly different socioeconomic, racial, and ethnic populations. The underlying assumption of this value was that the Westchester system has to adapt to these unique communities across the county. Of the three systems examined in this study, Westchester County was perhaps the most adaptive, as the adaptation was a necessity at not only a system level, but at the individual community level as well.

Because systems of care are intended to be community-based, it is not surprising to see the adaptation to local needs. But it can be observed that in the cases of these three systems, specific structures and processes were put into place to be proactively adaptive to community needs.

4. Shared leadership is critical to culture, but not person-specific.

Leadership, often a critical factor in system implementation, is said to be closely tied with organizational culture (Schein, 2004). Leadership was prominent in the sites,

but the data suggests that organizational culture was not dependent upon this leadership. According to a leader in Westchester, “I look at creating a culture and climate that’s not dependent on me. You wanna promote a culture that’s gonna continue.” This sentiment accurately captures the place that leadership plays in the cultures of these organizations. Though a value, leadership in and of itself should not be responsible for creating a culture. Rather, a strong leadership should be values within an organization, with the understanding that leaders within an organization are responsible for promoting the values of an organization.

5. Collaboration underlies many values of culture

Collaboration was specifically defined as a value in both Region 3 and Santa Cruz, but collaboration was also evident in Westchester County, though not specifically identified as a value by system stakeholders. Collaboration in Westchester County was evident in the *Community Organization Model*, as implicit in that value is the community working together to serve children, and it is also evident in the *Courage to Change*, which also refers to system partners willingness to “Collaborate with one another to effect change.” What is most interesting about collaboration is that the artifact of collaboration (co-location) was evident at all three sites, to various extents. Collaboration requires partners to share a responsibility of the system (Anderson, McIntyre, Rotto, & Robertson, 2002), and also collaboration is considered crucial for the development and sustainability of systems of care (Chorpita & Donkervoet, 2005). Given the barriers to collaboration that are often present in service systems, including mindsets, bureaucracies, and the location of services (Anderson, McIntyre, Rotto, & Robertson, 2002), a culture of collaboration may be the very thing that helps sustain a system. Future study is

necessary to understand the importance of a cohesive organizational culture in systems of care.

Emic/Etic Approach

Both emic and etic approaches were used in this study. An emic element is information or narrative that comes directly from the culture that is studied (Harris, 1976). In this case, the definitions that were generated at each site were emic, meaning that the stakeholders developed these factors and definitions. Researchers use emic accounts when trying to understand local meaning (in this case, the local implementation factors) (Harris, 1976). These factors were then classified into the four different categories by the RTC Study 2 research team. The etic approach to these data was done in order to facilitate comparative cross-site analysis. The distinction and use of both emic and etic approaches was useful in the comparison of the community-based systems with differing contexts.

It can be difficult to thoroughly compare the locally-identified factors created by system stakeholders. The factors should not be considered static. The importance and relative emphasis of each factor and its component parts changed over time as the systems developed and as they continue toward sustainability. Also, because the factors were emic, it's possible that across sites, they could be classified similarly by an external researcher. As an example, Courage to Change, Willingness to Change, and Responsiveness to Change are all describing a similar value. Because these definitions were etic, they were all labeled differently by the communities. The researchers of the Study 2 team have determined these to be different names for the same factor. As

another example, the Community Organization Model of Westchester County, as previously stated, could be Westchester County's version of collaboration.

Another caveat of these definitions is that they are multi-layered and comprised of many component parts. As an example, Leadership in Westchester County has components of system of care values in its definition. For Santa Cruz County, Interagency Collaboration includes leadership and shared values as component parts. Upon closer inspection, the definitions created by sites highlight the complexity and interplay of values, and how these values are connected to each other (for a more detailed analysis of factor definitions, see Ferreira, Hodges, Kukla-Acevedo & Mazza, 2008).

Table 7. *Cross-Site Results*

	Artifacts	Values	Assumptions
Region 3, Nebraska	Co-location; “paycheck”	Collaboration	Required for success in rural environment.
	“Three-legged stool”	Family & Youth Partnerships	Critical to system success.
	The Chili Story.	Leadership	Required for the shared vision; everyone is a leader.
	All stakeholders able to articulate a shared vision.	Shared Vision	SOC principles benefit children and families.
	Adapting the EICC from the ICCU	Responsiveness to Change	There is no other way to function.
Santa Cruz, CA	Collaboration with Hispanic organizations; literature in Spanish; training and education on cultural issues.	Cultural Competence	Critical because of the high Hispanic population.
	Emphasis on understanding ‘language and dialects’ of various agencies; collaborative efforts.	Interagency Collaboration	Necessary to seamlessly integrate services for children and youth
	“At home, in school, out of trouble”.	SOC Values	Accepted as an underlying core value to keep children in the community.
	Continuous development and system expansion.	Willingness to Change	Change is required for sustainability..
Westchester, NY	The network structure	Community Organization Model	System must be adapted to various community context.
	Narrative of the leader who started the first network; Family members as leaders.	Leadership	Leadership should be shared.
	Strength-based at all system levels.	Shared Values & Goals	Necessary to drive the system, but not universal yet.
	Various responses to local challenges and issues.	Courage to Change	Stakeholders agree to face challenges together.

Limitations

This research study was secondary qualitative data analysis of previously collected information, in which research questions, and therefore interview questions and research protocols were not related to organizational culture. However, because the study was centered on implementation, evidence of organizational culture at all three levels was still uncovered, and no substantial questions were unanswerable due to a lack of data.

The study only included 3 cases of established systems of care, so results may not be generalizable. The three cases that were selected for analysis were highly variable and provide data for contexts that vary in terms of population, community variability, and system structure. Also, there were no data available to compare with the established sites. An examination of the extent to which organizational culture is observable at less-established systems would offer a helpful comparison.

Suggestions for Future Research

Given that Schein's model does not thoroughly explain the processes by which organizational culture is created and reinforced, future studies should apply more dynamic and complex models to the study of organizational culture in systems of care. Although the model may easily be applied to single agencies and organizations, systems of care are coordinated arrays of services that involve the interaction and collaboration of various agencies and providers, often with conflicting mandates and organizational processes.

The hypotheses generated from this study should be tested. The hypotheses from this study indicate the following: system of care culture is driven by values and principles defined by Stroul & Friedman (1986, 1994), it is adapted to fit the context of the local community, the culture must be one of a willingness/responsiveness to change, a system

of care culture must be championed by leadership, and collaboration is a critical component of system of care culture.

A longitudinal study of how organizational culture emerges in a developing system of care might provide more insight into how the different of levels of culture emerge over time. Future study may also include examining how close or distal individual agency employees (from child welfare, juvenile justice, education) are from the larger system of care culture. An understanding of how members of various child-serving agencies “assimilate” into the system of care culture may also provide insight for stakeholders that are attempting to develop a value-based system.

Conclusion

Stakeholders within the system of care communities of this analysis of organizational culture were chosen for their ability to serve youth with SED and their families. Stakeholders within these systems challenged and encouraged each other to work toward the goal of improving outcomes for children and families. All of these systems were well-established (operating ~20 years). The larger purpose of this research study was to further understand how successful systems of care develop and sustain themselves.

The analysis of the organizational culture of these communities offers insight into what values are most critical to system of care functioning. The complexity of how communities come together to form a system of care with a unique culture warrants further exploration through the use of other models and research methods.

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Appendices

Appendix A: Semi-Structured System Implementation Interview Guide for RTC Study

2: Case Studies of System of Care Implementation

Historical Development of System of Care

- 1) Please tell me a little bit about the history of your system of care and your role in the process of developing or implementing it.
 - Initial context
 - Triggering conditions
 - Identifiable change agents
 - Foundational strategies
 - Mid-course changes or realignments
- 2) How would you describe the population of children and youth with serious emotional disturbance and their families in your community?
 - Clear identification of who the system is intended to serve
 - Issues of context or need specific to this community
 - Change over time
- 3) What goals does your system have for this population?
 - System of care values and principles
 - Change over time

Identification of Factors Affecting System of Care Implementation

- 4) What strategies have been used to develop a system of care that can serve the needs and achieve its goals for children and youth with serious emotional disturbance and their families?
 - Fundamental mechanisms of system implementation
 - Structures/processes related to networking, access, availability, administrative/funding boundaries
 - Center's identified factors
 - Participant's role or contribution
- 5) What strategies do you think have most affected the implementation of your system of care?
 - Clear definition of the named factor from perspective of participant
 - Center's conceptualization of factors
 - Articulation of why this factor has had such an effect
 - Participant's role or contribution

Relationship among System Implementation Factors

- 6) How have staff and stakeholders been involved in implementation of your system of care? Are there certain groups of staff and stakeholders that have been key to the process?
 - Collaboration across agencies
 - Leadership
 - Governance
 - Direct service
 - Family involvement
 - Evaluators
- 7) Do you think any of the strategies you identified were more important or fundamental than others?
 - Remind participant of factors he/she has identified
- 8) Do you think the strategies you identified worked best because they happened in a certain order?
- 9) Are there strategies that worked best in combination with other strategies?
- 10) How has the process of system implementation been communicated to staff, stakeholders, and the community?
- 11) What would you change about the process of implementing your system if you could do it again?
- 12) What strengths and successes do you associate with implementing your system of care?
- 13) What challenges do you associate with implementing your system of care?
 - Conditions that impede system development
 - Strategies designed to meet the challenges
- 14) What kinds of information do you get about how the system of care is performing and how do you use it?
 - Achievement of system goals and outcomes
- 15) Describe any mechanisms that have been developed to sustain your system of care.
- 16) Is there someone else who would be important for us to talk to, to help us understand the implementation of your system of care?
- 17) Is there anything you would like to add to this interview?

Appendix B: Local System Implementation Factors

Region 3, Nebraska

Collaboration is described as a process that involves relationships and partnerships with families, providers, child/family serving entities and other leaders. It is characterized by a commitment to shared vision, and mission and support by all participants to system of care objectives. Collaborators have mutual respect for one another's roles and responsibilities. They leverage, share and maximize resources and also share responsibility and accountability. Collaboration involves a commitment to learning and providing educational opportunities for system partners.

Family and Youth Participation is described as an important process through which the roles of families and youth are integrated within the system. In these roles, family and youth participants are involved in all critical aspects of the system including service delivery, planning, implementation and evaluation. Families and youth are valued as participants in the system and their involvement allows other stakeholders to understand the importance of family voice, choice, and leadership in the organization. Family and youth participation is facilitated by a strong family organization. The expressed goal of family and youth participation is family driven/youth guided care.

Leadership is described as a process that supports a strong and shared vision among empowered stakeholders including agencies, families and providers. Leadership is based on a strong commitment to the values, goals, and mission of the system of care and a belief in the system's ability to achieve results. Leadership facilitates the sharing of authority and responsibility, and it fosters a vision for the future and an understanding of how to get there. Leadership is characterized by all system stakeholders accepting and having the power to carry out their responsibilities.

Resource Commitment is described as a key support for system implementation that includes access and availability of quality staff and providers, continual skill development, knowledge of financing mechanisms, understanding how to use existing dollars more efficiently, and availability of state and federal funding support. In addition, the commitment of resources includes the effective use of cost data to monitor and assess the results of system efforts and successfully plan program implementation.

Responsiveness to Change is described as innovation as well as the willingness to adjust planning and implementation based on the system's experiences. Innovation is reflected in the ability to combine models and try new approaches to service delivery and system design. The flexibility to adjust planning and implementation is created by the availability of constant feedback and the willingness to take action on feedback given. Processes that support constant feedback include meetings at all levels and across all parts of the system and 360° feedback loops. This responsiveness includes being open to changes that provide funding opportunities.

Shared Vision is described as a strong desire to achieve better outcomes for children and families that is based on a common belief that system of care principles will benefit children and their families. This shared vision also includes building upon modes of service delivery that are aligned with system of care values and principles including access to community-based services throughout rural and frontier regions of the system, implementation of promising practices and evidence-based care, and using the wraparound approach to deliver services and supports. Stakeholders describe a determined effort to communicate this vision.

State-Level Support is described as a key aspect in system of care sustainability and is characterized by patience and persistence in the development of a shared understanding of perspectives and needs and a mutual effort to problem solve. The state provides financial support to the local system of care and recognizes the cost effectiveness of a system of care approach.

Santa Cruz County, California

Braided Leadership is described as the informal System of Care governance structure that supports the interagency System of Care mission, outcomes, and fiscal development. Elements of braided leadership include that the System of Care is included in individual agency mission statements. This allows the System of Care values to be maintained despite changing state-level commitment. Braided leadership also involves sharing resources and risk as well as shared problem solving. A shared fiscal focus and the use of “braided funding” approaches is an important aspect of braided leadership. This collaborative approach to leadership allows partner agencies to work strategically in the planning and implementation of services while maintaining their individual agency identities and roles.

County-Level Support is described as a local willingness to support funding for the system of care. This support is grounded in values but also based on the achievement of consistent program and fiscal outcomes. County-level support manifests in continued program support through various challenges and opportunities as well as ongoing investment in children and families.

Cross-System Expertise is described as a willingness to engage in cross-system learning; an ability to integrate the fiscal and clinical knowledge in specific individuals/groups that is necessary to create and sustain programs; a willingness to understand the “department languages and cultures” of participating agencies; and a willingness to understand differing contexts across agencies and levels of the system.

Cultural Competence is described as a core value of the System of Care, manifesting in strategic interagency processes to promote culturally relevant and sensitive services at all levels of the system. It includes an evolving focus on underserved and inappropriately served populations, and a responsiveness to changing populations, including specific change-efforts in key departments (e.g., Disproportionate Minority Confinement efforts to reduce overrepresentation of minority youth in detention; Outreach and Engagement

efforts through the Mental Health Services Act to Latino youth and families; an extensive training and education focus on cultural issues).

Family, Youth, Community Partnerships is described as increasing involvement of family and youth leadership at all levels of the system, as well as the increasing involvement of community-based agencies and other community partners in creating healthy pathways into the community for families and youth who are often stigmatized and disenfranchised.

Interagency Collaboration is described as the formal and informal System of Care processes that are key to Santa Cruz County's system development. Interagency collaboration promotes both structured and organic communication and embodies the willingness to learn and seek information about different child-serving agencies. Elements of interagency collaboration include shared values that are based on well-developed cross-system knowledge and are tied to community need. Interagency collaboration promotes joint training and strategic planning ventures. Interagency collaboration and commitment are constantly renewed through changing leadership. This collaboration recognizes that the various "dialects" or languages of agency reform are often consistent with each other, allowing reform efforts from mental health, Juvenile Probation, Child Welfare, and Special Education to be mirrored and supported by agency partners. This collaboration helps achieve the seamless integration of reform efforts within participating System of Care agencies.

System of Care Values is described as the shared mission adopted across partner and community agencies to support the original mission of keeping children and youth at home, in school, out of trouble. In addition, the values incorporate new initiatives such as the Mental Health Services Act and Child Welfare Reform which focus on keeping children and youth safe and healthy.

Willingness to Change is described as the creativity, flexibility, and "whatever it takes" attitude of staff in providing the best care possible within a "wraparound philosophy" focused on family needs and strengths; continuous development and system expansion, including a focus on practical application of system of care values and principles; maintaining adequate supervisory and support structures to keep the System of Care robust and vibrant; and incorporation of new literature and training on Evidence-based Practices and reform principles within participating agencies.

Westchester County Community Network, New York

The *Community Organization Model* is central to Westchester County's system of care. It refers to a strong belief that the community has responsibility for its children and families, and that communities, organized at many levels including the Network level, are key to the success of children and families at high risk/high need. "Wraparound" and all of the other system of care concepts are built on this framework. While the Network model is Westchester's "creative step," it is based on this underlying belief

in the power of community; and although the model has been replicated elsewhere, it is truly unique to the system of care in Westchester County.

Courage to Change refers to willingness to “take the system to the next level” and collaborate with one another to effect change, being unafraid to speak openly and honestly about what does or does not work. It also involves taking steps backward or “stopping the action” when necessary. Partners make an implicit agreement to face challenges together, take risks to achieve goals, and support one another throughout the process. Having the courage to change means willingness to create new solutions and think “outside the box.” They share a belief that the system is a dynamic process and that it must change and grow to be vital. Data is used to refine the issues, engage families in the process, bring together system partners, and foster the growth and development of the system in order to bring about needed change.

(Family & Youth Movement) The development, nurturance, and full investment in the viability of a free standing, independent family organization is viewed as critical to the system of care in Westchester County. It is described as a reciprocal relationship between the family organization and government, in which power is shared with families and there is a level of trust between the two groups. The family organization has greatly expanded over time, has a very solid fiscal base with diversified funding, and is integral to policy development, program planning, direct service, training and evaluation. Family resource centers throughout Westchester serve as “hubs” for the system of care. Westchester’s youth organization is an independent organization that emerged from the family organization and is mentored by a local mental health and community service organization. The family and youth movement components have numerous shared activities including participation in system level meetings, community meetings, and powerful planning committees.

Leadership within the Westchester Community Network began with one charismatic leader who exhibited energy, a sense of purpose, and the ability to communicate well. This leader strategically hired some like-minded people, and this core group, which continues to exist, became a leadership “think tank.” Leadership within the system is based its vision, on shared principles and values, and continues to communicate a sense of purpose and future possibilities. The leadership in the county is enthusiastic, energetic, and pragmatic and strongly believes that leadership must be shared across agencies and systems. This shared leadership is identified, recruited, and supported on every level and from every system.

The System of Care in Westchester County is based on a slowly and carefully built shared vision which is grounded in core values and articulated across partners. In the Westchester Community Network, *Shared Values and Goals* are collectively agreed upon, clearly articulated, and take continuous effort. A constantly restated values base provides continuity of mission across agencies, providers, and communities that includes commitment to individualized care and serving children and families within the community. The values base is aimed at meeting social justice goals—the success of youngsters who would not otherwise achieve success—and includes strength-based approaches to both families and systems.